



Fax completed form with signature to
 877-467-8538 (toll-free fax)

Patient Information Form

1. Patient Information

*Patient First Name		*Patient Last Name		*Date of Birth (Month/Day/Year)	*Gender
Parent/Guardian First Name		Parent/Guardian Last Name		*Home Phone Number	*Mobile Phone Number
*Street				Adult Patient or Parent/Guardian Email Address	
*City	*State	*ZIP Code		Are you currently using a pump <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Other					

2. Physician Information

*Physician First Name	*Physician Last Name	*City	*State	*Zip Code
Street		Phone Number		

3. Medical Insurance

*Insurance Company Name	
Plan Type (HMO, PPO)	
Claims Address	
Phone Number	
Group #	*Member ID

4. Pharmacy Insurance

*Pharmacy Plan Name	*Member ID
*RxBIN	*RxGRP
RxPCN	
*Plan Type:	<input type="checkbox"/> Commercial
	<input type="checkbox"/> Medicare
	<input type="checkbox"/> Medicaid
<input type="checkbox"/> I do not have/unsure if I have Pharmacy Insurance	

Policy Holder Information Same as patient information above

*Last Name	*First Name	*Date of Birth	*Relationship to Patient
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Authorization I authorize all medical and other personnel involved in my treatment to disclose to Insulet Corporation, its distributors and its affiliates and wholly-owned subsidiaries (collectively referred to as "Insulet and/or its Affiliates") any and all medical or other information necessary to process and submit all past, present and future claims to my insurer. I further authorize my insurer and any other third party payor which provides me with coverage, and their respective clearinghouses and agents, to disclose to Insulet and its Affiliates the information necessary to facilitate reimbursement. I request that payment of authorized public and private insurance coverage benefits (including, but not limited to, any Medicare benefits to which I am entitled) be made to Insulet or its Affiliates and authorize them to collect directly all such benefits due for any items furnished by them. I understand that my insurer and/or Medicare may impose co-payments or deductibles for which I am responsible. If benefit payments due Insulet or its Affiliates are made directly to me, I shall immediately and without request from Insulet or its Affiliates, endorse and remit those payments. I agree to pay for any items, including replacement Omnipod® Insulin Management System components provided to me at my request, which are not covered by my health insurance and are not covered by the Omnipod® Insulin Management System warranties. If I have any questions about the amounts I am responsible for, I will contact my insurance company. Treatment for diabetes mellitus requires the use of certain types of medical supplies, and I authorize someone from Insulet and its Affiliates to contact me to coordinate or arrange delivery of supplies or to discuss provisions of diabetes-related supplies and services, including those not yet furnished to me by Insulet and its Affiliates. Any contact with me pursuant to this authorization may be made by Insulet and its Affiliates by telephone, text message, pre-recorded voice message, telephone calls generated by an automated telephone dialing system, mail, e-mail (including unencrypted email), or by other means of communications. I affirmatively consent to receiving marketing and non-marketing calls and texts sent on behalf of Insulet and its Affiliates. I also understand my mobile device carrier's messaging plan and related rates may apply to any messages or calls received. I have read and understand my rights and responsibilities contained in the Customer's Bill of Rights and Responsibilities provided with this Patient Information Form. This authorization is in effect until I revoke it in writing"

Signature of Patient or Parent/Guardian (print/sign)

Date

You have the right to:

1. Receive considerate and respectful service
2. Receive service without regard to race, creed, national origin, sex, age, disability, sexual orientation, illness, or religious affiliation.
3. Expect confidentiality of all information pertaining to you, your medical care and service.
Please review our HIPAA Privacy Notice at www.myomnipod.com and in the Omnipod® User Guide.
4. Receive a timely response to your request for service.
5. Receive continued service.
6. Select the medical equipment supplier of your choice.
7. Make informed decisions regarding your care planning.
8. Understand what services will be provided to you.
9. Obtain an explanation of charges, including policy for payment.
10. Agree to or refuse any part of the plan of service or plan of care.
11. Voice complaints without fear of termination of service or other reprisals.
12. Have your communication needs met.
13. I understand my consent is not required as a condition of purchase, that I can text HELP for more information and that I may opt out of receiving messages or calls at any time by following the instructions received from Insulet or it's Affiliates in any message or by calling 1-800-591-3455.

You have the responsibility to:

1. Ask questions about any part of the plan of service or plan of care that you do not understand.
2. Use the equipment for the purpose for which it was prescribed, following instructions provided for use, handling, care, safety and cleaning.
3. Supply Insulet Corporation with insurance information necessary to obtain payment for services.
4. Be accountable for charges not covered by your insurance. You are responsible for settlement in full of your account.
5. Notify us immediately of:
 - a. Equipment failure, damage or need of supplies.
 - b. Any change in your prescription or physician.
 - c. Any change or loss in insurance coverage.
 - d. Any change of address or telephone number, whether permanent or temporary.