HARVARD UNIVERSITY
Student Health Program

Prescription Travel Override Request & Attestation Form

1. Submit this worksheet with a copy of your e-ticket (must include departure and return dates) or other official documentation showing travel dates (must be on letterhead) Requests can be submitted by email to mservices@huhs.harvard.edu or by fax to 617-496-6125
2. Allow at least 3 business days from submission date for processing
3. Limitations may apply: travel overrides can only be processed for the amount of time a member is traveling abroad or up until their insurance plan termination date
4. A separate worksheet is required for each member that needs an override

Member Name: _____ **Harvard/BCBS ID Number**:_____

Phone Number: _____ **Graduation date:** _____
MM/DD/YYYY

Departure Date: _____ **Return Date:** _____
MM/DD/YYYY MM/DD/YYYY

Prescription Information

Name of Prescription	Prescription strength	Number of months requested	Quantity needed

By signing below, I confirm that I will not waive the Student Health Insurance Plan for the period in which I am requesting the medication. Additionally, if I take a leave of absence during this time, I will purchase the Student Health Insurance Plan coverage. I understand that if I submit a waiver for a period during which an override was granted, my waiver will be denied and the cost of the insurance will be retroactively added back to my student bill.

Signature of the Student Date

Processed by: _____ Date:_____