# Kaiser Permanente for Individuals and Families

## 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
P.O.Box 203006
Denver, CO 80220-9006

**Fax to:** 866-846-2650

**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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3367KPIF-14
June 2014

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