HEALTHWELL FOUNDATION®
When health insurance is not enough.®

Oncology Caregiver Behavioral Health Fund Statement

Your patient is pre-approved for a grant at HealthWell, and we need to verify that their behavioral health treatment is related to their role as a family caregiver. Please complete, SIGN (required), and UPLOAD this form to the Provider Portal at healthwellfoundation.org/providerportal or fax it to 800-282-7692.

HealthWell Identification Number: _____

Section 1: Patient Information

Patient Name: _____

Patient Address: _____

_____

Patient Date of Birth: _____

Patient Phone Number: _____

Relationship to Oncology Grant Recipient:

_____

Type of assistance requested (Check all that apply):

- ☐ Medication
- ☐ Counseling/Therapy
- ☐ Travel (mileage, parking fees, taxi/rideshare, or public transportation reimbursement only)

Section 2: Treating Behavioral Health Clinician Information

Name and Credentials: _____

Facility Name (if applicable): _____

Address: _____

City, State, Zip: _____

Email: _____

Fax: _____

Primary Contact Name: _____

(First and last name preferred; first name and at least last name initial required)

Primary Contact Phone: _____

Primary Contact Fax: _____

Section 3: Key Information to be Completed by either the Prescribing or Non-prescribing Behavioral Health Clinician

Yes, I am currently treating the patient listed above (initial): _____

The patient's behavioral health diagnosis is: _____

(e.g., Anxiety, Depression)

Section 4. Signature

By signing this Oncology Caregiver Behavioral Health Fund Statement, I hereby certify and understand that:

- I am authorized in my state to treat the patient listed above.
- The behavioral health diagnosis above is accurate.
- Any identified patterns of inaccurate submissions to the Foundation may result in my – or the entity I represent – termination from the Foundation's program for a length of time as determined by the Foundation.
- I will supervise the patient's behavioral health treatment and will monitor related treatments being prescribed to this patient.
- I am a Medicare certified service provider. Verify at: medicare.gov/care-compare

PLEASE NOTE: Patients are free to change physicians, pharmacies, or the type of medication they are taking at any time.

Clinician's Original Signature Date

PRINTED Clinician's Name Clinician's Credentials or Title