**Ryan White Program**

**Dental Waiver Form**

*(Please Print or Type)*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **E-mail To:** | [Lisa.Garces@uhs-sa.com](mailto:Lisa.Garces@uhs-sa.com) | | | | **Agency Name:** | | | | **Tel #:** |
| **Attention:**  **Dental Waiver Processing** | | | | | **Address:** | | | | **Email:** |
|  | | | | | **From:** | | | | |
| **To Be Completed by Service Provider (Agency):** | | | | | | | | | |
| Patient’s Agency ID: | |  | | | | | Date of birth: | |  |
| Authorized Service Provider (Agency) Staff Person: | | | | | | | | | |
| Name: |  | | | | | | Position: |  | |
| Signature: |  | | | | | | Date: |  | |
| **To Be Completed by Dental Provider:** | | | | | | | | | |
| Please identify the condition requiring the dental waiver: | | | | | |  | | | |
| Please describe how the condition is related to the patient’s HIV diagnosis: | | | | | |  | | | |
| Please explain why the condition must exceed the cap and the total amount required for treatment: | | | | | |  | | | |
| Authorized Dental Provider Staff Person: | | | | | | | | | |
| Name: |  | | | | | | Position: |  | |
| Signature: |  | | | | | | Date: |  | |
| **To Be Completed by Ryan White Program:** | | | | | | | | | |
| Approved | | | Date: |  | | | | | |
| Ryan White Program Director/Manager | | |  | | | | | | |
| **This approval is contingent upon the following conditions:**   1. Approval is for no more than one (1) year from the date of approval. | | | | | | | | | |
| Denied | | | Date: |  | | | | | |
| Ryan White Program Director/Manager | | |  | | | | | | |