HEALTHWELL FOUNDATION®
When health insurance is not enough.®

Reimbursement Request Form – Premium Assistance
Upload COMPLETED FORM and supporting documentation through Patient Portal or Fax to 800-282-7692

Patient Information

Patient's Name (First Name, Middle Initial, Last Name) _____

Date of Birth _____ HealthWell Foundation ID _____

Insurance Premium Information – Medicare Part B

Important Notes:

- HealthWell will only pay or reimburse for health insurance coverage periods within this grant enrollment period.
- Beginning November 1, 2024, only standard Medicare Part B insurance premium requests will be eligible for reimbursement. Learn more: medicare.gov

Insurance Type	Frequency of Payments	Starting From	Premium Amount	Reference info to be printed on check (e.g., Patient's insurance member ID)
☐ MEDICAL	Monthly or Quarterly (*circle one*)	_____(month)/_____(year)	$	Ref #

Make Check Payable to (Patient's Name -OR- Name of Facility/Organization): _____

Address for Payment: _____

What to Submit

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

Completed Premium Reimbursement Request Form

AND

Quarterly Medicare Premium Bill

If you want HealthWell to reimburse *you (patient or guardian)* for premiums automatically deducted from Social Security Award (SSA) -or- Railroad Retirement Board (RRB) benefits, please submit:

Completed Premium Reimbursement Request Form

AND

Social Security Award (SSA) Letter/Railroad Retirement Board (RRB) letter showing deductions & premium amount

***Note:** HealthWell will reimburse the standard Medicare Part B premium amount each calendar year. If your grant spans between two calendar years, a copy of your new benefit letter is required when the Medicare Part B amount changes to be paid at the new year's rate.*

If you want HealthWell to reimburse *you (patient or guardian)* for premiums that are not automatically deducted, please submit:

Completed Premium Reimbursement Request Form

AND

Quarterly Medicare Premium Bill

AND

Two proofs of payment identifying the premium amount paid, date paid, and to whom the payment was made.

- ☑ Proof from Medicare - an invoice, letter, or document from Medicare showing confirmation of payment.
- ☑ Proof from the patient/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	