

## Understanding Payment Denial Reasons



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If your payment denial letter states this:	This is the expanded explanation:
The DOS is outside of approval period	The date(s) of service occurred either prior to the patient's approval period started or after the patient's approval period ended.
Request was submitted 120 days after DOS	Reimbursement requests must be received at HealthWell within 120 days from the date of service. We will not process or pay requests that are submitted after 120 days from the date of service.
The charges submitted are ineligible	The request is for charges that are not eligible for reimbursement under the program. Such charges include medical procedures, supplies and equipment, office visits, x-rays, radiation, transportation, laboratory, pharmacy dispensing fees, and diagnostic tests.
The medications submitted are ineligible	The request is for drugs that are not eligible for reimbursement under the program.
The insurer paid 100% of charges	The patient's insurance paid 100% of the allowable charges for eligible medication(s). The patient has no out of pocket cost and therefore, does not require payment from HealthWell.
The insurer paid \$0; we cannot assist	The patient's insurance did not pay for any portion of the eligible medication(s). HealthWell is a copayment program that provides assistance only when the insurer pays for a portion of the medication(s) FIRST.
The EOB shows no patient responsibility	There is no patient responsibility for this date of service and therefore, does not require payment from HealthWell.
This request has already been processed	The request is a duplicate request and has already been submitted, processed, and possibly paid.
Assistance type and request do not match	The patient was approved for copayment assistance and the payment request is for premium assistance. OR The patient was approved for premium assistance and the payment request is for copayment assistance.  If you are interested in changing assistance type, please contact us for additional information.
This patient is not approved; no grant	The patient is not approved in our program. The patient needs to go online or call to begin the approval process.
We cannot reimburse on this grant yet	We are missing key information before we can begin reimbursing on this grant. Missing information may include: <ul style="list-style-type: none"> <li>○ Statement of Treatment</li> <li>○ Front and back copies of Insurance and Pharmacy Cards</li> <li>○ Other grant approval documentation (e.g., premium assistance)</li> </ul>

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The patient is not approved in this fund	The patient is not approved in a disease fund that covers these treatments.
The EOB has not been submitted	We require an insurer-issued EOB in order to process a reimbursement request.
The EOB/patient costs are unclear	The information provide on the EOB is unclear, specifically, the patient's responsibility.
Other required documentation is missing	Other payment documentation is required before we can process reimbursement. Other documentation can include: <ul style="list-style-type: none"> <li>○ Receipt or screenshot from the pharmacy</li> <li>○ Proof of payment</li> <li>○ Premium documentation</li> </ul>
The grant is exhausted; partial payment	The patient has reached the fund cap. We are unable to pay the remainder of the request because the patient's grant has been exhausted. The patient is welcome to re-enroll in December.
The grant is exhausted; no payment	The patient has exhausted the grant. We are unable to pay this request. The patient is welcome to re-enroll in December.
The grant is inactive; partial payment	The patient's grant is inactive and there is limited funding available for this disease at this time. We provided a partial payment.
The grant is inactive; no payment	The patient's grant is inactive and there is no funding available for this disease at this time. We cannot provide payment.
The submitted charges are less than \$5	Reimbursement requests received for dates of service with line items with amounts less than \$5.00 will not be reviewed or considered for payment.
The patient has other assistance/payment	The patient was receiving assistance from another program, including but not limited to another foundation or organization, manufacturer program or medical Flexible Spending Account (FSA) at the time of service.
We do not process advance payments	We received the request before the medication(s) was dispensed. We are unable to provide advance payment.
Premiums not paid beyond 3 months	We are unable to pay the request because we can only pay premiums for up to 3 months in advance.
An EOB from the insurer is required	In order to receive appropriate reimbursement for this patient, we require an Explanation of Benefits (EOB) from the patient's insurance plan. We cannot accept EOBs that are generated by providers.
Medications must be dispensed in the US	The medication was not dispensed in the United States.

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