Mike Braun, 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 Instructions

These instructions should be followed when completing the Indiana Health Coverage Programs (IHCP) *Voluntary Self-Disclosure of Provider Overpayments Form*. The form and supporting documentation may be submitted by mail or electronically through Secure File Transfer Protocol (SFTP). For mailing address and other details, see the *Protocol for Voluntary Self-Disclosure of Provider Overpayments* page of the IHCP provider website. **Providers should only submit self-disclosures for claims more than two years from date of service. All claims less than two years should be corrected on the IHCP Provider Healthcare Portal (IHCP Portal).**

Field	Description
Section 1: Provider Information	
Provider or Group Name	Enter the billing provider or rendering provider name. **Required.**
Street Address (Line 1)	Enter the billing provider or rendering provider street address. **Required.** ***Please note that if you are submitting an address that does not match your provider profile, you will need to update your provider profile information as described on the Update Your Provider Profile webpage at in.gov/medicaid/providers.***
Street Address (Line 2)	Enter second address line if needed.
City	Enter the billing provider or rendering provider city. **Required.**
State	Enter the billing provider or rendering provider state. **Required.**
ZIP Code	Enter the billing provider or rendering provider ZIP code. **Required.**
Office Telephone	Enter the billing provider or rendering provider office telephone number. **Required.**
Rendering or Group National Provider Identifier (NPI)	Enter the billing provider or rendering provider NPI. Submit only one NPI per disclosure. **Required.**

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Field	Description
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	Enter the contact name. **Required.**
Job Title	Enter the contact's job title. **Required.**
Employer	Enter the contact's employer. **Required.**
Division or Department	Enter the contact's division or department name. **Required.**
Relationship to Provider	Enter the contact's relationship to the provider. **Required.**
Office Telephone	Enter the contact's office telephone number. **Required.**
Alternate Telephone Number	Enter the contact's alternate telephone number.
Street Address 1	Enter the contact's street address. **Required.**
Street Address 2	Enter the contact's second address line if needed.
City	Enter the contact's city. **Required.**
State	Enter the contact's state. **Required.**
ZIP Code	Enter the contact's ZIP code. **Required.**
Email Address	Enter the contact's email address. **Required.**
Preferred Contact Method	Select either email, mail or phone as how you prefer to be contacted.

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Field	Description
Section 3: Type of Self-Disclosure Overpayment Issue(s)	
1. Billing or Invoice Issue 2. Documentation or Records Issue 3. Coordination of Benefits 4. Facility Licensing Issue 5. Quality of Care Issue 6. Falsification/Alteration of Records/Documents 7. Employee Licensing or Credentialing 8. Other Reason:	Check one or more of the options provided. 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.* This section is **required**.
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	Check Yes or No.
Agency Notification Occurred	Check Yes or No.
Agency Name (e.g. CMS, MFCU, OIG, etc.)	Enter agency name.
Date Involvement or Notification Occurred	Enter the date involvement or notification occurred.
Agency Contact Name	Enter the agency contact name.
Agency Contact Title	Enter the agency contact title.
Agency Contact Telephone	Enter the agency contact telephone number.
Agency Contact Email Address	Enter the agency contact email address.

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Field	Description
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 health care 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	Enter the date or time frame the issue was identified. **Required.**
First and Last Names of Those Involved	Enter the last names of the people involved. **Required.**
Relevant Regulatory or Medicaid Policy	Enter the relevant regulatory or Medicaid policy in violation. **Required** if relevant to the disclosure.
Amount of Overpayment (Total–No Estimates)	Enter the amount of overpayment. **Required.**
Dates of Service Involved	Enter the dates of service involved. **Required.**
Provider extrapolated overpayment amount based on claim sampling	If this box is selected, use the Description field (or attached letter) to explain the extrapolation process used and how the overpayments were discovered. **Required** if extrapolation process is used.
Description of the Facts and Circumstances Surrounding the Errors/Inappropriate Payment	Enter a description of the facts and circumstances surrounding the errors and/or inappropriate payment. If more space is needed, write "See Attached Letter" and attach a letter with details. **Required.**
Section 6: Claim Details	
This section may be duplicated and submitted in Microsoft Excel. This section is for non-extrapolated claim 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)	Enter the Claim ID or internal control number (ICN). **Required.**
Claim Line (if at detail level)	Enter the claim line if at the detail level.

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Field	Description
IHCP Provider ID (including alpha suffix, if applicable)	Enter the IHCP Provider ID from claim information. If the Provider ID includes an alphabetic character (formerly known as the service location code), it must be include. **Required.**
IHCP Member ID	Enter the Member ID. **Required.**
Member Name	Enter the member's first and last name. **Required.**
Member Date of Birth	Enter the member's date of birth. **Required.**
Claim Paid Amount	Enter amount paid for the claim. **Required.**
Claim Refund Amount	Enter amount of the claim refund. **Required.**
Claim Refund Reason	Enter the **number** of the corresponding issue selected in Section 3 for the refund reason: 1. Billing or Invoice Issue 2. Documentation or Records Issue 3. Coordination of Benefits 4. Facility Licensing Issue 5. Quality of Care Issue 6. Falsification/Alteration of Records/Documents 7. Employee Licensing or Credentialing 8. Other Reason: **Required.**
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	Enter the description of the issue. **Required.**
Corrective Action	Enter corrective action that is planned or already occurred. **Required.**
Party Responsible to Complete	Enter name of party responsible to complete the corrective action. **Required.**
Expected Completion Date	Enter expected completion date of corrective action. **Required.**

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Field	Description
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 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 IHCP in its inquiry and verification of this disclosed matter.*	
Printed First and Last Name	Enter first and last name. **Required.**
Job Title	Enter job title of person signing this statement. **Required.**
Signature	Form must be signed by the person certifying this statement. No electronic signatures or signature stamps are allowed. **Required.**
Date	Enter date signed. **Required.**

PREFERRED METHOD: Please submit self-disclosures electronically through Secure File Transfer Protocol (SFTP) per instructions on the Protocol for Voluntary Self-Disclosure of Provider Overpayments webpage.

If needed, mail self-disclosure form to:

Audit and Overpayment
IHCP Program Integrity
PO Box 636297
Cincinnati, OH 45263-6297