MEDICAID REIMBURSEMENT NOTIFICATION 2014/2015

Re: Student: _____ DOB: _____

Dear Parent:

This letter is to notify you that contracts with Utah Medicaid to be reimbursed for specific special education and related services that may receive. This letter serves as official notice that engages in this practice, and a request for your consent for this reimbursement process.

In order for to participate in this reimbursement program you will be asked to provide the school with your child's Medicaid number. This information will be treated with the strictest confidentiality and will not, under any condition, be released to any other agency or department

The school district will be disclosing to the Medicaid agency your child's last name, first name, date of birth, Medicaid number, date of service and the service being provided. This information is disclosed for billing purposes only in an effort to obtain partial reimbursement for service provided to your student. The school district may access the child's or parent's public benefit or insurance to pay for services.

You have the right to refuse consent to bill Medicaid, and you have the right to revoke this consent to bill Medicaid at any time. If you do not provide consent, the district will still provide the services but will not receive any Medicaid reimbursement for these services. If you grant consent and revoke it at a later time, please note that your revocation will not be retroactive and the services performed during the time your consent was in place will still be billed to Medicaid.

We are required to notify you that the school district may seek reimbursement from Medicaid for medically related services provided to your child, and when seeking consent that personally identifiable information may be disclosed to Medicaid, and that withdrawal of consent does not relieve the school of the requirement to provide therapeutic services for no cost if required under an IEP. This will in no way affect any entitlements you may have through Medicaid or other insurance providers.

I give permission for to seek reimbursement from Medicaid for School Based Services rendered on behalf of my child for all services listed on the IEP dated:
I have been made fully aware of my rights as described in 34 CFR 300.154(d)

_____

Parent/Guardian Signature Date Medicaid #

If you have any questions,
please feel free to contact:

Sincerely,

_____ _____

Director - Special Education Phone