TANDEM™ DIABETES CARE

PATIENT INFORMATION / ASSIGNMENT OF BENEFITS

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

FAX completed signed form to:
(833) 509-3599

CANADA

PATIENT INFORMATION

PATIENT NAME (FIRST MIDDLE LAST)		PREFERRED PUMP ☐ t:slim X2
PATIENT STREET ADDRESS		GENDER ☐ Male ☐ Female
CITY / PROVINCE / POSTAL 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 NAME		SPECIALTY
OFFICE STREET ADDRESS		PHONE NUMBER
CITY / PROVINCE / POSTAL CODE		FAX NUMBER
DIABETES EDUCATION CENTRE	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
GROUP NUMBER	POLICY NUMBER	MEMBER ID # ODSP
POLICY HOLDER NAME IF DIFFERENT THAN ABOVE (FIRST, MIDDLE, LAST)		POLICY HOLDER DATE OF BIRTH (MM/DD/YYYY)

RELATIONSHIP TO PATIENT
☐ Self ☐ Spouse ☐ Parent ☐ 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
GROUP NUMBER	POLICY NUMBER	
POLICY HOLDER NAME IF DIFFERENT THAN ABOVE (FIRST, MIDDLE, LAST)		POLICY HOLDER DATE OF BIRTH (MM/DD/YYYY)

RELATIONSHIP TO PATIENT
☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Assignment of Insurance Benefits and Authorization to Release Information

I, _____ (PRINT PATIENT'S FULL NAME), hereby authorize Tandem Diabetes Care Canada, Inc. ("Tandem") to acquire from and/or release to my healthcare team, my insurer(s), and/or authorized distributors (e.g., Bayshore Specialty Rx Ltd.) 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, I assume responsibility for any deductible, co-pay, or other balance not covered by my insurance. I authorize Tandem or its authorized distributor to submit claims to my insurer on my behalf, and my insurer to pay benefits directly to Tandem or its authorized distributor. 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 or its authorized distributor. I will be informed of my insurance coverage and estimated out-of-pocket expense prior to product shipment or billing. I will notify Tandem in the event my insurance changes. I acknowledge that I have reviewed the Privacy Policy available at www.tandemdiabetes.ca, as well as all other posted policies such as the Terms of Use, and I understand and agree to the terms of such policies. I consent to Tandem and its authorized distributor 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. I understand and agree that all information I provide to Tandem may be stored and processed in any country 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. 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	DATE (MM/DD/YYYY)
X	

