If you are a student at NIU, students may appeal for exception to reimbursement. You will be requested to fully complete and submit pages 2-3.

If a review of your health information is required:
Complete the Student Application and Authorization(page 2). As you complete this paperwork, please keep the following in mind:

1. A licensed attending physician, Advanced Practice Provider (APN) or Certified Physician’s Assistant (PAC) must fully complete and sign the Licensed Provider Medical Documentation Form (page 3).

2. The original, signed documents must be received in its entirety by NIU Immunization, Compliance and Records before a medical review begins. Submit the completed, original form to this office in Room 209 of the Health Services Building. Please DO NOT fax/email information to us.

3. This document or information form will not be disclosed to anyone outside of our department without authorization for Release of Information signed by you.

4. We will review your submitted information. This review is typically completed in approximately 3 to 5 working days after the fully completed and appropriately signed information is received.

5. The Provost Office will be notified as to whether your documentation Supports or Does Not Support your request. You should contact the Provost Office in advance of submitting the attached documents to our office.

6. If the medical information provided from your physician / provider is not sufficient, our office will notify you of this determination. You may submit additional, new medical information for the administrative provider to review.

If you have questions, please contact us at: 815-753-9578, Mon – Fri, 8 AM – 4:30 PM.
APPEAL FOR EXCEPTION TO REIMBURSEMENT

STUDENT APPLICATION and AUTHORIZATION
MEDICAL DOCUMENTATION

I am seeking a medical verification for tuition reimbursement for the semester and year identified below.

Name _______________________________________________ Z-ID # _____________
Address______________________________
City ___________________ State _______ Zip Code ____________

Current daytime telephone number_________________________ Date of birth:_____________________

Semester (circle one): Fall Spring Summer Interim Year ________________

GRADUATE: ☐ UNDERGRADUATE: ☐

I HEREBY REQUEST AND AUTHORIZE the appropriate designee of Health Services, Northern Illinois University, DeKalb, IL 60115:

1. To verify the presence of an acute and/or prolonged, severe medical condition during the above semester to be forwarded to the VICE-PROVOST’S OFFICE or GRADUATE SCHOOL.

2. (Optional) The person/s listed below has my permission to discuss the status of my appeal (e.g., parent, spouse, etc.):

___________________________________________________________________________
(Name of person and relationship to applicant)

I HEREBY REQUEST AND AUTHORIZE Northern Illinois University, Immunization Compliance and Records Office, DeKalb, IL 60115, to verify the presence of a medical condition that warrants a special housing arrangement with Housing & Residential Services at NIU. I understand that I have the right to inspect and/or obtain a copy of the information prior to disclosure and that my refusal to authorize disclosure of this information will result in the following consequences: Denial of my request for a special housing and/or dining arrangement.

I may revoke this authorization at any time by written notification to Northern Illinois University, Immunization Compliance and Records Office. However, I understand revocation cannot be retroactive. I absolve and agree to hold harmless the individual or agency identified above, and the NIU Board of Trustees, together with its officers and employees, from any legal liability, claims or damages which may arise from the disclosure of this information. Unless revoked, this consent is valid until the request is completely processed.

Signature of applicant: ________________________________
Date: ________________________________

Student’s Full Name _________________________________ Z-ID# ________________

Semester and Year of Request _________________________________ DOB ________________

Please type or print the requested information in the space provided below and return this form with original signature to the address above. DO NOT FAX.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>DIAGNOSIS AND ICD – 10 CODE of the severe medical condition that requires a special housing and/or dining arrangement.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>For the above condition, indicate the: Date(s) of evaluation and f/u treatment during the past 6 months; Location of evaluation and f/u treatments (e.g., office, hospital OP, hospital IP, etc.); Nature/ purpose of each evaluation and/or treatment provided; Date of initial onset</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>PROVIDE THE SPECIFIC MEDICAL FINDINGS, RESTRICTIONS AND/OR OTHER OBJECTIVE DATA THAT requires SPECIAL HOUSING ARRANGEMENTS FOR THE ABOVE STUDENT.</td>
</tr>
</tbody>
</table>

________________________________________________________  _________________________
Signature of Attending Physician, Advanced Practice Nurse or Physicians Assistant - Certified