LEA:________________

Parental Consent
For Billing Public Insurance

Name of Student:____

Date of Birth:_______________SSN #______________________

Name of Parent/Guardian:_________________________________

1. **Health Insurance**: (Please check **all** that apply.)

______No Insurance ______Private Insurance (Private insurance will not be billed)

Medicaid Programs:____Medicaid ____Medallion ____FAMIS

____Sentara Family Care_____Optimum Choice____Virginia Premier
____HealthKeepers Plus _____Chartered Health Plan_____John Deer

MEDICAID #________________________________

FAMIS #____________________________________

2. **For Medicaid Insured Only**

Consent to Release Information: I consent for __________________(LEA) to release information about my child's participation in services billed to Medicaid to participating physicians, other health care providers, the Department of Medical Assistance Services, and any Department of Medical Assistance Services billing agents, and any LEA billing agent as necessary to process Medicaid claims for reimbursement of health-related services. I understand that my permission is voluntary and may be revoked at any time.

Procedural Safeguard: I understand my right to deny consent for the school system to access my child's medicaid coverage to seek reimbursement for the health-related services provided will not affect delivery of these services to my child.

____________________________________ __________________

Parent/Guardian Signature Date

Name of Physician____

MED-5
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