



**William & Mary**  
**Division of Sports Medicine**  
**Entering Student Athlete 2019-2020**

We are pleased to welcome you to the Tribe Athletics family. There are a few items that must be completed and returned no later than **June 1st** so that we can establish your personal, confidential file with the Division of Sports Medicine and with the Student Health Center. These items are necessary in medically clearing you for participation in intercollegiate athletics at William & Mary and establishing your eligibility for coverage under our secondary insurance policy. Incomplete forms will delay the process. **This process must be complete before you will be allowed to participate in any athletic activity.**

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### **Medical Forms**

- Please schedule an appointment as soon as possible with a physician for a physical examination and sickle cell screening. ***NCAA requirements mandate that your last physical be within the last 6 months for completion of our physical form.***
- You must print the following forms for you and your physician to complete at your appointment.
  - Student Health Center Health Evaluation Form  
([www.wm.edu/offices/wellness/healthcenter/documents/healthevaluationform.pdf](http://www.wm.edu/offices/wellness/healthcenter/documents/healthevaluationform.pdf))
    - **Please note the due date on page 1 of this form. There is a \$100 late fee for failure to submit the form by the required date.**
  - Athletic Participation Physical Form (included in this packet)

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### **Health Insurance Form**

- Please note that you must include a copy of the **FRONT** and **BACK** of your insurance card in the space provided.
- You are also required to provide proof of insurance to the Student Health Center. Please understand that this is separate from what Sports Medicine is asking you to do. Please do both.
- TriCare Special Notes:
  - **If you have TriCare, you MUST specify Prime or Select.**
  - If you are enrolled in TriCare Standard, be aware that it has transitioned into TriCare Select as of January 2019. Please enroll into the East Region, which will put you into TriCare Humana. You will have to select a Primary Care Physician (PCP) such as Dr. Glenn Rauchwarg or Dr. Christopher Ciccone.
  - If you are enrolled in TriCare Prime, know that your coverage from William & Mary Team Physicians will be limited. The scope of this plan requires you to see a physician at Fort Eustis in Newport News (40 minutes from campus).
  - If you would like to switch plans, a change of address qualifies as a life event to enroll outside of the normal enrollment period.

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### **Waive OR Enroll in the School's Insurance**

- **If you have existing health care coverage** for your child and DO NOT wish to purchase the health insurance coverage offered through the Student Health Center, you need to visit [www.wm.edu/health/insurance](http://www.wm.edu/health/insurance) to submit a waiver request. **YOU MUST SUBMIT THIS ONLINE.** However, if you have existing health care but do not have coverage in the state of Virginia, you may want to consider purchasing the health insurance policy offered through the Student Health

Center. You will need to submit an enrollment request for this. Please see item below regarding lack of insurance coverage.

- If you do not submit this request by the deadline on the website, you will be automatically billed for coverage under the student insurance administered by United Healthcare Student Resources. The opening & closing dates are available on the website at the above link.
- Denying the student health insurance DOES NOT affect your ability to be seen at the Student Health center or the Athletic Department's secondary insurance coverage.
- **If you do not have existing insurance coverage**, you should purchase the health insurance policy offered through the Student Health Center. Please visit [www.wm.edu/health/insurance](http://www.wm.edu/health/insurance) to submit an enrollment request. **YOU MUST SUBMIT THIS ONLINE.**
  - The opening & closing dates are available on the website at the above link.

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### **ADHD Medication Exemption Information Form (if applicable)**

- The National Collegiate Athletic Association (NCAA) bans certain classes of drugs because they can harm student-athletes and could create an unfair advantage in competition. The NCAA will grant medical exceptions if adequate documentation showing the student-athlete has undergone a diagnostic evaluation for a type of drug. Exceptions may be granted for substances included in the following classes of banned drugs: anabolic agents, stimulants, beta blockers, diuretics, anti-estrogens, and peptide hormone. If you are on these medications, print the ADHD Medication Exemption Information Form at the end of this packet and give to your doctor to obtain the proper documentation for your medication so that we have it on file in the Athletic Training Facility. Your physician needs to complete the form **and** include the necessary documentation required in the form. The NCAA now requires us to have this information on file.

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### **Submitting your forms**

Please mail the completed forms to the appropriate addresses shown below by **June 1<sup>st</sup>**. If you mail forms to the incorrect location, it will delay the processing of your paperwork.

Please keep pages 9-14 for your records.

