

Date/Fecha

Eligibility Specialist/Especialista de Elegibilidad

MEPD

Office Address and Telephone No./ Oficina y Teléfono

2526 Jacksboro Hwy
Fort Worth, TX 76114

(Name and Address of Client's Attending Practitioner)

CERTIFICATION OF NO MEDICAL CONTRAINDICATION- DENTAL

Name of Patient

Client No.

Facility Name and Address: _____

To the patient's attending practitioner:

When determining the amount that the patient must pay for his care in a nursing facility, this department allows a deduction from the patient's income for the cost of routine dental services. Your certification that these services

(List Dental Services)

Routine Dental Care: Exam, X-rays, Cleaning and further Treatment if required

Are not medically contraindicated for the patient is required before the department can allow this deduction.

Please complete this form and return it in the postage-paid envelope. **(The department cannot pay you for completing this form.)**

TO BE COMPLETED BY ATTENDING PRACTITIONER

As the above-named patient's attending practitioner, I certify that the following dental service(s) required

Routine Dental Care

Is/are not medically contraindicated for the patient.

Signature-Practitioner

Date

Name of Practitioner (please type or print)

Type of Practice *

Telephone No. (include Area Code)

Address

* MD, DO, nurse practitioner, clinical nurse specialist, or physician assistant

Dental Treatment Plan: Approved Disapproved

Signature DADS Regional Nurse: _____ Date: _____

Authorization to Release Medical Information / Autorización para divulgar información médica

SECTION I

Name of Patient _____

The Health and Human Services Commission (HHSC) is requesting completion of a medical report to determine your eligibility for services. When you sign this authorization, you are giving HHSC permission to contact your doctors and medical facilities to request copies of your health information as indicated below. Your signature is required on this authorization form to determine your eligibility for services.

I authorize (Write the name of the Doctor, Medical Facilities, or other Health Care Providers)

LifeCycle Dental Resource Inc.

to complete Form H1263, Certification of Medical Necessity, and release to the Health and Human Services Commission.

For the authorization to obtain your medical information, please indicate an expiration date or indicate open-ended if you prefer no date of expiration.

This authorization expires:

Date: _____ open-ended

SECCIÓN I

Nombre del paciente _____

La Comisión de Salud y Servicios Humanos de Texas (HHSC) ha pedido un informe médico completo para determinar si usted tiene derecho a los servicios. Al firmar esta autorización, le da permiso a la HHSC para comunicarse con su doctor y centros médicos para pedirles copias de su información médica como se indica a continuación. Su firma es necesaria en esta autorización para determinar si tiene derecho a los servicios.

Yo autorizo a (Escriba el nombre del doctor, centro médico u otro proveedor de atención médica)

para que llene la Forma H1263, Certificación de necesidad médica, y la entregue a la Comisión de Salud y Servicios Humanos de Texas

Esta autorización se vence el: _____

SECTION II / SECCIÓN II

Client or Personal Representative's Signature / Firma del Cliente o del Representante Personal _____

Date / Fecha _____

If you are signing for the client, please describe your authority to act for the client:
Si usted firma por el cliente, haga el favor de describir la autoridad con la que actúa por el cliente:

NOTE: If the person requesting the release of case information cannot sign his name, two witnesses to his mark (X) must sign below:

NOTA: si la persona que pide la divulgación de la información del caso no puede firmar su nombre, debe poner una marca (X) ante dos testigos, que deben firmar a continuación:

Witness / Testigo _____

Date / Fecha _____

Witness / Testigo _____

Date / Fecha _____

SECTION III

Notice to Client

HHSC, as receiver of this information, will protect your personal health information in accordance with federal and state privacy regulations. If you authorize release of your health information to other parties it may no longer be protected by privacy regulations.

You can withdraw permission you have given your doctor or health care provider to use or disclose health information that identifies you, unless they have already taken action based on your permission. You must withdraw your permission in writing.

SECCIÓN III

Aviso a los clientes

La HHSC como receptor de esta información, protegerá su información médica personal de acuerdo con las regulaciones federales y estatales de la vida privada. Si autoriza la divulgación de su información médica a terceros, tal vez ya no tenga la protección de las regulaciones de la vida privada.

Puede retirar el permiso que le ha dado al doctor o al proveedor de atención médica para divulgar la información médica que lo identifica a usted, a menos que éste ya haya actuado con su permiso. Tiene que retirar su permiso por escrito.

You, the client, or authorized representative are responsible to pay the deduction amount you are requesting from your income to the dentist effective upon notification of change in your payment to the facility.

If you, as the receiver of the service, or your authorized representative have a complaint about the services, you are responsible for making the complaint directly to the Texas State Board of Dental Examiners at 800-821-3205.