ND RYAN WHITE PART B PROGRAM REQUEST FOR ORAL HEALTH CARE
NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF SEXUALLY TRANSMITTED AND BLOODBORNE DISEASES
SFN 58589 (Rev. 07-2021)

Client's Name	ND Ryan White Client Number	Date

Procedure

1. Please attach estimated cost of procedure from the oral health care provider.
    - All preventive procedures may be covered up to 100 percent based on available funding.
    - Procedures other than preventative care will be covered up to $1,000 annual oral assistance cap. Procedures may be covered above the annual cap based on available funding.
2. Provide this form to your oral healthcare provider to complete and bring to your case manager.

Assistance Requested:

☐ Preventive procedures (routine oral exam, X-rays, cleaning, sealants, fluoride treatment)
☐ Filling(s) ☐ Extractions ☐ Crown/Cap
☐ Oral Surgery ☐ Root Canal ☐ Dentures/Partials ☐ Other:

Oral Health Care Provider's Info

Provider's Name		Telephone Number	
Street Address	City	State	Zip Code

Explanation of the Procedure(s) and Cost (to be completed by the oral health care provider)

Signatures

Oral Health Care Provider	Date
Client	Date

For Case Managers

Request Assistance Amount	Approved Assistance Amount
Notes	
Case Manager Signature	Date