Please mail the **Athletic Participation Physical Form, Health Insurance Form, and ADHD Medication Exemption Information Form** (if applicable) to:

William & Mary  
Division of Sports Medicine  
PO Box 399  
Williamsburg, VA 23187-0399

Please mail the **Student Health Center Health Evaluation Form** to:

William & Mary  
Student Health Center  
PO Box 8795  
Williamsburg, VA 23187-8795

If you have questions regarding these forms or have trouble downloading these forms, please email Melanie Eley at [mneley@wm.edu](mailto:mneley@wm.edu) or call (757) 221-3407.

**Athletic Participation Physical Form**

**William & Mary  
Division of Sports Medicine**

**I. Contact Information**

Student's Name: \_\_\_\_\_  
Last First MI

What is your legal gender (circle)? Male Female What is your pronoun (circle)? He/Him She/Her Them

SSN \_\_\_\_\_ Student ID # \_\_\_\_\_

Sport \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Entering Status (circle): Fr. So. Jr. Sr. Grad Expected year of Graduation: \_\_\_\_\_

Athlete's Email: \_\_\_\_\_ Athlete's Cell Phone ( ) \_\_\_\_\_  
(W&M account)

Parents' Names \_\_\_\_\_ Parent's Email: \_\_\_\_\_  
\_\_\_\_\_

Home Address \_\_\_\_\_  
(Parents) Street City State Zip

Parents' Home Phone ( ) \_\_\_\_\_ Parent's Cell Phone ( ) \_\_\_\_\_ (Mother)  
( ) \_\_\_\_\_ (Father)

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**CONSENT FOR TREATMENT**

I give authorization to the William & Mary Sports Medicine staff to evaluate and treat any injuries that occur during my athletic participation at the university. This includes immediate first aid and treatment, physical exam, follow-up, and rehabilitation in the athletic training facility as well as at the Student Health Center. I understand that the team physician has the authority to prohibit me from further participation because of injury and/or because of an undue liability risk to William & Mary.

Student-athlete Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's Signature (if athlete is under 18 years of age) \_\_\_\_\_ Date \_\_\_\_\_

**THE NEXT TWO PAGES TO BE COMPLETED BY THE STUDENT-ATHLETE OR PARENT:**

**Omitting or providing fraudulent information may result in dismissal from a team or a cancellation in athletic aid (scholarship).**

**II. Personal History - Please answer ALL questions. Leave no blank spaces.**

Childhood diseases \_\_\_\_\_

Do you have any drug allergies? \_\_\_\_\_ If yes, please list drug & reaction \_\_\_\_\_

Do you have any food or insect allergies? \_\_\_\_\_ If yes, please list food & reaction \_\_\_\_\_

Significant medical conditions (dates & diagnoses) \_\_\_\_\_

Surgeries not related to an athletic injury \_\_\_\_\_

Current medications and reasons for use \_\_\_\_\_

**Check either Yes (Y) or No (N) to indicate whether you have (or had in the past) these problems. Provide details below.**

Y	N		Y	N		Y	N	
		Hearing impairment			Cancer or malignancy			Rheumatic fever
		Visual impairment			Hepatitis or liver disease			Heat illness
		Allergies			Lung disease			Cold illness
		Anemia			Seizure disorder			Menstrual irregularities
		Asthma			Infectious mononucleosis			Eating disorder
		Diabetes			Kidney infection or stone			Depression
		High cholesterol			Headaches			Anxiety
		Gastrointestinal disorder			Pneumonia			Contacts
		Thyroid disorder			Tuberculosis or positive TB test			Other
		Bleeding disorder			Rheumatoid arthritis			

Details \_\_\_\_\_

**Check either Yes (Y) or No (N) to indicate whether you have (or had in the past) these problems. Provide details below.**

Y	N	
		Chest pain/discomfort/tightness/pressure related to exertion
		Unexplained syncope/near-syncope (temporary loss of consciousness or fainting)
		Excessive exertional and unexplained dyspnea (difficult of labored breathing), fatigue, or palpitations associated with exercise
		Prior recognition of a heart murmur
		Elevated blood pressure
		Prior restriction from participation in sports
		Prior testing for the heart, ordered by a physician

Details \_\_\_\_\_

\_\_\_\_\_(NAME)

**III. Family History – Check either Yes (Y) or No (N) to indicate if condition exists in your family (immediate family, grandparents, aunts, uncles). Please provide details below.**

Y	N		Y	N		Y	N		Y	N	
		Allergies			High blood pressure			Cancer			Psychiatric disorders
		Anemia			Bleeding disorders			Eye disorders			Other
		Asthma			Lung disease			Tuberculosis			
		Diabetes			Stroke			Ulcer			

Details \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Check either Yes (Y) or No (N) to indicate if condition exists in your family (immediate family, grandparents, aunts, uncles). Please provide details below.**

Y	N	
		<b>Premature</b> death (sudden and unexpected, or otherwise) before age 50 attributable to heart disease in $\geq 1$ relative
		<b>Disability</b> from heart disease in close relative < 50 years of age
		Hypertrophic cardiomyopathy OR dilated cardiomyopathy
		Long QT-syndrome
		Arrhythmias
		Other specific cardiac conditions (please indicate):

Details \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IV. Injury History - Please read and answer ALL questions!**

Have you ever been found to have only one of the following paired organs, and if so, which one is missing?

