

INSURANCE INFORMATION
University of Dayton Sports Medicine

Sport _____

Name _____ Date of Birth _____

Home Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Social Security No. _____

My son/daughter is **not** covered by insurance for athletic injuries.

My son/daughter is covered by insurance for athletic injuries under: **Mother / Father**

Policy Holder _____

Policy Holder's Date of Birth _____ Work Phone _____

Employer's Name _____

Other Parent's Name _____ Daytime Phone _____

Insurance Company _____

Mailing Address for Claims _____

City _____ State _____ Zip _____

Phone _____

ID# _____ Policy Number _____

Plan Number _____ Group Number _____

Is this insurance considered: **HMO** **PPO** **Other**

Does your insurance require a referral from your Primary Care Physician? **Yes** **No**

Primary Care Physician: _____ Office Phone _____

Pre-Authorization Procedures: _____

Does your insurance plan include coverage for **Dental Services**? **Yes** **No**

Does your insurance include coverage for **Prescription Drugs**? **Yes** **No**

(If yes, please include information on Dental coverage and/or a copy of Prescription Drug Card)

Other Medical Insurance? Please list on back.

I hereby authorize a claim to be filed on my behalf under the above group medical policy in the event an athletic injury is sustained by _____.

I hereby certify that the answers provided are true, complete and correct to the best of my knowledge.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature of Parent _____ **Date** _____