Date/Fecha

Eligibility Specialist/Especialista de elegibilidad MEPD
Office Address and Telephone No./Oficina y teléfono 2220 Mall Circle Drive Fort Worth, TX 76116

(Name and Address of Client's Attending Practitioner)

Certification of No Medical Contraindication — Dental / Certificación de que no hay contraindicación médica — 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 * MD	Telephone No. (include AC)
Address		

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

Dental Treatment Plan: ☐ Approved ☐ Disapproved

Signature-DADS Regional Nurse ______________________ Date ____________

Form H1263-B / 10-2007