McLaren HEALTH PLAN

mclarenhealthplan.org

Partners In Health

December 2025

CONTENTS

Introduction

Welcome to McLaren Health Plan's Partners in Health newsletter. This is a monthly communication that will be sent out via email and posted on our website at mclarenhealthplan.org/mclaren-health-plan/provider-communications.

If you would like to be added to our email distribution list to stay up-to-date on McLaren Health Plan's (MHP) processes and policies, learn about McLaren Health Plan community participation and sponsored events, Link directly to other online resources, and to receive this newsletter via email, please visit our website.

Customer Service

Phone: 888-327-0671 (TTY: 711)
Fax: 833-540-8648

Customer Service is responsible for assisting physicians, office staff, providers and members with questions. Representatives are available Monday through Friday from 9 a.m. to 6 p.m. Call if you have questions about:

- Transportation for MHP Medicaid and Healthy Michigan plan members
- Referrals
- Claims

MHP has FREE interpretation and translation services for members in any setting – ambulatory, outpatient, inpatient, office, etc. If MHP members need help understanding written materials or need interpretation services, call Customer Service.

McLaren Connect

If you have not yet registered for McLaren CONNECT, the provider portal, click here: https://www.mclarenhealthplan.org/mhp/mclaren-connect.aspx

McLaren CONNECT replaces the Health Edge portal and FACTSWeb. McLaren CONNECT is a secure web-based system for all MHP lines of business that allows you to:

- Verify member eligibility
- View member claims and EOPs
- View and print member eligibility rosters*
- View and print member benefit information
- View a member's demographic information
- Contact the MHP provider team

Your provider TIN and NPI are required for the login process. Logins require your username and password each time, for your security.

*Member eligibility rosters are no longer mailed to primary care offices. Using McLaren CONNECT provides access to an up-to-date roster while eliminating the delay of sending a printed roster mid-month.

McLarenHealthPlan.org

MHP's website contains information about the plan's policies, procedures and general operations. You'll find information about quality programs, preauthorization processes, health management programs, clinical and preventive practice guidelines, pharmaceutical management procedures, the pharmacy formulary, member rights and responsibilities, the provider appeal process and provider newsletters. Visit often for the most up-to-date news and information. If you would like a printed copy of anything on our website, please call Customer Service.

Interpretation and translation services are FREE to MHP members in any setting – ambulatory, outpatient, inpatient, etc. Oral interpretation services are available for people who are deaf, hard of hearing or have speech problems. If McLaren Health Plan members need help understanding MHP's written materials or need interpretation services, call 888-327-0671 (TTY: 711)

GetHelp.McLaren.org

Do you have patients who need help with food, education, housing, jobs or other 'quality of life' situations? McLaren Health Plan offers an online program to assist members who need community-based services. Simply put in a ZIP code and categories are listed with programs and services by location. There are thousands of resources to choose from, such as advocacy and legal aid; how to help pay for school; adoption and foster care services; tax preparation; mental health care; housing assistance; skills and training to enter or re-enter the workforce, among much more! Let your patients know about Gethelp.mclaren.org

Provider Relations

Phone: 888-327-0671 (TTY: 711)
Fax: 810-600-7979

The Provider Relations team is responsible for physician and provider-related issues and requests, including contracting.

Provider relations representatives are assigned to physician or provider practices by county. Their services include:

- Orientations for you and/or your office staff to learn about MHP – how to submit claims, obtaining member eligibility or claims via the MHP CONNECT provider portal
- Reviewing provider incentives, quality initiatives and program updates

If you have changes to your practice such as a new federal tax identification number, a payment address change or a name change, a new W-9 is required.

Current participating Primary Care Physicians who wish to open their practices to new MHP patients can do so at any time. Simply submit your request in writing, on office letterhead, to your Provider Relations representative, requesting to open your practice to new MHP members and your representative will make the change.

Other changes, such as hospital staff privileges, office hours or services, address or phone number or on-call coverage, please contact your Provider Relations representative Notification at least 30 days prior to any change is requested to allow time to make system changes.

If you are uncertain of who to contact, call us for the name of your representative.

REGION 2

Northwest Prosperity Region

Rep I – Kylie Weidenhammer
Work Cell: 810-845-4782
Kylie.Weidenhammer1@mclaren.org

Provider Group Assignments

REGION 3

Northeast Prosperity Region

Rep I – Kylie Weidenhammer
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Provider Group Assignments

REGION 4

West Michigan Prosperity Region

Rep I – Bev Hude
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Provider Group Assignments

REGION 5

East Central MI. Prosperity Region

Rep I – Jessica Kline
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Provider Group Assignments

REGION 6

East Michigan Prosperity Region

Rep I – Jessica Kline
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Provider Group Assignments

REGION 7

South Central Prosperity Region

Rep I – Mary K. Clinton
Work Cell: 810-733-9632
Mary.Clinton@mclaren.org

Provider Group Assignments

REGION 8

Southwest Prosperity Region

Rep I – Beverly Hude
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Beverly.Hude@mclaren.org

Provider Group Assignments

REGION 9

Southeast Michigan Prosperity Region

Rep I – Dawn Dunn
Work Cell: 810-701-2182
Dawn.Dunn@mclaren.org

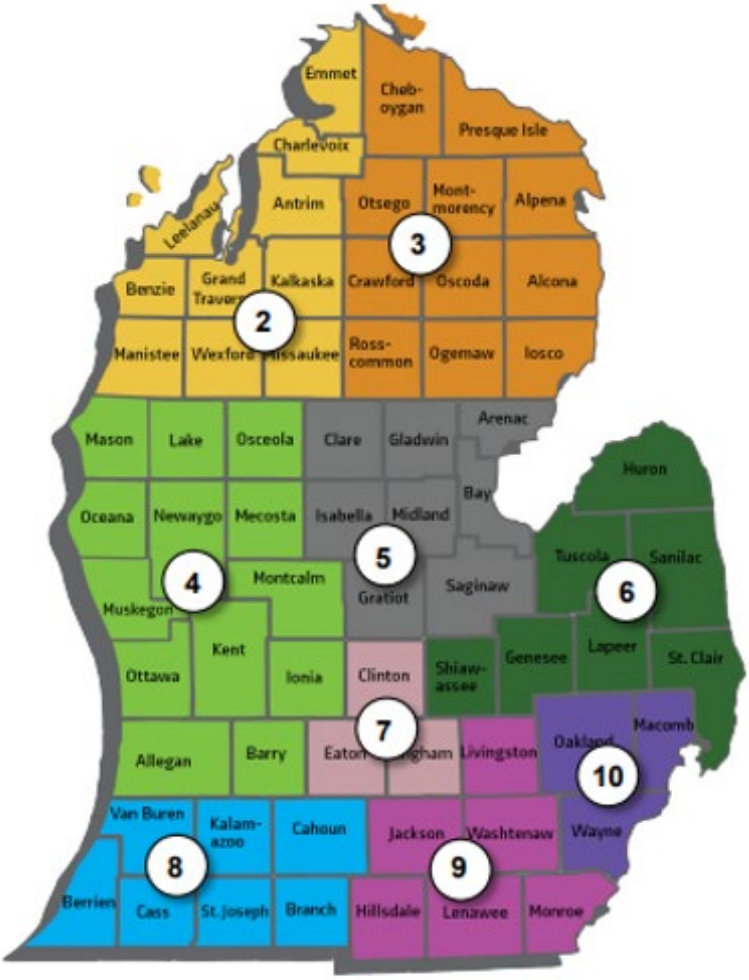
Provider Group Assignments

REGION 10

Detroit Metro Prosperity Region

Rep I – Open
MHPProviderServices@mclaren.org

Provider Group Assignments



Medical Management

Phone: 888-327-0671 (TTY: 711)
Fax: 810-600-7959

Medical Management supports the needs of both MHP providers and members. Medical Management coordinates members' care and facilitates access to appropriate services through the resources of our nurse care managers.

