CONSENT TO BILL MEDICAID

STUDENT INFORMATION

Student's Name	Initials	Birth Date	Age	Gender	Grade	Today's Date

Parent/Guardian Name	Parent/Guardian Address	
School District	School	Teacher

NOTIFICATION OF RIGHTS REGARDING MEDICAID BILLING

This notice is to inform you of your rights as a parent of a child with a disability regarding the ability of the school district to access your student's public benefits or public insurance program (i.e., Medicaid) for covered health-related services in your student's Individualized Education Program (IEP). These rights include:

-The services listed in your child's IEP must be provided at no cost to you;
-You have the right to refuse your consent or withdraw your consent at any time; and
-The services listed in your child's IEP must be provided whether or not you give consent for the school district to bill Medicaid.

Giving your consent to access Medicaid for covered health-related IEP services does not relieve the school district of its responsibility to comply with state and federal laws related to the provision of special education services.

WRITTEN CONSENT TO BILL MEDICAID

This consent form allows the school district to bill Medicaid for covered health-related services in your child's Individualized Education Program (IEP) and to release information to the school district's Medicaid Billing Agent for that purpose. It is important to know that granting this permission to bill Medicaid does not reduce your ability to seek other Medicaid reimbursable services outside of the school setting. Medicaid does not have a maximum number of eligible visits for services to children nor does Medicaid have a lifetime maximum for services. Signing this approval to bill Medicaid will not interfere with your access to other health care services that are reimbursable by Medicaid. I understand that:

-Providing consent will not impact my child's/my Medicaid coverage;
-Upon request, I may receive copies of records disclosed pursuant to this authorization;
-Services listed in the IEP must be provided at no cost to me;
-I have the right to withdraw consent at any time;
-Services listed in my child's IEP must be provided whether or not I give consent to bill Medicaid; and
-The school district must give me annual written notification of my rights regarding this consent.

☐ I **give permission** for the school district identified above to release information to Medicaid billing agents and for the district to access Medicaid insurance for the health-related services in my child's IEP.
☐ I **deny permission** for the school district identified above to release information to Medicaid billing agents and for the district to access Medicaid insurance for the health-related services in my child's IEP.

Parent/Guardian/Adult Student Signature

_____ _____
Signature Date

As a parent of a child with a disability you have certain protections under the Procedural Safeguards of the Individuals with Disabilities Education Act (IDEA). You may obtain a copy of the pamphlet "Procedural Safeguards in Special Education" by clicking the link, or by requesting a copy from the school district.

For assistance in understanding the provisions of the Individuals with Disabilities Education Act (IDEA) you may contact your child's school, the Office of Public Instruction at (406) 444-5661, or the Montana Parent Information & Training Center at 1-877-870-1190.

October 2019