**Ryan White Program**

**Dental Waiver Form**

*(Please Print or Type)*

|  |  |  |  |
| --- | --- | --- | --- |
| **E-mail To:**  | 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 |  |