HEALTHWELL FOUNDATION®
When health insurance is not enough.®

Diagnosis Verification

In order to assist your patient, we need to verify his/her diagnosis and medications. Please complete, SIGN (required), and UPLOAD this form through the PORTAL or fax it to 800-282-7692.

SECTION 1: PRESCRIBING PROVIDER INFORMATION

Prescribing Provider Name, Credentials: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone: _____ Fax: _____

Email: _____

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 _____

Date of Birth: _____ Last 4 digits of SSN: _____

SECTION 3: MEDICATION(S) Required for PEDIATRIC ASSISTANCE FUND purposes only

Drug Names: _____ _____ _____

By signing this Diagnosis Verification, **I hereby certify (i) that I am duly licensed and authorized in my state to prescribe medication(s), (ii) that the diagnosis listed above is accurate, and (iii) that I 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 he/she is taking at any time, and this will not affect his/her enrollment.

X _____ _____

Prescriber's Original Signature (STAMPED OR ELECTRONIC SIGNATURES NOT VALID) | **Date**

_____ _____

PRINTED Prescriber's Name | **Prescriber's Credentials – REQUIRED** (example: MD, DO, NP, PA)