Through care management services, nurses promote the health management of MHP members by focusing on early assessment for chronic disease and special needs and by providing education regarding preventive services. Nurses also assist the physician and provider network with health care delivery to MHP members. Nurses are available 24 hours a day, seven days a week and work under the direction of MHP's Medical Director.

Call the Medical Management team for information and support with situations about:

- Preauthorization requests https://www.mclarenhealthplan.org/mhp/referral-request-form-mhp1
- Inpatient hospital care (elective, urgent and emergent)
- Medically necessary determinations of any care, including the criteria used in decision making
- Care management services
- Complex care management for members who qualify
- Disease management – diabetes, asthma, depression, Sickle Cell, hypertension, Hepatitis C, maternity care, CKD, obesity, HIV/PrEP.
- Preventive health education and community outreach support
- Children's Special Health Care Services (CSHCS)

Through its utilization management process, Medical Management is structured to deliver fair, impartial, and consistent decisions that affect the health care of MHP members. Medical Management coordinates covered services and assists members, physicians and providers to ensure that appropriate care is received. Nationally recognized, evidence-based criteria are used when determining the necessity of medical or behavioral health services. The criteria are available to you upon request by calling the Medical Management team.

If there is a utilization denial, the member and physician will be provided with written notification – which will include the specific reason for the denial – as well as all appeal rights. MHP's Medical Director, or an appropriate practitioner, will be available by telephone to discuss utilization issues and the criteria used to make the decision.

Utilization decision making is based solely on appropriateness of care and service and existence of coverage. MHP does not specifically reward practitioners or other individuals for issuing denials of coverage, service or care. There are no financial incentives for utilization decision-makers to

encourage decisions which would result in under-utilization.

Care Management

Phone: 888-327-0671 (TTY: 711)
Fax: 810-600-7965

Care management is offered to all MHP members. A care management nurse is assigned to each primary care office to assist you with managing your MHP members. The MHP nurses help manage medical situations and are a resource for identified issues. This enables a circle of communication that promotes continuity of care, the member's understanding of their health care, support for the primary care physician and promotes the PCP office as the medical home.

MHP members are referred for care management services by physicians who identify at-risk patients. Complete a Referral to Care Management form found at https://www.mclarenhealthplan.org/Uploads/Public/Documents/HealthPlan/documents/Provider%20Forms/Referral%20to%20Case%20Management.pdf

When MHP receives the form, a nurse begins an assessment of the member and identifies a proactive approach to managing the totality of the member's health care needs. The program focuses on preventive health management, disease management, general and complex care management and Children's Special Health Care Services (CSHCS) care management.

Program goals are:

Empower members to understand and manage their condition

Support your treatment plan

Encourage patient compliance

Preventive health management helps by:

- Informing members of preventive testing and good health practices
- Mailing reminders to members about immunizations, well-child visits and lead screenings
- Highlighting ways to stay healthy and fit in member newsletters
- Identifying members who are due for annual checkups and screenings and notifying PCPs of these patients
- Initiating call programs to assist members with scheduling annual checkups and screenings

If you do not know who your care management nurse is, please call Customer Service at 888-327-0671 (TTY: 711).

Asthma and Diabetes DM programs

MHP has nurses who understand asthma and diabetes. They will work with your patients to help them understand their conditions and provide support. Your patients with MHP will get:

- Support from their nurse so they know the best ways to manage their condition.
- Newsletters with the most up-to-date information about asthma and diabetes
- Materials that will help patients understand and manage their medicines and plan visits to their doctors

Your patients with MHP are enrolled in this program as a free benefit of MHP. Membership in this program is the patient's choice. They do not have to join. Patients with MHP may call us at 888-327-0671 (TTY: 711) to opt out of the program.

Hypertension DM program

MHP has a program called "Down with Hypertension." Any member 18 years and older is eligible. This is a voluntary and free program.

Your patients with MHP will get:

- Newsletters
- Phone calls and educational mailings from your nurse
- Support in their self-management plan

Your patients with MHP are enrolled in this program as a free benefit of MHP. Membership in this program is the patient's choice. They do not have to join. Patients with MHP may call us at 888-327-0671 (TTY: 711) to opt out of the program.

Taking it Off DM program

MHP nurses help both adults and children who want to lose weight. Members receive:

- Educational materials mailed to their home upon their request
- Phone calls to offer support
- Coordination with their PCP

Your patients with MHP are enrolled in this program as a free benefit of MHP. Membership in this program is the patient's choice. They do not have to join. Patients with MHP may call us at 888-327-0671 (TTY: 711) to opt out of the program.

Tobacco Cessation:

McLaren Health Plan has a tobacco cessation program for our Medicaid and Community members. We have partnered with smokefree.gov and Quitlogix by National Jewish Health to assist our members in tobacco cessation. Our Nurse Care Managers support your McLaren Health Plan patients in their tobacco cessation efforts. Members receive support from their nurse to make sure members know the best ways to stop tobacco use and materials to help members understand tobacco cessation and tobacco cessation benefits. Members are eligible to join the tobacco cessation program if they are a tobacco user. Members are enrolled in the program as a benefit of McLaren Health Plan. If members do not want to participate, they may opt out by calling us at 888-327-0671 (TTY: 711).

