



STUDENTATHLETE MEDICAL BILLING POLICY

The College of the Holy Cross provides a medical insurance program for its studentathletes. THIS POLICY, HOWEVER, IS SECONDARY, OR IN EXCESS OF, PERSONAL FAMILY MEDICAL INSURANCE COVERAGE. This coverage covers only injuries/illnesses/accidents resulting from the direct participation in the intercollegiate athletics program during the dates of the primary competitive season and designated off

It is the responsibility of the StudentAthlete to provide personal health insurance through their employer, HMOs

If a student-athlete's primary insurance is not through their employer, the College of the Holy Cross strongly encourages the studentathlete to see their primary care physician (PCP) to a College of the Holy Cross physician. The studentathlete is encouraged to have a network of physicians at the College of the Holy Cross Sports Medicine staff.

INSURANCE POLICY CHANGES:
All Student-Athletes must provide a copy of their insurance policy in their medical file prior to participating in intercollegiate athletics. In the event of policy changes, the College of the Holy Cross is not responsible for any delays in payment.

EXCLUSIONS AND LIMITATIONS:
The College of the Holy Cross Athletic Department is not responsible for medical services resulting from an injury/illness unrelated to intercollegiate athletics.

The College of the Holy Cross Athletic Department is not responsible for medical services for a Student-Athlete for medical services incurred while the Student-Athlete is a member of the College of the Holy Cross.

The College of the Holy Cross Athletic Department is not responsible for medical services while the Student-Athlete is uninsured.

The College of the Holy Cross Athletic Department is not responsible for medical services for injuries/illnesses that are recurrent or result from participation in the intercollegiate sports program at the College of the Holy Cross.

of the Holy Cross

The College of the Holy Cross Athletic Department is not responsible for expenses for athletic injuries incurred after completion of the StudentAthlete's intercollegiate athletic eligibility.



THE PROCEDURE:

1. If a student-athlete is referred to a doctor's office or the hospital for an athletically incurred injury, a claim form will be submitted by the Athletic Trainer to A-G.
2. The student-athlete must present their primary insurance card along with the athletic issued A-G Insurance Card when they arrive at their appointment or the hospital.
 - If you don't initially present A-G as your secondary insurance to the provider, you and/or your insurance policy holder, are responsible for calling the provider to resolve your bills. If this step is not complete, you may incur penalty charges and/or collections.
3. Claims will be processed through your primary insurance first. Any excess amount not covered by the primary will be submitted to A-G.
4. If itemized insurance bills,



STUDENT ATHLETE INSURANCE INFORMATION

Student-Athlete: _____ Date of Birth: _____

Anticipated Year of Graduation: _____ Student ID#: _____ Sport(s): _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone#: _____ Student Cell Phone#: _____

Emergency Contact #1 Name: _____ Relationship to Athlete: _____

Home Phone#: _____ Cell Phone#: _____

Emergency Contact #2 Name: _____ Relationship to Athlete: _____

Home Phone#: _____ Cell Phone#: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's Home Phone#: _____ Policy Holder's Cell Phone#: _____

Policy Holder's Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Customer Service Phone#: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Group Number: _____ ID/Member Number: _____ Other Number: _____ Insurance Type: HMO †

PPO † POS † UNRESTRICTED † If policy is an HMO, is guest coverage available? YES † NO

Primary Care Physician (PCP): _____ PCP Phone#: _____

Does your policy cover athletic related injuries? † YES † NO Is a referral required from your PCP to see a specialist? † YES † NO

Policy Holder's Name: _____ Date of Birth: _____