HEALTHWELL FOUNDATION®
When health insurance is not enough.®

Reimbursement Request Form - Copayment Assistance
Upload COMPLETED FORM and supporting documentation to Portals or Fax to 800-282-7692

HealthWell Identification Number: «HEALTHWELL_ID»

1. Patient's Name (First Name, Middle Initial, Last Name)			2. Patient's Birth Date	
3. Who will receive reimbursement? (Check one) ☐ Clinic ☐ Hospital ☐ Patient/Guardian ☐ Pharmacy ☐ Physician's Office	4. Make Check Payable to the name of the Patient/Parent/Guardian or Facility/Organization (Note - HealthWell cannot issue checks to a person's name at any entity such as hospital/provider): 5. Address for payment (Street, City, State, Zip Code)			
	6. Telephone	7. Fax	8. E-mail Address	
9. Date(s) of Service	10. Name of Medication(s) /J-Code	11. Insurer Allowed Amount	12. Insurer Paid Amount	13. Patient's Requested Reimbursement Amount (e.g., Copay, coinsurance and/or deductible amount)

14. Patient's Reference Information to be printed on check (e.g., Patient's Account Number, Prescription Number, Patient ID) 20 *characters max*

☑ **Document Checklist**

What to Submit when the HealthWell Pharmacy Card *cannot* be used:

Documentation must include: patient's name, date of service (DOS), drug name or eligible drug code, the insurer paid amount, & patient responsibility (copay, coinsurance, &/or deductible amounts).

If you want HealthWell to make Direct Payment to the *Provider*, please submit:

Completed Reimbursement Request Form, HCFA, UB-04, CMS-1500, or UCF

AND

Explanation of Benefits (EOB) from the insurer

If you want HealthWell to make Direct Payment to the *Pharmacy*, please submit:

Completed Reimbursement Request Form

AND

Processed prescription from the pharmacy (such as Pharmacy Receipt label from a local Pharmacy), Mail Order Pharmacy Invoice, or Pharmacy Screenshot (via the Pharmacy's software system)

If you want HealthWell to make payment to *you*, these are the requirements when reimbursing patients directly:

Completed Reimbursement Request Form

AND

Explanation of Benefits (EOB) from the insurer, Processed prescription from the pharmacy (such as Pharmacy Receipt label from a local Pharmacy), Mail Order Pharmacy Invoice, or Pharmacy Screenshot (via the Pharmacy's software system)

AND

Two Proofs of Payment showing the payment was made and how it was paid:

☑ Proof from facility - examples include a register receipt, a detailed payment invoice from the provider/ pharmacy, or a mail order pharmacy receipt.

☑ Proof from the patient/parent/guardian - a copy of a bank/credit card statement showing the account holder's name and the last 4 digits of the account number.

Authorized Requestor's Declaration: I verify that the information provided in this request is complete & accurate. I further verify that to the best of my knowledge, the information presented in the patient's original application for assistance to HealthWell has not changed. I understand that I am required to notify HealthWell if I am aware that the patient's contact information (address, phone, email), financial situation, insurance status, or medical condition changes from that which is reported in the original application. I have not received any other reimbursement for the expenses for which I am seeking reimbursement from HealthWell, nor will I receive such reimbursement from any source (including, but not limited to Medicaid, state drug assistance programs, copayment assistance programs, other foundations, discount cards), or an FSA, HSA, HRA, or RRA account. I understand that I must submit claims as soon as possible after services are rendered & that HealthWell will not pay claims received more than 120 days after the grant period end date. I understand that HealthWell reserves the right at any time & without notice to modify or discontinue any or all the programs with respect to any applicant or in their entirety, to modify the related eligibility criteria, or to terminate assistance. I attest that the documentation submitted is truthful and accurate.

15. **Authorized Requestor's Signature (REQUIRED):**	16. **Date (If undated, HealthWell will deem the date-of-submission as the day of processing)**
X	

«TABLEEND:REPORTDATA»