ASSIGNMENT OF PATIENT BENEFITS

PATIENT INFORMATION

Patient Name	DOB
Address	City/State/Zip
Phone	Email

PRESCRIBER INFORMATION

Prescriber Name	Phone
Address	City/State/Zip

PRIMARY INSURANCE

Insurance Name	Phone
Address	City/State/Zip
Policy Number	Group Number
Policy Holder Name	Policy Holder DOB
Relationship to Patient	Effective Date

SECONDARY INSURANCE

Insurance Name	Phone
Policy Number	Group Number

WHICH INSULIN PUMPS ARE YOU INTERESTED IN RECEIVING BENEFIT INFORMATION ON?

Animas One Touch Ping	Medtronic MiniMed Revel
Animas Vibe	Tandem t:slim
Insulet OmniPod	Tandem t:slim G4
Medtronic MiniMed 530G	Dexcom G4/G5

While every attempt is made to provide up-to-date information, Premier Care does not ensure the accuracy of the information provided. Since health or medical insurance reimbursement is affected by many factors, Premier Care makes no representation or guarantee that a patient will be successful in obtaining insurance reimbursement or any other payment.
I do hereby authorize Premier Care to submit claims to my insurance company/companies on my behalf, and my insurance company/companies to make payments directly to Premier Care for my diabetic products.

Patient/Guardian Signature: _____ Date:_____

PREMIER CARE
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