WAKE FOREST UNIVERSITY SPORTS MEDICINE - HEALTH INSURANCE INFORMATION 08-09

Athlete's Name (first, middle, last) ____ Social Security No.___________________________________

Sport ______________________________ Date of Birth ______________________________ Class: FRSH SOPH JR SR 5TH YR

Athlete's Cell Phone:_____________________

The Wake Forest University Department of Athletics accident policy provides insurance for student-athletes with *injuries occurring only when participating in the play or practice of intercollegiate sports*. The accident policy is considered "EXCESS" or "SECONDARY" to any other collectible group insurance benefits. Therefore, any claims for benefits must *first* be filed with the group insurance company providing coverage for the son/daughter through the parent's employer or individual policy. Only after all available benefits have been exhausted, our athletic insurance company will then consider payment for any remaining balances.

Wake Forest University does not have the option of waiving the requirement of filing with your group insurance company.

FATHER'S INFORMATION	MOTHER'S INFORMATION
Name ____	Name ____
(required) SS #:__________________ (required) Date of Birth ___________________	(required) SS #: ______________________ (required) Date of Birth __________________
Home Address ____ ____	Home Address ____ ____
Employer ____	Employer ____
Employer Address ____ ____	Employer Address____ ____
Home Phone _________________ Work Phone ___________________ Cell Phone ___________________	Home Phone __________________ Work Phone ___________________ Cell Phone _____________________
Name of Insurance Co. ____________________________________	Name of Insurance Co. ____________________________________
Subscriber ID#: ______________________ Group Policy#__________________	Subscriber ID#: ____________________ Group Policy#___________________
Claims Phone # _________________ Pre-authorization Phone #_____________________	Claims Phone # _________________ Pre-authorization Phone #_____________________
Mailing Address for Claims ____________________________________ ____	Mailing Address for Claims ____________________________________ ____
Is your dependant son/daughter covered under this policy? ❐ yes ❐ no	Is your dependant son/daughter covered under this policy? ❐ yes ❐ no
Please check the type of insurance that your son/daughter has: ❐ HMO (health maintenance org.) ❐ PPO (preferred provider org.) ❐ POS (point of service)	Please check the type of insurance that your son/daughter has: ❐ HMO (health maintenance org.) ❐ PPO (preferred provider org.) ❐ (POS (point of service)
If you have an HMO, do you have Out-of-Network Benefits? ❐Yes ❐No	If you have an HMO, do you have Out-of-Network Benefits? ❐Yes ❐No
Is a referral required from your Primary Care MD? ❐Yes ❐No	Is a referral required from your Primary Care MD? ❐Yes ❐No
Primary Care MD Name ____________________________ Primary Care MD Phone ____________________________	Primary Care MD Name ____________________________ Primary Care MD Phone ____________________________
❐ Notification is required for an Emergency Dept. visit. ❐ Pre-authorization is required for medical - diagnostic services. If you have two health insurances, which one is primary? _____________	❐ Notification is required for an Emergency Dept. visit. ❐ Pre-authorization is required for medical - diagnostic services. If you have two health insurances, which one is primary? _____________

READ CAREFULLY

- I hereby authorize a claim for payment of medical benefits to all providers for all services and materials they provide during the care of an injury/illness.
- I agree to supply any and all information requested by my primary insurance, Wake Forest Univ. and their excess insurance company in a timely manner in order to expedite the claims process.
- I hereby authorize Wake Forest University and their excess insurance company to secure and inspect copies of case history records, lab reports, diagnoses, x-rays, and any other data pertaining to the injury/illness I am receiving care for or previous confinements of disabilities relevant to the care of the injury/illness.
- I hereby authorize the Sports Medicine staff of Wake Forest University and/or my coach to hospitalize and secure treatment for me for any athletic injury/illness. If the athlete is under 18 years of age, the undersigned parent grants permission to the Sports Medicine staff of Wake Forest University and/or their coach to hospitalize and secure treatment for their son/daughter or ward for any athletic injury/illness.
- A photocopy or fax of this authorization shall be deemed as effective and valid as the original.
- I will notify the Sports Medicine staff of Wake Forest University immediately upon any change in the above health insurance information.
- I hereby certify that the answers provided are true, complete and correct to the best of my knowledge.

Date ____________ Signature of Parent ____________________________________ Signature of Athlete ____________________________________