

Student Medical Leave Form Employer Group

Instructions for the Subscriber:

Please apply for coverage if your dependent enrolled under student coverage needs a medically necessary leave of absence.					
Subscriber complete Section 1 and sign					
Forward Section 2 to dependent's doctor					
☐ Once all pages are complete and returned to you, mail the entire original form to: P.O. Box 21146, Eagan, MN 55121					
☐ Send a copy of the form to your employer					
The following information is required to determine whether your dependent is eligible for a medically necessary leave of absence. Section 1: Subscriber and Dependent Information (Completed by Subscriber)					
scriber Last Name:	Subscriber First Name:		•	MI:	
scriber ID:	Group Number:				
endent's Last Name:	Dependent's First Name:		MI:		
s Dependent presently married? Yes No Dependent's Date of Birth:					
Name of school dependent is/was attending:					
Address of school student is/was attending:					
Is the student an "Away from Home Care" member? Yes No					
I request coverage under my policy for my student dependent named on this form. I understand that their enrollment may be continued only as long as they are unmarried. I also understand that I'll inform Excellus BlueCross BlueShield of any changes in the status of my dependent's medical leave or eligibility for coverage (for example, marriage). Upon approval of a medically necessary leave of absence, students may continue to be covered as an active dependent on their parent's policy (or as an active sponsored student enrolled in their own name) for up to six months from the first date of absence or until they reach the maximum age as defined in the contract.					
person who knowingly and with intesson files an application for insurance prmation, or conceals for the purpose serial thereto, commits a fraudulent in	or statem of mislea nsurance	ent of claim conta ding, information act, which is a cri	aining any materia concerning any fa me, and shall be s	ally false act ubject	
	Subscriber complete Section 1 and sign Forward Section 2 to dependent's doctor Once all pages are complete and returned Eagan, MN 55121 Send a copy of the form to your employed collowing information is required to determine sary leave of absence. Ition 1: Subscriber and Dependent Information is required to determine sary leave of absence. Ition 1: Subscriber and Dependent Information is required to determine scriber Last Name: Secriber ID: Sendent's Last Name: Secriber ID: Sendent presently married? Yes See of school dependent is/was attending: The student an "Away from Home Care" means attended in the continued only as lone continued only as lone and the student on their parent's policy (or a see) for up to six months from the first date and in the contract. The person who knowingly and with interest of the purpose coverage in the contract. The person who knowingly and with interest in the contract. 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Subscriber complete Section 1 and sign Forward Section 2 to dependent's doctor Once all pages are complete and returned to you, mail the entire origin Eagan, MN 55121 Send a copy of the form to your employer collowing information is required to determine whether your dependent is sary leave of absence. Ition 1: Subscriber and Dependent Information (Completed by Subscriber Scriber Last Name: Subscriber First Name: Subscriber First Name: Group Number: endent's Last Name: Dependent's First Name: ependent presently married? Yes No Dependent's Date are of school dependent is/was attending: The student an "Away from Home Care" member? Yes appeared to the student and this is encounted and the student and	Recessary leave of absence. Subscriber complete Section 1 and sign Forward Section 2 to dependent's doctor Once all pages are complete and returned to you, mail the entire original form to: P.O. 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Student Medical Leave Form Employer Group

Instructions for the Physician:

This form is to determine whether your patient is eligible to continue student coverage due to a medically necessary leave of absence. Thank you in advance for your prompt and thorough attention to this form on behalf of your patient as it is critical for the determination.

☐ Complete and sign Section 2						
☐ Attach any applicable documentation to support status (i.e. clinical summary)						
☐ Return the original to the subscriber						
The tarm the original to the subscriber						
Section 2: Medical Information- Completed by Attending Provider (MD, DO, NP or PA)						
Physician's Last Name:	First Name):				
Physician's Address:						
City:	State:	Zip:				
Phone Number: () -	Onset Date of Illness/Injury:					
Patient's symptoms result from: Illness Injury Other:						
In your medical opinion is the student too ill to return home? Yes No						
It is my recommendation, based on medical necessity, that the medical leave period being applied for						
begin on						
The anticipated end date of the Medical Leave period is						
I certify that this patient is presently under my care and that I see this patient on a regular ongoing basis.						
Any person who knowingly and with intent to defraud any insurance company or other						
person files an application for insurance or statement of claim containing any materially						
false information, or conceals for the purpose of misleading, information concerning any						
fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each						
such violation.						
Name of Physician (please print):						
Physician's Signature:		Date:				