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 _____

Insurance Premium Information
HealthWell can only assist with one medical insurance policy at a time

Premium Amount Due _____ Due Date _____

Frequency of Payments:

☐ Monthly starting from _____ (month) / _____ (year)

-OR-

☐ Quarterly starting from _____ (month) / _____ (year)

Important Reminder: HealthWell will only pay or reimburse for medical insurance coverage periods within your grant enrollment period.

Payee Information

I would like my insurance premium:

☐ Paid Directly to My Insurer (please confirm the insurance company will accept checks from third parties)

-OR-

☐ Paid to Me (Patient) as Reimbursement

Note: If both options apply, submit a separate Premium Reimbursement Request Form for each.

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

Address for payment: _____

Telephone _____ Fax _____ Email _____

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

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 my/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 my/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/the patient must use the HealthWell grant regularly to keep it active.** In addition, 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 (REQUIRED)	**Date (If undated, HealthWell will deem the date-of-submission as the day of processing)**
X	