LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS
ELDERS DENTAL PROGRAM APPLICATION

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

Elders Living Within the 27-County Service Area

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

- The Elder's Dental Program can only be accessed **one (1) time** within the current calendar year.
- Since the Elder resides within the LTBB 27-county service area, they **must** utilize the LTBB Dental Clinic and will be eligible for a maximum benefit of $1,500 per calendar year.
- A **Treatment Plan** from the dentist must be submitted with the application.
    - *The LTBB Dental Front Desk Assistant will provide that to the Health Services Navigator, who reviews applications for approval.*
- 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 Elder's Dental Program is considered the PAYER OF LAST RESORT. This means **all** dental/medical insurance **must be billed prior** to the Elder's Dental Program issuing payment.
    - *The LTBB Dental Front Desk Assistant will keep track of payments from insurances*.
- The Elder is responsible for ensuring their Tribal ID card **is in their file** and that their **yearly signatures** are up-to-date at Central Registration.
- The Elder is responsible for completing this application in **its entirety.**

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.

****

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.

_____ _____
SIGNATURE AND DATE **DATE OF BIRTH**

_____ _____
MAILING ADDRESS **TRIBAL ID #**

_____ _____
CITY/STATE/ZIP **PHONE #**

FOR OFFICE USE ONLY | LEAVE BLANK

Documentation Checklist

- ☐ Did the patient submit a completed application?
- ☐ Did the patient submit a Treatment Plan?
- ☐ Does Central Registration have their Tribal ID on file?
- ☐ Did the patient sign their yearly signatures at Central Registration?
- ☐ Does the patient have any dental insurance?

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

Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

☐ 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)

LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

ELDERS 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 _____