[Date]

[Name]

[Title]

[Facility]

[Street]

[City, ST Zip]

Dear [**Name**]:

**RE: School District Expectations of \_\_\_\_\_\_\_\_\_\_\_\_ relative to Medicaid Documentation**

For the purpose of accessing reimbursement from the New Hampshire “Medicaid to Schools” Program (the Program) for related services including OT, PT, Speech, Language, Hearing, Vision, Psychological, Psychiatric, Nursing, Mental Health, Rehabilitative Assistance Services and Specialized Transportation, please recognize MSB™ as an agent of the [ ] School District. Our expectation is that your facility will provide all appropriate documentation to SAU [**XX]** with each invoice. This appropriate documentation includes information pertaining to the delivery of health related services provided to [**Student Name(s)**] in compliance with the Program regulations, such as student attendance information, practitioner referrals, your practitioners’ rates and credentialing information, and other pertinent requests related to service delivery to our students.

We appreciate your assistance in helping SAU [XX] claim services provided to the above-mentioned student(s) for the entire 2017-18 school year. SAU [XX] expects to claim for all services covered under the Program for each student for the entire school year.

Again, thank you for your cooperation.

Sincerely,

[Insert Name]

Special Education Director

[Insert District]