2024-2025 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.

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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.