TANDEM® DIABETES CARE

PATIENT INFORMATION / AOB

(Florida Residents Please See Reverse)
This form can also be filled out online at tandemdiabetes.com

Fax completed 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 public or private insurance provider(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 products 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 Notices of Privacy Practices for Tandem Diabetes Care and of the state and federal Medicare, health care fraud, and abuse disclosures or have reviewed those documents online at tandemdiabetes.com. If the recipient of the Tandem product is a minor, then I represent that I am the minor's guardian and I am signing on his/her 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. I further acknowledge that Tandem has various policies posted on Tandem's website (including Privacy Policy) and that I agree to the terms of those policies.

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

Florida Residents

- You have the right to report a complaint regarding the services you receive by calling Florida's Agency for Health Care Administration toll-free, at (888) 419-3456.
- You have the right to report abuse, neglect, or exploitation by calling toll-free (800) 962-2873.
- You have the right to report suspected Medicaid fraud by calling toll-free (866) 762-2237.

