



This form can be accessed online at tandemdiabetes.ca

CANADA

PATIENT INFORMATION	PATIENT'S NAME (FIRST MIDDLE LAST)		
	PATIENT'S STREET ADDRESS		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Decline to State
	CITY	PROVINCE	POSTAL CODE
	EMAIL ADDRESS		DATE OF BIRTH (MM/DD/YYYY)
	HOME PHONE		MOBILE PHONE
	NAME OF PARENT/LEGAL GUARDIAN (IF UNDER 18)		PREFERRED METHOD OF CONTACT <input type="checkbox"/> Phone <input type="checkbox"/> Email
EMERGENCY CONTACT NAME (FIRST, MIDDLE, LAST)		BEST TIME TO CALL <input type="checkbox"/> AM <input type="checkbox"/> PM	
RELATIONSHIP		EMERGENCY CONTACT PHONE NUMBER	

PRESCRIBING PROVIDER INFO	PRESCRIBING PROVIDER'S NAME		SPECIALTY
	OFFICE STREET ADDRESS		PHONE NUMBER
	CITY	PROVINCE	POSTAL CODE
	DIABETES EDUCATION CENTRE		FAX NUMBER
	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	PROVINCE	POSTAL CODE
	FAX NUMBER		
	MEMBER ID	POLICY NUMBER	
	POLICY HOLDER'S NAME (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		
	↓ 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	PROVINCE	POSTAL CODE
	FAX NUMBER		
	MEMBER ID	POLICY NUMBER	
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			

Consent to Use Information and Assignment of Insurance Benefits

I, _____ (PRINT PATIENT'S FULL NAME), expressly consent to Tandem Diabetes Care Canada, Inc.'s ("Tandem") collection of the personal data I've provided on this form, and I consent to its use by and disclosure to Tandem, my healthcare team, my insurer(s) or provincial payor, and/or authorized distributors (e.g., Bayshore Specialty Rx Ltd.), for purposes of confirming my eligibility, verifying my insurance coverage, and/or processing payments for Tandem products. I acknowledge that I have reviewed and understand the Privacy Notice available at tandemdiabetes.com/en-ca/privacy/privacy-policy or tandemdiabetes.com/fr-ca/privacy/privacy-policy. I consent to Tandem and its authorized distributors contacting me via the email address, telephone number, and/or postal mail address provided above with respect to current and future products that may be of interest or to conduct surveys regarding Tandem's products and services. I understand and agree that all information I provide to Tandem may be stored and processed in foreign countries Tandem or its service providers have operations and I consent to the transfer of my personally identifiable information to countries outside of my country of residence. I understand that upon acceptance of products from Tandem, I assume responsibility for any deductible, co-pay, or other balance not covered by my insurance or provincial plan. Where applicable, I authorize Tandem or its authorized distributor to submit claims to my insurer or provincial payor on my behalf and I authorize Tandem and its authorized distributor to share information about shipment of products and payment of claims by my insurer or provincial payor with each other. I further authorize my insurer or provincial plan to pay benefits directly to Tandem or its authorized distributor. Should any such payment be made directly to the insured/registrant for monies due on this account, I agree to immediately pay over these funds to Tandem or its authorized distributor. I will be informed of my plan/insurance coverage and estimated out-of-pocket expense prior to product shipment or billing. I will notify Tandem in the event my insurance or plan changes. If the recipient of the Tandem product is a minor, then your signature below represents that you have the legal authority to sign on his or her behalf and that you authorize Tandem to assist the minor or caretaker directly to provide support for Tandem products and services at no additional charge. This authorization will remain in effect until I revoke it in writing.

PATIENT/GUARDIAN SIGNATURE X	DATE (MM/DD/YYYY)
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