Woodlands Behavioral Healthcare Network
960 M60 E
Cassopolis, MI 49031
269-445-2451

Provider Disputes and Appeals Process

All contracted / participating providers in the Woodlands Behavioral Healthcare Network (WBHN) network have the right to appeal actions taken by WBHN relating to a participating provider's status within the provider network and actions related to a provider's professional competency or conduct.

This appeals process does not apply to medical necessity appeals or conditions dictated in the provider contract that result in immediate termination such as provider loss of required certification/licensure; listing of the provider by a department or agency the State of Michigan as being suspended from service participation in the Michigan Medicaid and/or Medicare programs; and/or the provider being listed by a department or agency of the State of Michigan in its registry for Unfair Labor Practices.

If an organizational provider, facility provider, group/individually licensed practitioner disagrees with a determination by WBHN in the application process or during review of a provider's status, and wishes to have the matter reviewed at a higher level, the provider may do so by submitting a written request to the payor's representative within (30) calendar days of disposition. The request must include the following (see attached Appeals Request Form):

1. Reason for dispute;
2. Documentation to support the appeal

The Appeals Request Form and supporting documentation must be sent to WBHN Manager - Provider Network Development who will begin the process to review the appeal.

Providers can mail the Appeal Request Form to:

Woodlands Behavioral Healthcare Network
Attn: Manager - Provider Network Development
960 M60 E
Cassopolis, MI 49031

Or the appeal request can be emailed to Chaka Darden at chakad@woodlandsbhn.org or Yvonne Roebeck at yvonner@woodlandsbhn.org.

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APPEAL REQUEST FORM

Provider Name: ____

Today's Date: ____________________________

Date notified of WBHN's network participation decision: ____________________

Reason for dispute: ____

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Additional information: ____

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Please attach any relevant supporting documentation.

Provider Signature:_______________________________________

For Office Use Only
Date appeal received: _____________________
Date appeal reviewed by first level panel: _____________________
Determination and findings: _________________________________
Date request reviewed by second level panel (if applicable): __________________
Determination and findings: ___________________________________