



ADRIAN COLLEGE

110 S. Madison ■ Adrian, MI 49221 ■ PHONE: 517.264.3969 ■ FAX: 517.264.3802

Required Health Insurance Information For Athletes

The following is used when a student is referred to off-campus health care providers in order to coordinate insurance benefits. When completed, please send to: **Adrian College Athletic Training Department, 110 S. Madison St., Adrian, MI 49221**

Failure to complete all blanks will result in claim processing delays. If the information is not applicable, please indicate the reason (e.g., divorced, deceased, unknown)

Please Attach A Copy Of Both Sides Of Any Insurance Card(s)

Name of Student _____ Soc. Sec. # _____ Date of Birth _____

School Address _____ School Phone _____ Cell Phone _____

Home Address _____ Home Phone _____

City _____ State _____ Zip _____

Father

Name _____

Address _____

Phone _____

Date of Birth _____ SSN _____

Employer _____

Insurance Co. _____

Phone # _____

Contract ID # _____

Group/Coverage # _____

Does The Plan Cover Your Child? **Yes No**

Is Your Insurance a: **PPO Plan HMO Plan Managed Care**

Does The Plan Require Preauthorization For Any Physician Visits?
Yes No

Does The Plan Require A Second Opinion Prior To Surgery?
Yes No

Does The Plan Require An Office Visit Co-pay? **Yes No**

Does The Plan Offer Prescription Coverage? **Yes No**

Co-pay Amount _____

Mother

Name _____

Address _____

Phone _____

Date of Birth _____ SSN _____

Employer _____

Insurance Co. _____

Phone # _____

Contract ID # _____

Group/Coverage # _____

Does The Plan Cover Your Child? **Yes No**

Is Your Insurance a: **PPO Plan HMO Plan Managed Care**

Does The Plan Require Preauthorization For Any Physician Visits?
Yes No

Does The Plan Require A Second Opinion Prior To Surgery?
Yes No

Does The Plan Require An Office Visit Co-pay? **Yes No**

Does The Plan Offer Prescription Coverage? **Yes No**

Co-pay Amount _____

If you participate with an HMO, PPO, HAP, or another managed care insurer, authorization from your own primary care physician is often required for referral to local non-network physicians. Please provide name and phone number of your primary care physician.

Name: _____

Phone: _____

Our athletic team physician, Dr. J. Michael Maxwell, is an orthopedic surgeon. If Dr. Maxwell is not a participating physician with your medical insurance, please check with your insurance representative for an orthopedic provider in Lenawee County. If no providers are listed your student may be required to return home for treatment. If Dr. Maxwell is not a provider in your insurance plan, please list the name, address and phone number of any approved ORTHOPEDIC providers in Lenawee County. Please consult with your employer or insurance company.

Our Orthopedic Provider: **Yes** **No**
Dr. J. Michael Maxwell
227 Riverside Dr.
Adrian, MI 49221

If no, please indicate:
Physician Name _____

Address _____

Phone _____

Release Of Information:

I/we hereby authorize Adrian College and First Agency of Kalamazoo, MI to inspect or secure copies of case history records, laboratory reports, diagnoses, X-rays, and any other data covering this and/or previous confinements or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

We authorize that the Adrian College insurance agent pay the medical vendors directly for any bills incurred from accidents that are covered under the coverage purchased by the College.

Parent(s) Signature _____ Date _____

Student Signature _____ Date _____

Please return this form to Adrian College Athletic Training Department, at the address below, as soon as possible. Without this form on file, your student will not be eligible to play or practice. Please notify the Athletic Training Department and Goldsmith Health Center of ANY changes in your medical insurance.

Adrian College Athletic Training Department
Adrian College
110 S. Madison Street
Adrian, MI 49221
(517) 2643969