Vaya Health

Enrollment Initiation Form: Licensed Practitioner (LP)

Use this form to initiate the Vaya Health (Vaya) provider network enrollment process. Submit the completed form via secure email to ProviderEnrollment@vayahealth.com or via U.S. mail to:

Vaya Health
Attn: Provider Enrollment Services
200 Ridgefield Court, Suite 218
Asheville, NC 28806

Instructions

All licensed practitioners (LPs) seeking to provide clinical services to Vaya members and/or recipients must be credentialed in NCTracks. This includes LPs who bill through an organization, group practice, or facility seeking a direct contract with Vaya. For more information, please visit the NCTracks website at https://www.nctracks.nc.gov/content/public/providers/provider-enrollment/getting-started.html.

This minimal information collected will allow Vaya to retrieve your data details from the Provider Enrollment File (PEF), which is maintained by the NC Department of Human and Health Services (NCDHHS).

Requested effective date: _____

Practitioner Information

Name: _____ _____ _____
First *Middle* *Last*

Individual NPI Number: _____ TIN (Tax ID#): _____

Provider Type

☐ MD ☐ LCSW ☐ PA ☐ OT ☐ LDN
☐ DO ☐ LMFT ☐ NP/RN ☐ PT ☐ RT
☐ LCMHC ☐ LCAS ☐ PhD/LPA/PsyD ☐ ST

Contact Information

Contact person: _____

Contact phone: _____ Contact email: _____

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Attestation and Signature

By signing below, I hereby acknowledge, agree, and certify that all of the information provided herein are true, accurate, and complete to the best of my knowledge and belief as of the date of signature below. I further understand that any false or misleading information may be cause for denial, suspension, or termination of any and all agreements with Vaya Health (Vaya). I further acknowledge, agree, and signify my willingness for Vaya to verify any and all information presented in this request. I agree to submit any additional information upon request to verify the accuracy and truthfulness of the information contained herein or submitted herewith and to address any issues that may arise during the processing of this request. I further consent to the inspection by representatives of Vaya all documents that may be material to an evaluation of the information provided herein.

I release from liability all representatives of Vaya for their acts performed in good faith and without malice in connection with evaluating the information provided herein, and I release from any liability all individuals and organizations that provide information to Vaya in good faith and without malice concerning my enrollment in the Vaya network. If I am accepted for participation in the Vaya provider network, I hereby consent to inspection by Vaya of my health records relating to Vaya members/recipients as necessary for its peer and utilization review purposes as permitted by federal and state laws, rules, and regulations and agree to notify Vaya within five (5) business days of any changes to the information provided herein.

Signature of Practitioner: _____ Date: _____

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