Anchorage School District

ANCHORAGE SCHOOL DISTRICT SCHOOL-BASED MEDICAID PARENT REVOCATION OF CONSENT TO BILL

5530 E Northern Lights
Anchorage, AK 99504
(907) 742-4236

MEDICAID CONSENT

Student Name: **Date of Birth:**

I, as parent or guardian of the above named student, revoke consent for Anchorage School District (ASD) to bill Alaska Medicaid for reimbursement of services rendered to my student. I have been fully informed of my and my student's rights to receive services from Anchorage School District. I understand that my consent for ASD to bill Alaska Medicaid for services is voluntary.

I understand that my revocation of consent to bill Alaska Medicaid will have no impact on my student's access to a Free and Appropriate Public Education (FAPE) through ASD, including any services outlined as part of an Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). I understand that my revocation prevents ASD from sharing information relevant to services rendered to my student for the purpose of reimbursement by Alaska Medicaid.

I understand that my revocation is not retroactive and does not erase consent for ASD receiving reimbursement from Alaska Medicaid for services eligible under a prior consent.

I understand that this revocation has no impact on my student's Alaska Medicaid eligibility or lack thereof.

Parent/Guardian Signature **Date Signed**

☐ ASD Medicaid Annual Notice to Parents provided