HealthWell Foundation®

When health insurance is not enough.®

What to Submit for Copayment Requests

Important Message: Please do not black out, redact, or alter information on your documents. For Social Security Numbers, bank/credit card, or routing numbers, please make the last four digits visible; you may black out the remaining numbers. If using an online banking website, please leave all information on the bank statement, even if it is not directly related to the requested payment information. All information received will be stored securely and used for reimbursement purposes only.

For direct patient reimbursement, please submit the following:

1. **Completed Reimbursement Request Form**

AND

2. **Explanation of Benefits (EOB)** from your insurance company, pharmacy label/ invoice, or pharmacy screenshot.

AND

3. **Two Proofs of Payment**, one from the account used for payment showing payment and how it was paid, and one from your doctor or pharmacy.

Examples are available in the Message Center in our Patient Portal:

- **Credit Card/Bank Statement** (if you paid by check, please include a front copy of the canceled check)

AND (please choose one of the following to accompany the bank statement):

- **Register Receipt and Pharmacy Label/Screenshot**
- **Provider or Pharmacy Invoice/Statement**

Additional visual samples of acceptable documents are available in our Patient Portal.

Explanation of Benefits (EOB) or Remittance Advice (RA) *requirements*:

- Patient's Name/Insurance Member ID
- Date of Service (DOS)
- Product Name, NDC Number or J-Code
- Amount Insurance Paid
- Patient Responsibility (Copay, Deductible or Coinsurance)

ZEPN Insurance Company

ZEPN Insurance Company
P.O. Box 0000, Insuranceville, TX 11111

This is NOT a bill

This is your Explanation of Benefits. This statement shows how we applied your coverage to cliam(s) submitted to us. If you have a question, call the customer service number shown at the bottom of this page.

Patient Name: Healin Smith

Issue Date: 06/15/2024

Member ID: 123AD4567

Date of Service	Provider	Product Name/J-Code or NDC	Billed/Charged Amount	Allowed Amount	Amount Insurance Paid	Deductible	Copayment	Coinsurance	Amount Not Covered
05/19/2024	Dr. John Doe	Salcet/J-1234/84444-2222-00	$6,213.06	$4,002.83	$3,247.77	$0.00	$755.06	$0.00	$0.00
05/19/2024	Dr. John Doe	Dilavir/J-1111/88888-2222-00	$3,419.59	$2,103.18	$1,706.45	$0.00	$396.73	$0.00	$0.00
		Claim Total:	$10,114.13	$6,358.09	$4,954.22	$0.00	$1,403.87	$0.00	$0.00

You are responsible for: $1,403.87