HEALTHWELL FOUNDATION®
When health insurance is not enough.®

Travel Fund Reimbursement Request Form
Upload COMPLETED FORM and supporting documentation to Portals or fax to 800-282-7692

HealthWell Identification Number: _____

1. Patient's Name (First Name, Middle Initial, Last Name)	2. Patient's Birth Date
3. Telephone	4. E-mail
5. Patient's Address for payment (Street number, Street Name, City, State, Zip Code):	

6. Date(s) of Service	7. Type of Travel Reimbursement	8. Facility Name and Address (Street number, Street Name, City, State, Zip Code):
	☐ Mileage ☐ Parking fees ☐ Taxi/rideshare ☐ Public transportation	
	☐ Mileage ☐ Parking fees ☐ Taxi/rideshare ☐ Public transportation	
	☐ Mileage ☐ Parking fees ☐ Taxi/rideshare ☐ Public transportation	
	☐ Mileage ☐ Parking fees ☐ Taxi/rideshare ☐ Public transportation	

What to Submit for Travel Reimbursement

- **Proof of Date of Service:**

  Explanation of Benefits (EOB) from insurer with patient name, date of service, eligible treatment code/name.

  OR

  Receipt or Screenshot from Pharmacy with patient name, date of service, eligible treatment code/name.

AND

- **Supporting Travel Reimbursement Documentation:**

  ☐ **Mileage** – If you, a family member, or a friend drives, we will calculate reimbursement based on the address(s) listed above at the IRS standard business mileage rate for the most cost-effective direct route. You do not need to submit mileage receipts.

  ☐ **Parking fees** - Submit receipt(s) showing the date and fee paid.

  ☐ **Taxi, rideshare, or public transportation** - Submit receipt(s) showing the date and fee paid. If you do not have receipts, HealthWell will use best estimates to determine the reimbursement.

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 the travel expenses 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.

9. Authorized Requestor's Signature (REQUIRED):	10. Date (If undated, HealthWell will deem the date-of-submission as the day of processing)
X_____	_____