Consent for Medicaid School Based Services

Student Name: ___________________________ **Birth Date:** _________________

School District: ____

_____________________________________ has the opportunity to bill the Medicaid program for partial reimbursement for health-related services provided in the schools to special education students who are eligible for Medicaid.

If your child receives any of the services listed in the School Based Services provider manual and qualifies for Medicaid benefits at any time during the school year, we request your permission to bill your child's Medicaid insurance to receive reimbursement. You have the right to refuse consent to bill Medicaid, and you have the right to revoke this consent to bill Medicaid. If you do not provide consent, the district will still provide the services but will not receive any Medicaid reimbursement for these services. If you grant consent and revoke it at a later time, please note that your revocation will not be retroactive and the services performed during the time your consent was in place will still be billed to Medicaid.

The Medicaid School Based Services program does **NOT** affect a family's Medicaid benefits and there is **NO** cost to the family, now or in the future.

The school district will be disclosing to the Medicaid agency your child's last name, first name, date of birth, Medicaid number, date of service and the service being provided. This information is disclosed for billing purposes only in an effort to obtain partial reimbursement for service provided to your student.

I give permission for to seek reimbursement from Medicaid for School Based Services rendered on behalf of my child for all services listed on the IEP dated: _________________ I have been made fully aware of my rights as described in 34 CFR 300.154(d)

Medicaid Id # ____________________________________

Parent/Guardian Signature: ____