Out-of-Area Student Certification Form

Please complete and sign the form below.

Subscriber name: _____

Subscriber medical record number: _____

Subscriber address: _____

City: _____ State: _____ ZIP code: _____

Dependent student name: _____

Dependent student medical record number: _____

Dependent student date of birth: _____

School name: _____

School address: _____

City: _____ State: _____ ZIP code: _____

By signing below, I certify that my dependent meets the eligibility criteria and is attending the school above as a full-time student, beginning _____(month/year).

_____

Subscriber signature Date

Once completed, please mail or fax this form to:

Mail to: Kaiser Permanente Membership Administration
P.O.Box 203011
Denver, CO 80220-9011

Fax to: 1-866-311-5974

Please note: The subscriber must submit this form every calendar or plan year, as applicable. The subscriber or dependent student must also notify Kaiser Permanente if anything affecting the dependent student's eligibility changes.

To be completed by Kaiser Permanente:

Date received:_____ Date reviewed: _____

Group#: _____ Subgroup #: _____ Bill group #: _____

Out-of-Area benefit: ❑ Yes ❑ No Visiting Member: ❑ Yes ❑ No

State: _____ Qualified: ❑ Yes ❑ No

Effective date:_____ End date:_____

Reviewed/completed by: _____

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