



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 Furman Phone Number 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



FURMAN UNIVERSITY SPORTSMEDICINE CENTER

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*****