



**MEDICAID AUTHORIZATION FORM**  
*FOR PART C SERVICES*

**CHILD'S INFORMATION**

CHILD'S NAME: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

CHILD'S MEDICAID NUMBER: \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

(Please initial one)

\_\_\_\_\_ **I give my consent.** I give my consent for Birth to Three Connections providers to submit claims to Medicaid for covered services. I authorize Medicaid to make these payments to the Birth to Three Connections provider. I authorize the release of any information from the Birth to Three Connections provider to Medicaid as necessary to request payment of Medicaid benefits. I understand that if I have private health insurance, Medicaid has the right to recoup the costs from my private health insurance. These costs may count against the lifetime cap of my private health insurance. I understand that I may revoke this permission at any time by notifying my Birth to Three Connections Service Coordinator.

\_\_\_\_\_ **I do not give my consent.**

I understand that all services will be provided to my child, without delay, without regard to Medicaid coverage status during the time frame of the IFSP. If the level of services increases during the duration of the IFSP, a new consent authorization form must be signed. Services to be provided are documented in child's IFSP.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date