Villanova Sports Medicine Health Insurance Information

Date_____________

Name___________________

Sport____________________

Sex: Male Female

Year: 1 2 3 4 5

Social Security Number_____________________

Birthdate__________________

Home Address__________________________
____

Home Phone____________________________

Insurance Information

Insurance Company_________________________________

Type of plan: HMO PPO Standard Medical

Address:____________________________________
____

Phone Number:_______________________________

Policy Holder:________________________________

Policy Number:_______________________________

Address:_____________________________________
____

Group Number:___________________________

Contact Code:___________________________

Primary Care Physician:__________________________

Primary Care Physician's Phone:___________________

Pharmacy Coverage?: Yes No

Pharmacy Co-Pay?: Yes No

Co-Pay Amount:____________________

Parent Information

Father:_____________________________

Father's Work Phone:_____________________________

Mother:____________________________

Mother's Work Phone:____________________________

Emergency Contact, If parents are unavailable

Name:_____________________________

Relationship:____________________________

Phone Number:__________________________

- I authorize payment of medical benefits to all providers of services 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 care insurance, Villanova University and their excess insurance company in a timely manner in order to expedite the claims process.
- I hereby authorize Villanova 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 injury/illness I am receiving care for or previous confinements of disabilities relevant to the care of injury/illness.

- I authorize the Villanova University Sports Medicine Staff and/or my coach to hospitalize and secure treatment for me for any injury/illness. If the athlete is under 18 years of age, the undersigned parent grants permission.

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

- I will notify the Villanova University Sports Medicine Staff immediately upon any change in health insurance information.

Signature:_____________________________

Date:________________________________

- PLEASE FILL OUT COMPLETELY, LEAVE NO AREAS BLANK
- **PLEASE INCLUDE COPY OF INSURANCE CARD**