



## INSURANCE INFORMATION FORM

Please copy your insurance card form (FRONT & BACK) below

Type of Insurance Plan (HMO, PPO, etc)\_\_\_\_\_ If HMO, Family Physician\_\_\_\_\_

Policy Holder's Full Name:\_\_\_\_\_ Policy Holder's SSN:\_\_\_\_\_  
(information will be used for insurance purposes only)

### PLEASE READ CAREFULLY

- I authorize payment of medical benefits to all providers for all services and materials they provide during the care of an injury/illness.
- I agree to supply any and all information requested by my primary insurance and /or Oxford College of Emory University in a timely manner in order to expedite the claims process.
- I hereby authorize OC of Emory University to secure and inspect copies of case history records, lab reports, diagnostic testing and any other data pertaining to the injury/illness I am receiving care for or previous confinements or disabilities relevant to the care of the injury/illness.
- A photostatic copy of this authorization shall be deemed as effective and valid as the original
- I will notify the OCOEUSM staff immediately upon any change in the above health insurance information.

**SIGNATURE:**\_\_\_\_\_ **Date:**\_\_\_\_\_  
(If under 18, parents MUST sign; otherwise, form can be signed by either parent OR student-athlete)