Care Coordination and the Importance of Communicating With the PCP

The coordination of medical care is essential to a patient's overall state of health. MHP encourages physicians to communicate with each other when co-treating a patient, including behavioral health issues. It is the responsibility of every treating provider to adequately inform the patient's PCP of all recommendations and medical treatment being proposed. Communication among physicians and providers is one of the best ways to successfully treat a patient. The patient's primary care provider is the medical home for all health information regarding the patient's care. Consider this question: What does the PCP need to know to treat this patient in the safest and most efficient manner? It's critical to have medical information relayed to the PCP by:

- Prompting patients to return to their PCP after a consultation or hospital stay
- Having specialists send summaries of recommendations to PCPs
- Providing communication from pharmacy data identifying polypharmacy to PCPs
- Notifying members of PCP terminations
- Improving the process for members to authorize sharing of behavioral health information with their PCPs
- Promoting the sharing of information by the PCP to the behavioral health specialists when coexisting medical and behavioral health conditions exist
- Providing behavioral health services in the primary care home

Complex Care Management

Phone: 888-327-0671 (TTY: 711)
Fax: 810-600-7965

MHP has nurses trained in Complex Care Management (CCM) who coordinate services for members with complex conditions and promote access to high quality, cost-effective, needed services. Our goal-oriented program focuses on engaging members, their providers and MHP in a collaborative effort to help

them regain optimum health or improved functional capability, improving their quality of life. Members considered for CCM have complex care needs including, but not limited to:

- Members listed for a transplant
- Members who have frequent hospitalizations or ER visits
- Members that are part of the Children's Special Health Care Services (CSHCS)
- Members with multiple chronic conditions
- Members with severe conditions.

Contact MHP at 888-327-0671 (TTY: 711) and ask for your nurse to learn more about or join the complex care management program.

Hospitalizations and re-hospitalizations

Reducing hospital readmissions has become a top priority in US healthcare reform (Dhaliwal & Dang, 2024). When patients are readmitted to the hospital in a short period of time, it may indicate suboptimal quality of care, inadequate education of the patient, and difficulties with the transition from hospital to home (Dhaliwal & Dang, 2024).

- Post-discharge follow-up. Your patients should see you as soon as possible after discharge (generally within 7 days)
- Medication reconciliation. Hospitals should check the patient's medications and make sure they understand how and when to take them. Their doctor should also do this.
- Patient education. Your patient may need education on the reason for their hospitalization, the treatment they received, their treatment plan and what they should be watching for or doing after discharge.
- Address social needs. Does your patient need resources for food, housing, transportation or other things that may not be covered by their insurance? McLaren Health Plan can help. Advise your patient to contact McLaren Health Plan at (888) 327-0671 and ask for their nurse.
- Family involvement. Does your patient have family members or others helping them? Do their caregivers understand the discharge plans and post discharge care needs? Are the caregivers able to help with the things the patient needs?

Dhaliwal, J.S. & Dan, A.K. (2024). *Reducing Hospital Readmissions*. National Institutes of Health, retrieved from: https://www.ncbi.nlm.nih.gov/sites/books/NBK606114/ on 11/21/2025.

Chlamydia Screening

The Chlamydia Screening HEDIS Measure assesses the percentage of members who are recommended for routine chlamydia screening, identified as sexually active, and who received at least one chlamydia test during the measurement year. According to the Centers for Disease Control and Prevention (CDC, 2021) Chlamydia testing is recommended as demonstrated below. McLaren Health Plan encourages our members to be screened for Chlamydia as recommended. Please join us in this effort.

Childbearing Persons	Pregnant Persons	Men who have sex with men	Trans Persons	Persons with HIV
Sexually active under 25 years of age	All under 25 years of age	At least annually for sexually active men at sites of contact regardless of condom use	Recommendations should be adapted based on anatomy	Sexually active screen at first HIV evaluation, and at least annually thereafter
Sexually active age 25 and older if at increased risk	Pregnant age 25 and older if at increased risk	Every 3-6 months if at increased risk	Consider screening at the rectal site based on reported sexual behaviors and exposure	More frequent screening might be appropriate depending on individual risk behaviors and local epidemiology
Retest approximately 3 months after treatment	Retest during 3rd trimester if under age 25 or at risk			
Rectal testing can be considered based on reported sexual behaviors and exposure	Test of cure 4 weeks after treatment and retest within 3 months			

https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm Retrieved 11-21-2025.

Most Pregnancy Related Deaths are Preventable:

Although deaths related to pregnancy are rare, too many people still die each year in the United States from complications due to pregnancy. Most of these pregnancy-related deaths are preventable. Recognizing the urgent maternal warning signs, getting accurate and timely diagnosis,

and quality care can save lives. Please consider referring to the CDC's Hear Her Program for resources you can post in your office such as Urgent Maternal Warning Signs (For more information on the Hear Her Campaign, visit https://www.cdc.gov/hearher/maternal-warning-signs/index.html)

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).

The SSD measure evaluates whether eligible patients (18-64 years old using antipsychotics without a diabetes diagnosis) received an annual diabetes screening (glucose or HbA1c test). Please assist MHP to reach our goals by completing the appropriate screenings.

Electronic Prior Authorization Requirement

Effective December 31, 2025, all authorization requests for Commercial lines of business must be submitted electronically through McLaren's CONNECT provider portal. The CONNECT provider portal allows providers to submit requests for prior authorization through JIVA, the preferred method of sending authorizations to McLaren Health Plan.

Out of network users must register and create a new account to access the portal by completing an Out of Network Provider Request Form at mclarenhealthplan.org and submitting it to mhpproviderservices@mclaren.org with an updated W-9. Completed forms and W-9 may also be faxed to: 810-600-7979. As a reminder, incomplete submissions will delay access to the portal or claims payment.

Providers can access McLaren CONNECT portal here: Login

Providers rendering services to Commercial patients are encouraged to visit mclarenhealthplan.org to access current prior authorization requirements and electronic authorizations.

The list of Service Codes Requiring Preauthorization is available online at mclarenhealthplan.org > Providers > Medical Management and Authorization > Referral and Authorization Guidelines.

Authorization Updates, Changes, and Clarifications Updates, changes, and clarification to authorization requirements are completed on a quarterly basis and available online. Any updates, changes, or clarifications will be effective in January, April, July and October of each year.

For more information on how to submit authorizations electronically, please contact McLaren Health Plan Customer Service at 888-327-0761 (TTY: 711).

Mental Health Toolkit

Did you know there is a mental health toolkit available on our website? Find it by going here: https://www.mclarenhealthplan.org/mclaren-health-plan/trainings-and-webinars-mhp

Enhancing Community Connections: Partnership Opportunity with 211

Providers who prescribe pre-exposure prophylaxis (PrEP) are encouraged to apply for inclusion in Michigan 2-1-1, a free, confidential service connecting people with local and statewide resources. Trained specialists are available 24/7 via phone, text, or online to help individuals with housing, food, healthcare, and crisis support.

