

Request for Claims Denial Appeal Review (Level I)

Submit your completed request for a Vaya Health (Vaya) Claims Denial Appeal Review (Level I), along with any supporting documentation, by secure email to claims.appeals@vayahealth.com. Vaya must receive your request by 5 p.m. no later than 30 days from the final notification of nonpayment of the claim(s).

Documentation must be submitted via secure email at the same time as this request form for consideration by the Vaya Claims Denial Appeal Review Panel. This form is applicable to both Vaya's Behavioral Health and Intellectual/Developmental Disabilities (I/DD) Tailored Plan and NC Medicaid Direct Prepaid Inpatient Health Plan (PIHP). If you have questions about the Appeal Review process, call 1-800-893-6246, ext. 2455 (behavioral health) or ext. 2456 (physical health), or email claims.appeals@vayahealth.com.

I hereby request a Claims Denial Appeal Review (Level I) of the denied claim(s) identified on the following page. I understand this will be a desk review based on documents provided and Vaya claims records.

I understand an Appeal Review is my opportunity to present documents and information disputing the claim(s) denial identified below and that the documentation I wish to be considered for the review must be submitted electronically at the same time as this request form.

Additional documentation (please check one):

Additional Appeal Review documentation accompanies this request.

No additional documentation is being submitted for this Appeal Review.

Submitter Information

Name: _____ Title: _____
Email: _____ Organization: _____
Signature: _____ Date: _____

Provider Information

Contact name
(if different from above): _____ Email: _____
Legal business name: _____
Mailing address: _____
Phone: _____ Provider NPI: _____

Claim Information

Plan type:

NC Medicaid Direct PIHP
Tailored Plan – NC Medicaid Managed Care
Tailored Plan – State-Funded Services

Service type:

Behavioral health (mental health, substance use disorder, I/DD, or traumatic brain injury)
Physical health

Member/Recipient Name	Medicaid ID #/ SSN	Patient Account Number	Date(s) of Service	Claim Header #	Vaya Case # (EFT # From RA)	Date of Final Notification of Denial (RA):	Applicable Service Code(s):	Denial Reason:

Reason for Appeal Request:
