



ND RYAN WHITE PROGRAM PART B REQUEST FOR ORAL HEALTH CARE

NORTH DAKOTA DEPARTMENT OF HEALTH

DIVISION OF DISEASE CONTROL

SFN 58589 (04-15)

Client's Name	ND Ryan White Client Number
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Date Application Completed

<p>Instructions</p> <ul style="list-style-type: none"> • Please attach estimated cost of procedure from oral health care provider. • All procedures will be covered up to 100 percent based on available funding. • All procedures besides preventative care will be subject to an oral health care consult to determine the need and if the procedure will be covered by the program. • Obtain signatures from your oral health care provider and case manager.
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<p>Assistance Requested</p> <input type="checkbox"/> Preventive treatment <input type="checkbox"/> Filling(s) <input type="checkbox"/> Crown/Cap <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Root Canal <input type="checkbox"/> Bridge <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Extractions <input type="checkbox"/> Dentures/Partials <input type="checkbox"/> Other _____

Dentist's Name	Telephone Number
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Street Address	City	State	Zip Code
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<p>Explanation of Procedure (to be completed by oral health care provider)</p> <hr/> <hr/> <hr/> <hr/> <hr/>
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Signatures	
_____	_____
Oral Health Care Provider	Date
_____	_____
Client	Date
_____	_____
Case Manager	Date

<p>ND Ryan White Program Part B Coordinator Approval/Denial</p> <input type="checkbox"/> Approved <input type="checkbox"/> Denied
