



Diagnosis Verification

In order to assist your patient, we need to verify his/her diagnosis and medications. Please complete, SIGN (required), and UPLOAD this form through the PORTAL or fax it to 800-282-7692.

SECTION 1: PRESCRIBING PROVIDER INFORMATION

Prescribing Provider Name, Credentials: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Who is the Primary Office Contact for this application? (social worker, nurse) first and last name preferred; first name and at least last name initial required \_\_\_\_\_

Primary Contact Telephone: \_\_\_\_\_ Primary Contact Fax: \_\_\_\_\_

SECTION 2: PATIENT INFORMATION

My patient, \_\_\_\_\_, is being treated for \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_

SECTION 3: MEDICATION(S) Required for PEDIATRIC ASSISTANCE FUND purposes only

Drug Names: \_\_\_\_\_

By signing this Diagnosis Verification, I hereby certify (i) that I am duly licensed and authorized in my state to prescribe medication(s), (ii) that the diagnosis listed above is accurate, and (iii) that I will be supervising the patient's treatment accordingly.

By signing this Diagnosis Verification, I hereby certify that I understand that:

- The HealthWell Foundation® (Foundation) offers assistance to eligible patients for treatments/products expressly covered by the Foundation;
• While the Foundation will make every effort to grant assistance when needed, the Foundation's program is limited by available resources and may be discontinued or changed at any time; and
• Any identified patterns of inappropriate 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.

PLEASE NOTE: A patient is free to change his/her physician, pharmacy, or the type of medication he/she is taking at any time, and this will not affect his/her enrollment.

X
Prescriber's Original Signature (STAMPED OR ELECTRONIC SIGNATURES NOT VALID)

\_\_\_\_\_
Date

PRINTED Prescriber's Name

Prescriber's Credentials – REQUIRED
(example: MD, DO, NP, PA)