



THE PUBLIC SCHOOLS of SPRINGFIELD, MASSACHUSETTS

Dear Parent,

The Public Schools of Springfield has undertaken a project to collect reimbursement from Medicaid for health related services it provides to Medicaid eligible students. In order to receive these funds from Medicaid, the City must file claims for Medicaid eligible students receiving services.

If your child is eligible for Medicaid or was ever eligible, we are asking your help in providing the information necessary to obtain Medicaid reimbursement. Please read and sign the section below, and complete the boxed area.

ALL PARENTS SHOULD COMPLETE THIS FORM REGARDLESS OF WHETHER THEIR CHILDREN ARE CURRENTLY RECEIVING SPECIAL EDUCATION SERVICES.

I, the parent/guardian of _____ hereby give my consent to the Public
(Parent Name)

Schools of Springfield and/or its assignee to seek payment from Medicaid for health related services provided to my child by the Public Schools of Springfield. In giving consent, I understand that:

- My child will receive a free appropriate education to meet his/her needs, whether or not I volunteer information about Medicaid benefits.
- I will not pay any charges or experience any losses as a result of billing Medicaid.
- I can change my mind about giving or withholding permission to use this information to bill Medicaid.

(Signature)

(Date)

(Home Phone #)

Please Note- If the student is 18 years old or older, he/she should sign this form him/herself

Please provide the following information regarding your child:

Student's Name _____
(First Name) (Last Name)

Student's Home Address: _____

(City)

(State)

(Zipcode)

School Name: _____ Student's Medicaid Number: _____

Student's Sex: _____M _____F (Check One) Date of Birth: ____/____/____
(Month/Day/Year)

- My child has never been eligible for Medicaid benefits
- My child has been/is currently eligible for Medicaid benefits

Student's Social Security Number: _____-_____-_____