New Avenues
Midwest Behavioral Health Network

PROVIDER REQUEST FOR RECONSIDERATION

New Avenues, Inc./Midwest Behavioral Health Network
P.O. Box 360 * South Bend, IN 46624
Phone: 574-271-5177 or 866-925-5730 Fax: 574-271-5980

New Avenues, Inc. and Midwest Behavioral Health Network (MBHN) provide behavioral healthcare and or Employee Assistance Program benefit administration on behalf of the enrollee's employer. If you have had benefit coverage denied, you may submit a grievance within 180 days from the date of the initial adverse decision (this date is the "printed date" on the provider's Detailed Remittance Advice).

In order for New Avenues to give full consideration, we ask that you provide necessary information per type of denial from the following list. Please complete the information requested and include all of the information pertaining to the reason for the denial and your request for reconsideration. Fax or mail all information to the above address/fax number.

When the required information is received, it will be reviewed and you will be notified of a decision within 20 business days. **We know timeliness of resolution is important to you. Failure to include all of the requested information may result in a delay.** If you have questions about the reason for denial or what should be submitted, please call MBHN at 866-925-5730, option 3. We thank you for your cooperation: The Member Services Review Committee

Date Submitting Request: _____ **Date(s) of Service: _____**
Person Submitting Requesting: **Member/Patient: _____**
Name:_____ **Provider: _____**
Agency:_____ **Member/Patient DOB: _____**
Telephone:_____ **Health Plan: _____**
Fax:_____ **Claim/Auth #: _____**
Email:_____

If your claim was denied for timely filing please submit

- Proof of timely filing that includes the date originally submitted, claim number, member name, and date of service
- Copy of insurance card and date received
- Copy of Remittance Advice or EOB if filed with incorrect payor

If your claim or request for authorization was denied for no authorization please submit

- Rationale for not obtaining an authorization within 48 business hours of service rendered
- proof of attempt made to obtain authorization, include phone record, file note, etc. with date called, number dialed, and person spoken with
- Copy of insurance card and date received
- Original claim sent

If your claim was denied for diagnosis code, service code, or frequency not matching authorization please submit

- Submit in writing explanation of use of different code/frequency including any pertinent information from member's file to support rationale of reversal
- Original and corrected claim if applicable

If your claim or authorization was denied for any other reason not listed please submit all information pertaining to the procedure and reason for denial