

**UNIVERSITY OF LOUISIANA at MONROE
DEPARTMENT OF ATHLETICS
PARENT'S INSURANCE AUTHORIZATION FORM**

2004-05

ATHLETE'S NAME		SPORT	
SOCIAL SECURITY NUMBER		DATE OF BIRTH	

PARENT'S NAME		SOCIAL SECURITY NO.	
PHONE		POLICY HOLDER DATE OF BIRTH	
ADDRESS			
CITY, STATE, ZIP			

PARENT'S EMPLOYER		PHONE	
ADDRESS			
CITY, STATE, ZIP			

- [] **YES, I HAVE MEDICAL INSURANCE COVERING THE ABOVE NAMED ATHLETE. I HEREBY AUTHORIZE THE ULM DEPARTMENT OF ATHLETICS TO FILE A CLAIM ON MY BEHALF FOR THE ATHLETIC INJURY SUSTAINED BY THE ABOVE NAMED ATHLETE UNDER THE GROUP MEDICAL POLICY. I AGREE AND CONSENT THAT ANY AMOUNTS PAYABLE UNDER THIS POLICY BE PAID TO THE MEDICAL PROVIDER. (PLEASE ATTACH COPY OF CARD AND COMPLETE THE REMAINDER OF THE FORM)**
- [] **NO, I DO NOT CARRY MEDICAL INSURANCE ON THE ABOVE NAMED ATHLETE. (PLEASE SKIP TO THE BOTTOM OF THE PAGE, SIGN THE FORM AND RETURN)**

INSURANCE COMPANY		PHONE	
ADDRESS FOR CLAIMS			
CITY, STATE, ZIP			
GROUP NUMBER		POLICY NUMBER	

IS YOUR INSURANCE COMPANY PART OF A HMO, PPO, OR EPO? YES () NO ()

DOES YOUR INSURANCE COMPANY REQUIRE A SECOND OPINION FOR SURGERY? YES () NO ()

IS ANY OF THE FOLLOWING PART OF YOUR INSURANCE COVERAGE? *IF YES, PLEASE PROVIDE COPY OF CARD*

PRESCRIPTION CARD: YES () NO () VISION: YES () NO () DENTAL: YES () NO ()

DOES YOUR INSURANCE COMPANY REQUIRE A PRE-ADMISSION/AUTHORIZATION REVIEW? YES () NO ()

PLEASE EXPLAIN ALL "YES" ANSWERS: _____

I HEREBY AUTHORIZE TO INSPECT OR SECURE COPIES OF CASE HISTORY RECORDS, LABORATORY REPORTS, DIAGNOSIS, X-RAYS, AND OTHER DATA COVERING THE ABOVE NAMED ATHLETE. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE DEEMED EFFECTIVE AND VALID AS THE ORIGINAL.

PARENT'S SIGNATURE	DATE
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RETURN COMPLETED FORM TO: **Phillip A. Shaw, ATC, LAT**
 Head Athletic Trainer -- University of Louisiana at Monroe
 308 Stadium Drive
 Monroe, LA 71209