

\*\*\* IN ORDER TO FULLY EXPEDITE BENEFITS, THIS FORM MUST BE COMPLETELY FILLED OUT \*\*\*

## PATIENT INFORMATION

Patient name:		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
Social Security no.:	Date of birth:	E-mail address:	
Address:			
City:	State:	Zip:	
Home phone:	Work phone:	Cell phone:	

## DOCTOR INFORMATION

Doctor's name:	Phone:		
Address:			
City:	State:	Zip:	

## PRIMARY INSURANCE INFORMATION

Insurance company: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS	Phone:		
Address:			
City:	State:	Zip:	
Policy no.:	Group no.:		
Policy holder:	Date of birth:		
Relationship to patient: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER			Social Security no.:
Employer:			Employer's phone:
Employer's address:			
City:	State:	Zip:	

## SECONDARY INSURANCE INFORMATION

Insurance company: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS	Phone:		
Address:			
City:	State:	Zip:	
Policy no.:	Group no.:		
Policy holder:	Date of birth:		
Relationship to patient: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER			Social Security no.:
Employer:			Employer's phone:
Employer's address:			
City:	State:	Zip:	

## MEDICARE COVERAGE

<input type="checkbox"/> YES <input type="checkbox"/> NO	Medicare no.:
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## PATIENT INFORMATION RELEASE AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

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, \_\_\_\_\_, do hereby authorize MiniMed Distribution Corporation, hereafter known as MDC (a wholly owned subsidiary of Medtronic MiniMed, Inc.), its parent, or any of its subsidiaries, to acquire from and/or release to my healthcare team and/or my insurance company(s), any information required for the purposes of healthcare management and/or for processing all medical claims on my behalf. I understand that upon acceptance of products from MDC, I assume responsibility for any deductible, copay, or other balance not covered by my insurance carrier. I authorize MDC to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to MDC. 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 MDC. I will be informed of my insurance coverage and estimated out-of-pocket expense prior to any shipment of product or any bills being sent.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Primary Policy Holder Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Secondary Policy Holder Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mail or fax to:  
**MEDTRONIC DIABETES**  
 18000 Devonshire Street  
 Northridge, CA 91325-1219  
**Fax: 1-800-433-9867**

Attn: Insulin Pump Therapy Consultants