# Billing Medicaid for Health-Related Services

**Student:** _____ **STN:** _____

**DOB:** _____ **Age:** _____ **Grade:** _____ **Gender:** _____

I hereby authorize the public agency to verify my child's eligibility for Medicaid. I also authorize the public agency to bill Medicaid for covered health services articulated in the Individualized Education Program (IEP) as provided to my child.

I understand that funds received from Medicaid help pay the cost to provide special education and related services. Informed parental consent to bill Medicaid must be obtained at least annually and the public agency must again obtain parental consent any time the Individualized Education Program is revised to required additional services or increased frequency of services.

Additionally, I understand that my child's right to receive the services listed in the IEP will continue, without interruption and at no cost to me, whether or not I authorize Medicaid billing. Giving consent will not impact my child's Medicaid coverage. I understand that I may revoke this consent in writing at any time, but that the revocation will have no effect on the provision of information or Medicaid billing that has occurred prior to the date the written revocation is received by the public agency. Upon request, I may receive copies of records disclosed pursuant to the authorization.

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**Sign** **Date**