BlueCross BlueShield of Nebraska

An Independent Licensee of the Blue Cross and Blue Shield Association

Extension of Coverage Request for Full-Time Students on Leave of Absence

(pursuant to Michelle's Law)

Michelle's Law allows coverage for dependent children who are full time students to continue during a medically necessary leave of absence, *not to exceed one year from the first day of the leave of absence*, provided Blue Cross and Blue Shield of Nebraska receives a written certification from the dependent child's treating physician stating that the dependent child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

SECTION I *(To be completed by the Subscriber)*

Name of Subscriber: _____

Address of Subscriber: _____

Identification Number or Social Security Number: _____

Name of Dependent: _____

Dependent's Date of Birth (Mo., Day, Year): _____

First day of the leave of absence from school (Mo., Day, Year): _____

Date of expected return to school as a full-time student (Mo., Day, Year): _____

SIGNATURE OF PARENT/SUBSCRIBER: _____

DATE SIGNED: _____

SECTION II *(To be completed by the Dependent's Treating Physician)*

Diagnosis of condition necessitating a leave of absence from school:

Primary: _____ Date of onset: _____

Secondary: _____ Date of onset: _____

Does the above illness or injury necessitate a leave of absence from full-time school attendance? Yes ☐ No ☐

Dates of medically necessary leave of absence from full-time school attendance:
(The leave of absence cannot exceed one year from the first day of the leave of absence.)

From: _____ (Month) _____ (Day) _____ (Year) To: _____ (Month) _____ (Day) _____ (Year)

I certify that I am the above-named Dependent's treating physician, and that he/she is suffering from a serious illness or injury necessitating a medically necessary leave of absence from full-time school attendance.

SIGNATURE OF TREATING M.D.: _____

Printed Name and Address of M.D.: _____

DATE SIGNED: _____

TREATING M.D.: Please complete Section II of this form and mail to:
Blue Cross and Blue Shield of Nebraska, P.O. Box 3248, Omaha, NE 68180-0001

FOR BLUE CROSS AND BLUE SHIELD OF NEBRASKA ONLY

Signature: _____ Approved From _____ to _____
Rejected Date: _____