Eyes	Yes	No	Right	Left
Kidneys	Yes	No	Right	Left
Ovaries	Yes	No	Right	Left
Testicles	Yes	No	Right	Left

1. Have you or a family member been diagnosed with Marfan’s Syndrome? **YES** (If yes, who?) \_\_\_\_\_ **NO**

2. Have you or a family member been diagnosed with the Sickle Cell Trait? **YES** (If yes, who?) \_\_\_\_\_ **NO**

3. Do you have any other medical illness or injury, past or present, that we should know about for your own protection?  
**YES NO**

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any of the following problems that may have limited your performance and/or caused prolonged pain/discomfort? If **YES**, please provide details below (**date of onset and side, left or right**).

Problem	Yes	No	Date of Onset	Left	Right	Explain (further details at bottom)
Knocked Unconscious						
Concussion						
Neck Injury						
“Burner, Stinger”						
Back Pain						
Shoulder						
Knee						
Ankle						
Foot						
Lower Leg						
Hip						
Elbow						
Wrist						
Arm						
Hand						
Surgery						
Physical Therapy						

Details/Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**V. Physical Examination**

**TO THE LICENSED HEALTH PROFESSIONAL (D.O., M.D., P.A., N.P.) PERFORMING THIS EVALUATION:**

- Please review the student’s health history and provide additional details as needed.
- Please complete the physical examination and comment on all positive findings.
- All sections of examination must be filled out.

Height \_\_\_\_\_ inches Weight \_\_\_\_\_ lbs. BP \_\_\_\_\_ Pulse \_\_\_\_\_ Vision R 20/\_\_\_\_ L 20/\_\_\_\_

Date of Sickle Cell Solubility Test \_\_\_\_\_

Result \_\_\_\_\_

(This testing is **REQUIRED** by the NCAA for **ALL** Student-Athletes regardless of ethnicity, family history, etc.)

**Cardiac Exam – Please complete ALL sections. Leave no areas blank.**

**Family History of Heart Disease Yes No If yes, explain \_\_\_\_\_**

**Heart, including murmur: \_\_\_\_\_**

**Lung: \_\_\_\_\_**

**Peripheral Pulses for Coarctation: \_\_\_\_\_**

**Please record examination findings below. If abnormal, please elaborate.**

	Normal	Abnormal	Explanation		Normal	Abnormal	Explanation
HEENT				Genitourinary			
Eyes				Back			
Breasts				Extremities			
Gastrointestinal				Skin			
Hernia				Surgical Scars			
Neuropsychiatric				Endocrine			

	Yes	No		Yes	No		Yes	No
Shortness of breath			Dyspnea on Exertion			Chest Pain		
Palpitations			Dizziness			Syncope		

**Are there any physical stigmata of Marfan syndrome?** \_\_\_\_\_

**Physical Examination:** Are there any conditions of which we should be aware? Describe fully. Use an additional sheet if necessary.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have reviewed the information above and make the following recommendations for his/her participation in athletics:

\_\_\_\_\_ Cleared                      \_\_\_\_\_ Not Cleared                      \_\_\_\_\_ Cleared – f/u needed (explain below)

F/U Recommendations: \_\_\_\_\_

Examiner’s Signature (not typed)                      Street                      City                      State                      Zip

Examiner’s Name (PRINTED)                      Telephone                      Date

**ACCEPTANCE OF RISK/LIABILITY WAIVER**

**Please read completely and carefully, and sign below:**

- a. The undersigned hereby certifies that the answers to questions on the Athletic Participation Physical Form and physical examination are correct, true, and honest.
- b. We understand that having passed the pre-participation medical/physical examination does not necessarily mean that the student-athlete is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify them.
- c. We understand and accept the risks of injury, the possibilities of permanent disability, and death inherent to the relevant sport. By signing below the student-athlete pledges to do the best to reduce these risks by keeping in the best physical condition and following the advice of the team physician, attending physician, athletic trainer, and coach concerning the prevention, treatment, and rehabilitation of athletic injuries.
- d. We grant permission to the Sports Medicine staff to hospitalize and/or secure treatment for me for any athletic injury. If the student-athlete is under the age of 18, the undersigned parent grants permission to the Sports Medicine staff to hospitalize and secure treatment for my son/daughter or ward for any athletic injury.
- e. I give permission for Certified Athletic Trainers (within the Athletic Department), Student Health Center staff, and all consulting physicians to exchange, written or orally, any information concerning any injuries or illness that effect my ability to participate in physical activities throughout the time in which I am an official student athlete at William & Mary. Any change in this status must be made in writing by the student-athlete and rendered to all parties concerned.

