Date/Fecha

Eligibility Specialist/Especialista de elegibilidad
Office Address and Telephone No./Oficina y teléfono

(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:

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

is/are not medically contraindicated for the patient.

Signature-Practitioner | Date

Name of Practitioner (please type or print)	Type of Practice *	Telephone No. (include AC)
	General	
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.)**

Dr. Wendy E. Skulman & Dr. Greg E. Skulman, DDS

to complete Form H1263-B, Certification of No Medical Contraindication — Dental, 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 llena los requisitos para recibir servicios. Al firmar esta autorización, usted le da permiso a la HHSC para comunicarse con su doctor y los centros médicos para pedirles copias de su información médica como se indica a continuación. Su firma es necesaria en esta autorización para determinar si llena los requisitos para recibir servicios.

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

____

para que llene la Forma H1263-B, Certificación de que no hay contraindicación médica — Dental, y la entregue a la Comisión de Salud y Servicios Humanos de Texas.

Para la autorización para obtener su información médica, por favor, indique la fecha de vencimiento o marque “Abierta” si prefiere no tener una fecha de vencimiento.

Esta autorización se vence el: ☐ Fecha: ____________________ ☐ Abierta

SECTION II

____________________ **Signature–Client or Personal Representative** ____________________ **Date**

☐ **If you are signing for the client, please describe your authority to act for the client:**

____

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

Witness	**Date**	**Witness**	**Date**

SECCIÓN II

____________________ Firma del cliente o del representante personal ____________________ Fecha

☐ Si usted firma por el cliente, favor de describir la autoridad con la que actúa en nombre del cliente:

____

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:

Testigo	Fecha	Testigo	Fecha