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 assist with your medical, supplemental, prescription, dental, and vision insurance premiums as requested by you on this Form

Important Notes:

- HealthWell will only pay or reimburse for health insurance coverage periods within your grant enrollment period.
- **If you are requesting to pay directly to your insurer, please confirm the insurance company will accept checks from third parties.**
- **If you have requests to both reimburse you (Patient) and pay your insurer directly, you must submit separate Premium Reimbursement Request Forms for each.**

Insurance Type	Frequency of Payments	Starting From	Premium Amount	Reference info to be printed on check (e.g., Patient's insurance member ID)
☐ MEDICAL	Monthly or Quarterly (*circle one*)	_____(month)/_____(year)	$	Ref #
Make Check Payable to (Patient's Name -OR- Name of Facility/Organization): ____________________ Address for Payment: ____________________				
☐ SUPPLEMENTAL	Monthly or Quarterly (*circle one*)	_____(month)/_____(year)	$	Ref #
Make Check Payable to (Patient's Name -OR- Name of Organization): ____________________ Address for Payment: ____________________ (Note: Write "same" if it is the same payee and address as above)				
☐ PRESCRIPTION	Monthly or Quarterly (*circle one*)	_____(month)/_____(year)	$	Ref #
Make Check Payable to (Patient's Name -OR- Name of Organization): ____________________ Address for Payment: ____________________ (Note: Write "same" if it is the same payee and address as above)				
☐ DENTAL	Monthly or Quarterly (*circle one*)	_____(month)/_____(year)	$	Ref #
Make Check Payable to (Patient's Name -OR- Name of Organization): ____________________ Address for Payment: ____________________ (Note: Write "same" if it is the same payee and address as above)				
☐ VISION	Monthly or Quarterly (*circle one*)	_____(month)/_____(year)	$	Ref #
Make Check Payable to (Patient's Name -OR- Name of Organization): ____________________ Address for Payment: ____________________ (Note: Write "same" if it is the same payee and address as above)				

What to Submit

1. **If you want HealthWell to make Direct Payment to Insurer (preferred), please submit:**
   ☐ Completed Premium Reimbursement Request Form AND
   ☐ Proof of Health Insurance Policy (Invoice/Coupon) indicating coverage period to be paid, due date, and premium amount
2. **If you want HealthWell to make Reimbursement to Patient with Automatic Deductions for Premium Amount, please submit:**
   ☐ Completed Premium Reimbursement Request Form AND
   ☐ Social Security Awards Letter, Annuity/Pension Statement, Paystub -OR- Premium Invoice showing Electronic Funds Transfer (EFT) Direct Debit amount
3. **If you want HealthWell to make Reimbursement to Patient with NO Automatic Deductions for Premium Amount, please submit:**
   ☐ Completed Premium Reimbursement Request Form AND
   ☐ Proof of Health Insurance Policy (Invoice/Coupon) indicating coverage period, due date, and premium amount
   ☐ Proof of payment, such as a bank statement/credit card statement or payment receipt/confirmation
   Note: For Option 3, HealthWell will require patients to submit proof of payment each time to get reimbursement

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	