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:			**SIMS:**
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 this article);**
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 this article.**

☐ **I CONSENT**[1] 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. These costs may count against the lifetime cap of my private health insurance.
I understand that I may revoke this permission at any time by notifying the ___________ District.
(Refer to ARSD 24:05:14:01.02 through 24:05:14:01.06)

☐ **I DO NOT CONSENT**[1] for the ___________ district to submit claims to Medicaid for covered services.

Parent/ Guardian Signature: ____ Date: ___________

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

For District Use:
Date consent was received by the district: ___________