Consent for Medicaid Billing:

I give consent to and authorize Merit Academy to release to Colorado Health Care Policy and Financing (HCPF)information related to Medicaid eligible services the District provides to the student identified above, as necessary, to apply for and recover partial Medicaid reimbursement. If at any _me you would like to revoke this permission, please contact the school Medicaid Office at 719-520-2251.

Parent/Guardian
Signature:____

Date: :____