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)
2. By email: mservices@huhs.harvard.edu or fax 617-496-6125
3. Allow at least 3 business days from the date you submit paperwork for processing
4. 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
5. You must submit a separate worksheet for each member in your family 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. I understand that if I submit a waiver for a period during which an override was approved, it will be denied and the cost of the insurance will be retroactively added back to my term bill.

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Signature of the Student Date

Processed by: _____________ **Date:**____________