

2011 - 2012 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)
_____ (Address)

STUDENT'S MEDICAID NUMBER _____

STUDENT'S SIMS NUMBER _____

STUDENT INFORMATION

STUDENT NAME: _____ BIRTH DATE: _____

PARENT'S NAME: _____ MALE _____ FEMALE _____

ADDRESS: _____

CITY, STATE, ZIP _____ PHONE _____

PHYSICIAN'S NAME: _____

ADDRESS: _____ PHONE: _____

CITY, STATE, ZIP _____

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 covered 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. If the amount of services changes during the duration of the IEP, a new consent authorization form must be signed. Consent must be obtained each time access to public benefits is sought. Services to be provided are documented in student's the IEP.

Signature of Parent or 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.

Cornbelt Educational Cooperative

715 East 14th Street
Sioux Falls, SD 57104-5151

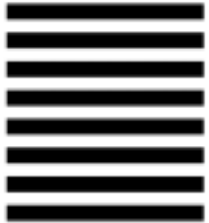


NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 139 MARION SD

POSTAGE WILL BE PAID BY ADDRESSEE

CORNBELT EDUCATIONAL COOPERATIVE
MEDICAID BILLING AGENT
27139 445TH AVE
MARION SD 57043-9902



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