Little Traverse Bay Bands of Odawa Indians
HEALTH DEPARTMENT
1260 Ajijaak Ave. Petoskey, MI 49770
Telephone: 231.242.1600 Fax: 231.242.1617

LTBB HEARING AID ASSISTANCE REIMBURSEMENT REQUEST

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

City/State: _____ Zip Code: _____

Tribal ID#: _____ Reimbursement Requested: _____

Program Guidelines:

- This program covers $1500 per hearing aid every 4 years.
- **YOU MUST APPLY PRIOR TO RECEIVING SERVICES TO BE ELIGIBLE FOR PROGRAM**
- If the patient establishes the medical necessity for bilateral (2) hearing aids, two will be covered at the above benefit level.
- This program is the payer of last resort, all other resources must be used prior to coverage under this program.
- Your application will be reviewed for approval once your Tribal Identification, Documentation of Medical Necessity, Provider Invoice, and Proof of Payment is received.
- If approved, you will be issued an approval number that obligates this benefit for your use. This approval will be valid for 6 months from the date of the approval letter. If you do not use your benefit in the allotted time, the funds will be released back into the program.

Expectations of Patient:

- The patient will participate in the periodic maintenance of the hearing aid units including: cleaning, adjustments, and battery changes.
- The patient will notify their hearing aid provider of any issues or problems that need to be addressed within 30 days of receiving the unit.

IMPORTANT: FUNDS ARE AVAILABLE ON A FIRST COME FIRST SERVE BASIS. AVAILABILITY OF FUNDS IS NOT GUARANTEED

Applicant Signature: _____Date: _____

FOR INTERNAL USE ONLY: DATE OF LAST BENEFIT:_____

□ TRIBAL ID(COPY) □DOCUMENTED MEDICAL NECESSITY

DATE OF APPROVAL:_____ APPROVAL#:_____

□W-9 □INVOICE AND PROOF OF PAYMENT CHECK#:_____