HEALTHWELL FOUNDATION®

When health insurance is not enough.®

PREMIUM Reimbursement Request Form

Upload COMPLETED FORM and supporting documentation through Portals or Fax to 800-282-7692

Patient Information

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

Date of Birth _____ HealthWell Foundation ID _____

Name of Medication(s) _____ Date of Service or Last Refill _____

Payee Information (as listed on insurance invoice/coupon)

Make Check Payable to (Name of Person, Facility, or Organization) _____

Address for payment: _____

Telephone _____ Fax _____ Email _____

Insurance Premium information

HealthWell can only assist with one policy's individual/medical premium amount at a time

Coverage Period _____ Due Date _____

Premium Amount Due _____ How often is your premium due: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly ☐ Quarterly

Grant Payment Spread: ☐ Entire premium payment to the grant cap (some grants will not last for the entire 12-month enrollment year)
(choose one) ☐ Divide grant cap evenly throughout the enrollment year (please verify your insurer will accept partial payment)

Reference Information to be printed on check (e.g. Patient's insurance member ID) _____

To make premium payments directly to your insurance company, please submit the following along with first request form:

- ☐ **Insurance Invoice or Coupon** indicating coverage period to be paid, due date, and premium amount
- ☐ **Proof of Active Treatment** (submit one of the following showing that you are currently receiving treatment)
  - Pharmacy receipt or pharmacy history with patient name, date of service, eligible drug code/drug name, insurer paid amount and patient copayment amount
  - Explanation of Benefits (EOB) with patient name, date of service, eligible drug code/drug name, insurer paid amount and patient copayment amount

To reimburse the patient/guardian for premium payments, please submit the following along with this request form:

- ☐ **Insurance Invoice or Coupon** indicating coverage period, due date, and premium amount
- ☐ **Proof of Active Treatment** (submit one of the following showing that you are currently receiving treatment)
  - Pharmacy receipt or pharmacy history with patient name, date of service, eligible drug code/drug name, insurer paid amount and patient copayment amount
  - Explanation of Benefits (EOB) with patient name, date of service, eligible drug code/drug name, insurer paid amount and patient copayment amount
- ☐ **Proof of Payment** (submit any one of the following showing **<u>your</u>** actual payment for your premium)
  - Bank statement (must show account holder's name)
  - Credit card statement (must show account holder's name)
  - Two consecutive pay stubs
  - Cancelled Checks (must be accompanied by a bank statement)
  - Medicare Part B deductions from Social Security, submit bank statement showing Social Security Deposit
  - Premium deduction from Pension, submit bank statement showing pension deposit

Authorized Requestor's Declaration

I verify that the information provided in this request is complete and 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 or other foundations), or a health care flexible spending account. **I understand that I must submit claims as soon as possible after services are rendered and that HealthWell will not pay claims received more than 120 days after the patient's date of service.** In addition, I understand that I will no longer be entitled to reimbursement under the patient's original grant if no claims have been submitted for a period of 120 days. Finally, I understand that HealthWell reserves the right at any time and without notice to modify or discontinue any or all of the programs with respect to any applicant or in their entirety, to modify the related eligibility criteria, or to terminate assistance.

Authorized Requestor's Signature (<u>REQUIRED</u>) _____ **Date (REQUIRED)** _____