LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS
ELDERS VISION PROGRAM APPLICATION

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

REIMBURSEMENT REQUEST

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

- The Elders Vision Program can only be accessed **one (1) time** each calendar year.
- This program is open nationwide to LTBB citizens aged **55 and older** living outside of the 27-county service area.
- This program covers **$200** for an eye exam and **$300** for frames, lenses, and/or contacts.
    - Glasses/contacts do not need to be purchased at the time of the appointment.
    - Each year a maximum of $300 can be reimbursed for one or multiple pairs of frames, lenses, or contacts
- The Elders Vision Program is considered the PAYER OF LAST RESORT. This means **all** other insurance **must be billed before** the Elders Vision Program issues payment.
- The Elder is responsible for completing and submitting this application in **its entirety**, including submitting *any insurance information and the itemized statement/receipt showing payment.*

I UNDERSTAND THAT FAILURE TO FOLLOW THESE INSTRUCTIONS WILL RESULT IN MY APPLICATION BEING DENIED. I ALSO UNDERSTAND PROVIDING 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.

☐ **Eye Exam** ☐ **Eyeglass frames, lenses, and/or contacts**

_____ **SIGNATURE**

_____ **DATE**

_____ **ADDRESS**

_____ **DATE OF BIRTH**

_____ **CITY/STATE/ZIP**

_____ **Enrollment #**

_____ **Email Address (optional)**

_____ **PHONE #**

FOR OFFICE USE ONLY | LEAVE BLANK

Documentation Checklist

- ☐ Did the patient submit a completed application?
- ☐ Did the patient submit a copy of their enrollement number?
- ☐ Does the patient have any other insurance?
- ☐ Did the patient submit a copy of the statement/receipt showing payment?

YES/NO Has the patient already utilized the Elders Vision Program in this calendar year?

Notes:

☐ APPROVED ☐ DENIED

APPROVAL'S SIGNATURE **DATE**

APPROVAL'S PRINTED NAME AND POSITION TITLE

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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

ELDER'S VISION 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 Vision 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 Vision 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**