LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

HEARING AID PROGRAM APPLICATION

1260 Ajijaak Ave Petoskey, MI 49770
Email: PRCfax@ltbbodawa-nsn.gov
Fax: 231-242-1617

ASSISTANCE REQUEST

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

- **YOU MUST APPLY PRIOR TO RECEIVING SERVICES TO BE ELIGIBLE FOR THE PROGRAM**
- This program covers $2,625 per hearing aid every 4 years.
- If the patient establishes the medical necessity for bilateral hearing aids, two will be covered at the above benefit level.
- **Documentation of Medical Necessity** from the doctor must be submitted with the application.
- The Hearing Aid Assistance Program is considered the PAYER OF LAST RESORT. This means **all** other insurance **must be billed prior** to the Hearing Aid Assistance Program issuing payment.
- The patient is responsible for completing and submitting this application in **its entirety**, including submitting *any insurance information, documentation of medical necessity (hearing test/note from audiologist), provider invoice, proof of payment (for reimbursement only).*

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.

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.

☐ **Direct Payment** ☐ **Reimbursement**

_____ _____
SIGNATURE AND DATE | DATE OF BIRTH

_____ _____
MAILING ADDRESS | TRIBAL ID #

_____ _____
CITY/STATE/ZIP | PHONE #

_____ _____
PROVIDER NAME AND ADDRESS | PROVIDER PHONE #

FOR OFFICE USE ONLY | LEAVE BLANK

Documentation Checklist

- ☐ Did the patient submit a completed application?
- ☐ Did the patient submit Documentation of Medical Necessity?
- ☐ Did the patient provide their enrollment number?
- ☐ Does the patient have any other insurance?
- ☐ Did the patient submit a copy of the Provider Invoice?
- ☐ Did the provider supply a W-9?
- ☐ Did the patient submit a copy of the Provider Invoice and Proof of Payment?

YES/NO Has the patient already utilized the Hearing Aid Program in the last 4 years?

Notes:

APPROVAL #: **CHECK #:**

☐ 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)

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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 Hearing Aid Program. However, I believe this decision should be reconsidered for the following reasons:

_____

_____

_____

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_____

In light of the information above, I respectfully request that you reconsider coverage for my services through the Hearing Aid 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 _____