Cancer-Related Behavioral Health Fund Statement

HEALTHWELL FOUNDATION®
When health insurance is not enough.®

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.

HealthWell Identification Number: _____

Section 1: Patient Information

Patient Name: _____
Patient Address: _____
_____
Patient Date of Birth: _____
Patient Phone Number: _____
Type of Cancer: _____
I plan to request assistance for the following (check all that apply):

- ☐ Medication
- ☐ Counseling/Therapy
- ☐ Travel (mileage, taxi, or public transportation reimbursement only)

Section 2: Treating Behavioral Health Clinician Information

Name and Credentials: _____
Facility Name (if applicable): _____
Address: _____
City, State, Zip: _____
Email: _____
Fax: _____
Primary Contact Name: _____
(First and last name preferred; first name and at least last name initial required)

Primary Contact Phone: _____
Primary Contact Fax: _____

Section 3: Key Information to be Completed by either the Prescribing or Non-prescribing Behavioral Health Clinician

Yes, I am currently treating the patient listed above (initial): _____
The patient's cancer-related behavioral health diagnosis is: _____
(e.g., Anxiety, Depression)

Patient needs assistance with the following (check all that apply):

☐ Medication ☐ Counseling/Therapy

Section 4. Signature

By signing this Cancer-related Behavioral Health Fund Statement, I hereby certify and understand that:

- I am authorized in my state to treat the patient listed above.
- The behavioral health diagnosis above is accurate.
- 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.
- The patient has cancer.
- I will be supervising the patient's behavioral health treatment and will monitor related treatments being prescribed to this patient.

PLEASE NOTE: Patients are free to change physicians, pharmacies, or the type of medication they are taking at any time.

_____
Clinician's Original Signature Date

_____
PRINTED Clinician's Name Clinician's Credentials or Title