

**MEDICAID CONSENT FORM
FOR PART B SERVICE**

ARSD 24:05:14:01.02, 24:05:14:01.03, 24:05:14:01.04, 24:05:14:01.05 & 24:05:14:01.06

STUDENT NAME:		
PARENT/GUARDIAN NAME:		PHONE:
ADDRESS:		WK PHONE:
SCHOOL DISTRICT:	SCHOOL:	
DOB:	AGE:	GRADE:

MEDICAID NUMBER:	
PHYSICIANS NAME:	PHONE:
ADDRESS:	

(Please sign and return)

The district must obtain written parental consent consistent with § 24:05:29:13 prior to accessing a student's or parent's public benefits or insurance for the first time.

I understand the following:

- 1. Personally identifiable information that may be disclosed (e.g., records or information about the services that may be provided to a particular student);**
- 2. Purpose of the disclosure (e.g., billing for services under state special education rules);**
- 3. Disclosure will be made to the state Medicaid agency; and**
- 4. As parents, I understand and agree that the public agency may access the parent's or student's public benefits or insurance to pay for services under state special education rules.**

☐ **I CONSENT¹** for _____ District to submit claims to Medicaid for covered services. I authorize Medicaid to make these payments to the _____ District. I authorize the release of any information from the _____ District to Medicaid as necessary to request payment of benefits. I understand that if I have private health insurance, Medicaid has the right to recoup the costs from my private health insurance. I understand that these costs may count against the lifetime cap of my private health insurance. I further understand that I will not incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services. However, the district may pay the cost that I otherwise would be required to pay in order to access either my private or public benefits or insurance. I understand that if I do not permit the district to access my public benefits or insurance, the district is still required to provide my child with all the services necessary to ensure FAPE at no cost to me.

I understand that I may revoke this permission at any time by notifying the _____ District in writing.
(Refer to ARSD 24:05:14:01.02 through 24:05:14:01.06)

☐ **I DO NOT CONSENT¹** for the _____ district to submit claims to Medicaid for covered services.

Parent/ Guardian Signature: _____ Date: _____

For District Use:

Date consent was received by the district: _____

¹ Consent definition can be found in Administrative Rules of South Dakota (ARSD) 24:05:29:13 and (ARSD) 24:05:13:01(8)