HEALTHWELL FOUNDATION®
When health insurance is not enough.®

Reimbursement Request Form - Copayment Assistance
Upload COMPLETED 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. Who will receive reimbursement? (Check one) ☐ Clinic ☐ Hospital ☐ Patient/Guardian ☐ Pharmacy ☐ Physician's Office	4. Make Check Payable to (Name of Person, Facility, or Organization)		
	5. Address for payment (Street, City, State, Zip Code)		
	6. Telephone	7. Fax	8. E-mail Address

9. Date(s) of Service	10. Name of Medication(s)/J-Code	11. Diagnosis/ICD-10 Code	12. Amount Billed to Insurer	13. Insurer Allowed Amount	14. Patient's Copay Amount

15. Patient's Reference Information to be printed on check (e.g. Patient's Account Number, Prescription Number, Patient ID) 20 *characters max*

COPAYMENT REQUEST

Patient/Guardian/Pharmacy/Physician MUST submit the following for copayment reimbursement requests:

- **Explanation of Benefits (EOB) from insurer** with patient name, date of service, eligible drug code/drug name, insurer paid amount and patient copayment amount

OR

- **Receipt from Pharmacy (Pharmacy Invoice for Pediatric Assistance)** with patient name, date of service, eligible drug code/drug name, insurer paid amount and patient copayment amount

OR

- **Screenshot from Pharmacy** with patient name, date of service, eligible drug code/drug name, insurer paid amount and patient copayment amount

AND

Proof of Payment REQUIRED WHEN REIMBURSING PATIENT DIRECTLY: Copy of bank statement (must show account holder's name), cancelled check (must be accompanied by a bank statement), credit card statement (must show account holder's name), or register receipt. Please note that the option of reimbursing patients directly does not apply to the Pediatric Assistance fund.

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.

16. **Authorized Requestor's Signature (REQUIRED)**	17. **Date** **(If undated, HealthWell will deem the date-of-submission as the day of processing)**
X_____	_____