MEDICAID FINANCE AND CONSULTING SERVICES

2010-2011 SHARS SERVICE SIGNATURE ON-FILE AUTHORIZATION FORM

Audiology Services

Your Name (Please Print)	
District Name (Required)	
Your District e-Mail	
Your Job Title (Required) **(Credentials/Licensure)**	**Please check all that apply** ___ Licensed Audiologist ___ Licensed Audiologist Assistant ___ Other (Please List)

Are you a contracted services employee (not a district employee)? Yes_____ No_____

If applicable, provide your current license/credentials number and expiration date? (Optional)

License Number:_____ Expiration Date:_____

Campus Number/Name **(Indicate campus # if known)**	**Please list campus name(s) where you provide services (required).**			
	#		#	
	#		#	
	#		#	

Telephone No. **New eSHARS User __Yes __No**

Please be advised that my signature on this document is verification that all claims submitted on my behalf by electronic and/or standard paper means of submission shall be true, accurate, and complete. This is also to certify that all information submitted by me and filed under my name represent SHARS services that have been or will be personally provided by me or under my personal direction while under the auspices and/or employment with the specified Independent School District and will be true, accurate and complete. By signing, I also agree to comply with confidentiality rules as applicable regarding the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA).

Once signed, this document certifies that my signature is on file for the claims that have been or will be generated and submitted via the e-SHARS Medicaid Billing System. This document, to be retained by the specified ISD and MFCS, bears my true and original signature.

CERTIFICATION OF SIGNATURE ON FILE FOR SHARS SERVICE CLAIMS

Signature:

Date Signed:

For additional information or assistance please contact the MFCS at 800-381-6334 or eSHARS@houstonisd.org

MFCS Office Use Only					
Utilities:	Password:	District Site:	Training Site:	Rep:	Date:
PDF #:	Clinician #	Portal #		Rep:	Date: