LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

ELDERS DENTAL PROGRAM APPLICATION

1260 Ajijaak Ave Petoskey, MI 49770
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

- **Approval** is required **prior** to services performed.
- 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. Upon receiving application and treatment plan, an approval or denial letter will be sent to the Elder.
- Some dental services **are not** 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

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

Dental Provider Information:

_____
_____
_____
_____
_____

Dental Insurance Information:

_____
_____
_____
_____
_____

LITTLE TRAVERSE BAY BANDS HEALTH DEPARTMENT

RELEASE OF PROTECTED HEALTH INFORMATION

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment or health care operations, or other disclosures. I also have the right to authorize the release of my protected health information to members of my family, friends, and/or any person that is involved in my care.

I authorize the following person(s) to obtain my health information:

_____

_____

_____

_____

_____

_____

_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE
(IF LEGAL REPRESENTATIVE, STATE RELATIONSHIP TO PATIENT)

_____ _____

DATE EXPIRATION DATE OF AUTHORIZATION

_____

WITNESS NAME & SIGNATURE

_____

CLINIC USE ONLY – DO NOT WRITE BELOW THIS LINE

DATE RECEIVED:_____
CLINIC INTAKE INITIALS:_____

LTBB HEALTH RECORD NUMBER (HRN)_____

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:

_____

_____

_____

_____

_____

_____

_____

_____

_____

☐ 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

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 _____