Animas® CORPORATION a Johnson & Johnson company

Patient Insurance Information and Assignment of Benefits

Patient Information			
Patient Name:		Date of Birth:	
Street Address:			
City:	State:	ZIP:	
Home Phone:		Cell Phone:	
Work Phone:		Email Address:	
Prescribing Physician			
Physician Name:		Group Practice:	
Street Address:			
City:	State:	ZIP:	
Phone:		Fax:	
Primary Insurance			
Insurance Name:		Plan Phone:	
Plan Type: ☐ HMO; ☐ PPO; ☐ POS			
Street Address:			
City:	State:	ZIP:	
Policy #:		Employer/Group #:	
Rx ID:	Rx BIN:	Rx Grp:	Rx PCN:
Policy Holder Name:		Policy Holder Date of Birth:	
Relationship to Patient:		Effective Date:	
Secondary Insurance			
Insurance Name:		Plan Phone:	
Plan Type: ☐ HMO; ☐ PPO; ☐ POS			
Street Address:			
City:	State:	ZIP:	
Policy #:		Employer/Group #:	
Rx ID:	Rx BIN:	Rx Grp:	Rx PCN:
Policy Holder Name:		Policy Holder Date of Birth:	
Relationship to Patient:		Effective Date:	

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

Animas Corporation 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 Animas to obtain medical information from your healthcare team, please complete, sign and date the statement below.

I do hereby authorize Animas to submit claims to my insurance company/companies on my behalf, and my insurance company/companies to make payments directly to Animas and or their contracted supplier. I also authorize Animas to forward my insurance and account information to Animas' contracted distributors if necessary to obtain additional supplies for continuous glucose monitoring (CGM). I understand I am responsible for any deductible, co-payment, and other amounts not covered by my insurance company/companies. Animas will make every reasonable effort to collect payment from my insurance company. In the event the insurance company refuses to pay Animas, 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 Animas" within five days. I agree to notify Animas 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 Animas contracted distributors, for the purposes of healthcare management and/or for processing of medical claims.

Patient/Guardian Signature:_____ **Date:**_____

Print Patient Name:_____

The Animas® Vibe® Insulin Pump and Continuous Glucose Monitoring (CGM) System is approved for patients 2 and older in the US.

Please fax completed form and front/back of insurance card to Animas at 1-877-331-7300 or fax to your Territory Manager at _____.