HEALTHWELL FOUNDATION®

Cancer-Related Behavioral Health Fund Statement

In order to continue assisting your patient, we need to verify that their behavioral health treatment is related to their cancer diagnosis. Please complete, SIGN (required), and UPLOAD this form through the PORTAL or fax it to 800-282-7692.

Section 1: Patient Information

1. Patient's Name (First Name, Middle Initial, Last Name)	2. Patient's Address (Street number, Street Name, City, State, Zip Code)	
3. Patient's Birth Date & Social Security Number		
4. Telephone	5. Email	6. Insurance Name:
7. Patient Cancer Diagnosis:	8. Name of Fund: (if currently enrolled)	
Patient Signature & Date: _____		

Select the type of assistance requested (may select all if applicable)

- ☐ **Prescription**
- ☐ **Talk Therapy**
- ☐ **Cognitive Behavioral Therapy**
- ☐ **Mindfulness**
- ☐ **Transportation** (mileage, taxi, or public transportation reimbursement only)

Estimated Out of Pocket Need for 12 month period: _____

Section 2: Prescribing Provider Information

Prescribing Provider Name, Credentials: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

Email: _____

Primary Office Contact (social worker, nurse): _____

first and last name preferred; first name and at least last name initial required

Primary Contact Telephone: _____ Fax: _____

My Patient: _____, is being treated for _____

Provide Diagnosis

I am recommending the following treatment for my patient's Cancer-Related Behavioral Health:

- ☐ **Prescription**
- ☐ **Talk Therapy**
- ☐ **Cognitive Behavioral Therapy**
- ☐ **Mindfulness**

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By signing this Cancer-related Behavioral Health Fund Statement, I hereby certify that:
I am duly licensed and authorized in my state to prescribe **this specific medication(s)** used to treat behavioral health and the diagnosis listed above is accurate. I will be supervising the patient's treatment and **will monitor all treatments being prescribed** to this patient. By signing this Cancer-related Behavioral Health Fund Statement, I hereby certify that I understand that: 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.
PLEASE NOTE: Patients are free to change physicians, pharmacies, or the type of medication they are taking at any time.

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)