Northern Illinois University
Medical Appeal Provider Verification Form

NIU students who wish to appeal for exception to the reimbursement policy for medical reasons are required to fully complete and submit pages 2 -3 of this document.

Undergraduate students must also complete the appeal online form.

Graduate Students should send an email inquiry to gradsch@niu.edu **after** receiving notice from the office that all paperwork has been reviewed.

1. The student must complete the Student Application and Authorization (page 2).

2. 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).

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 appropriate (undergraduate or graduate) Appeals Committee will be notified as to whether your documentation Supports or Does Not Support your request.

6. The final outcome of your Exception to Reimbursement is determined by the appropriate Appeals Committee.

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

8. Falsification of any of these documents will be reported to the Office of Student Conduct for further action.

9. Submission methods:

   Email: medappeal@niu.edu (preferred)

   Fax: 815-753-0701

   Mail: Medical Appeals
   Jeanie Sparacino
   Altgeld Hall 215
   1425 W Lincoln Hwy
   DeKalb, IL 60115

Medical Appeals
Jeanie Sparacino
Altgeld Hall 215
1425 W Lincoln Hwy
DeKalb, IL 60115
medappeal@niu.edu
Fax: 815-753-0701
Phone: 815-753-8387

Northern Illinois University
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Appeal for Exception to Reimbursement

Student 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:_____

Current Email Address:_____

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

GRADUATE: ☐ UNDERGRADUATE: ☐

I HEREBY REQUEST AND AUTHORIZE the appropriate designees of 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 appropriate appeals committee (Undergraduate or Graduate).

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 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.

I may revoke this authorization at any time by written notification to Northern Illinois University, Office of Academic Affairs. 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, of 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:_____

Medical Appeals
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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 by email to medappeal@niu.edu (preferred), fax: 815-753-0701, or mail to the address listed above.

1. DIAGNOSIS AND ICD – 10 CODE of the severe medical condition that requires a special housing and/or dining arrangement.	
2. 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	
3. Provide the specific medical findings, restrictions and/or other objective data that documents how the students class attendance or participation was impaired or obstructed during the above semester(s)	

_____ _____
Signature of Attending Physician, Advanced Practice Nurse or Physician's Assistant - Certified

_____
Printed Name, Business Address, Telephone Number

_____