



Athletic Treatment Center

HEALTH INSURANCE INFORMATION

PLEASE PRINT

NAME OF STUDENT: _____ DATE OF BIRTH ____/____/____

STUDENT ID #: _____ SS# _____ SPORT: _____

TUCSON ADDRESS: _____ ZIP: _____ PHONE: () _____

FATHER/GUARDIAN'S NAME: _____ PHONE () _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ PHONE: () _____

MOTHER/GUARDIAN'S NAME: _____ PHONE: () _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

EMPLOYER: _____ PHONE: () _____

Please place your initials here if your son/daughter is not covered under your insurance policy _____

INSURANCE COVERAGE

POLICY HOLDER:(NAME): _____ POLICY HOLDERS DATE OF BIRTH: _____

ID#(i.e. XDB) _____ GRP# _____ EFFECTIVE DATE _____

RX CODE: _____ **PLEASE PROVIDE US WITH COPIES OF CARDS - FRONT AND BACK**

INS COMPANIES NAME: _____ **HMO** ___ **PPO** ___ **GROUP** ___ **STANDARD** ___

CLAIMS ADDRESS: _____ CITY: _____ STATE ___ ZIP: _____

PHONE: () _____

DEDUCTIBLE : Individual \$ _____ Family:\$ _____ Does this policy have coverage limitations? Y N

VISION COVERAGE ? : Y N CONTACT/GLASSES COVERAGE ? Y N

PLEASE COMPLETE THE OTHER SIDE

PLEASE CIRCLE THE ANSWER TO THE FOLLOWING QUESTIONS

- Does this insurance require pre-authorization for services from a primary care physician? Y N
If this policy is an HMO does it only cover services provided in your home State? Y N
Is your son/daughter on a insurance guest plan out of state while attending The University of Arizona? Y N
Can this athlete choose a primary care doctor in the State of Arizona? Y N
Does this athlete have any pre-existing conditions not covered by this policy? Y N
Are there any specific limitations to this policy we should know about? Y N

List: _____

DENTAL/OTHER INSURANCE COVERAGE

PLEASE PROVIDE COPY OF CARD

POLICY HOLDER:(NAME): _____ POLICY HOLDERS DATE OF BIRTH: _____

ID#(INCLUDE ANY ALPHA CHARACTERS) _____ GRP# _____ EFFECTIVE DATE : _____

COMPANIES NAME: _____ NETWORK _____ GROUP _____ STANDARD _____

CLAIMS ADDRESS: _____ CITY: _____ STATE _____ ZIP: _____

PHONE: () _____ COVERAGE LIMITATIONS: _____ DEDUCTIBLE : _____

NETWORK GROUP: _____

I/we have read and understand The University of Arizona's Medical Policy. <http://www.u.arizona.edu/~cats/> (Important dates and Info) The information provided is accurate and completed to the best of my/our knowledge. I/we understand that any incorrect or undisclosed information can result in medical claims being incorrectly processed and delay payment of said claims. In the event the primary insurance pays you directly, it is your responsibility to forward the payment to the provider of service, along with a copy of the insurance explanation of benefits. I/we also do hereby give release to the insurance company to pay any benefits due to the Provider of Services.

FATHER/GUARDIAN'S SIGNATURE : _____ DATE: _____

MOTHER/GUARDIAN'S SIGNATURE : _____ DATE: _____

ADDITIONAL INFORMATION:

Please provide your e-mail address: _____

Direct your questions to mbrinton@u.arizona.edu or (520) 621 0819

The University of Arizona
Mckale Center N108
Tucson AZ 85721-0096