GRANTS AND DONATIONS DEPARTMENT
MANDAN, HIDATSA, ARIKARA NATION
LOCATED AT: CHRC 3RD FLOOR (1293 ELBOWOODS LOOP)
MAILING ADDRESS: 307 5TH AVE.
NEW TOWN, ND 58763
OFFICE: (701) 627-4863 FAX: (701) 627-4868

Dental Assistance Request Application

TYPES OF ASSISTANCE:

_____**Dental Care** ***Lifetime Maximum*** *amount allowable is up to* ***$10,000.00*** *per enrolled member.*

_____**Orthodontics** ***Lifetime Maximum*** *amount allowable is up to* ***$5,000.00*** *per enrolled member.*

_____**Dental Implants** ***Lifetime Maximum*** *amount allowable is up to* ***$10,000.00*** *per enrolled member.*

Must Provide: (listed below)

- 2 Treatment Plans
- Predetermination Invoice
- PRC Referral from EMHC
- W-9 Form (From Vendor/Provider. Out of State)

Please Print Legibly (Client Receiving Care)

Legal Full Name (First, Middle, Last) Enrollment Number DOB

_____ 301U-_____ _____

Contact Number(s) (____)_____ **or** (____)_____

Dental Insurance: **ID #**

_____ _____

Dental Provider:

_____ Contact Number (____)_____

Have you received Dental Assistance through our Program before? Yes ☐ No ☐

If yes, what kind of Dental Assistance? _____ _____
Date

FOR OFFICE USE ONLY

Amount Approved: $_____ Approved By:_____ Date_____

Dental $_____

Orthodontics $_____

Implants $_____

_____****Please Note Approval Process May Take Up to 2 Weeks****_____

"The Tribal Business Council of the Three Affiliated Tribes hereby embraces a philosophy of care for our sickest, most vulnerable critically ill patients, and promises the patient's clinical condition as priority."