YpsoPump®

YpsoPump®
Insurance Verification Information Form

Provide the following information to begin the insurance verification process. Please print clearly.

Patient Information

Patient Name: ______________________________

Address: ______________________________

City: ______________ Province: ______________

Postal Code: ______________________________

Email: ______________________________

Day Phone: ______________________________

Mobile Phone: ______________________________

Evening Phone: ______________________________

Date of Birth (yyyy-mm-dd): ______________________________

Female Male

Parent/Guardian Information (If patient is 18 years old or younger)

Name (Last Name, First Name): ______________________________

Daytime Number: ______________________________

Where did you hear about the YpsoPump® Insulin Pump?

____

Your preferred method of contact:

Email Telephone

Physician and Clinic Information

Physician Name: ______________________________

Physician Email Address: ______________________________

Physician Phone Number: ______________________________

Clinic Name: ______________________________

Address: ______________________________

City: ______________ Province: ______________

Postal Code: ______________________________

Clinic Phone: ______________________________

Clinic Fax: ______________________________

Educator Name: ______________________________

Email: ______________________________

Insurance: Are you currently registered for your Provincial Insulin Pump Program for coverage?

Yes No

More freedom. More confidence. With Ypsomed.

YPSOMED
SELFCARE SOLUTIONS

YpsoPump®

Primary Health Insurance Coverage

Policy Holder Name: ______________________________
Birth Date (yyyy-mm-dd): ______________________________
Policy Holder Phone Number: ______________________________
Policy Holder Email: ______________________________
Relationship to Patient: ______________________________
Employer: ______________________________
Insurance Company: ______________________________
Insurance Policy Number: ______________________________
Insurance Certificate Number: ______________________________

Secondary Health Insurance Coverage

Policy Holder Name: ______________________________
Birth Date (yyyy-mm-dd): ______________________________
Policy Holder Phone Number: ______________________________
Policy Holder Email: ______________________________
Relationship to Patient: ______________________________
Employer: ______________________________
Insurance Company: ______________________________
Insurance Policy Number: ______________________________
Insurance Certificate Number: ______________________________

I hereby confirm having read and understood the Ypsomed Data Privacy Policy.

Authorization for Client Insurance Verification

I hereby authorize Ypsomed Canada Inc. to act on my behalf (or my dependant's behalf) in the investigation and determination as to medical benefits coverage for the acquisition of the YpsoPump® Insulin Pump and/or related supplies required for an ongoing basis.

Primary Policy Holder Signature:
______________________________ Date (yyyy-mm-dd) ______________________________

Secondary Policy Holder Signature:
______________________________ Date (yyyy-mm-dd) ______________________________

Patient Signature or Parent/Guardian
______________________________ Date (yyyy-mm-dd) ______________________________

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