We, the undersigned, have read and understand the Acceptance of Risk/Liability Waiver statements and agree to follow its policies and procedures. We also hereby release William & Mary and its agents and employees, from any liability caused by, or arising out of the athletic participation in the university's athletic program, unless solely caused by the negligence of the university or its agents and employees.

\_\_\_\_\_  
**Athlete's signature\***

\_\_\_\_\_  
**Parent's signature\***

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**

**\*Parent's signature is needed if student-athlete is under 18 years of age.**





**William & Mary  
Division of Sports Medicine  
Insurance FAQs**

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**What type of athletic insurance does the athletic department carry?**

As a service to our student athletes, the Athletic Department provides a secondary or supplemental athletic accidental insurance. The secondary policy will only be applied to medical costs incurred for services rendered by a participant in the William & Mary Sports Medicine network and their specific written referral for further care. That care must still be coordinated through the athletic training staff prior to the visit. The secondary policy is applicable only for athletic injuries that are a direct result of intercollegiate activity during a required practice or competition supervised by a coach.

The secondary insurance policy requires that the injured athlete first make a claim under their primary medical or hospitalization insurance. Medical expenses not covered by the primary insurance will be paid under the school's policy (subject to its limitations and conditions). Although we attempt to purchase the most comprehensive policy within our resources, this is not an all-inclusive policy.

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**How does my child qualify for secondary coverage?**

You must complete an annual Health Insurance Form that asks for the personal insurance information under which your child is covered. The Understanding Your Health Insurance Coverage While Away From Home form explains the procedures that we must follow to access your primary insurance. In addition, you must complete the Insurance Card Form in which you must copy, paste, or otherwise attach a copy of the front and back of your insurance card. These three forms must be on file in the athletic training facility prior to an injury.

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**How does the insurance coverage work?**

The secondary insurance policy requires that the injured student-athlete first make a claim under the primary insurance. We send your primary insurance information when the student-athlete is referred for care. The provider should file a claim with your insurance company for the services rendered. Your company will evaluate the claim and either pay you or the provider directly or deny the claim. If the provider does not file with the primary insurance, the provider may send you a bill for you to file with your insurance company.

If after 60 days of the date of injury, you have not received anything from your insurance company:

1. Call your insurance company to check the status of the claim, and/or
2. Submit the bill from the provider to your insurance company.

We will also send the providers our secondary insurance information and notify our insurance company that a claim may be forthcoming. The provider should file a claim against our secondary insurance company after your primary insurance has been exhausted.

- You should contact the providers directly to make sure they have filed with primary and secondary insurance companies. You may need to file these claims yourself.
- All claims must be resolved with the secondary insurance company within 52 weeks of the date of injury.

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**When is an athlete referred to a physician?**

Whenever the team physician or the athletic trainers are of the opinion that a consultation would facilitate/improve the care of an injury, arrangements for such a visit will be made. Coaches do not have the authority to refer an athlete to any physician except for emergency medical care when the Sports Medicine staff is not available.

## **What if I belong to an HMO?**

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If you belong to a Health Maintenance Organization (HMO), you are limited to the HMO's physician and facilities. You are requested to send us specific instructions, requirements, and/or limitations which may be included with the policy. This information is necessary for the claims process to be filed correctly. Failure to follow the proper HMO procedures will void your eligibility for coverage under the athletic department's secondary insurance.

## **Which physicians can an athlete see under the secondary insurance plan?**

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For an athlete to be covered under the Athletic Department's secondary insurance, they may be seen only by participants in our Sports Medicine network. This network is composed of a wide range of specialists from the local medical community. This group is dedicated to providing the best possible health care to William & Mary athletes. We formed this network to insure accurate and continuous communication between the physicians and the Sports Medicine staff.