Benefits of listing with 2-1-1:

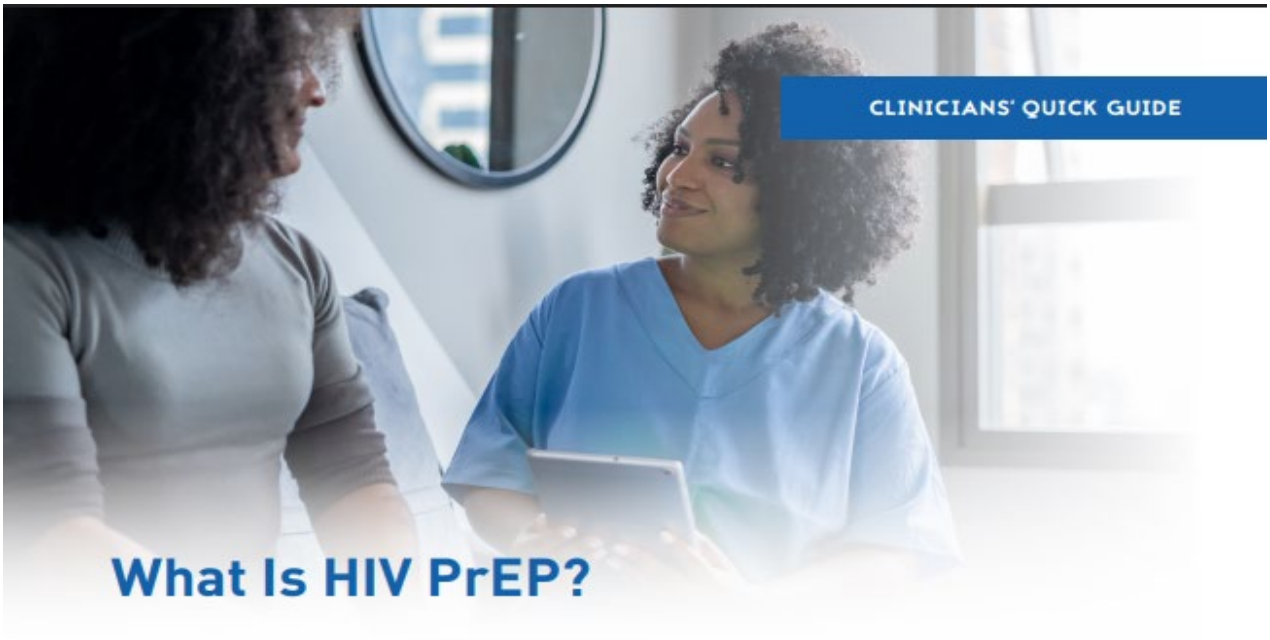
- Increased Visibility and Referrals: 211 is a central hub, acting as a referral point for services.
- Reduced Burden on Staff: 211 helps to pre-screen individuals, ensuring referrals align with eligibility requirements. This allows staff to focus on direct service delivery.
- Better Understanding of Community Needs: Participating in 211 helps to understand community needs and service gaps.
- Partnership Opportunities: Collaborating with 211 opens doors for potential partnerships and funding opportunities.

More information about partnering with 211 can be found on the website at mi211.org/providers. To search 2-1-1 resources by agency, visit mi211.org/providers/search. To apply to be part of Michigan 2-1-1's statewide resource database, visit mi211.org and review participation criteria. Then, contact the resource manager in your area.

Syphilis Screening

All pregnant persons should be screened for Syphilis in the first trimester at the first prenatal visit and again during third trimester (between 28-32 weeks). Pregnant persons with risk factors should be screened at any stage of pregnancy and at 36 weeks. Pregnant persons with no prenatal care should be screened with rapid testing upon presentation at any medical facility (including the ED and L&D Department).

PrEP



What Is HIV PrEP?

PrEP is short for pre-exposure prophylaxis. It is the use of antiretroviral medication to prevent HIV infection among people who could be exposed to HIV through sex or injection drug use. PrEP reduces the risk of getting HIV from sex by up to 99% and from injection drug use by at least 74%.

In 2021, the US Preventive Services Task Force issued a graded recommendation to inform all sexually active adults and adolescents about PrEP (grade IIIB).

Who Is PrEP for?

PrEP is for adults and adolescents who don't have HIV, are at risk of getting HIV from sex or injection drug use, and weigh at least 35 kg (77 lb).

Health care providers should have conversations with all their sexually active patients about PrEP and how it can protect them from HIV. These conversations help to:

- Increase the number of people who know about PrEP.
- Decrease feelings of embarrassment or stigma that may prevent patients from talking about their sexual and drug use behaviors with their providers.

PrEP can be prescribed to any adult or adolescent patient who asks for it, even if they do not report HIV risk factors, as part of their comprehensive prevention plan.

To learn more about prescribing HIV prevention, visit:
cdc.gov/HIVNexus

CDC | Let's Stop HIV Together | Ending the HIV Epidemic

Where Can I Learn More About Prescribing and Managing Patients on PrEP?

The Centers for Disease Control and Prevention (CDC) has published comprehensive guidelines in their *Preexposure Prophylaxis for the Prevention of HIV Infection in the United States—2021 Update*, which consists of two parts:

- The *Clinical Practice Guideline for PrEP* describes CDC guidelines for prescribing PrEP, required baseline and ongoing assessments, information about how patients can pay for PrEP and related services, and evidence of PrEP's safety and efficacy. Access the guideline at: cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf.
- The *Clinical Providers' Supplement for PrEP* contains additional tools, such as a patient/provider checklist, patient and provider information sheets, a risk incidence assessment, supplemental counseling information, billing codes, and practice quality measures. Access the supplement at: cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-provider-supplement-2021.pdf.

CDC also offers additional *Clinicians' Quick Guides* on PrEP, as well as other materials for providers, patients, and practices. To download these materials, visit: cdc.gov/hiv/clinicians/materials/prevention.html.

What PrEP Options Are Available?

Various PrEP medication and dosing options are available to meet patients' needs:

Oral PrEP	**Daily oral PrEP.** Two medications are US Food and Drug Administration (FDA) approved to be used as daily oral PrEP by adults and adolescents weighing at least 35 kg (77 lb): • Emtricitabine (F) 200 mg in combination with tenofovir disoproxil fumarate (TDF) 300 mg (F/TDF—brand name **Truvada®** or generic equivalent). • Emtricitabine (F) 200 mg in combination with tenofovir alafenamide (TAF) 25 mg (F/TAF—brand name **Descovy®**). Only F/TDF is approved for use by people who are at risk through vaginal sex. F/TAF has not yet been studied in women and other people who could get HIV through receptive vaginal sex. **Off-label 2-1-1 dosing of oral PrEP.** Health care providers can prescribe F/TDF off-label using 2-1-1 dosing for adult gay, bisexual, and other men who have sex with men. This is also known as event-driven, intermittent, on-demand, or coitally timed PrEP. When using 2-1-1 dosing, the patient takes F/TDF doses based on when they plan to have sex. Patients who could benefit from 2-1-1 dosing are those who: • Request non-daily dosing. • Have sex less often than once per week. • Can anticipate or delay sex to permit the first two-pill dose at least 2 hours before sex. ***Note that 2-1-1 dosing is not approved by the FDA and is not recommended by CDC.***
Injectable PrEP	Cabotegravir (CAB) 600 mg injection (brand name **Apretude®**) is FDA approved to prevent HIV infection in adults and adolescents weighing at least 35 kg (77 lb). It is recommended for patients at risk for HIV through sex and may be especially useful for patients who: • Are not oral PrEP candidates. • Have problems taking oral medication as prescribed. • Prefer getting an injection every 2 months instead of taking oral PrEP.

