Princeton University
Athletic Activity Fund Program
McCosh Health Center - Washington Rd.
Student Health Plan Office – Rm. G24
Princeton, New Jersey 08544
Phone: 609-258-3138

Athletic Activity Fund (AAF) Reimbursement Request Form

The AAF provides partial reimbursement to families for certain out-of-pocket expenses associated with student-athlete injuries or illnesses resulting from the practice or play of NCAA or other Qualified Intercollegiate Sports. To be eligible for the AAF, all NCAA or other Qualified Intercollegiate athletic-related injuries or illnesses must be reported immediately to the Team Physician/UHS Athletic Medicine Staff. **Medical care or services not authorized by a member of the Team Physician/UHS Medicine Staff are not eligible for reimbursement by the AAF.**

For authorized medical services, ***the AAF will reimburse a maximum $200 medical insurance deductible, a maximum $100 prescription deductible, in-network office visit copays, and 10% of in-network co-insurance payments***. Prior to submitting any claim for NCAA out-of-pocket expense reimbursement, claims must be processed through the insurance company (Student Health Plan or Private Health Insurance). **If you have signed up through TigerHub for Direct Deposit, payment will be sent directly to the designated account. If you have not signed up for Direct Deposit, payment by check will be sent to the student's campus mailbox.**

Last Name: _____ **First Name**: _____ **Class Year:** _____

Date of Birth: ___ / ___/ ____ **PUID#:** _____ **NCAA Sport:** _____

Name of Athletic Medicine physician or University Health Services physician who referred you for off-campus care: _____ **Date of visit:** ____ /____ /_____

Type of treatment for which referral made and # of visits:

_____

_____

Description of your injury/illness you sustained while participating in your NCAA sport:

_____

_____

Documentation that is required to be attached to this AAF Reimbursement Form to be processed:

1. **Bill** from the medical provider/hospital showing the charges for services/treatment received. **No balance due bills will be accepted**. Bill must show date(s) of service, treatment type, or services rendered and itemized amounts.
2. **Explanation of Benefit Statement (EOB)** from your insurance carrier showing the provider/hospital charges and how much was reimbursed by your insurance carrier.

Completion of this document in its entirety is required to process your AAF reimbursement request. Incomplete forms will not be processed. Please allow 4-6 weeks for your request to be completed.