Prior written authorization must be granted by a Sports Medicine network physician if an athlete wishes to seek medical attention outside of the network. Authorization is granted only in cases where our consulting physicians cannot provide the required care. If an athlete seeks a second opinion or care from an out-of-network provider, he/she will be medically ineligible to participate in athletics or utilize the services of the William & Mary Sports Medicine Program until medical records are received and reviewed by the Sports Medicine staff. The athlete has the responsibility to see that the physician forwards all requested information. You also assume the financial responsibility for any travel cost and the services of that provider. Our secondary insurance cannot be applied to those services.

## **Towards which bills can the secondary insurance coverage be applied?**

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The Athletic Department's secondary insurance can be applied only to those bills for an athletic injury:

1. When prior approval for a referral was granted through the Sports Medicine staff,
2. When the care has been coordinated through the Sports Medicine staff,
3. For services rendered by participants in the Sports Medicine network and their specific written referral,
4. For care rendered within 52 weeks of the date of injury, and
5. Your insurance company has responded to and resolved all claims.

## **What types of things are not covered under secondary insurance?**

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- Any injury sustained in an activity that is not associated with a required intercollegiate practice or competition supervised by a coach.
- A chronic or recurrent injury that was sustained prior to participation in athletics at William & Mary.
- Any degenerative condition as diagnosed by a physician.
- Any illness (cold, flu, infection, etc.).
- Unauthorized consultations or treatments.
- Conditions as a result of non-compliance with school's policies, team rules, or the advice of the team physician, attending physicians, the athletic trainers or coach.
- Any injury that is not reported to the athletic trainers within 7 days of occurrence or onset of symptoms.
- Costs, including travel, associated with second opinions.

## **What are the parent's and/or athlete's responsibilities?**

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It must be clearly understood that you and/or your child are financially responsible for all charges for the care of an athletic injury and the resolution of all claims. The Athletic Department at William & Mary assumes no financial liability for expenses generated for medical care of an athlete. We will try to relieve any financial burden that may occur from the care of athletic injuries through the department's secondary insurance policy. However, this is not an all-inclusive policy and benefits will be applied subject to the terms and limitations of this policy.

In addition, the parents and/or athlete have the responsibility to follow the proper procedure to access the secondary insurance policy to seek benefits for charges that arise from an athletic injury. Again, all charges are ultimately the responsibility of the athlete. Therefore, if the threat of collection or garnishment arises from an unpaid bill, the parents and/or athletes are strongly urged to pay all balances to avoid harm to his or her credit rather than wait for the insurance company to decide on benefits.

### **Will I have to pay for any health care costs that arise due to an athletic injury?**

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For all athletes--both those who receive athletic grant-in-aid and those who do not--our secondary insurance policy carries a **\$250 deductible per injury** that must be met by either a) your primary insurance or b) the athlete or his or her parents. Further, any remaining balances or charges that are not met after all insurance benefits are exhausted are the responsibility of the athlete.

### **Where can I find more information regarding secondary insurance?**

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Specific questions should be directed to Melanie Eley, Insurance Coordinator for Sports Medicine at (757) 221-4845 or [mneley@wm.edu](mailto:mneley@wm.edu).

### **What if my primary insurance coverage changes during the year?**

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It is the athlete's responsibility to notify the Sports Medicine staff promptly of any changes in his or her primary insurance coverage including changes in insurance carrier, address, benefits, primary care physician, etc. In order to maintain coverage under our athletic injury policy, the student athlete must provide the following:

1. Health Insurance Form completed with the new information
2. Understanding Your Health Insurance Coverage While Away From Home completed
3. Insurance Card Form completed with new insurance card attached

### **What if my child does not have primary insurance?**

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You should purchase the health insurance policy – United Healthcare Student Resources (UHCSR) – offered through the Student Health Center. Please visit [www.wm.edu/health/insurance](http://www.wm.edu/health/insurance) to submit an enrollment request. **YOU MUST SUBMIT THIS ONLINE.** The opening & closing dates are available on the website at the above link.

## **Establishing a Primary Care Physician in Williamsburg**

In an attempt to provide the best possible health care to our student-athletes, our staff is headed by Michael B. Potter, M.D. Dr. Potter is a Family Practice physician, with specialized training in Sports Medicine.

If your health insurance requires a referral from a specific physician for care, we would ask that you transfer that designation to Dr. Christopher Ciccone. If he is not listed under your insurance plan, you should designate Dr. Jeffrey Blanchard or Dr. Glenn Rauchwarg, DO. When you call please identify yourself as a William & Mary student-athlete. Their office addresses are below. To make this change, you will need to contact your insurance company. Your efforts now will help expedite care for you son/daughter in the event of an injury.

Please feel free to call upon us if we can be of assistance to you with this process.

