PARENTAL CONSENT FOR BILLING PUBLIC INSURANCE

For Medicaid, Medicaid Expansion or FAMIS (Family Access to Medical Insurance Securities) Insured Only

<u>Consent to Release Information</u>:

I consent for <u>Rappahannock County Publics Schools</u> (LEA) to release information about my child's participation in services to participating physicians, other health care providers, the Department of Medical Assistance Services (DMAS), any DMAS billing agents, and any LEA billing agent as necessary, to process claims for reimbursement by DMAS for covered health-related services, evaluations for these services and transportation on the day the student receives any health-related services which are outlined in the child's IEP.

<u>Procedural Safeguard:</u>
I understand my right to refuse consent for the school system to access my child's Medicaid or FAMIS coverage to seek reimbursement for the health-related services.   I understand that any refusal will not affect delivery of these services to my child and delivery of such services will be at no cost. I understand that my permission is voluntary and may be revoked at any time. I also understand that I have the right to request a copy of the records disclosed.

☐   I give consent for claims to be submitted to the Virginia Department of Medical Assistance Services (DMAS), as described above, for the health-related services outlined in the Individualized Education Program (IEP), including duration and frequency and/or evaluations for IEP services.

☐   I do not give consent for the school system to access my child's Medicaid or FAMIS coverage.

_____
Child's Name

Consent period: August 12, 2025 – August 11, 2026

_____
Parent/Guardian Signature

_____
Date