Travel Fund Reimbursement Request Form
Upload COMPLETE FORM and supporting documentation through Portals or fax to 800-282-7692

HealthWell Identification Number: _____

1. Patient's Name (First Name, Middle Initial, Last Name)	2. Patient's Birth Date
3. Patient's Address (Street number, Street Name, City, State, Zip Code)	

4. Telephone	5. Email	6. Date you received your prescription, infusion, or blood monitoring:

7. Do you have a grant with HealthWell?

No	**Yes**
Along with this completed form, please also send: • Explanation of Benefits (EOB) from insurer with patient name, date of service, eligible drug code/drug name OR • Receipt or Screenshot from Pharmacy with patient name, date of service, eligible drug code/drug name	Along with this completed form, please also send an associated Date of Service payment

8. Please enter the name and address of the pharmacy, provider's office, infusion center, or blood monitoring site:

Facility Name:_____

Street number and name: _____

City, State, Zip Code:_____

9. Did you or a family member or friend drive to the pharmacy, provider's office, infusion center, or blood monitoring site?

No	**Yes**

10. Were there any parking fees at the pharmacy, provider's office, infusion center, or blood monitoring site?

No	**Yes**, please include receipt(s) showing the date and fee paid.

11. Did you use a train, taxi or public transportation to get to and from the pharmacy, provider's office, infusion center, or blood monitoring site?

No	**Yes**, please include receipt(s) showing the date and fee paid. If you do not have receipts, HealthWell will use best estimates to determine the reimbursement.

12. Did you use air transportation to get to and from the pharmacy, provider's office, infusion center, or blood monitoring site?

No	**Yes**, please include receipt(s) showing the date and fee paid.

13. Are you requesting hotel/lodging reimbursement?

No	**Yes**, please include receipt(s) showing the date and fee paid. NOTE: The pharmacy, infusion center, or blood monitoring site should be at least 75 miles, one way, from your home. One night maximum stay at a maximum of $150.00 nightly rate.

Patient'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 my original application for assistance to HealthWell has not changed. I understand that I am required to notify HealthWell if my 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 travel expenses for which I am seeking reimbursement from HealthWell. 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.

14. Authorized Requestor's Signature (REQUIRED)	15. Date (REQUIRED)
X_____	_____