Medicaid Consent for LEA, AEA or CHSC Reimbursement

Date:
Learner's Name: Learner's Date of Birth:
Dear (Parent/Guardian Name):

Your child has the selected program or plan:

◯ CHSC ◯ Individualized Family Service Plan ◯ Individualized Education Program

The plan or program selected above contains licensed or certified health providers and services covered by Medicaid. Iowa Medicaid grants permission for one or more of the provider types or services in the plan(s) or program to be reimbursed by your child's health insurance with your consent. Local Education Agency(s) [LEA], Area Education Agency(s) [AEA], or Child Specialty Health Clinics (CHSC) access this reimbursement to help meet costs of the provision of health-related services for your child. These services provided by the LEA, AEA, or CHSC occur regardless of your consent or type of insurer. Federal law requires the LEA, AEA, or CHSC to obtain your permission and consent prior to requesting reimbursement and your information from health insurers such as Medicaid.

This letter is asking your permission to request eligibility information and reimbursement from Medicaid for providers and services listed in your child's selected program or plan(s). Medicaid does limit the number of eligible visits nor the amount of services your child receives.

Granting this permission for the LEA, AEA and/or CHSC to request reimbursement from Medicaid:

- Will not reduce your existing benefits,
- Will not increase premiums or your ability to seek other Medicaid-covered health-related services outside the LEA, AEA, or CHSC setting,
- Will not decrease lifetime Medicaid coverage, and
- Will not lead to the discontinuation of benefits.

After you have provided informed consent, it is necessary that the LEA, AEA and/or CHSC obtain your written permission to release information to Medicaid. This permission must be obtained prior to the LEA, AEA and/or CHSC releasing your child's personal information from educational records for reimbursement purposes from your child's insurance program. Medicaid requires documentation of the services provided for reimbursement and program integrity. You have the right to refuse or withdraw your consent at any time with no impact to providers or services your child receives at the LEA, AEA or CHSC.

◯ **I AGREE** and hereby allow and give informed consent for the LEA, AEA or CHSC to request reimbursement and eligibility information from Medicaid and release information to Medicaid for reimbursement purposes, in addition to A-D:

A. I understand and agree that provider(s) and services identified in my child's program and plan(s) will be offered regardless of this consent.

B. I understand and agree that the LEA, AEA, or CHSC may access my child's health insurance for reimbursement of services granted by Medicaid.

C. I understand and agree that personal information (i.e. information on the services provided to my child) may be provided at the request of the State Education Agency or Insurance Program for the purpose of obtaining reimbursement and required for Medicaid program integrity.

D. I understand that I have the right to withdraw this consent and permission in writing at any time.

◯ **I DO NOT** give permission for the LEA, AEA or CHSC to release information for Medicaid purposes And **I DO NOT** give consent for the LEA, AEA or CHSC to access Medicaid insurance.

Parent(s)Guardian(s) Signature Date
LEA or AEA Date