



Date:

Caseworker:

Office address and phone number:

Name and address of client or authorized representative:

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**We need proof that you received dental services.**

Name of client:	Client number:
Name and address of place of care where client lives:	
Name and address of dental service provider:	

**We need to know if you received \_\_\_\_\_ .**

If you received these dental services, we can take the cost off (deduct) what you pay for nursing care. This is called an "incurred medical expense deduction." We can't do this until we get this form.

**Did you get these services?**

We need to make sure you got these services. Fill out the following:

Yes, I have received the services listed above. I received them on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ .  
Date (mm/dd/yyyy)

No, I didn't get the services listed above.

**Sign and date:**

_____ Signature – Client or Authorized Representative	_____ / _____ / _____ Date (mm/dd/yyyy)
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