Insurance & Authorization

(REQUIRED TO BE ON FILE IN HEALTH CENTER)

New/Returning Student (CIRCLE ONE) Spring/Fall Year 20 __ (CIRCLE ONE)

Every student must complete this form as a new student and with any subsequent changes to the information below. This form authorizes treatment and provides important information to hospitals, clinics and attending physicians.

Name _____ Student ID J# _____

Date of Birth _____ Sport(s) if applicable _____

Home Street Address _____ Cellular Phone ( ) _____

City _____ State _____ Zip _____

○ Not insured at this time

FATHER/GUARDIAN/SELF

○ *Same as Mother/Guardian Information*

Father's Name _____

Telephone ( ) _____

Address _____

Social Security Number _____

Medical Insurance _____

Company or Plan _____

Address _____

Policy Number _____

Telephone ( ) _____

Is this Plan an HMO or PPO? Yes No

Is pre-authorization required to obtain treatment? Yes No

Is a second opinion required before surgery? Yes No

MOTHER/GUARDIAN

○ *Same as Father/Guardian Information*

Mother's Name _____

Telephone ( ) _____

Address _____

Social Security Number _____

Medical Insurance _____

Company or Plan _____

Address _____

Policy Number _____

Telephone ( ) _____

Is this Plan an HMO or PPO? Yes No

Is pre-authorization required to obtain treatment? Yes No

Is a second opinion required before surgery? Yes No

AUTHORIZATION

I hereby grant permission to any physician, hospital or clinic to which I am referred by the Concordia University Health Center and/or Athletic Training Staff to treat any health problems or injuries deemed reasonably necessary for my well-being. I also hereby authorize Concordia University Health Center and/or Athletic Training Staff to treat any health problems or injuries for which I seek treatment and to release medical information necessary to process insurance claims in order to receive benefits.

Intercollegiate Athletes: Your signature below authorizes the Concordia University Health Center and Athletic Training Staff to discuss pertinent information related to your health or injuries. You have the right to revoke any part of this at any time by sending written notification to the Director of Health Services or the Athletic Trainer.

* The insurance policyholder needs to sign for release of insurance information.
* The parent or guardian needs to sign for authorization for treatment and for release of information if student is less than 19 years of age.

Required: Enclose a copy of the front and back of your insurance card.

_____ _____

PRINTED NAME OF STUDENT SIGNATURE OF STUDENT

_____ _____

SIGNATURE OF INSURANCE POLICY HOLDER/PARENT/GUARDIAN DATE

A copy of this document shall be considered as valid as the original.

Please enclose this form in the postage paid envelope.
Concordia University, Attn: Health Center, 800 N. Columbia Avenue, Seward, NE 68434