Christopher J. Ciccone, MD  
Tidewater Physicians Multi-Specialty Group  
Colonial Family Medicine  
4125 Ironbound Road # 200  
Williamsburg, VA 23188  
(757) 345-2829  
(737) 345-6927 fax

Jeffrey G. Blanchard, MD  
Tidewater Physicians Multi-Specialty Group  
Williamsburg Family Medicine  
132 Professional Circle  
Williamsburg, VA 23185  
(757) 707-3669  
(757) 903-4304 fax

Glenn T. Rauchwarg, DO  
Tidewater Physicians Multi-Specialty Group  
Discovery Park Family Medicine  
5424 Discovery Park Blvd.  
Building A, Suite 201  
Williamsburg, VA 23188  
(757) 345-2071  
(757) 903-4877 fax

If the above physicians do not work, any physician at this location may work.

Velocity Urgent Care  
4374 New Town Avenue  
Williamsburg, VA 23188  
(757) 259-1900  
(757) 259-1322 fax

## Guidelines for the Resolution of Athletic Insurance Claims

If you receive a bill:

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1. Check whether your primary policy has been billed FIRST. Please contact your primary insurance company by phone or online to make this determination.
  - a. If your primary policy has been billed, please find the corresponding Explanation of Benefits (EOB) for the date of service. A copy of this form must be sent to our secondary insurance company to complete the billing process.
  - b. If your primary policy has not been billed, please follow the directions in step 2 to have an itemized bill sent to your primary insurance company.
2. Determine if the bill is itemized – the bill should have the service(s) that were rendered and their individual costs. **A balance statement is not sufficient.** Contact the medical provider and have them send an itemized statement to yourself, or directly to the insurance policy.

If you do not receive a bill **within 30 days** of the date of service, or **60 days** from the date of injury:

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1. Contact the medical provider to determine whether or not they have filed with your primary insurance company.

Please understand:

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1. For the resolution of claims, the secondary policy needs an EOB from your primary policy and itemized bill from the medical provider for **each** date of service.
2. The secondary policy has its own \$250.00 deductible PER INJURY that must be met by your primary insurance policy, or from out-of-pocket costs. If you do not reach the secondary's deductible, you are responsible for the remaining balances associated with the injury.
3. The secondary policy can only be applied to those bills,
  - a. where services are tendered of the treatment of an athletic injury, and
  - b. when prior approval of that referral was granted through the athletic training staff, and
  - c. when the care has been coordinate through the athletic training staff, and
  - d. when your insurance company has responded to all claims
4. The claim for this injury expires 52 weeks from the date of injury. The secondary insurance company may deny claims for bills after that date.

We are willing to advise you through the process, but **the responsibility for the payment of all bills and the resolution of all claims rests with you.** Should you have any questions about the claims process, please feel free to contact the Athletic Insurance Coordinator at (757) 221-4845. Should you have any questions concerning any bills from medical providers, please contact them first before contacting the Athletic Insurance Coordinator.

Thank you for your cooperation in this matter.

## **Notice of Privacy Practices**

The Division of Sports Medicine developed this document to keep you informed as to how the Sports Medicine staff may use and disclose your protected health information to carry out treatment, payment, or health care operations. It describes your rights to access and control your protected health information and governs the mechanism in which you can give your consent to the Division of Sports Medicine to release your protected health information to other entities.

Please visit <http://www.wm.edu/offices/sportsmedicine/documents/privacy-practices.pdf> to view or to download the entire Notice of Privacy Practices.



**William & Mary  
Division of Sports Medicine  
Health Insurance Form for 2019-2020 School Year**

Athlete's Name: \_\_\_\_\_ Male Female DOB: \_\_\_\_\_

\_\_\_\_\_ Permanent Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP

\_\_\_\_\_ Mailing Address if different from Permanent Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP

\_\_\_\_\_ Home Phone Number \_\_\_\_\_ Athlete Cell Phone Number \_\_\_\_\_ Athlete Email \_\_\_\_\_ Sport: \_\_\_\_\_

