Kansas

Parent Consent for Release of Information and Medicaid Reimbursement

Consent to Release Information:

I consent for _____ (School) to release records or information about my child's participation in services to participating physicians, other health care providers, the Kansas Department of Health and Environment (KDHE), any KDHE billing agents, and any school billing agent, as necessary, to process claims for reimbursement by KDHE for covered health-related services, evaluations for these services and transportation, on the day the student receives any health-related service, which are outlined in the child's Individualized Education Program (IEP), including duration and frequency of IEP services.

Consent to Access Public Benefits

- I give consent for the school to access the child's or parent's public benefits or insurance to pay for services under 34 C.F.R. part 300.

Procedural Safeguards:

- I understand that the school may be required to provide certain health-related services to a student who has an IEP at no additional cost to the student's parent(s), and that my refusal to sign this form will not affect whether such services are provided at no cost to the student named above.
- I understand that I will not be required to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services. I understand that my child's Medicaid benefits will not be used if that use will:

  (a) decrease available lifetime coverage or any other insured benefit; (b) result in your family paying for services that would otherwise be covered by a public benefit or insurance program and that are required for the child outside of the time the child is in school; (c) increase premiums or lead to the discontinuation of benefits of insurance; or (d) risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.
- I also understand that the granting of consent is voluntary and may be withdrawn at any time. If I later revoke consent, that revocation is not retroactive (i.e. it does not negate any action that has occurred after the consent was given and before the consent was revoked).

☐ I give consent for the school to release Education Records or information and to access Public Benefits as described above in order to submit claims to the Kansas Department of Health and Environment (KDHE),

☐ I do not give consent.

Child's Name	Date of Birth	Begin Date

Parent/Guardian Signature	Date

Physician Authorization Medicaid Billing

USD Name and Number:_____

Student Education ID #_____

Students Name:_____

Students DOB:_____

Physicians Name:_____

Dear Health Care Provider:

As specified in the student's Individual Education Plan (IEP), the student qualifies to receive one or more of the following services during the time period specified in the student's IEP.

Audiology	Occupational Therapy	Physical Therapy
Nursing Services	Speech/Language Therapy	Psychological Testing/Social Work Services

If/as appropriate, the Local Education Agency (LEA) may seek reimbursement from Kansas Medicaid for service's the student receives as listed above. In order to do that, however, the LEA must obtain the signature of a qualified health care provider.

Your signature certifies that the student requires the above-listed service (s) specified in the student's IEP. In this regard, this document will service as the required "physician's Prescription" with respect to those services.

Physician Signature:_____

Date Signed:_____

For the period from :_____ **To:**_____