

2026-2027 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 _____ 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.