SSN: \_\_\_\_\_ WM Student ID #: \_\_\_\_\_

**REQUIRED**

**REQUIRED**

Policy Holder's Information	Secondary (if applicable)
Name _____	Name _____
Home Address: _____	Home Address: _____
Home Phone ( ) _____	Home Phone ( ) _____
Work Phone ( ) _____	Work Phone ( ) _____
Insurance Co. _____	Insurance Co. _____
Policy Holder's ID #: _____	Policy Holder's ID #: _____
Policy Group #: _____	Policy Group #: _____
Claims Phone #: _____	Claims Phone #: _____
Mailing Address for Claims _____	Mailing Address for Claims _____
Policy holder's relationship to athlete: _____	Policy holder's relationship to athlete: _____
Is your dependent son/daughter covered under this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Policy Holder's DOB:</b> _____	Is your dependent son/daughter covered under this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Policy Holder's DOB:</b> _____
What type of insurance do you have? <input type="checkbox"/> Traditional <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Other	What type of insurance do you have? <input type="checkbox"/> Traditional <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Other
Does your insurance cover prescriptions? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your insurance cover prescriptions? <input type="checkbox"/> Yes <input type="checkbox"/> No

**If you have more than one insurance, please make sure that you do a coordination of benefits and verify which one is primary.**

	Parent Information	Secondary Emergency Contact Person
<b>Name(s)</b>		
<b>Address</b>		
<b>City ST Zip</b>		
<b>Email(s)</b>		
<b>Work/Cell #s</b>		

**I hereby certify that I have read and understand the attached Insurance Frequently Asked Questions (FAQ).**

**Signature of Policy Holder or Designee** \_\_\_\_\_ **Date** \_\_\_\_\_

**PLEASE FILL OUT COMPLETELY, LEAVE NO AREAS BLANK**

\_\_\_\_\_ (NAME)

### **\*Understanding Your Health Insurance Coverage While Away From Home\***

It has been our experience that it would be beneficial for you to contact your insurance company **NOW**, long before your child enters school, to ensure your child has adequate, hassle-free coverage while he/she is away at school. We have developed the following questions to help you understand the scope of your insurance coverage to determine if it will meet the needs of your child. The coverage that you have experienced at home may not be the coverage your son/daughter receives while away at college. In case of injury or illness while away from home, you would hope that your son or daughter should be able to access the same level of health care in Williamsburg without difficulty. If your insurance does not allow out-of-network coverage, your son/daughter may have to go home for care or be exposed to higher co-pays and higher out-of-pocket expenses. Such restrictions also inevitably slow the access to comprehensive care that will return your child to health and to competition. You may ultimately find it advantageous or necessary for you to change your insurance plan or even insurance company to maintain the coverage at school that you have experienced at home. **Failure to provide current and complete information and/or notify us of any changes could compromise and complicate access to the athletic department's secondary insurance policy making you solely responsible for all medical bills.**

1. Does your son/daughter have coverage and/or out-of-network benefits in Williamsburg, VA for services other than emergency care (i.e. diagnostic testing such as MRI or x-ray, chiropractic care, physical therapy, etc.)?

YES NO

If no, consider switching insurance. We suggest you speak with the William & Mary Sports Medicine staff at (757) 221-3407 to discuss your coverage needs.

2. Does your son/daughter need a referral from their PCP to access other providers (imaging, specialists, etc.)?

YES NO

If YES:

PCP Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

If so, we ask that you make either Dr. Chris Ciccone, Dr. Jeffrey Blanchard, Dr. Glenn Rauchwarg, or another physician in Williamsburg as their PCP instead? When you call please identify yourself as a W&M student-athlete. Please contact us at (757) 221-4845 if we can be of assistance in selecting a PCP in the local area.

3. Please circle all eligible providers within your benefits. You may check these providers by calling your insurance company or logging into your insurance company's website. Please search the providers and locations listed below.

Robert M. Campolattaro, MD	Christopher J. Ciccone, MD	Thomas Durbin, MD
Alexander L. Lambert II, MD	Jonathan R. Mason, MD	Robert M. Pinto, DC
Michael B. Potter, MD	Nicholas K. Sablan, MD	Scott W. Sautter, Ph.D
Joel Stewart, MD	Hampton Roads Orthopedics	Med Express
Peninsula Radiological Associates	Riverside Diagnostic Center	Sentara CarePlex Hospital
Sentara Regional Hospital	Velocity Urgent Care	Tidewater Diagnostics Imaging
Pivot Physical Therapy	VA Anesthesia & Perioperative Care Specialist	



**PLEASE COPY YOUR INSURANCE CARD (FRONT & BACK) BELOW**

**READ CAREFULLY**

- I authorize payment of medical benefits to all providers 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 insurance, William & Mary, and their excess insurance company in a timely manner in order to expedite the claims process.
- I hereby authorize William & Mary 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 the injury/illness I am receiving care for or previous confinements or disabilities relevant to the care of the injury/illness.
- I authorize the Sports Medicine staff at William & Mary and/or my coach to hospitalize and secure treatment for me for any athletic injury/illness. If the athlete is under 18 years of age, the undersigned parent grants permission to the Sports Medicine staff at the university and/or their coach to hospitalize and secure treatment for their son/daughter for any athletic injury/illness.
- I authorize The Division of Sports Medicine at William & Mary to release medical records to other healthcare providers in order to facilitate timely & appropriate treatment or care.
- A photostatic copy of this authorization shall be deemed as effective and valid as the original.
- I will notify the Sports Medicine staff at William & Mary immediately upon any change in the above health insurance information.

**SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**(If under 18, parents must sign, otherwise must be signed by parent or student-athlete)**

**\*\*PLEASE COMPLETE ONLINE WAIVER FORM IF APPLICABLE\*\***

If you have existing health coverage and DO NOT wish to purchase the student health insurance coverage offered through the Student Health Center at William & Mary, you need to visit [www.wm.edu/health/insurance](http://www.wm.edu/health/insurance) to submit a waiver request. **If you do not submit this waiver request online by the date on the website you will be charged for the student insurance!** Denying the student health insurance DOES NOT affect the ability to be seen at the Student Health Center or the Athletic Department's secondary insurance coverage.

**William & Mary Division of Sports Medicine**  
**Attention Deficit Hyperactivity Disorder (ADHD) Medication Exemption Information Form**

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**Primary Care Physician/Health Care Provider:**

The student-athlete presenting this form to you plans to or already participates in intercollegiate athletics at the William & Mary. Our institution is governed by the rules and regulations of the NCAA ([www.ncaa.org](http://www.ncaa.org)), thus requiring the collection of medical records for those student-athletes diagnosed/treated for ADHD/ADD utilizing specific medication which may be **banned by the NCAA**. In order to show compliance with this legislation, we are asking our student-athletes to take this letter to their primary care physician/health care provider to fill out and to provide the following information **in order to continue/begin their NCAA participation** while also continuing to take their ADHD/ADD medication.

**Please return this form & supporting documentation to the student-athlete or to the following address or fax number:**

William & Mary  
c/o Division of Sports Medicine  
PO Box 399  
Williamsburg, VA 23187-0399  
Phone (757) 221-3407 // Fax (757) 221-4361

*I authorize the release of this information and the results of this examination to William & Mary Division of Sports Medicine staff.*

Student Signature: \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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Student-Athlete's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of initial evaluation: \_\_\_\_\_ Date of most recent follow-up: \_\_\_\_\_

Physician's Diagnosis: \_\_\_\_\_

Medication Prescribed/Follow-up Orders: \_\_\_\_\_

**(Examples of the NCAA Banned-Drug Class:** Stimulants include amphetamine, atomoxetine, dexamethylphenidate, dextroamphetamine, methamphetamine, and methylphenidate. For more information please visit [www.ncaa.org/health-safetly](http://www.ncaa.org/health-safetly).)

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- ✓ Please attach a brief summary of the comprehensive clinical evaluations used to diagnose this student-athlete with ADHD/ADD (reference DSM-IV criteria) and any supporting documentation.
- ✓ Please attach any ADHD Rating Scale (ex: Connors, ASRS, CAARS) scores and report summaries.
- ✓ Please include medication documentation, along with a copy of the script for the current medication. The student-athlete does not have to be put on a trial of non-stimulant medication **but** documentation must note that a non-stimulant alternative was considered and why the stimulant medication was chosen instead.
- ✓ If available, please provide copies of the following:
  - Any psychological testing results
  - Laboratory/testing results helping to diagnose ADHD/ADD

Name of Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Specialty: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

STAMP



**William & Mary  
Division of Sports Medicine  
Entering Student Athlete 2019-2020**

Please make sure that you have completed the following items:

- Medical Forms
    - Student Health Center Health Evaluation Form
    - Athletic Participation Physical Form
  - Health Insurance Form
  - Waived or Enrolled in the School's Insurance *online*
  - ADHD Medication Exemption Information Form (if applicable)
  - Reviewed the Privacy Practices *online*
- 

**Submitting your forms**

Please mail the completed forms to the appropriate addresses shown below by **June 1<sup>st</sup>**. If you mail forms to the incorrect location, it will delay the processing of your paperwork.

Please keep pages 9-14 for your records.

Please mail the **Athletic Participation Physical Form, Health Insurance Form, and ADHD Medication Exemption Information Form** (if applicable) to:

William & Mary  
Division of Sports Medicine  
PO Box 399  
Williamsburg, VA 23187-0399

Please mail the **Student Health Center Health Evaluation Form** to:

William & Mary  
Student Health Center  
PO Box 8795  
Williamsburg, VA 23187-8795