Flagler College Sports Medicine

Medical Insurance Information/Authorization Form

Dear parent(s) or guardian(s): The Flagler College Athletic Insurance Policy which provides insurance for your student athlete for injury sustained while participating in intercollegiate sports is a Secondary or "Excess" coverage plan. This means it pays benefits only after taking into consideration those amounts payable under any other insurance plan. We, as the school do not have the option of waiving this provision. Please provide the information requested below, i.e. medical insurance information/authorization, copy of insurance card, copy of prescription card, etc.

Student-Athlete Name_____ Date of Birth___/___/___ Sex_____

SS#_____ Sport_____

Father's Name_____ SS#_____

Address_____

Home Phone Number (_____)_____ Cell Phone Number(_____)_____

Father's Date of Birth___/___/___

Father's Employer_____ Work Phone Number (_____)_____

Employer's Address_____

Insurance Provider_____ Policy #_____ Group #_____

Mailing Address for Insurance Provider Claims Office

Effective Date of Policy___/___/___ Expiration Date of Policy___/___/___

Mother's Name_____ SS#_____

Address_____

Home Phone Number (____)_____ Cell Phone Number(_____)_____

Mother's Date of Birth___/___/___

Mother's Employer_____ Work Phone Number (_____)_____

Address_____

Insurance Provider_____ Policy #_____ Group #_____

Mailing Address for Insurance Provider Claims Office

Effective Date of Policy___/___/___ Expiration Date of Policy___/___/___

The following questions will assist the medical staff of Flagler College in expediting the care of your son/daughter in case of injury. You must contact your primary insurance provider to answer the following questions:

Is your student-athlete covered by medical insurance? Yes___ No___

Is your primary insurance a PPO? Yes___ No___

Is your primary insurance an HMO? Yes___ No___

If your student-athlete is an out of state student, will he/she be covered in FL, GA, AL, & TN?
Yes___ No___

Does your insurance cover athletic injuries? Yes___ No___

Do you need referrals for office visits to specialists? Yes___ No___

Do you need pre-certification/authorization for outpatient x-rays? Yes___ No___

Do you need pre-certification/authorization for outpatient MRI/CT/NUC MED scans?
Yes___ No___

If so, does your insurance require pre-certification for hospitalization/surgeries?
Yes___ No___

Does your insurance require a second opinion for surgery? Yes___ No___

Is there a deductible on your insurance plan? Yes___ No___

If so, how much is your deductible? $_____

Do you need to provide certification that your son/daughter is a full-time college student in order for them to be covered under your insurance plan? Yes___ No___

Does your insurance include dental coverage in FL? Yes___ No___

Should your son or daughter be covered by an HMO, please provide the following:

Name of Plan_____ Phone Number (___)_____

Phone Number for Out-Of-Area or After-Hours Care (___)_____

Mailing Address of HMO Provider_____

Primary Care Physician_____ PCP's Phone Number (____)_____

PCP's Office Address _____

***A copy of the insurance card and if provided, a copy of the prescription card must be attached to this form.**

_____ ___/___/___

Parent or Guardian Signature Date

_____ ___/___/___

Student-Athlete Signature Date

Photocopies of this form are as binding as is the original and shall remain in effect until revoked in writing.