

Rider University 2007-2008 Parent/Guardian Insurance Information Form

Please fill out **COMPLETELY** and provide a copy of the front and back of your insurance card

Name: _____ Sport: _____ D.O.B. _____
 S.S.#: _____ - _____ - _____ College Address: _____

Home Address: _____

 College Phone #: _____

Home Phone #: _____ Cell Phone #: _____

Father/Guardian: _____ Mother/Guardian: _____
 D.O.B. _____ D.O.B. _____
 Address: _____ Address: _____

Employer: _____ Employer: _____
 Address: _____ Address: _____

 Phone #: _____ Phone #: _____

Medical Insurance: _____ Primary Care Physician: _____
 Policy Holder: _____
 Policy/ Plan #: _____ Practice Name: _____
 Address: _____ Address: _____

 Phone #: _____ Phone #: _____

- | | | |
|--|---|---|
| 1. Does your insurance require a referral from your primary care physician? | Y | N |
| 2. Does your insurance require a pre-certification for x-rays, MRIs, or bonescans? | Y | N |
| 3. Does your insurance require a second opinion before surgery? | Y | N |
| 4. Do you have a prescription plan? | Y | N |
| 5. Does your insurance plan provide major medical benefits? | Y | N |
| 6. Does your insurance plan provide dental benefits? | Y | N |

I/ We authorize the Rider University Sports Medicine Department to share information necessary for treatment with Rider team physicians, student health services, coaches, administrators, and parent(s)/ guardian(s). I have been informed that I have the right to revoke this authorization at any time. I understand that my medical records are kept secure and that I have the right to view those records upon request.

Parent's Signature _____ (under 18 only) Date _____

Student's Signature _____ Date _____