NEW JERSEY OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION

Part I – Provider Self Disclosure

Type of Self-Report Issue (select one or more)	
Billing Issues	☐
Documentation/Records Issues	☐
Quality of Care	☐
Cost Report Issues	☐
Claims for Services Not Provided	☐
Reporting Health Insurance	☐
Licensing and/or Certificate of Need	☐
Falsification/Alteration of Records/Documents	☐
Employee Licensure and/or Credentialing	☐
Other:	☐

Provider Information						
Vendor/Facility Name						
Provider First Name			Last Name			
Provider Type			Provider Specialty			
Medicaid ID No.			License No.			
Physical Address	Street					
	City		State		Zip Code	
Mailing/Alternate Address	Street					
	City		State		Zip Code	
Telephone numbers must include the area code						
Work Telephone Number	( )			Ext.		
Fax Number	( )					
Cell Telephone Number	( )					

Contact Information						
First Name				Last Name		
Title						
Employer/Agency/Company						
Division						
Relationship to Organization	☐ Employee ☐ Attorney ☐ Consultant ☐ Other					
Address	Street					
	City		State		Zip Code	
Telephone numbers must include the area code						
Work Telephone Number	( )			Ext.		
Cell Telephone Number	( )					
Email Address						

Federal or State Agency Involvement (if applicable)			
State or Federal Agency and/or Law Enforcement Notified?	☐ State ☐ Federal ☐ Law Enforcement		
AGENCY Notified:			
DATE Notified:			
CONTACT/Person:			
First Name:		Last Name:	
Title:			
Telephone numbers must include the area code			
Work Telephone Number	( )		
Cell Telephone Number	( )		

Part II – Other Information

Contractor/Sub Contractor Information (if applicable)						
Contractor Company Name:						
Owner Name:						
Company/Owner Address	Street					
	City		State		Zip Code	
Telephone numbers must include the area code						
Company Owner Telephone Number	( )		Ext.			

Patient Information (if applicable)			
First Name:	*	Last Name:	
Social Security Number		Date of Birth	
Medicaid Number			
Date of Service	Service rate code		
Amount paid by Medicaid			

**If more than one patient, attach a computer disk containing an excel spreadsheet with the applicable data listed above.*

Discovered Primary Payor Health Insurance Information (if applicable)						
Patient Medicaid Number						
Insurance Company Name						
Insurance Company Address	Street					
	City		State		Zip Code	
Telephone numbers must include the area code						
Work Telephone Number	( )		Ext.			
Cell Telephone Number	( )					
Policy Holder Name						
Policy Holder SSN						
Employer Name						
Group Number						
Insurance Eff. Date		Insurance Term. Date				

List below any family members that are on the Health Insurance Policy:	
1.	*4.*
2.	*5.*
3.	*6.*

You must provide written, detailed information about your self disclosure. This must include a description of the facts and circumstances surrounding the possible fraud, waste, abuse, or inappropriate payment(s), the period involved, the person(s) involved, the legal and program authorities implicated, and the estimated fiscal impact. (Please refer to the OSC-MFD self disclosure Guidance for additional information.)

Attach the written, detailed information and any additional relevant documentation to this form and mail the completed form and attachments to the address listed in the instructions above.

I certify that, to the best of my knowledge, the information in this self-report is truthful and is based on a good faith effort to assist the OSC-MFD in its inquiry and verification of the disclosed matter.

_____

Print Name

_____

Signature

_____

Title

_____

Date