Medicaid Referring Provider Form for School-Based Services

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| Student’s Name: | Click or tap here to enter text. | | | DOB: Click or tap here to enter text. |
| School District: Click or tap here to enter text. | | | | |
| Student State ID Number: | | | Click or tap here to enter text. | | |
| IEP Dates of Service: | | Click or tap here to enter text. | | |
| Primary Care Provider Name: | | Click or tap here to enter text. | | |

Ordering and Referring Provider

The following is (are) the referring service provider(s) that participated as part of the IEP team to develop the goals and objectives for ENTER STUDENT NAME including the level and amount of services required to meet the annual goals (functional and academic) of the child. The referring provider may or may not have attended the IEP meeting, following the excusal attendance requirements. However, they did contribute to the development of the IEP and determination of need for special education and related services. The referring provider assisted in the determination of such services that are needed by the child.

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| Ordering and Referring Provider Name and Credentials  (i.e., Audiologist, Occupational Therapist, Physical Therapist, Speech-Language Pathologist) | Ordering and Referring Provider NPI# | Service Ordered  (Audiology, Occupational Therapy, Physical Therapy, Speech-Language Pathology) |
| Click or tap here to enter text. | Click here | Choose an item. |
| Click or tap here to enter text. | Click here | Choose an item. |
| Click or tap here to enter text. | Click here | Choose an item. |
| Click or tap here to enter text. | Click here | Choose an item. |

*Note to IEP Teams: Related services other than the four listed on this form continue to be Medicaid reimbursable, but do not require the completion of this form.*

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| **Annual Notification to Parents of Medicaid Billing** |
| I have received a copy of my annual Written Notification of the school district’s access of my child’s Medicaid benefits to pay for Medicaid-Eligible IEP services and release and exchange of necessary information and medical records with my child’s Primary Care Provider (PCP) and the Medicaid agency from my child’s school to complete the billing process.  I understand that I have previously given my Consent to Access Medicaid and Disclose Confidential Information and that my consent is voluntary and may be revoked at any time.  However, I understand that if I revoke consent, my revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked). I understand that Medicaid reimbursement for school-based services does not impact my family’s Medicaid services, funds, or limits, including those of any Medicaid Waiver program.  Parent Initials \_\_\_\_\_\_\_\_\_ |