STATEMENT OF REASSIGNMENT

____

Name of the Outside Contracted Provider

By this reassignment the above-named outside contracted provider of services agrees:

1. to reassign all Medicaid reimbursements to the school district that you contracted with for providing medical services billed under the School Supportive Health Services Program (SSHSP).

2. to accept as payment in full the contracted reimbursement rates for covered services.

3. to comply with all the rules and policies as described in your contract with the school district.

4. to agree not to bill Medicaid directly for any services that the school district will bill for under the SSHSP program.

NOTE: Nothing in this "Agreement of Reassignment" would prohibit a Medicaid practitioner from claiming reimbursement for Medicaid eligible services rendered outside of the scope of the School Supportive Health Services Program (SSHSP)

__________________ ____

(Date) (Outside Contract Service Provider's Signature)

____

(Printed Name)

____

School District (under contract with): List additional ones on back of this form.)

Additional School Districts with Which you Contract: