

## PATIENT INSURANCE INFORMATION AND ASSIGNMENT OF BENEFITS

Please provide the following to begin the insurance claims filing process.  
All information is personal and confidential.

### PATIENT INFORMATION

Patient Name:	Date of Birth:	<input type="radio"/> Male <input type="radio"/> Female
Address:	City, State, Zip:	
Home Phone:	Cell Phone:	
Work Phone:	Email Address:	

### PRESCRIBING PHYSICIAN

Physician Name:	Group Practice:
Address:	City, State, Zip:
Phone:	Fax:

### PRIMARY INSURANCE

Insurance Name:	Plan Type: <input type="radio"/> HMO <input type="radio"/> PPO <input type="radio"/> POS	Plan Phone:
Mailing Address:	City, State, Zip:	
Policy Number:	Employer/Group Number:	
Policy Holder Name:	Policy Holder Date of Birth:	
Relationship to Patient: <input type="radio"/> Spouse <input type="radio"/> Parent <input type="radio"/> Other	Effective Date:	

### SECONDARY INSURANCE

Insurance Name:	Plan Type: <input type="radio"/> HMO <input type="radio"/> PPO <input type="radio"/> POS	Plan Phone:
Mailing Address:	City, State, Zip:	
Policy Number:	Employer/Group Number:	
Policy Holder Name:	Policy Holder Date of Birth:	
Relationship to Patient: <input type="radio"/> Spouse <input type="radio"/> Parent <input type="radio"/> Other	Effective Date:	

While every attempt is made to provide up-to-date information, Dexcom, Inc. does not ensure the accuracy of the information provided. Since health or medical insurance reimbursement is affected by many factors, Dexcom, Inc. makes no representation or guarantee that a patient will be successful in obtaining insurance reimbursement or any other payment.

Dexcom, Inc. recognizes that medical information is confidential and will maintain the privacy of your medical information. Information will only be used and disclosed in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, many insurance companies require that medical information be submitted with claims to determine medical necessity. In order to authorize Dexcom to obtain medical information from your healthcare team, please complete, sign and date the statement below.

I do hereby authorize Dexcom to submit claims to my insurance company/companies on my behalf, and my insurance company/companies to make payments directly to Dexcom for my continuous glucose monitoring products. I also authorize Dexcom to submit referrals to Dexcom's contracted distributors if necessary to obtain reimbursement. I understand I am responsible for any deductible, co-payment, and other amounts not covered by my insurance company/companies. Dexcom will make every reasonable effort to collect payment from my insurance company. In the event the insurance company refuses to pay Dexcom, I will assume full responsibility for the payment. I understand that if my insurance company does not accept assignment of benefits, all correspondence and payments for service may be sent directly to me. I agree when such payments are received by me, I will make payment on my bill with a credit card, personal check, or by endorsing the insurance check "Pay to the Order of Dexcom" within five days. I agree to notify Dexcom immediately of any changes to my insurance coverage or if I change my insurance company. I consent to the release of all information, including medical records to or from my physician or representative of my physician and to or from the insurance company or Dexcom contracted distributors, for the purposes of healthcare management and/or for processing of medical claims.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name

Please fax completed form and front/back of insurance card to  
Dexcom at: **1.877.633.9266**

