2025-2026 MEDICAID AUTHORIZATION FORM

PLEASE COMPLETE THIS FORM AND RETURN IT TO YOUR LOCAL SCHOOL DISTRICT.
ALL INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL.

MEDICAID INFORMATION / DISTRICT'S AUTHORIZATION FORM

SCHOOL DISTRICT_____

ADDRESS_____CITY_____ STATE/ZIP_____

Student's MEDICAID Number_____

Student's SIMS Number_____

Service(s) Received (circle): Speech Therapy - OT - PT - Nursing - SPED Instruction

STUDENT INFORMATION

STUDENT'S NAME_____

BIRTH DATE_____AGE_____MALE____FEMALE____GRADE_____

PARENT/GUARDIAN NAME_____

ADDRESS_____

CITY_____STATE_____ZIP_____ PHONE_____

PHYSICIAN'S NAME_____

PHYSICIAN'S FACILITY_____

ADDRESS_____

CITY_____STATE_____ZIP_____ PHONE_____

AUTHORIZATION FOR MEDICAID CLAIM

(Please initial one)

_____ **My child is Medicaid eligible.** I give my consent for the Cornbelt Educational Cooperative to submit claims to Medicaid for coverage services. I authorize Medicaid to make these payments to the school district. I authorize the release of any information from the school district to the Cornbelt Educational Cooperative, and by the Cornbelt Educational Cooperative to Medicaid as necessary to request payment of Medicaid benefits. I understand that I may revoke this permission at any time by notifying the Cornbelt Educational Cooperative.

_____ **My child is not Medicaid eligible.**

_____ **I do not wish to provide this information.**

I understand that all services will be provided to my child, without delay, without regard to Medicaid coverage status during the time frame of the IEP. Services to be provided are documented in the student's IEP.

_____ _____
Signature of Parent/Guardian **OR** 18-year-old as own Guardian Date

Please fold this form and tape at spots indicated. Postage is prepaid, no cost to parents.