



# MEDICAID RECOVERY OFFICE SY 20-21

## AUTHORIZED PURCHASER FORM School Incentive Funds

PLEASE provide the following information to the Medicaid Office. Only the authorized purchasers listed will be able to utilize the incentive funds for your school. Thank you.

### AUTHORIZED PURCHASER REGISTRATION

Print Name:

School Name:

Phone#:

Email:

### ALTERNATE PURCHASER

Print Name:

Email:

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Primary Authorized Purchaser Signature