# LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS
# ELDERS DENTAL PROGRAM APPLICATION

**Email: PRCfax@ltbbodawa-nsn.gov**
**Fax: 231-242-1617**

## Elders Living Outside the 27-County Service Area

**I, ______________________________________ , have reviewed the following:**
PLEASE PRINT YOUR FULL NAME

- The Elders Dental Program can only be accessed **one (1) time** within the current calendar year.
- Since the Elder resides outside the LTBB 27-county service area, they may utilize a dental provider of their choice and will be eligible for a maximum benefit of $2,400 per calendar year.
  - IMPORTANT NOTE: The Elder **must** discuss with their provider about receiving payment from the Elders Dental Program. If they do not accept payment from the program, the Elder **will be responsible** for all payments, and the program will reimburse them upon proof of payment to the dentist.
- A **Treatment Plan** from the dentist must be submitted with the application.
- Anything deemed cosmetic in nature **will not** be covered by the program. This includes, but is not limited to, dental implants, orthodontics, and specialty coatings.
- The Elders Dental Program is considered the PAYER OF LAST RESORT. This means **all** dental/medical insurance **must be billed prior** to the Elders Dental Program issuing payment.
- The Elder is responsible for completing and submitting this application in **its entirety** including submitting *any dental insurance information, the treatment plan, and the Release of Information Agreement*

**I UNDERSTAND THAT FAILURE TO FOLLOW THESE INSTRUCTIONS WILL RESULT IN MY APPLICATION BEING DENIED. I ALSO UNDERSTAND IF I PROVIDE FALSE INFORMATION CAN RESULT IN REFERRAL TO THE PROSECUTING ATTORNEY FOR FRAUD, AND/OR RECOVERY OF FUNDS PAID ON MY BEHALF.**

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**IF APPROVED, THE APPROVAL WILL BE VALID FOR 6 MONTHS FROM THE DATE OF THE APPROVAL LETTER OR UNTIL THE END OF THE CALENDAR YEAR. IF YOU DO NOT USE YOUR BENEFIT IN THE ALLOTTED TIME, THE FUNDS WILL BE RELEASED BACK INTO THE PROGRAM, AND YOU WILL NEED TO REAPPLY TO ACCESS FUNDS.**

☐ **I AM CHOOSING TO BE REIMBURSED BY THE PROGRAM**

☐ **THE DENTAL PROVIDER HAS AGREED TO ACCEPT PAYMENT FROM THE PROGRAM**

| | |
|---|---|
| ______________________ | ______________________ |
| SIGNATURE AND DATE | DATE OF BIRTH |
| ______________________ | ______________________ |
| MAILING ADDRESS | Enrollment # |
| ______________________ | ______________________ |
| CITY/STATE/ZIP | PHONE # |

# LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

# ELDERS DENTAL PROGRAM APPLICATION

## Release of Information Agreement

______________________________ PLEASE PRINT YOUR FULL NAME

______________________________ DATE OF BIRTH

______________________________ MAIDEN NAME (IF APPLICABLE)

______________________________ Enrollment #

______________________________ ADDRESS

______________________________ PHONE #

______________________________ PO BOX

______________________________ CITY/STATE/ZIP

**I HEREBY AUTHORIZE MY CONFIDENTIAL DENTAL INFORMATION TO BE RELEASED FROM THE OFFICES THAT HOLD INFORMATION REGARDING ANY CARE AND/OR TO REALEASE ANY CONFIDENTIAL INFORMATION BETWEEN THE LTBB HEALTH DEPARTMENT LISTED IN THIS AGREEMENT.**

______________________________ SIGNATURE

______________________________ DATE

## AGENCIES RELEASING INFORMATION TO EACH OTHER:

**Little Traverse Bay Bands of Odawa Indians**
**Health Department**
**1260 Ajijaak Avenue**
**Petoskey, MI 49770**

**AND**

**Dental Provider Information:**

______________________________

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**Dental Insurance Information:**

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______________________________

**Elders Dental Program**
**P:231-242-1600**
**F:231-242-1617**

**FOR OFFICE USE ONLY | LEAVE BLANK**

# Documentation Checklist

- ☐ Did the patient submit a completed application?
- ☐ Did the patient submit a Treatment Plan?
- ☐ Did the patient provide their enrollment number?
- ☐ Does the patient have any dental insurance?
- ☐ Did the patient complete the Release of Information Agreement?

**YES/NO** Has the patient already utilized the Elder's Dental Program within the calendar year?

## Notes:

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☐ APPROVED ☐ DENIED

______________________________ _______________

**APPROVAL'S SIGNATURE** **DATE**

________________________________________

**APPROVAL'S PRINTED NAME AND POSITION TITLE**

**FOR OFFICE USE ONLY | LEAVE BLANK**

# What happens next?

**#1** The application is submitted to the Citizen Program Specialist (CPS) for review.

**#2** The CPS will review the application, treatment plan, and all other supporting documents.

**#3** A letter will be submitted to the patient with the determination of coverage.

If **approved**, the patient may now coordinate with their doctor and schedule appointments for the services.

If **denied**, and the patient disagrees with the determination, then they may submit a ***written*** appeal to the Purchased/Referred Care Manager.

**Address:**
**LTBB Health Department**
**ATTN: Citizen Program Specialist**
**1260 Ajijaak Avenue**
**Petoskey, MI 49770**

A fillable appeal form is attached to this application.

*Questions?*
Call 231-242-1600 (PRC)

Mina Mskiki Gumik

# LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

## ELDER'S DENTAL PROGRAM APPLICATION

## APPEAL OF DENIAL

| PLEASE PRINT YOUR FULL NAME | DATE OF BIRTH |
|---|---|
| ADDRESS | ENROLLMENT # |
| CITY/STATE/ZIP | PHONE # |

Dear Purchased/Referred Care (PRC) Manager for LTBB,

I have recently received notification from the Citizen Program Specialist that I have been denied coverage through the Elders Dental Program. However, I believe this decision should be reconsidered for the following reasons:

In light of the information above, I respectfully request that you reconsider coverage for my services through the Elders Dental Program. If you have any questions or need further information, please contact me using the information listed above.

Thank you for your attention on this matter.

| SIGNATURE | DATE |
|---|---|