TANDEM Diabetes Care

PATIENT INFORMATION / ASSIGNMENT OF BENEFITS (AOB)

Email or FAX completed form to:
(833) 509-3599
benefitscanada@tandemdiabetes.com

This form can be accessed online at tandemdiabetes.ca

CANADA

PATIENT INFORMATION

PATIENT'S NAME (FIRST MIDDLE LAST)			
PATIENT'S STREET ADDRESS			SEX ☐ Male ☐ Female ☐ Decline to State
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 NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP		EMERGENCY CONTACT PHONE NUMBER

PRESCRIBING PROVIDER INFO

PRESCRIBING PROVIDER'S 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'S NAME (FIRST, MIDDLE, LAST)			POLICY HOLDER'S 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'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

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. LMC Pharmacy), 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	DATE (MM/DD/YYYY)
X	

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