Medicaid Fraud Division
Self-Disclosure Form

Part 1 - Provider Information

Type of Self-Report Issue (Select one or more) *	
Billing for Services not Rendered	
Missing or Insufficient Support Documentation	
Improper Coding / Upcoding	
Falsification /Alteration of Documentation	
Excluded, Unlicensed, or Uncertified Individuals or Entities	
Misrepresentation of Credentials	
Cost Report Issues	
Credit Balance	
Quality of Care	
Other:	

Provider Type *	
Physician	
Independent Clinic	
Nurse Practitioner	
Independent Lab	
Pharmacy	
Dentist	
Hospital	
Home Health	
FQHC	
Other:	

Provider Information *				
Vendor/Facility Name				
DBA				
Provider First Name		Provider Last Name		
Provider Specialty		NPI Number		
Medicaid ID Number		License Number		
Physical Address	Street			
	City			
	State		Zip Code	
Mailing Address	Street			
	City			
	State		Zip Code	
Phone numbers must include the area code.				
Work Phone Number	( )		Ext.	
Cell Phone Number	( )			

Contact Information *				
This contact will be required to respond to requests for information relevant to this submission.				
First Name		Last Name		
Title				
Employer/Agency/Company				
Relationship to Provider	Employee			
	Legal Representative			
	Consultant			
	Other			
Mailing Address	Street			
	City			
	State		Zip Code	
Phone numbers must include the area code.				
Direct Phone Number	( )			
Alternate Phone Number	( )			

Federal or State Agency Involvement (If applicable)			
Yes	State	Federal	Law Enforcement
No			
Date of Notification			
Agency			
Name		Title	
Email Address			
Phone numbers must include the area code.			
Phone Number	( )		

Part II - Other Information

Contractor/Sub-Contractor Information (If applicable)				
Contractor Company Name				
Owner Name				
Company/Owner Address	Street			
	City			
	State		Zip Code	
Phone numbers must include the area code.				
Phone Number	( )			
Email Address				

Claims Data Information		
Types of claims affected	Managed Care	☐
	FFS (Fee-for-Service)	☐
Have the disclosed claims been voided or adjusted?		
Yes ☐		
No ☐		
If the disclosed claims have been voided or adjusted, provide the date(s) of the void(s) / adjustment(s).		
*A detailed list of claims paid or submitted that comprise the overpayments must be submitted in an Excel format (properly encrypted) including the fields found in the **Claims Data Form** template.*		

Overpayment Information *		
Overpayment Amount		
Date the overpayment was identified		
Time period reviewed		
Overpayment Calculation Methodology (Select one or more *)	Claim-by-Claim Review	☐
	Statistical Sampling & Extrapolation	☐
	Non-Claim Overpayment	☐
If the overpayment calculation methodology is a non-claim overpayment for the employment of an ineligible provider, the following must be provided: • The identity of the ineligible individual and any provider identification number; • The job duties performed by that individual; • The dates of the individual's employment or contractual relationship; • A description of any background checks that the disclosing party completed before and/or during the individual's employment or contract; and • The total compensation including gross wages, pension, and benefits.		
*If the overpayment calculation methodology is extrapolation, use the **SD RS&E** template as a guide for the minimum information that must be provided.*		

Part III - Statement Explaining the Overpayment

Describe completely and fully the error or matter that occurred, including an explanation of the circumstances that led to the overpayment, the type of program, services, and claims affected, etc.

List any rules, policies, regulations and/or laws that are relevant to the error or matter that occurred.

Provide the names and titles of the individuals who were involved in the error or matter that occurred.

Describe completely and fully how the error or matter was found, including the names and titles of the individuals who discovered it.

Describe all actions taken to stop the error or matter, including the names and titles of the individuals who were involved in rectifying the problem.

Describe all corrective actions taken to prevent recurrence of the error or matter, including the date the corrective actions were put in place.