HEALTHWELL FOUNDATION®
When health insurance is not enough.®

COVID-19 Ancillary Costs Fund 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_____

Payee Name and Address _____

_____

Reimbursement Type(s)

For which type(s) of eligible claims are you seeking reimbursement?

- ☐ Costs associated with Delivered Food and Medication as a result of COVID-19 risk or incidence
  - Proof of Payment: Credit Card Receipt, Proof of Delivery etc.

- ☐ Cost of Transportation related to COVID-19
  - Proof of Payment: Credit Card Receipt, Detailed Trip Summary etc.

- ☐ Cost of Tele-Health and associated fees
  - Proof of Payment

Important Reminder: HealthWell will only pay or reimburse with costs associated with delivered food, medication, diagnostics, transportation and telehealth as a result of COVID-19 risk or incidence within in this grant enrollment period. Medications treating diseases other than COVID-19 will not be paid for under this grant.

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 COVID-19 ancillary costs 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) X_____	15. Date (REQUIRED) _____