CDC | Let's Stop HIV Together | Ending the HIV Epidemic

PubNo. 301168
August 2022

Complete Core Measures for your Patients with Diabetes

McLaren Health Plan reminds its members with diabetes to regularly visit their PCP to have an annual check-up to be sure they are getting all necessary tests. All of the diabetic core measures included in these tests are covered benefits for McLaren Health Plan members, including their annual diabetic eye exams. Encourage your patients to get these necessary tests.

Hepatitis C

The Michigan Department of Health and Human Services (MDHHS) recommends screening for hepatitis C at least once in a lifetime for people ages 18-79. McLaren Health Plan covers the drugs used to treat Hep C. Please make sure your eligible patients are screened for this contagious infection.

Blood Pressure Monitoring – Pregnancy and Postpartum

MDHHS is proposing effective 10/1/2025 revisions to the blood pressure monitoring policy by expanding coverage of blood pressure monitors to any Medicaid beneficiary who is pregnant or who is within the 12-month postpartum period. To align with PA 244, The MDHHS is removing from the standards of coverage the requirement of having a hypertensive disorder (e.g., preeclampsia) or uncontrolled blood pressure to receive a blood pressure monitor. The ordering practitioner must report a pregnancy or postpartum related diagnosis code on the order/prescription. Prior authorization is not required if the standards of coverage are met. All other blood pressure monitoring policy standards of coverage, documentation, and prior authorization requirements remain unchanged. [1]

[1] Michigan Department of Health and Human Services, (2025, August 29 proposed). Revisions to Blood Pressure Monitoring Policy. Notice of Proposed Policy, 1-2.

Children's Health: Lead Testing Guidelines

All children should be tested for lead twice: Once at the age of 1 and again by age 2.

Are your patients at risk for lead poisoning?

Symptoms of lead poisoning can be silent and hard to recognize. Preventing lead poisoning before it happens is the best way to keep your patients safe. Asking parents the following questions can help determine if a child is at risk for lead poisoning:

- Does the child live in a home built before 1950 or have they lived in a home built before 1950 in the recent past?
- Does the child live in a home built before 1978 that was recently remodeled?
- Does the child have a brother or sister or playmate with lead poisoning?

- Does the child live with an adult whose job or hobby involves lead?
- Does the child's caregiver use home remedies that contain lead? Does the parent need advice about identifying and removing lead paint or remodeling their home? Refer to the Lead and Healthy Homes Section at 866-691-LEAD or www.michigan.gov/lead

Tips & Best Practices

- Avoid missed opportunities by taking advantage of every office visit to provide lead testing
- Order lead testing at one year well visit or earlier and revisit at the 18-month visit
- Consider a standing order for in-office lead testing
- Educate parents about the dangers of lead poisoning and the importance of testing
- If patient is referred to a laboratory, implement a process for follow-up if order is outstanding after 30 days (sooner if the child's second birthday is approaching within 30 days)
- Date of service and result must be documented with the notation of the lead screening test
- Lead test is considered late if performed after the child turns 2 years of age

For more information and coding details on these and all HEDIS measures, please see the McLaren Health Plan HEDIS Quality Toolkit at: https://www.mclarenhealthplan.org/mclaren-health-plan/hedisinformation

Provider Data Attestation: Better Doctor

McLaren Health Plan has partnered with Better Doctor (Quest Analytics) to gather data attestations quarterly as required by MDHHS, CMS, NCQA and other governing bodies. This process also helps ensure our directory information is accurate. Providers and offices will receive a communication every 90 days from Better Doctor asking to have a representative visit verify.betterdoctor.com and use the access code provided to confirm the demographic information MHP currently has in our systems for each practice. The process is simple and required for continuing participation with MHP.

The easiest way to attest is by sharing your provider roster each quarter with McLaren Health Plan at mhpproviderservices@mclaren.org and Better Doctor at rosters@questanalytics.com.

When providing a roster to your Provider Relations Representative, please copy Better Doctor in your email message and add rosters@questanalytics.com to your distribution list. Attesting or sharing your roster each quarter allows MHP to keep your information most up-to-date in our records, systems and provider directories while also properly documenting information for compliance and reporting purposes.

Failure to attest to your demographic information quarterly may result in being removed from the Provider Directory.

Michigan Medicaid Mental Health Framework

The Michigan Department of Health and Human Services (MDHHS) is shifting to a more person-centered approach to serving Medicaid enrollees with mental health needs. As part of MIHealthyLife, an initiative to strengthen the Comprehensive Health Care Program (CHCP) that began in 2022, MDHHS is partnering with Medicaid Health Plans (MHPs), including McLaren Health Plan, Prepaid Inpatient Health Plans (PIHPs), and providers to improve access to and coordination of mental health care statewide.

Under the Mental Health Framework, an enrollee's level of mental health need, as determined through a State-identified standardized assessment tool, will more clearly determine which payer—the enrollee's health plan or PIHP—is responsible for their mental health coverage and care.

Also, MHPs will begin covering some additional mental health services for enrollees with lower levels of mental health need, so MHPs are accountable for more of these enrollees' continuum of care.

Beginning in October 2026:

- MHPs will cover most mental health services for CHCP enrollees with lower levels of mental health need, and
- PIHPs will cover all mental health services for CHCP enrollees with higher levels of mental health need

Referrals for mental health care, including those across MHP and PIHP systems, will be standardized to facilitate enrollee access to care.

What Does this Mean for Mental Health Providers?

Beginning October 2025, all qualified mental health providers[1] participating in Michigan's Medicaid program and contracted with an MHP and/or PIHP will need to incorporate into their practice:

- Use of standardized tools for assessing the level of mental health need of CHCP enrollees seeking mental health. MDHHS' designated assessment tools are:
    - Michigan Child and Adolescent Needs and Strengths (MichiCANS) Screener for children and youth (enrollees under age 21)
    - Level of Care Utilization System (LOCUS) for adults (enrollees aged 21 and older)

MDHHS will provide more information and access to trainings on these tools in the coming months. This is only a requirement for CHCP enrollees (enrolled in a Medicaid Health Plan). Information

regarding the assessment frequency requirement, billing, and instructions for accessing the tools will be included in an upcoming policy guide.

- Adoption of a standardized referral process for mental health services, including use of a new referral platform accessible to mental health providers, primary care providers, Community Mental Health Services Programs (CMHSPs), MHPs and PIHPs.

Beginning in October 2026, MHPs will begin covering additional mental health services—including inpatient psychiatric care, crisis residential services, partial hospitalization services, and targeted case management for enrollees with lower levels of mental health need. Providers of these services should prepare to contract with MHPs, as well as PIHPs, for coverage effective October 1, 2026. In the coming months, MDHHS will provide more detailed guidance to facilitate these efforts.

