



**Provider Certification of Student Medically Necessary Leave
of Absence or Change of Enrollment**

Student Name:

Student DOB:

Name of Post-Secondary School:

[Health Insurance id number?]

The above-named student is suffering from a serious illness or injury and is unable to attend classes or any other school functions resulting in a requested leave of absence or other change of enrollment that may result in the loss of health insurance coverage. I certify that such leave of absence or change or enrollment is medically necessary. The first day of the medically necessary leave of absence or change of enrollment is ___/___/____.

I certify that the above statement is accurate and based on my best medical knowledge of the above-referenced student which is supported by my medical records.

Signature and degree or title: _____

Printed Name and degree or title: _____

Member Instructions:

Please return completed form to your Benefits Plan Administrator. Your Benefits Plan Administrator will provide to your Blue Cross and Blue Shield dedicated representative for processing.

Mailing Instructions:

Please mail to:

Blue Cross and Blue Shield of North Carolina

Document Operations

P.O. Box 2291

Durham, NC 22702-2291