COVID-19 Frontline Health Care Workers 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 working as a qualified frontline healthcare worker during the COVID-19 pandemic. 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: _____

Job Title: _____

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 behavioral health diagnosis resulting from frontline work during the COVID-19 pandemic is: _____

(e.g., Anxiety, Depression)

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

☐ Medication ☐ Counseling/Therapy

Section 4. Signature

By signing this COVID-19 Frontline Health Care Workers 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 worked or is working as a qualified frontline healthcare worker during the COVID-19 pandemic.
- 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