TEXAS
Health and Human Services

Date/Fecha

Eligibility Specialist/Especialista de Elegibilidad

(Name and Address of Client's Attending Practitioner)

Office Address and Telephone No./ Oficina y Teléfono

CERTIFICATION OF MEDICAL NECESSITY

Name of Patient	Client No.

To the patient's attending practitioner:

When determining the amount that the patient must pay for his care in a nursing facility, this department allows a deduction from the patient's income for the cost of medically necessary routine dental services, prosthetic devices, walking aids, and special shoes/support for feet. Your certification that

(List Medically Necessary Items)

was/were medically necessary (as defined below) is required before the department can allow this deduction.

Medically necessary is defined as the need for medical services in an amount and frequency sufficient, according to accepted standards of medical practice, to preserve health and life and to prevent future impairment.

Please complete this form and return it in the postage-paid envelope. **(The department cannot pay you for completing this form.)**

TO BE COMPLETED BY ATTENDING PRACTITIONER

As the above-named patient's attending practitioner, I certify that the patient required

as a matter of medical necessity.

Signature-Practitioner _____ Date _____

Name of Practitioner (please type or print)	Type of Practice *	Telephone No. (include Area Code) ( )
Address		

*** MD, DO, nurse practitioner, clinical nurse specialist, or physician assistant**

Authorization to Release Medical Information / Autorización para divulgar información médica

SECTION I

Name of Patient _____

The Health and Human Services Commission (HHSC) is requesting completion of a medical report to determine your eligibility for services. When you sign this authorization, you are giving HHSC permission to contact your doctors and medical facilities to request copies of your health information as indicated below. Your signature is required on this authorization form to determine your eligibility for services.

I authorize **(Write the name of the Doctor, Medical Facilities, or other Health Care Providers)**

_____

to complete Form H1263, Certification of Medical Necessity, and release to the Health and Human Services Commission.

This authorization expires:

_____

SECCIÓN I

Nombre del paciente _____

La Comisión de Salud y Servicios Humanos de Texas (HHSC) ha pedido un informe médico completo para determinar si usted tiene derecho a los servicios. Al firmar esta autorización, le da permiso a la HHSC para comunicarse con su doctor y centros médicos para pedirles copias de su información médica como se indica a continuación. Su firma es necesaria en esta autorización para determinar si tiene derecho a los servicios.

Yo autorizo a (Escriba el nombre del doctor, centro médico u otro proveedor de atención médica)

_____

para que llene la Forma H1263, Certificación de necesidad médica, y la entregue a la Comisión de Salud y Servicios Humanos de Texas

Esta autorización se vence el:

_____

SECTION II/ SECCIÓN II

_____ _____

Client or Personal Representative's Signature / Firma del Cliente o del Representante Personal — **Date** / Fecha

☐ **If you are signing for the client, please describe your authority to act for the client:**
Si usted firma por el cliente, haga el favor de describir la autoridad con la que actúa por el cliente:

_____

_____

NOTE: If the person requesting the release of case information cannot sign his name, two witnesses to his mark (X) must sign below:

NOTA: si la persona que pide la divulgación de la información del caso no puede firmar su nombre, debe poner una marca (X) ante dos testigos, que deben firmar a continuación:

_____ _____

Witness / Testigo — **Date** / Fecha

_____ _____

Witness / Testigo — **Date** / Fecha

SECTION III

Notice to Client

HHSC, as receiver of this information, will protect your personal health information in accordance with federal and state privacy regulations. If you authorize release of your health information to other parties it may no longer be protected by privacy regulations.

You can withdraw permission you have given your doctor or health care provider to use or disclose health information that identifies you, unless they have already taken action based on your permission. You must withdraw your permission in writing.

SECCIÓN III

Aviso a los clientes

La HHSC como receptor de esta información, protegerá su información médica personal de acuerdo con las regulaciones federales y estatales de la vida privada. Si autoriza la divulgación de su información médica a terceros, tal vez ya no tenga la protección de las regulaciones de la vida privada.

Puede retirar el permiso que le ha dado al doctor o al proveedor de atención médica para divulgar la información médica que lo identifica a usted, a menos que éste ya haya actuado con su permiso. Tiene que retirar su permiso por escrito.