Eric Holcomb, Governor
State of Indiana

Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

Voluntary Self-Disclosure of Provider Overpayments Form

Date self-disclosure form completed: _____

Section 1:Provider Information *Complete the following fields for the rendering or billing provider.*					
*Provider or Group Name					
*Street Address (Line 1)					
Street Address (Line 2)					
*City		*State		*ZIP Code	
*Office Telephone					
*Rendering or Group National Provider Identifier (NPI)**					

Mandatory fields required to process self-disclosure

****Submit one NPI per disclosure.***

Please note that the submission of address changes via this process does not modify your provider enrollment information. See the Update Your Provider Profile page at in.gov/medicaid/providers for information on how to update your provider enrollment information.

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Section 2: Contact Information

Complete the following fields as applicable. If the information is the same as listed in Section 1, indicate "See Provider Information" for that line. This contact information is used in the event there are questions regarding the information you submitted in the self-disclosure.

*Name		*Street Address 1	
*Job Title		Street Address 2	
*Employer		*City	
*Division or Department		*State	
*Relationship to Provider		*ZIP Code	
*Office Telephone		*Email Address	
Alternate Telephone Number		Preferred Contact Method	◯ Email ◯ Mail ◯ Phone

Mandatory fields required to process self-disclosure

Section 3: Type of Self-Disclosure Overpayment Issue(s)*

Check one or more of the options provided, below. If you select "8. Other Reason," include a brief narrative describing the issue. Note: The numbers corresponding to the issues checked should be used as reasons for Section 6.

☐ 1. Billing or Invoice Issue	☐ 4. Facility Licensing Issue	☐ 6. Falsification/Alteration of Records/Documents
☐ 2. Documentation or Records Issue	☐ 5. Quality of Care Issue	☐ 7. Employee Licensing or Credentialing
☐ 3. Coordination of Benefits	☐ 8. Other Reason:	

***This section must be completed to process self-disclosure.**

Section 4: State/Federal Agency or Law Enforcement Involvement

*ONLY complete this section if the overpayment issue(s) has (have) been referred to a state or federal agency or law enforcement **OR** if you were made aware of the issue(s) as a result of state or federal agency or law enforcement notification.*

Notification Initiated by Provider	◯ Yes ◯ No	Agency Contact Name	
Agency Notification Occurred	◯ Yes ◯ No	Agency Contact Title	
Agency Name (e.g. CMS, MFCU, OIG, etc.)		Agency Contact Telephone	
Date Involvement or Notification Occurred		Agency Contact Email Address	

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Section 5: Self-Disclosure Details

Provide detailed information about the self-disclosure. ***DO NOT INCLUDE CLAIM NUMBERS OR MEMBER INFORMATION IN THIS SECTION.***

Please be advised that under federal law, a provider that identifies an overpayment shall report the overpayment and return the entire amount to a Medicaid program within 60 days after it is identified. 42 U.S.C. § 1320a-7k(d). A provider that retains an overpayment after the 60-day deadline incurs an obligation under the federal False Claims Act and may be subject to criminal and civil liability, including civil monetary penalties, treble damages and, potentially, exclusion from participation in federal healthcare programs. A provider that fails to report a suspected overpayment and to make the repayment within 60 calendar days of receipt of the final notification of overpayment may also be at risk of a "whistleblower" lawsuit.

*Date or Time Frame Issue Was Identified		*Amount of Overpayment (Total–No Estimates)	
*First and Last Names of Those Involved		*Dates of Service Involved	
+Relevant Regulatory or Medicaid Policy			

+ ☐ Provider extrapolated overpayment amount based on claim sampling
(*If this box is selected, please use the Description field (or attached letter) to explain the extrapolation process utilized and how the overpayments were discovered.)*

*Description of the Facts and Circumstances Surrounding the Errors/Inappropriate Payment *(If more space is needed, write "See Attached Letter" and attach a letter with details.)*

Section 6: Claim Details

This section may be duplicated and submitted in Excel. This section is for non-extrapolated clam information only. Provide the following minimum detailed information about *ALL* claims associated with the self-disclosure. ***If you are unable to provide individual claim numbers, the claim overpayment will need to be decided via extrapolation.***

*Claim ID (ICN)	Claim Line	*IHCP Provider ID with Location (Service Location)	*Member ID	*Claim Paid Amount	*Claim Refund Amount	*Claim Refund Reason (List the **number** of the corresponding issue selected in Section 3.)

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+ ***Required field if relevant***

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Section 7: Corrective Action Detail

*Describe planned corrective action and/or corrective action that has already occurred (attach document with same format as below and indicate 'See Attached Corrective Action Plan' in this section if additional space is necessary). Corrective action **SHALL INCLUDE** each action to be taken or already taken, the responsible party for each action, and the date each action has been or will be completed.*

*Description of Issue	*Corrective Action	*Party Responsible to Complete	*Expected Completion Date

Section 8: Certification Statement

Self-disclosure offers providers the opportunity to minimize the potential cost and disruption of a full-scale audit and investigation. The Indiana Health Coverage Programs' (IHCP's) acceptance of self-disclosure review results and any overpayment associated therewith does not waive the right to further audit or to examine these claims, or any other claims within the time frame covered by your internal review process. Any claims identified as part of this self-disclosure process continue to be subject to review by the IHCP, the Centers for Medicare & Medicaid Services (CMS), the Office of Inspector General (OIG), other state or federal agencies, or other investigative entities. Self-disclosure will not absolve the provider of criminal or civil culpability. If a law enforcement agency determines that a crime was committed, any information shared with the IHCP will be forwarded to the appropriate agency.

I certify that, to the best of my knowledge, the information in this self-disclosure is truthful and is based on a good faith effort to assist the Indiana Health Coverage Programs in its inquiry and verification of this disclosed matter.

*Printed First and Last Name		*Job Title	
*Signature		*Date	

Mandatory fields required to process self-disclosure