MDHHS encourages all mental health providers to send any questions or comments to: MDHHS-MentalHlthFramework@michigan.gov.

Training for Standardized Assessments

Standardized assessment training will be free for providers and eligible for CME/CEU credit (details vary between each training).

- LOCUS: The LOCUS Training will be an online, self-paced training. Once available, there will be a link provided on MDHHS' webpage, and communications will be sent out from MDHHS.
- MichiCANS: Please utilize these instructions to register for the MichiCANS training. Providers must complete the TCOM Training prior to taking the Overview Training.

MDHHS Webinars and Meetings:

- Mental Health Framework 101
  - Recording: https://somdhhs.adobeconnect.com/pjm8km93ykdy/
  - Presentation: MHF 101
- MichiCANS Screener and LOCUS All Provider Draft Rate Meeting
  - Recording: https://somdhhs.adobeconnect.com/pfxrnsu70vyr/
  - Presentation: Mental Health Framework SFY 2026 All Provider 8/6/25

The feedback process related to the Mental Health Framework MichiCANS Screener and LOCUS All Provider Draft Rate Meeting is now closed. Feedback received earlier will be reviewed and considered.

Quality Quick Tips

November – Diabetes

November is National Diabetes Awareness Month. It's a great opportunity to connect with your patients who have Diabetes and ensure they have received or are scheduled to receive their routine screenings. Diabetes is a chronic, complex condition that requires continuous medical care. You play an important role in supporting your patients to prevent complications. McLaren Health Plan wants to support you and your practices with educating and caring for these patients.

The following tests are recommended on an annual basis:

- Hemoglobin A1C Test
- Blood Pressure Control (<140/90mm Hg)
- Dilated Eye Exam (Retinal)
- Urine Microalbumin Test & Estimated Glomerular Filtration Rate*
- Physical examination including a foot exam at least twice a year

*The Kidney Health Evaluation for Patients with Diabetes (KED) measure looks at the percentage of members 18-85 years of age with diabetes who received both an estimate glomerular filtration rate (eGFR) and a urine albumin creatinine ratio (CPT Codes 82565, 82043 and 82570) during the measurement year.

McLaren Health Plan offers ***incentive opportunities*** for your Medicaid members with diabetes ages 18-75. Please review this and other incentive programs at www.McLarenHealthPlan.org.

Complete All Services	McLaren Health Plan Incentive
1. HbA1c test 2. Estimated glomerular filtration rate (eGFR) & urine albumin-creatinine ratio (uACR)	$50
Diabetic Management 1. Controlled blood pressure <140/90 2. Controlled A1c <8	$25 for each controlled measure

A continued focus and a strong partnership with you will aid in providing these important services to all eligible members. Please help our members get these important services. If we can assist your office by contacting these members, or if you would like a list of your patients who have not received these services, please email us at MHPQuality@mclaren.org.

December – Oral Health

As many as 90% of common diseases have oral symptoms and can be detected by a Dentist during a routine exam. More than 120 symptoms of nondental disease can be detected through a routine oral exam. Some health conditions, such as diabetes, pregnancy, medications, and eating disorders, can impact the patient's oral health. It's important to encourage your patients to obtain routine oral health care to improve and maintain their overall health. Oral health may also contribute to various diseases such as endocarditis, cardiovascular disease, pneumonia, pregnancy and birth complications.

Who has Dental Coverage?

- **Medicaid beneficiaries aged 21 and older-** McLaren members have dental coverage through Delta Dental at no out of pocket cost.
- **Healthy Kids Dental** – McLaren's Medicaid members under the age of 21 qualify for Healthy Kids Dental through MDHHS.
- **Pregnant Women's Dental** – McLaren's pregnant members have dental coverage through Delta Dental during their entire pregnancy and an extended 12 months post-partum with no out of pocket cost.

Many other plans have dental coverage through another vendor, still encourage your patients to see a dentist twice a year and check their benefits with their insurance.

What's covered? Below is a listing some, but not all, of the covered dental services:

- Oral exams
- X-rays
- Deep teeth cleaning
- Extractions
- Dentures
- Root Canals
- Teeth cleanings
- Cavity Fillings
- Emergency treatment
- Crowns
- Sealants
- Care to keep your gums healthy

Do your McLaren Health Plan members need a ride to access their dental care needs?
McLaren Health Plan members can call 1-888-327-0671 M-F 8:00 am – 6:00 PM to request a ride.

Remember to talk to your patients about *smoking cessation*, McLaren Health Plan has a free stop smoking program for MHP Community and Medicaid members, call 800-784-8669.

Provider Availability and Member Access to Care Requirements

McLaren Health Plan maintains standards and processes to ensure member access to care by contracted primary care physicians and participating specialists. Accessibility of services from

providers is assessed during initial credentialing and each year thereafter for high-volume PCPs, high-volume and high-impact specialists, including but not limited to: OB-GYNs and oncology specialists, and high-volume mental health specialists through quality improvement site visit audits and surveys. The availability of physician access after-hours is also measured.

Providers are required to follow MHP's Access to Care appointment standards listed below to ensure health care services are provided in a timely manner. The PCP or their designee must be available 24 hours a day, days a week to members.

The established monitoring standards are set as minimum guidelines of measurement. The following are the MHP Commercial, Marketplace, and Medicaid/Healthy Michigan Plan standards for PCP accessibility to members:

Type of Service	Standard
Emergency Services	Immediately 24 hours per day,7 days per week
Urgent Care	Within 48 hours
Routine/Regular Care including preventive services (physicals)	Within 30 business days of request
Non-Urgent Symptomatic Care	Within 7 business days of request
In Office Wait Time	Patient seen within 30 minutes of time of their appointment
After-Hours Coverage (Information/advice is given to patients when medical care is needed after regular office hours)	100%

Type of Service	Standard
Urgently needed or emergency services	Immediately
Non-Urgent Symptomatic Care	Within 7 business days
Routine/Regular Care including preventive services (physicals)	Within 30 business days

The following are the McLaren Health Plan Commercial, Marketplace, Medicaid and Medicare monitoring standards for high-volume and high impact specialty care provider accessibility to

members:

Routine Specialty Care (non-urgent)	Within 6 weeks of request
Acute Specialty Care	Within 5 business days of request

The following are the McLaren Health Plan Commercial, Marketplace Medicaid and Medicare monitoring standards for mental health (MH) provider accessibility to members:

Visit Type	**Timeframe**
MH Non-Life-Threatening Emergency	Within 6 hours of request
MH Urgent	Within 48 hours of request
MH Initial Visit for Routine Care	Within 10 business days of request
MH Follow-up for Routine Care	Within 45 business days of request

The following are the McLaren Health Plan Commercial, Marketplace, and Medicaid monitoring standards for prenatal care provider accessibility to pregnant members:

Visit Type	**Timeframe**
Initial prenatal appointment (Obstetrician, OB-GYN, PCP, certified nurse midwife, or other advanced practice registered nurse with experience, training and demonstrated competence in prenatal care)	If member is in first or second trimester: Within 7 business days of member being identified as pregnant.
	If member is in third trimester: Within 3 business days of member being identified as pregnant.
	If there is any indication of the pregnancy being high-risk (regardless of trimester): Within 3 business days.

