



**New York State Office of the Medicaid Inspector general
Part I – Provider Self Disclosure**

Date Completed	
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Type of Self-Report Issue (select one or more)	
Billing Issues	<input type="checkbox"/>
Documentation/Records Issues	<input type="checkbox"/>
Quality of Care	<input type="checkbox"/>
Cost Report Issues	<input type="checkbox"/>
Claims for Services Not Provided	<input type="checkbox"/>
Reporting Health Insurance	<input type="checkbox"/>
Licensing and/or Certificate of Need	<input type="checkbox"/>
Falsification/Alteration of Records/Documents	<input type="checkbox"/>
Employee Licensure and/or Credentialing	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>

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			
<i>Telephone numbers must include the area code</i>						
Work Telephone Number	()	Ext.				
Fax Number	()					
Cell Telephone Number	()					

Contact Information						
First Name				Last Name		
Title						
Employer/Agency/Company						
Division						
Relationship to Organization	<input type="checkbox"/> Employee <input type="checkbox"/> Attorney <input type="checkbox"/> Consultant <input type="checkbox"/> Other _____					
Address	Street					
	City		State		Zip Code	
<i>Telephone numbers must include the area code</i>						
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?	<input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> Law Enforcement					
AGENCY Notified:						
DATE Notified:						
CONTACT/Person:						
First Name:				Last Name:		
Title:						
<i>Telephone numbers must include area code</i>						
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
<i>Telephone numbers must include the area code</i>					
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
<i>Telephone numbers must include the area code</i>					
Work Telephone Number	()	Extension:			
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 OMIG 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 OMIG in it's inquiry and verification of the disclosed matter.

Print Name

Signature

Date

Title