



PATIENT INFORMATION	PATIENT'S NAME (FIRST MIDDLE LAST)		PREFERRED PUMP <input type="checkbox"/> t:slim X2 <input type="checkbox"/> t:flex	
	PATIENT'S STREET ADDRESS		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	
	CITY	STATE	ZIP CODE	DATE OF BIRTH (MM/DD/YYYY)
	EMAIL ADDRESS	HOME PHONE		MOBILE PHONE
	NAME OF PARENT/LEGAL GUARDIAN (IF UNDER 18)	PREFERRED METHOD OF CONTACT <input type="checkbox"/> Phone <input type="checkbox"/> Email		BEST TIME TO CALL <input type="checkbox"/> AM <input type="checkbox"/> PM
	EMERGENCY CONTACT	RELATIONSHIP	EMERGENCY CONTACT PHONE NUMBER	

PRESCRIBING PROVIDER INFO	PRESCRIBING PROVIDER'S NAME		SPECIALTY	
	OFFICE STREET ADDRESS		PHONE NUMBER	
	CITY	STATE	ZIP CODE	FAX NUMBER
	GROUP PRACTICE NAME	OFFICE CONTACT NAME		

INSURANCE INFORMATION (CHECK ALL THAT APPLY)	↓ PRIMARY INSURANCE (to expedite please provide a copy of the <i>front and back</i> of your insurance card) ↓			
	INSURANCE NAME			
	CLAIMS MAILING STREET ADDRESS		PHONE NUMBER	
	CITY	STATE	ZIP CODE	FAX NUMBER
	GROUP NUMBER	POLICY NUMBER	PLAN TYPE (PPO, HMO, ETC.)	
	POLICY HOLDER'S NAME IF DIFFERENT THAN ABOVE (FIRST, MIDDLE, LAST)			POLICY HOLDER'S DATE OF BIRTH (MM/DD/YYYY)
	RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian			POLICY HOLDER'S SOCIAL SECURITY NUMBER
	RX BIN	RX PCN	RX GROUP	EMPLOYER'S NAME
	↓ SECONDARY INSURANCE (to expedite please provide a copy of the <i>front and back</i> of your insurance card) ↓			
	INSURANCE NAME			
	CLAIMS MAILING STREET ADDRESS		PHONE NUMBER	
	CITY	STATE	ZIP CODE	FAX NUMBER
	GROUP NUMBER	POLICY NUMBER	PLAN TYPE (PPO, HMO, ETC.)	
	POLICY HOLDER'S NAME IF DIFFERENT THAN ABOVE (FIRST, MIDDLE, LAST)			POLICY HOLDER'S DATE OF BIRTH (MM/DD/YYYY)
RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian			POLICY HOLDER'S SOCIAL SECURITY NUMBER	
RX BIN	RX PCN	RX GROUP	EMPLOYER'S NAME	

Assignment of Insurance Benefits and Authorization to Release Information

Please be aware that all medical information is confidential under certain state and federal laws. Such information may not be released without your consent. Many insurance carriers require medical information to be submitted with claims to evaluate medical necessity. Please provide your written consent to release related information when required or requested to your insurance company(s) and/or your healthcare team.

I, _____ (PRINT FULL NAME), do hereby authorize Tandem Diabetes Care to acquire from and/or release to my healthcare team, and/or my insurance company(s), and/or contracted distributors, and/or product development partners any information required for the purposes of healthcare management and/or for processing all past, present and future medical claims on my behalf. I understand that upon acceptance of products from Tandem Diabetes Care, I assume responsibility for any deductible, co-pay, or other balance not covered by my insurance carrier. I authorize Tandem Diabetes Care to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to Tandem Diabetes Care. Should any insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over these funds to Tandem Diabetes Care. I will be informed of my insurance coverage and estimated out-of-pocket expense prior to any shipment of product or any bills being sent. I will notify Tandem Diabetes Care in the event my insurance changes. This authorization will remain in effect until I revoke it in writing. I acknowledge that I have received a copy of the Notice of Privacy Practices for Tandem Diabetes Care or have reviewed the privacy policy online at tandemdiabetes.com, and that I've read, understand, and agree to the attached HIPAA Authorization for Using and Disclosing Protected Health Information. If the recipient of the Tandem product is a minor, then you represent that you are the minor's guardian and you are signing on their behalf and that this signature also releases Tandem Customer Support to assist the minor or caretaker to provide product support at no additional charge for Tandem product and services. You further acknowledge that Tandem has various policies posted on Tandem's website (including Privacy Policy) and that you agree to the terms of those policies.

PATIENT/GUARDIAN SIGNATURE X	DATE (MM/DD/YYYY)
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HIPAA Authorization for Using and Disclosing Protected Health Information

- 1. Authorization of Uses and Disclosures.** I hereby authorize and direct Tandem Diabetes Care, Inc., its employees and its agents, including its distributors, product development partners, and trainers (“Tandem and/or its Agents”) to use and disclose my “protected health information” (“Information”), as described below. I also authorize Tandem and/or its Agents to contact me via telephone, mail, e-mail (including unencrypted e-mail), or by other means of communications.
- 2. Description of Information.** I understand that my Information includes, but is not limited to, my name and other personal information (including my address), information from the Tandem Patient Information Form, medical information, including information about diabetes and related medical conditions, medical records, and financial information (including information about my insurance) as well as other personal information collected by Tandem about me, such as information on the Health and Product Questionnaire.
- 3. Purposes.** I authorize and direct Tandem to use and disclose my Information for the following purposes: (a) reviewing Information about me, and using and disclosing that information to coordinate or arrange delivery of diabetes-related supplies, services or training, including those not yet furnished to me by Tandem and/or its Agents; (b) providing product updates, including regulatory notices relating to existing or future products; and (c) providing information that promotes medical products and/or services that may be of interest to me.
- 4. Expiration.** This Authorization expires the later of when I no longer am a patient of Tandem, or ten years after the date of this authorization.
- 5. Revocation.** I understand that I have the right to revoke this Authorization by sending a written request to Tandem Diabetes Care, ATTN: Customer Support, 11045 Roselle Street, San Diego, CA 92121, however, I understand that such revocation will not be effective with respect to Information that has already been used and/or disclosed per this Authorization.
- 6. Treatment not Conditioned.** I understand that Tandem will not deny me treatment, products, or service based on whether or not I sign this Authorization.
- 7. Potential for Redisclosure.** I understand that Information disclosed pursuant to this Authorization may be redisclosed by recipients (including me) and may no longer be protected by the Health Insurance Portability and Accountability Act (“HIPAA”), a federal privacy law.
- 8. Copy.** I understand that I will be provided with a copy of this signed Authorization by Tandem.