Report Social Determinants of Health When Identified During Patient Visits

Social determinants of health (SDoH) are conditions in the places where people are born, live, learn, work, worship and play that affect a wide range of health risks and health outcomes. There are six rates reported for the Social Need Screening and Intervention HEDIS measure. These include: food

screening, food intervention, housing screening, housing intervention, transportation screening and transportation intervention. For more information, please visit our website here: HEDISProviderManual.pdf

Monitoring Appointment Access and Timeliness

The information about monitoring appointment access applies to primary care, obstetrician-gynecologist, specialty and mental health practitioners. McLaren Health Plan conducts appointment access reviews annually. Reviews are conducted more frequently for practitioners who do not meet access standards.

McLaren Health Plan contacts the practitioner's office to determine access and records the next available appointment for each of the designated appointment types. Physician-specific member complaints related to access are also analyzed.

An annual evaluation and analysis is conducted by Provider Relations staff on the following:

- Primary care appointment availability for regular, routine and urgent care appointments
- Primary care after-hours availability
- Mental Health care appointment availability (a separate analysis is performed for Mental Health care providers who prescribe medication and those who do not prescribe medication)

As a reminder, providers must offer hours of operation that are no less than the hours of operation offered to commercial members, or hours of operation must be comparable to Medicaid fee-for-service office hours if the provider serves only Medicaid enrollees. McLaren Health Plan monitors for complaints to ensure providers offer and maintain hours of operations that are compliant with these expectations. Results are reported to the Quality Improvement committee.

MHP requires an 80 percent compliance rate for all access measures. Those providers who don't meet the 80 percent requirement will be notified and asked to submit a corrective action plan to MHP within 30 days. Failure to comply with this requirement may result in departicipation.

If you have any questions, contact McLaren Health Plan Customer Service at 888-327-0761 (TTY: 711) for assistance or visit mclarenhealthplan.org.

Benefits of Patient-Centered Medical Home Certification

McLaren Health Plan recognizes the importance of Patient Center Medical Home (PCHM) principles being incorporated into provider practices.

Benefits to a provider practice becoming and maintaining PCMH designation include:

- Lowering of overall cost of care

- Alignment with state/federal initiatives focusing on Value Based Care
- Improving access to care
- Increased chronic disease management.
- Reduction in the fragmentation of care
- Alignment with McLaren Health Plan's quality of care initiatives
- Increased provider practice satisfaction
- Improved patient experience

McLaren Health Plan accepts NCQA PCMH certification and Blue Cross Blue Shield of Michigan's Physician Group Incentive Program (PGIP) designation for PCMH.

We capture provider PCMH designation information and share this status with members in Provider Directories to assist those looking for a PCMH practice.

Vaccines for Children Program (VFC)

- The Vaccines for Children (VFC) program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. Michigan providers have participated in VFC since 1995.
- The success of this program is built upon the cooperation and collaboration of many agencies. Your participation is vital to increasing Michigan's immunization rates and ensuring all children are protected against vaccine-preventable diseases.
    - Being a VFC provider is a sound investment in your practice and your patients. It reduces up-front costs by providing vaccines for VFC-eligible children. Your patients benefit by not having to go elsewhere for vaccines, and there's no charge to the provider.
    - VFC providers work with their Local Health Department for support to ensure VFC requirements are followed per CDC and MDHHS guidelines.
    - The LHD is a provider's main contact for VFC-related questions and can also offer additional support to improve vaccination rates and practices.
- **Do your providers participate in VFC? Let us know!** surveymonkey.com/r/mhp_vfc McLaren Health Plan is capturing this information to include in our Provider Directory to assist members seeking vaccination treatment options for their children.
- For more information, visit Michigan.gov to access MDHHS' VFC Resource Guide
- MI VFC Provider Manual
- MI VFC Frequently Asked Questions
- VFC program: Vaccines for Uninsured Children, visit: cdc.gov

Eligibility & Claim Inquiries

- Prior to rendering services, always verify eligibility and coverage using the McLaren Connect Provider Portal. Eligibility can be verified on the McLaren Connect Provider Portal with just the Member ID.
- For questions regarding the status of a claim, login to the McLaren Connect Provider Portal, to view the status of a claim, if you have additional questions, please initiate a request on the McLaren Connect Provider Portal.
- Maintain your tracking number from your portal request in the event you need to reach to Customer Service for further information.
- Direct all claims inquiries to MHP Customer Service to investigate any issues by calling MHP Customer Service at 888-327-0671 or initiating a request on the McLaren Connect Provider Portal.
- To dispute a claim denial, providers **must** submit an Appeal within 90 calendar days of the action and include supporting documentation.
    - Submit corrected claims within 90 days.
    - Visit the MHP Appeals information page online and the Provider Administrative Appeal Form.
- Provider Relations Representatives can assist with claims issues after a provider has already contacted MHP Customer Service and is unable to achieve resolution though established channels. Provider Relations intervention is limited to exclusive situations when denials occur due to complex configuration, contracting or enrollment issues following Customer Service involvement.

Authorization Changes

For the most recent and upcoming authorization information, visit McLaren Health Plan's website at mclarenhealthplan.org and select the Provider tab.

- All changes and announcements are posted online at least 60 days prior to becoming effective.
- There are several changes for authorization requirements effective February 1, 2026 and March 1, 2026. Please review the resources below.
- Upcoming-Authorization-Changes.pdf
- For all current prior authorization requirements, visit: Prior Authorization Codes List
    - For all current Medicare prior authorization requirements, visit: Medicare Prior Authorization Information
- Please refer to the website for an updated authorization requirements list with effective dates of January 1, April 1, July 1, or October 1 of each year. Please review our website periodically

for interim changes and to view upcoming authorization changes please visit the website here: Upcoming-Authorization-Changes.pdf

If you have any questions, please contact your Provider Relations Representative at 888-327-0761 (TTY: 711) for assistance.

Thank you for the quality care you deliver!

Provider Portal:

The McLaren CONNECT provider portal is your central online resource for streamlined plan management, offering quick, secure access to essential patient data and administrative functions. Through the portal's integrated Jiva link for "Auth & Case Management," providers can efficiently submit pre-authorizations and track their status, ensuring timely care coordination. The platform allows you to submit authorization requests, check the status of submitted requests, access criteria used for medical necessity decision making, and other useful features.

Out of network providers must register and create a new account to access the portal by completing an Out of Network Provider Request Form and submitting it to mhpproviderservices@mclaren.org with an updated W-9. The Out of Network Provider Request Form and W-9 (if needed) can be found below. Completed forms and W-9 may also be faxed to: 810-600-7979. As a reminder, incomplete submissions will delay access to the portal or claims payment.
For mote information visit: https://www.mclarenhealthplan.org/mclaren-health-plan/physician-connect-link-mhp

Member Language Needs and Resources

McLaren Health Plan uses census data to track and monitor the language needs of its enrolled members – as well as the language of the population in its geographical area – to ensure appropriate language assistance.

