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

______________ ______________ ______________ Sport: __________
Home Phone Number Athlete Cell Phone Number Athlete Email

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?	Is your dependent son/daughter covered under this policy?
☐ Yes ☐ No **Policy Holder's DOB**: ______	☐ Yes ☐ No **Policy Holder's DOB**: ______
What type of insurance do you have?	What type of insurance do you have?
☐ Traditional ☐ HMO ☐ PPO ☐ POS ☐ Other	☐ Traditional ☐ HMO ☐ PPO ☐ POS ☐ Other
Does your insurance cover prescriptions? ☐ Yes ☐ No	Does your insurance cover prescriptions? ☐ Yes ☐ 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
Name(s)		
Address		
City ST Zip		
Email(s)		
Work/Cell #s		

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) 221-4845 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
Hampton Roads Orthopaedics	Med Express	Peninsula Radiological Associates
Riverside Diagnostic Center	Sentara CarePlex Hospital	Sentara Regional Hospital
Velocity Urgent Care	Tidewater Diagnostics Imaging	Pivot Physical Therapy
Joel Stewart, MD	VA Anesthesia & Perioperative Care Specialist	

____ (NAME)

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** 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