STUDENT-ATHLETE MEDICAL BILLING POLICY

The College of the Holy Cross provides a medical insurance program for its student-athletes. **THIS POLICY, HOWEVER, IS <u>SECONDARY</u> TO, OR IN EXCESS OF, PERSONAL FAMILY MEDICAL INSURANCE COVERAGE,** and 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-seasons.

Student-Athlete's parent(s)/guardian(s) are encouraged to contact their insurance company prior to their son/daughter's arrival at Holy Cross to ensure that medical coverage is extended to "out of network" coverage during their duration of their time at Holy Cross. If your insurance company will not allow out of network coverage, you must purchase the College's student health insurance policy.

It is the responsibility of the Student-Athlete and his/her parent(s) / guardian(s) to understand the conditions that apply to their personal health insurance policy and comply with any requests for information, etc. from the primary insurance company.

HMOs

If a student-athlete's primary insurance is an HMO, the College of the Holy Cross Sports Medicine Department strongly encourages the student-athlete and/or his/her parent(s) / guardian(s) to change the primary care physician (PCP) to a College of the Holy Cross Team Physician or local physician. This will allow the student-athlete to have a network of physicians in the Worcester, MA area as well as better access to care. The College of the Holy Cross Sports Medicine staff can assist in this process.

INSURANCE POLICY CHANGES:

All Student-Athletes must provide a copy of their insurance card to the Sports Medicine Department to be retained in their medical file prior to participation of their respective sport. In the event that the Student-Athlete's insurance policy changes, the College of the Holy Cross staff must receive any changes to a health insurance policy as soon as they occur. If proper notification is not received, the College of the Holy Cross Department of Athletics may not be responsible for any delays in payment.

EXCLUSIONS AND LIMITATIONS:

The College of the Holy Cross Athletic Department **is not** responsible for bills incurred by a Student-Athlete as a result of injury/illness unrelated to intercollegiate athletic participation.

The College of the Holy Cross Athletic Department **is not** financially responsible for expenses incurred by a Student-Athlete for medical services obtained without referral or authorization by the Team Physician or a member of the College of the Holy Cross Sports Medicine Staff.

The College of the Holy Cross Athletic Department **is not** responsible for payment of medical expenses incurred while the Student-Athlete is uninsured or has allowed their personal policy to lapse/expire/term.

The College of the Holy Cross Athletic Department **is not** responsible for payment of medical expenses of injuries/illnesses that are recurrences of injuries/illnesses which were sustained before participation in the intercollegiate sports program at the College 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 Student-Athlete'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, including Explanation of Benefits (EOB), are received from your primary carrier, please mail/email them to the claims administrator below.

   A-G Administrators – Claims Department
   PO Box 21013
   Eagan, MN 55121

   claims@agadm.com

5. Questions regarding benefits, medical bill status, etc. should be directed to A-G Administrators – Claims Department (610) 933-0800.

I have read and agree to comply with the Student-Athlete Medical Billing Policy as put forth by the College of the Holy Cross Athletic Department. My signature below verifies that I have read, understand, and have been provided with a copy of this policy and its procedures.

SIGNATURE OF POLICY HOLDER:____DATE:____________________________

PRINT NAMEOF STUDENT-ATHLETE:____SPORT:___________________________

STUDENT-ATHLETE INSURANCE INFORMATION

PLEASE PRINT ALL INFORMATION REQUESTED ON THIS FORM LEGIBLY
All information will be kept confidential and used solely for the purpose of providing appropriate medical care for the student–athlete.

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 #:_____________________________

PRIMARY INSURANCE INFORMATION

Please fill in the following information with the **student-athlete's** primary insurance information.

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

SECONDARY INSURANCE INFORMATION

(IF APPLICABLE)

Please fill in the following information with the **student-athlete's** secondary insurance information.

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:______________

I hereby certify that the answers provided are true, complete and correct to the best of my knowledge. I understand that my son/daughter must carry an insurance policy that will remain valid during their duration as a student-athlete. I understand that it is my responsibility to update the Holy Cross Sports Medicine Department of any changes or updates to the student-athlete's insurance information.

SIGNATURE OF POLICY HOLDER:___________________________________DATE:____________________