(School district letterhead)

Date: _____

Dear Parent:

Your child's Individualized Education Program (IEP) includes special education and related services provided by our special education staff. One or more of the services included on your child's current IEP qualifies for reimbursement from Medicaid. Schools in Montana routinely access Medicaid funding to help meet costs of providing special education services. Medicaid funds help support our school in our effort to provide quality educational services.

Recent changes in the federal special education law now require that we annually seek your permission to submit bills for reimbursement from public insurers such as Medicaid. This letter is asking your permission to bill Medicaid for Medicaid reimbursable services contained in you child's current IEP.

It is important to know that granting this permission to bill Medicaid does not reduce your ability to seek other Medicaid-covered health-related services outside of the school setting. Medicaid does not have a maximum number of eligible visits for services to children nor does Medicaid have a lifetime maximum for services. Signing this approval to bill Medicaid will not interfere with your access to other health care services that are reimbursable by Medicaid.

Along with this request for permission to bill Medicaid it is also necessary that we ask your permission to release information to Medicaid. Medicaid requires documentation of the services provided prior to making payment to our school. We are asking for your permission to share this documentation with Medicaid and our billing agent.

Be assured that any services your child receives from our district will continue whether or not you give us permission to release information or submit bills for reimbursement.

☐ I **give permission** for the *(school district)* to release information to Medicaid billing agents and **give permission** for the district to access Medicaid insurance for the duration of my child's current IEP.

☐ I **deny permission** for the *(school district)* to release information to Medicaid billing agents and **deny permission** for the district to access Medicaid insurance for the duration of my child's current IEP.

_____ _____

Signature Date

Please sign both copies and return one to *(school district)* and retain the other copy for you records. Thank you for your attention to this matter.

Sincerely,