HEALTHWELL FOUNDATION®
When health insurance is not enough.®

Diagnosis Verification Form

Online Version

Your patient has been approved for a grant at HealthWell. To utilize the grant we need to verify their diagnosis. Please complete, SIGN (required), and UPLOAD this form to the Provider Portal at healthwellfoundation.org/providerportal or fax it to 800-282-7692.

SECTION 1: PRESCRIBER INFORMATION

Prescriber Name:

Facility Name:

Address:

City: State: Zip code:

Telephone: Fax:

Email: Mobile:

Who is the Primary Office Contact for this application? (social worker, nurse)
First and last name preferred; first name and at least last name initial required:

Primary Contact Telephone: Primary Contact Fax:

SECTION 2: PATIENT INFORMATION

My patient, is being treated for:

ICD-10 code:

Date of Birth: Last 4 digits of SSN:

SECTION 3: SIGNATURE

Is someone other than the Prescriber completing the form (if yes, provide the following information): ☐ **YES** ☐ **NO**

Name of Person Completing Form: **Position of Person Completing Form:**

By signing this Diagnosis Verification, **I hereby certify (i) that I am duly licensed and authorized in my state to prescribe medication(s) or is authorized by the prescriber to complete this form on his/her behalf, (ii) that the diagnosis listed above is accurate, and (iii) that I or the prescriber listed above will be supervising the patient's treatment accordingly.**

By signing this Diagnosis Verification, I hereby certify that I understand that:

- The HealthWell Foundation® (Foundation) offers assistance to eligible patients for treatments/products expressly covered by the Foundation;
- While the Foundation will make every effort to grant assistance when needed, the Foundation's program is limited by available resources and may be discontinued or changed at any time; and
- Any identified patterns of inappropriate 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.

PLEASE NOTE: A patient is free to change his/her physician, pharmacy, or the type of medication they are taking at any time, and this will not affect their enrollment.

X

Signature **Date**

PRINTED Prescriber Name **Prescriber's Credentials - REQUIRED**