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

Insulet Corporation
600 Technology Park Drive, Suite 200
Billerica, MA 01821
Fax: 877-467-8538
MyOmnipod.com

omnipod®
Insulin Management System

Patient Information Form

Confidential Patient Healthcare Information

1. Patient Information

Patient Name (Last, First) _____ Date of Birth (Month/Day/Year) ___/___/___ ☐ Male ☐ Female

Parent/Guardian (For children under 18 only) _____ Home Phone Number ___-___-___ Work Phone Number ___-___-___

Street _____ Adult Patient or Parent/Guardian Email Address _____

City _____ State _____ ZIP Code _____ Are you currently using a pump? ☐ Yes ☐ No Date when you started using the pump ___/___/___

2. Physician Information

Physician Name (Last, First) _____ Phone Number ___-___-___ Fax Number ___-___-___

Street _____ Email Address _____

City _____ State _____ ZIP Code _____ **Physician Staff Contact: Name** (Last, First) _____

3. Primary Insurance

IMPORTANT:
Please provide a copy of the front and back of your insurance card.

Policy holder contact information
☐ Same as patient information above

☐ HMO
☐ PPO
☐ POS
☐ Other

Insurance Company Name _____ Name (Last, First) _____

Claims Address _____ Date of Birth (Month/Day/Year) ___/___/___ Relationship to Patient _____

Phone Number ___-___-___ Street _____

Group # _____ Member ID _____ City _____ State _____ ZIP Code _____

Home Phone Number ___-___-___ Work Phone Number ___-___-___

PHARMACY INSURANCE:

RxBIN _____ RxPCN _____ RxGrp _____ Member ID _____

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 provision 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, mail, e-mail (including unencrypted e-mail), or by other means of communications. 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 ___/___/___

Signature of Policy Holder (print/sign) _____ Date ___/___/___

Fax completed form to **877-467-8538** or mail to address listed above. If you have any questions, call 800-591-3455.

INSULET CORPORATION

CUSTOMER'S BILL OF RIGHTS AND RESPONSIBILITIES

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.

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.