TANDEM™ DIABETES CARE

PATIENT INFORMATION / ASSIGNMENT OF BENEFITS

This form can be accessed online at tandemdiabetes.ca

Fax or Email completed form to:
(833) 509-3599
BenefitsCanada@TandemDiabetes.com

CANADA

PATIENT INFORMATION

PATIENT NAME (FIRST MIDDLE LAST)

STREET ADDRESS

GENDER ☐ Male ☐ Female ☐ Decline to State

CITY | PROVINCE | POSTAL CODE

DATE OF BIRTH (MM/DD/YYYY)

EMAIL ADDRESS

HOME PHONE NUMBER ( ) -

MOBILE PHONE NUMBER ( ) -

NAME OF PARENT/LEGAL GUARDIAN (IF UNDER 18)

PREFERRED METHOD OF CONTACT ☐ Phone ☐ Email

BEST TIME TO CALL ☐ AM ☐ PM

EMERGENCY CONTACT NAME (FIRST, MIDDLE, LAST)

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 ( ) -

MEMBER ID | POLICY NUMBER

POLICY HOLDER NAME (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 ( ) -

MEMBER ID | 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

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 Notice of Privacy Practices available at tandemdiabetes.com/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. 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. 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)