RELEASE OF INFORMATION/CONSENT TO BILL MEDICAID

DATE:__________ STUDENT'S NAME:______________________________ D.O.B.:__________

Dear ______________________________
(Parent(s)/Guardian(s) Name(s))

Your child's individual education plan (IEP) includes special education and related services provided by our special education staff. One or more of the services your child's IEP qualifies for reimbursement from Medicaid. Schools routinely access Medicaid funding to help meet costs of providing special education services. Federal special education law requires that school districts seek parental permission prior to submitting bills for reimbursement from public insurers such as Medicaid. This letter is asking your permission to bill Medicaid for services listed in your child's IEP.

Granting this permission to bill Medicaid will not reduce your ability to seek other Medicaid-covered health-related services outside the school setting. This permission will not decrease lifetime coverage, increase premiums, or lead to the discontinuation of benefits, as Medicaid does not have a maximum number of eligible visits or a lifetime maximum for services.

Along with this request to bill Medicaid, it is also necessary that the district ("the School") obtain your written permission to release information to Medicaid. This permission must be obtained prior to the School ever releasing your child's personal information from educational records for billing purposes to a public benefits or insurance program. Medicaid requires documentation of the services our staff provided prior to making payments to the School.

You have the right to withdraw consent at any time. Your child's free appropriate public education and related services will continue regardless of consent, refusal of consent, or withdrawal.

[ ] I AGREE and hereby allow and give permission for the School to release information to Medicaid for billing purposes and I give my consent to the School to access/bill Medicaid for provided services.

A. I understand and agree that the School may access my or my child's public benefits or insurance to pay the School for services described in their IEP and provided by the School.

B. I understand and agree that personal information (e.g. information on the services provided to my child) may be provided to the applicable State Agency or Insurance Program for the purpose of obtaining payments for such services.

C. I understand that I have the right to withdraw this permission in writing at any time.

[ ] I DO NOT give permission for the School to release information to Medicaid billing purposes and I DO NOT give consent for the School to access/bill Medicaid insurance for provided services.

______________________________ ______________________________
Parent(s)/Guardian(s) Signature Date