The College of the Holy Cross provides a medical insurance program for its student-athletes. **THIS POLICY, HOWEVER, IS SECONDARY 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 responsible for deductibles or copayments associated with hospital, physician office visits, diagnostic testing (i.e. X-ray, MRI, CT scan, Ultrasound) or prescriptions determined by the Student-Athlete’s primary insurance company.

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:

Step 1: As soon as possible following an injury, the Student-Athlete must report to the Sports Medicine Department in the Hart Center, to complete a Holy Cross Athletic Department Student-Athlete Injury Report Form as well as an NCAA Special Assistance Fund Application Form*.

*Student-athletes MAY qualify for reimbursement of some medical expenses not covered by insurance from the NCAA Special Assistance Fund, however, reimbursement from this fund is based upon fund availability.

Step 2: Once the forms have been completed, they will be submitted to the designated Athletic Insurance Coordinator within the Athletic Department.

Step 3: Following the initial diagnosis, the policy holder must contact the primary insurance company to obtain authorization for any further follow-up exams, diagnostic tests (e.g. x-ray, MRI, CT scan), a minor/major procedure or a referral to a specialist.

Step 4: When the Student-Athlete receives a medical bill for an injury/illness, it must first be submitted to the Student-Athlete’s primary insurance. Only after the Student-Athlete has exhausted his/her primary insurance can a claim be filed against the College’s secondary policy.

Step 5: When the Student-Athlete receives a bill, statement, Explanation of Benefits (EOB), or other information from an insurance company for an injury/illness that occurred as a direct result of participation in intercollegiate athletics at the College of the Holy Cross, the Student-Athlete must submit all correspondence to the Insurance Administrative Assistant in a timely manner. Bills not received in a timely manner may be the responsibility of the Student-Athlete and/or the student athlete’s parent(s)/guardian(s). Submit all correspondence to:

COLLEGE OF THE HOLY CROSS ATHLETICS DEPARTMENT
ATTN: Athletic Insurance Coordinator
Field House
1 COLLEGE STREET
WORCESTER, MA 01610
Fax- (508) 793-3863

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 NAME OF 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: ____________________________ Relationship to Athlete: ____________________________

Address (if different than above): ____________________________ City: ___________ State: __ Zip: ______

Emergency Contact #2: ____________________________ Relationship to Athlete: ____________________________

Address (if different than above): ____________________________ City: ___________ State: __ Zip: ______

---

**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: ____________________________

Insurance Address: ____________________________ City: ___________ State: __ Zip: ______

Group Number: ____________________________ ID/Member Number: ____________________________ Other Number: ____________________________

Insurance Type (please circle): 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: ____________________________

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: ____________________________