



Date
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Advisor	
Office Address	
Telephone No.	Fax No.


**Medical Expense Verification**

Case Name	Case No.
Patient Name	Social Security No.

The person named above reports that he/she incurs out-of-pocket medical expenses. To correctly evaluate the household's situation, the Texas Health and Human Services Commission (HHSC) needs your assistance. Please complete the information in the sections indicated below and return the form to me in the postage-paid envelope provided. Please return it as soon as possible, but no later than \_\_\_\_\_.

**Section I – Client Release**

Patient's Name
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HHSC is requesting verification of your medical needs to determine your eligibility for services. When you sign this authorization, you are giving HHSC permission to contact your doctors, medical facilities, or other health care providers 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 \_\_\_\_\_ (doctors, medical facilities, or other health care providers) to complete this form and release the information to HHSC.

This authorization expires on \_\_\_\_\_.

\_\_\_\_\_ Date  
Client or Personal Representative Signature

If you are signing for the client, please describe your authority to act for the client: \_\_\_\_\_

**Note:** If the person requesting the release of case information cannot sign his/her name, two witnesses to his/her mark (X) must sign below.

\_\_\_\_\_ Date  
Witness

\_\_\_\_\_ Date  
Witness

**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.

**Section II – Over-the-counter Medication/Medical Supplies**

Please list all over-the-counter medication or medical supplies you prescribed for the identified patient.

Item Prescribed	How often Prescribed

**Section III – Prescription Information**

Please attach a prescription printout for the identified patient for the following period:

From: \_\_\_\_\_ Thru: \_\_\_\_\_

**Section IV – Physician/Pharmacist Information**

Name of Physician/Pharmacist (please print)	Telephone No. (including area code)
Office Address (Street or P.O. Box City, ZIP)	
Signature – Physician/Pharmacist	Date



**Sección II – Medicamentos y artículos médicos que se compran sin receta**

Por favor, anote todos los medicamentos o artículos médicos que se compran sin receta que le ha recetado al paciente nombrado.

Artículo recetado	Frecuencia de la receta

**Sección III – Información sobre la receta**

Por favor, adjunte un listado de las recetas para el paciente nombrado para el periodo a continuación:

De: \_\_\_\_\_ Hasta: \_\_\_\_\_

**Sección IV – Información del doctor o farmacéutico**

Nombre del doctor o farmacéutico (Por favor, escriba en letra de molde)	Teléfono (Incluso la clave del área)
Dirección (Calle o Apartado Postal, Ciudad, Estado, Código Postal)	
Firma del doctor o farmacéutico	Fecha