RYAN WHITE PROGRAM
Letter of Medical Necessity for Utilization of Oral Health Care Codes D4249, D4271 and D4273

Date: _____

As the oral health care provider for _____, who has a diagnosis of HIV or AIDS, it is my considered opinion that he/she requires the following oral health care procedure(s): *(check all that apply)*

___D4249 Clinical Crown Lengthening-Hard Tissue
___D4271 Free Soft Tissue Graft Procedure (Including Donor Site Surgery)
___D4273 Subepithelial Connective Tissue Graft Procedure, per tooth

I attest that the patient is a good candidate for the procedure(s) noted above. I have done all of the following:

- Fully discussed the treatment plan and the procedure(s) with the patient;
- Advised the patient of the ongoing maintenance required to maintain the procedure(s);
- Reminded the patient of the $3,000 cap for oral health care services paid for by the Ryan White Part A Program during the fiscal year; and explained that these procedures may expend their cap for the year.

Sincerely,

_____
DENTIST NAME (PRINT)

_____, D.D.S/D.M.D. _____
DENTIST SIGNATURE (*circle one)* Florida Dental License #

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Oral Health Care Subcommittee and/or a qualified member of the Subcommittee). Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.