

Little Traverse Bay Bands of Odawa Indians  
Elders Program  
7500 Odawa Circle  
Harbor Springs, MI 49740  
Ph: (231) 242-1422 or (231) 242-1423  
Fax: (231) 242-1430

Date 1/5/2016

Aanii LTBB Tribal Elder:

This letter is intended to provide you with information regarding the Elders Dental Service Program. The Elder's Dental Services Program can be accessed one (1) time within current calendar year prior to any dental services performed. Work must have taken place on or after January 1, 2016. The Elders Dental program will provide services to all LTBB Elders. To be eligible for the program Tribal Elder must provide copy of their enrollment card.

- ❖ Tribal Elder must provide an invoice that contains dental services being provided along with a cost of the services. Only the following services shall be approved for payment: dentures, bridges, crowns, all prep work necessary to complete the aforementioned items, or such other items that would not be considered general maintenance or cosmetic in nature as shall not to exceed \$2,400.00 per calendar year per Elder.
- ❖ The LTBB elder must exhaust all their available medical/dental coverage options before applying for this program. The LTBB Elder's Dental services program is the payer of last resort.
- ❖ Work performed must have taken place on or after January 1, 2016 to be eligible for this program.
- ❖ If an Elder resides within the LTBB 27 county service area they are to use our LTBB Dental clinic and shall request an invoice of costs for services from the Dental Clinic.
- ❖ If an Elder resides outside the LTBB 27 county service area, they may participate in a direct billing option which requires the Dental Service provider to participate as an LTBB Vendor including submission of an invoice, prior to dental services being paid, **or**
- ❖ If an Elder resides outside the LTBB 27 county service area, they may participate in the reimbursement option. This option will require the Elder to first check with the Elder's Dental program to ensure that there are adequate funds available for reimbursement. The Elder's Dental program will reimburse the Elder upon receipt of an invoice for services showing that payment has been made.
- ❖ Complete release of information agreement.

Each elder is required to complete the enclosed application. In order for the application to be processed in a timely manner, it is important that the directions for this program be followed and completed properly.

Applicant will be notified once a decision has been made. If approved, a requisition will be submitted to tribal accounting offices for direct payment to vendor. If denied a notice will be mailed to applicant, stating reason for denial.

If you have any questions about the application process, please contact Elders Department (231) 242-1423

Little Traverse Bay Bands of Odawa Indians  
Elder's Program  
2016 Elder's Dental Program Fund

Name \_\_\_\_\_ Enrollment # \_\_\_\_\_  
Address \_\_\_\_\_ Birth date \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

**Dental Contact Information:**

Dentist Name \_\_\_\_\_  
Complete Mailing Address \_\_\_\_\_  
Your Account Number \_\_\_\_\_

- The Elder's Dental Services Program can be accessed one (1) time within current calendar year prior to any dental services performed. Work must have taken place on or after January 1, 2016. I hereby certify that all information in this application is true, correct and complete to the best of my knowledge.
- I understand that giving false or incomplete information can result in referral to the prosecuting attorney for fraud, and/or recovery of funds paid on my behalf.
- I understand that failure to provide all necessary information and documentation can result in denial of my application
- I understand that I may request a hearing if I disagree with action taken on this application
- I understand that I have the right to a hearing if I do not receive a decision notice within that time.
- I understand that there is no guaranteed payment towards my bill until my application has been approved.
- **Must provide copy of Tribal ID.**
- **If you live outside the Indian Health Service 27 county area you must provide your dental contact information.**
- **You must complete a release of information agreement.**
- **You must exhaust all your dental insurance before applying for this fund.**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Elder's Program Signature \_\_\_\_\_ Date \_\_\_\_\_

Documentation Checklist-Office use only do not write below this line

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- Completed application
- Release of information
- Treatment Plan