The top languages spoken by MHP members:

- English
- Spanish
- Arabic
- Swahili

MHP offers providers detailed reports on service area language needs and the language needs of assigned members. Language assistance resources are made

available to providers and staff, along with training to identify needs and services available.

Please contact Customer Service at 888-327- 0671 (TTY: 711) to obtain a list of language needs of assigned members in your practice or to request training about language services.

Medicare STARS

Importance of Annual Eye Exams for Patients with Diabetes (EED)

Diabetes is known to damage the small blood vessels in the retina, causing diabetic retinopathy. The early stages of diabetic retinopathy aren't always detectable symptoms for some individuals. Only an eye exam can detect the problem. Diabetes also increases risk of glaucoma. Getting regular eye exams will identify necessary steps to prevent a worsening of eye damage.

Early diagnosis and proper treatment can greatly lower the chance of blindness from diabetic retinopathy. You may play an important role in supporting our members with diabetes by encouraging an annual retinal or dilated eye exam by an eye care specialist.

To meet HEDIS requirements for diabetic eye exams, providers should educate patients on the need for an annual dilated retinal exam by an optometrist or ophthalmologist, document the exam results, and set up systems like EMR reminders to track compliance. It's crucial to ensure the exam is a retinal/dilated one and not a routine vision exam, and documentation must include the date of service, results and the eye care professional's name and credentials.

How you can help:

- Educate patients: In early stages of retinopathy, people often don't experience any symptoms. Inform patients about the importance of a dilated retinal eye exam and how it differs from a routine eye exam. Blindness isn't an exclusion for a diabetic eye exam.
- Refer and schedule: Refer patients to an optometrist or ophthalmologist for an annual dilated retinal exam and assist with scheduling if possible. Ask patients to have the optometrist or ophthalmologist send the eye test results to you and/or their primary care physician. This will increase coordination of care between the PCP and eye care provider. Coordination of care may lead to better outcomes for patients.
- Track and document:
    - Use electronic medical records (EMRs) to set up alerts for upcoming screenings.
    - Follow up on specialist reports and lab results.

    - Document the date of the exam, the results, and the name and credentials of the eye care professional in the patient's chart. Using the name of a vision care center alone isn't acceptable for compliance reporting.
- Use reminders: Send appointment reminders via phone calls, text messages, or patient portals.
- Ensure proper exams:
    - Confirm the exam is a dilated or retinal exam and not a routine one for glasses or cataracts.
    - Make note if retinopathy is present or of any eye enucleations.
    - Make sure that any fundus photography or digital imaging results are read and interpreted by an eye care professional.

Documentation of "diabetes without complications" doesn't meet criteria

Fraud, Waste and Abuse

Health care fraud and abuse is both a state and federal offense. The HIPAA Act of 1996 indicates a dishonest provider or member is subject to fines or imprisonment of not more than 10 years, or both. In addition to fines, probation or incarceration, fraudulent or abusive activities may result in a denial, suspension or termination of the provider's license under the Michigan Public Health Code or similar action from Medicaid under the Michigan Social Welfare Act. MHP asks providers to partner with us to identify and eliminate fraud, waste and abuse.

What is Fraud, Waste and Abuse?

Fraud is intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal and state law (42 CFR § 455.2).

Waste is the overuse of services or other practices that directly or indirectly result in unnecessary costs. Waste is generally not considered to be caused by criminally negligent actions, but rather the misuse of resources.

Abuse consists of provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or commercial health care program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR § 455.2), or commercial health care program.

Examples of fraud, waste and abuse include:

- Billing more than once for the same service

- Billing for services never performed or provided
- Performing inappropriate or unnecessary services
- Providing lower-cost or used equipment and billing for higher-cost or new equipment
- Using someone else's identity altering or falsifying pharmacy prescriptions

Member Rights and Responsibilities

McLaren Health Plan Members have the right to:

- Confidentiality
- Be treated with respect and recognition of their dignity and the right to privacy, including to be free from restraint and seclusion
- Have access to a primary care provider or provider designee 24 hours a day, 365 days a year for urgent care
- Receive culturally and linguistically appropriate services
- The right to receive covered benefits consistent with your contract and State and Federal regulations
- Obtain a current provider directory of participating providers and access to a choice of specialists within the network who are experienced in treatment of chronic disabilities, with a referral
- Obtain OB-GYN and pediatric services from network providers without a referral request
- Continue receiving services from a provider who has been terminated from the Plan's network, through the episode of care, as long as it remains medically necessary to continue treatment with this provider, including female members who are pregnant have the right to continue coverage from a terminated provider that extends to the postpartum evaluation of the member, up to 6 weeks after delivery
- Have no "gag rules" from the Plan. Doctors are free to discuss all medical treatment options, even if they are not covered services
- Participate in decision-making regarding his/her health care, including the right to refuse treatment, to obtain a second opinion, and express preferences about treatment options
- Receive a copy of their medical record upon request, and request those to be amended or corrected
- Know how the Plan pays its doctors, allowing Members to know if there are financial incentives or disincentives tied to medical decisions; and the right to be provided with a telephone number and address to obtain additional information about compensation methods, if desired
- Voice complaints or appeals about McLaren Health Plan, the care provided or a decision to deny or limit coverage, including that a member or provider cannot be penalized for filing a complaint or appeal in compliance with federal and state laws
- Receive information about McLaren Health Plan, including the services provided, the practitioners and providers, and the members' rights and responsibilities
- Make recommendations regarding McLaren Health Plan's member's rights and responsibilities
- Be free from other discrimination prohibited by State and Federal regulations

- Having the member's medical record be kept confidential by McLaren Health Plan and the PCP

McLaren Health Plan Members have the responsibility to:

- Schedule appointments in advance and be on time; and cancel an appointment with the doctor's office as soon as possible
- Use the hospital emergency room only for acute or emergency care, not for routine care - this means following the protocol and using the emergency room only when medically necessary, and contacting the PCP prior to a visit to the emergency room
- Become a partner with the PCP in planning individual health care and completing treatments, including supplying the information (to the extent possible), to practitioners, providers, and the health plan that is needed to deliver the services needed
- Follow plans and instructions for care that the member has agreed on with all their treating health care providers and practitioners
- Understanding their health problems and participate in developing treatment goals to the degree possible
- Notify McLaren Health Plan's Customer Service immediately for any change in address or telephone number
- Allow McLaren Health Plan to assist with health care and services to which a member is entitled and of notifying the Plan of any problem related to health care, benefits, etc.
- Forward suggestions to McLaren Health Plan in writing or contacting Customer Service for assistance
- Carry the McLaren Health Plan Member ID card at all times