



# FURMAN UNIVERSITY SPORTSMEDICINE CENTER

## ATHLETIC INSURANCE ENROLLMENT FORM

FULL NAME OF STUDENT ATHLETE \_\_\_\_\_

SPORT(S) \_\_\_\_\_

Permission is hereby granted to FURMAN UNIVERSITY ATHLETIC DEPARTMENT to seek any needed medical or minor surgical treatment, x-ray examinations, physical therapy, and immunization for the above named student. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious manner possible. If said physician is unable to communicate with me, the treatment necessary for the best interest of the above named student may be given. I hereby authorize the Furman University Sportsmedicine Center to release my (student) information acquired in the course of my examination or treatment. I hereby authorize payment directly to the provider of medical treatment under my reimbursement of benefits included under my insurance policy. A copy of this authorization shall be deemed as effective and valid as the original and remain effective for one year from the date signed below.

PARENT SIGNATURE \_\_\_\_\_ RELATIONSHIP TO STUDENT \_\_\_\_\_ STUDENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

### ATHLETE INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ # \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Birth date \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Permanent Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Parent Home Number \_\_\_\_\_ Parent Work Number \_\_\_\_\_ Parent Email Address \_\_\_\_\_ Student Cell Phone \_\_\_\_\_

### EMERGENCY CONTACT

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance Company \_\_\_\_\_ Group # or Name \_\_\_\_\_ Policy Number \_\_\_\_\_ Type  HMO  PPO  POS  Other \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Father  Mother  
 Self  Other

Relationship to Athlete \_\_\_\_\_ Name of Insured \_\_\_\_\_ Insured's Birth date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Group # or Name \_\_\_\_\_ Policy Number \_\_\_\_\_ Type  HMO  PPO  POS  Other \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Father  Mother  
 Self  Other

Relationship to Athlete \_\_\_\_\_ Name of Insured \_\_\_\_\_ Insured's Birth date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Does your insurance company require a second opinion?  Yes  No  
What is their toll-free telephone number? \_\_\_\_\_ Does your insurance company provide prescription coverage?  Yes  No

Does your insurance company require referral/pre-certification from Primary Care Physician or insurance company?  Yes  No  
IF YES, YOU MUST COMPLETE PAGE 2 (REFERRAL/PRE-CERTIFICATION FORM).

IF YOUR INSURANCE COMPANY WILL NOT ALLOW YOUR CHILD TO BE SEEN OUTSIDE THEIR NETWORK, THEN YOU NEED TO ASK FOR SOME TYPE OF GUEST MEMBERSHIP (TELL THEM THAT HE/SHE IS A COLLEGE STUDENT).

If you do not have ANY insurance, we need a written statement from you to accompany this form.  
Failure to complete and return this form will result in your son/daughter being withheld from ALL athletic activity.  
PLEASE NOTIFY THE SPORTSMEDICINE CENTER OF ANY CHANGE IN INSURANCE COVERAGE



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## PRE-CERTIFICATION FORM

Athlete Name: \_\_\_\_\_ Sport: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Phone: \_\_\_\_\_

Insured Parent/Guardian: \_\_\_\_\_

Contract Number

Group Number

Plan Number

Policy Number

**PLEASE CONTACT YOUR INSURANCE COMPANY AND REQUEST ALL INFORMATION BELOW**

Referral or Pre-certification Required For:

- Doctor Visit \_\_\_\_\_
- Outpatient Surgery \_\_\_\_\_
- Inpatient Surgery \_\_\_\_\_
- MRI \_\_\_\_\_
- Physical Therapy \_\_\_\_\_

Who should be contacted for referral/pre-certification?  Insurance Company  
 Primary Care Physician

Name Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company Pre-certification Phone Number: \_\_\_\_\_

Will your insurance company allow your child to be treated out of your network?  Yes  
 No

What are your out of network benefits:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date Insurance Company was contacted: \_\_\_\_\_

**FURMAN UNIVERSITY ATHLETIC DEPARTMENT RESERVES THE RIGHT TO REQUIRE MEDICAL SERVICES, DUE TO AN ATHLETIC INJURY, BE PERFORMED WITHIN YOUR HMO/PPO NETWORK.**

Parent Signature

Date

\*\*\*PLEASE NOTIFY THE SPORTSMEDICINE CENTER OF ANY CHANGES IN INSURANCE COVERAGE\*\*\*