NEVADA HEALTH AUTHORITY
NevadaMedicaid.nv.gov

Partial Denture Delivery Receipt

Date and Time of Acceptance:

Provider Name:	Recipient Name:	Recipient Medicaid ID:

Nevada Medicaid provides payment benefits of certain prosthodontics for qualified recipients. Education given by the dentist on the proper care of the prostheses is expected and included in the purchase of any prosthetic service. [Medicaid Services Manual (MSM) 1000, Section 1003.5.A.1]

Denture/partial relines and adjustments required within the first six months after the date of purchase are considered prepaid with Medicaid's payment for the prosthetic. [Medicaid Services Manual (MSM) 1000, Section 1003.5.A.7].

Provider:

Quantity of partial dentures: _____

The signature of the provider below indicates the services provided meet the standard of care and are of an acceptable product quality.

Provider Signature:_____ **Date:** _____

Recipient:

The signature of the recipient, guardian or designated power of attorney below verifies the partial denture(s) was received and is accepted/acceptable.

Recipient/Guardian/Designated Power of Attorney Signature: _____

Date: _____

Provider: This form must be completed and all signatures present upon date of delivery. You may not bill Nevada Medicaid for partial dentures until they have been delivered to the recipient and this form is completed. This form must be attached to the claim. The claim must not be submitted prior to the delivery date.