TANDEM® DIABETES CARE

# PATIENT INFORMATION / AOB

(See reverse for HIPAA Authorization for Using and Disclosing Protected Health Information)

This form can also be filled out online at www.tandemdiabetes.com

FAX completed signed form to:

**(855) 875-4648**

## PATIENT INFORMATION

| | | |
|---|---|---|
| PATIENT'S NAME (FIRST MIDDLE LAST) | | PREFERRED PUMP ☐ t:slim X2 |
| PATIENT'S STREET ADDRESS | | GENDER ☐ Male ☐ Female |
| CITY / STATE / TERRITORY / 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 ☐ Phone ☐ Email | BEST TIME TO CALL ☐ AM ☐ PM |
| EMERGENCY CONTACT | RELATIONSHIP | EMERGENCY CONTACT PHONE NUMBER |

## PRESCRIBING PROVIDER INFO

| | | |
|---|---|---|
| PRESCRIBING PROVIDER'S NAME | | SPECIALTY |
| OFFICE STREET ADDRESS | | PHONE NUMBER |
| CITY / STATE / TERRITORY / 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 ***front and back*** of your insurance card) ⬇

| | | | |
|---|---|---|---|
| INSURANCE NAME | | | |
| CLAIMS MAILING STREET ADDRESS | | | PHONE NUMBER |
| CITY / STATE / TERRITORY / 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 ☐ Self ☐ Spouse ☐ Parent ☐ 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 ***front and back*** of your insurance card) ⬇

| | | | |
|---|---|---|---|
| INSURANCE NAME | | | |
| CLAIMS MAILING STREET ADDRESS | | | PHONE NUMBER |
| CITY / STATE / TERRITORY / 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 ☐ Self ☐ Spouse ☐ Parent ☐ 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 and reviewing all past, present and future medical claims on my behalf, including deductible amounts. 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 | DATE (MM/DD/YYYY) |
|---|---|
| X | |

 

## 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, 11075 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.

 