VIRGINIA MILITARY INSTITUTE
Cadet Health Insurance Information

CADET INFO

Cadet's Name: _____

Cadet's Social Security Number:_____

Cadet's Date of Birth: _____

FOR NCAA ATHLETES ONLY

Sport: _____

INSURED INFO

Insured's Name: _____ Insured's DOB: _____

Insured's Street Address: _____

City: _____ State: _____ Zip Code: _____

Insured's Phone: Home: _____ Work: _____ Cell: _____

Insured's Employer: _____

INSURANCE CO. INFO

Insurance Company Name: _____

Insurance Company's Street Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company's Phone Number: _____

Insured's Policy/ID Number: _____ Group Number or Name: _____

PRE AUTHORIZATION INFORMATION

Do you need a referral from your PCP to see a specialist? _____Yes _____No

If yes, what if the PCP's name? _____ PCP's Phone Number: _____

Do you need pre-authorization to go for x-rays or off-post physician? _____Yes _____No

If yes, whom do we contact? (Insurance company, PCP, etc)

Name: _____ Phone: _____

Do you have prescription coverage? _____Yes _____No

If yes, please provide a copy of your medical/prescription information including co-pay amount.

PLEASE INCLUDE A CLEAR COPY OF BOTH SIDES OF INSURANCE CARD WITH THIS FORM

PARENT CONTACT INFO

Father/Guardian	Mother/Guardian
Name: _____	Name: _____
Address: _____	Address: _____
City: _____	City: _____
State: _____ ZIP: _____	State: _____ ZIP: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____

EMERGENCY

If parent (s) or guardian(s) listed above can not be contacted, please notify the following:

Name:_____ Relationship:_____

Address: _____

Phone Number: _____

MILITARY INFO

Military Dependents:

Military Dependent covered by Tricare _____ Yes _____ No

If "yes", please provide the sponsor's Social Security Number _____

Please check which coverage: _____Tricare Standard _____Tricare Prime

Because of recurrent problems with PCM assignment/referrals for off post care for cadets while here at VMI, we urge switching your child to **TRICARE STANDARD instead of TRICARE PRIME.** Details are available from your local Tricare Service Center or you may want to visit the TRICARE website: http://www.mytricare.com

CONSENT

I give consent for my son/daughter to receive treatment at the VMI Hospital and for any other treatment or testing needed off post. I will notify the VMI Hospital immediately of any changes in my son/daughter's insurance coverage.
I have included a clear copy of both sides of my insurance card.

Date: _____ Signature of Parent or Guardian: _____

Printed Name of Parent or Guardian: _____

NCAA ATHLETES ONLY

For NCAA Athletes Only

- o I have read and understand VMI's Athletic Insurance policy which is available online at www.vmi.edu. (To view policy, click on the following tabs: Athletics, Intercollegiate, Sports Medicine, Sports Medicine Brochure)
- o I will comply with all medical insurance policies and procedures and I agree to the terms of coverage.
- o Following any medical services, I understand that I have 12 weeks to send bills and explanations of benefits to VMI Sports Medicine or I may become financially responsible.
- o I will notify VMI Sports Medicine immediately upon any change in my son/daughter's health insurance coverage.

Date: _____ Signature of Parent or Guardian: _____

Printed Name of Parent or Guardian: _____