BlueCross BlueShield of North Carolina

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
Manager Enrollment and Billing Operations
P.O. Box 2291
Durham, NC 22702-2291