NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

Questions/Complaints Regarding Medicaid Behavioral Health Managed Care

OMH is asking that all questions or complaints regarding Medicaid Managed Care be submitted to OMH-Managed-Care@omh.ny.gov. This will ensure that all questions or complaints related to Medicaid Managed Care coverage of Mental Health Services are reviewed and responded to by appropriate staff within OMH or the Department of Health. You may copy and paste this form into your email.

***Note*: DO NOT** include any patient identifying information on this form, in the body of your email, the email subject line, or within any attachments other than the encrypted spreadsheet/password protected document. Thank you.

Submit via Central Field Office	Submit via Hudson River Field Office	Submit via Long Island Field Office	Submit via NYC Field Office	Submit via Western Field Office

Some web browsers may not be compliant with Adobe Reader and require dowloading the form before submission.

BASIC INFORMATION	
Provider Name:	
NPI:	
Address:	
Telephone Number:	
Provider Agency Name:	
Program Type:	
Primary Area of Inquiry: (For example: claims; prior authorization; network; contracts; internal/external appeals.)	
Details of the question, issue or concern. If related to a specific service, please specify:	
Have you contacted another State Agency regarding this question, issue or concern? If so, what was the outcome?	
The other State Agency contact information (State Agency name, contact name, telephone number, email address, etc.)	

IF APPLICABLE, PLEASE ALSO INCLUDE THE FOLLOWING INFORMATION:	
MCOs Involved in Issue: **Note:** If the Plan uses a Behavioral Health vendor, please list the specific MCO along with the vendor	
Do you participate in the plan's network?	
If related to claims, please submit an encrypted spreadsheet or password protected document with the following information: 1. Member Client ID Number(s) (CIN) 2. Date(s) of service 3. Date(s) claims submitted 4. Claim numbers 5. Date(s) claims were paid/denied 6. Payment amount 7. Denial reason(s)	
Outreach to the Plan, including: 1. Dates of contact 2. Names of Plan representatives with whom you spoke or corresponded 3. Customer service reference numbers (if available) 4. A brief description of the contact 5. Copies of emails or any other correspondence you/your agency has had with the plan representatives related to the identified issue 6. Any denial letters/explanation of benefits related to the issue. 7. Has an appeal been filed? If so, provide copy of Plan's/Vendor's response to the appeal.	