New Avenues, Inc.

New Avenues EAP and Midwest Behavioral Health Network
P.O. Box 360 South Bend, IN 46624
Telephone: EAP: 800-731-6501; MBHN: 800-223-6246; Fax EAP & MBHN: 574-271-5980
Please mail or fax this form to above.

Member Consent for Case Management and Authorizations

Initial in box

Permission for Contacting Me:

I authorize the staff of New Avenues/Midwest Behavioral Health Network (MBHN) to contact me for the purpose of coordination of my treatment. **I can be reached by telephone at:**

Preferred Phone Number #1: ____________________ □ Cell □ Home □ Work □Other
It is acceptable for MBHN to leave a message on this phone number: □Yes □No
Phone Number # 2: ______________________ □ Cell □ Home □ Work □Other
It is acceptable for MBHN to leave a message on this phone number: □Yes □No

By Mail: Mail containing health care information may be sent to me at the following address:
Address to me: ____________________________
Mailing Address: ____________________________
City, State, Zip ____________________________

Initial in box

Authorization for Release of Information to My Family Members or Authorized Persons:

I , *Name*,______________, give authorization for New Avenues/MBHN care management staff to be in contact with the following family members or authorized persons for the purpose of facilitating my treatment. *List names of family members whom I wish to be involved in my care.*____.

***Check one*:**

☐ **Restricted contact** with persons listed above to discussions or leaving messages regarding appointment reminders, authorizations, and claim issues, but request that no personal information about my condition or about my treatment be disclosed with the party.

☐ **Unrestricted authorization** for communication that may include disclosure of information about my condition, treatment recommendations, my progress, and treatment providers.

Initial in box

Authorization for Release of Information to My Health Care Providers:

I , *Name*,______________, give authorization for New Avenues/Midwest Behavioral Health Network care management staff to be in communication through telephone, fax, or correspondence with the following health care professionals or authorized persons for the purpose of facilitating my treatment. In addition this document serves as authorization for my Care Manager to have access to my medical record; and to disclose relevant information to my treating providers that will improve the quality of my care.

Primary Care Physician:__________________________ Agency/Practice Name: ____________________
Treating Psychiatrist: __________________________ Agency /Practice Name: ____________________
Therapist: ________________________________ Agency/Practice Name:____________________
Other: __________________________________ Relation to Member: ______________________

Initial in box

Agreement to Participate in Case Management ***Check one***

☐ Yes, I am agreeing to receive case management services to assist me with the coordination of my treatment. I would like to receive, at no additional cost, assistance from a care manager who will (a) contact me or my treatment providers for purpose of arranging, authorizing or coordinating treatment, (b) provide me with additional information about my condition and treatment options through mailings or telephone calls, (c) coordinate treatment with my primary care physician, and (d) communicate with me telephonically on a regular basis until I feel services are no longer needed. I understand that participation with case management is voluntary and may be revoked at any time.

☐ I am not sure; please contact me at home to discuss this further.

☐ I am declining case management services at this time, and understand that only authorization or claim payment documents (EOBs) related to treatment as required by health plan policies shall be sent to my home.

This consent is subject to revocation at any time except to the extent that New Avenues/Midwest Behavioral Health Network already has taken action in reliance on it.

______________________________________ ____________________
Signature of Member or Authorized Representative/Parent of Minor *Date*

______________________________________ ____________________
Printed Name *Member Insurance ID*