NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Health Benefits

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
DAVE RICHARD • Deputy Secretary, NC Medicaid

Voluntary Provider Self-Audit Forms

Step One

Prepare and send the following documents to the Office of Compliance and Program Integrity – Business Intake:

A. **Original** cover letter on your business letterhead that summarizes:
   - Overview of the issues identified
   - Period covered by the review (evaluate the problem for the full period for which it occurred)
   - Type of sampling (100%, random, etc.)
   - Error percentage rate

B. **Original** Chart of Self-Audit Findings
C. **Original** Provider Plan of Correction
D. **Copy** of the Refund Check (if applicable)
E. **Copy** of the Provider Refund Attachment

Send documents A through E to the following address:

Office of Compliance and Program Integrity – Business Intake
Division of Health Benefits
2501 Mail Service Center
Raleigh, NC 27699-2501

Step Two

Prepare and send the following documents to the Office of Controller:

F. **Original** Refund Check (if applicable)
G. **Original** Provider Refund Attachment
H. **Copy** of cover letter (document A)

Send documents F through H to the following address:

DHHS Office of the Controller
Accounts Receivable – Health Benefits
2022 Mail Service Center
Raleigh, North Carolina 27699-2022

Call DHB Office of Compliance and Program Integrity Business Intake at (919) 814-0181 if you have any questions regarding the Voluntary Provider Self-Audit Forms.

PROVIDER REFUND ATTACHMENT

******ATTACH THIS FORM TO YOUR REFUND CHECK******

IDENTIFYING INFORMATION

Provider Name ____

Provider Address ____

Provider Address 2 ____

NPI Number ____

Legacy Provider Number ____

Overpayment Amount $___________

REPAYMENT OPTIONS – CHECK ONE

____ **Withhold overpayment amount from future Medicaid / Health Choice Payments.**

____ **Attached is a check for the full amount of overpayment.**

Make check payable to**: N.C. Division of Health Benefits.** Make sure to include your Legacy Provider number on your check.

Mail the **original** of this form and the **original** of the refund check to the following address:

DHHS Office of Controller
Accounts Receivable – Health Benefits
2022 Mail Service Center
Raleigh, NC 27699-2022

Mail a **copy** of this form and **copy** of the refund check to the following address:

Office of Compliance and Program Integrity – Business Intake
Division of Health Benefits
2501 Mail Service Center
Raleigh, NC 27699-2501

CONTACT INFORMATION FOR FOLLOW-UP

Individual's Name ____

Direct Telephone Number ____

Email Address ____

Provider Signature: ____ **Date:** _______________

FOR DHB OFFICE USE ONLY:

Program Integrity Section: _______________

Investigator: _______________

Program Integrity Case Number: _______________

CHART OF SELF-AUDIT FINDINGS

Fill out this chart and return at the completion of your review. Use this form as a guide when creating a spreadsheet containing the findings of your self-audit. You may choose to include additional columns (i.e. modifier, units, tooth numbers, etc.) depending on your specialty.

Mail the **original** of this chart (or similar) and the **copy** of the refund check to the following address:

Office of Compliance and Program Integrity – Business Intake
Division of Health Benefits
2501 Mail Service Center
Raleigh, NC 27699-2501

Beneficiary Name	Beneficiary Medicaid ID #	Date of Service	Procedure Code	Claim TCN	Billing Provider NPI #	Billed Amount	Paid Amount	Paid Date	Provider Refund Amount	Reason for Error
								TOTAL REFUND		

PROVIDER PLAN OF CORRECTION

IDENTIFYING INFORMATION

Provider Name ____________________________________

Provider Address ____________________________________

Provider Address 2 ____________________________________

NPI Number ____________________________________

Legacy Provider Number ____________________________________

Provider Signature: ____________________________________ **Date:** ______________

Complete all requested information and mail the **original** of this form to:

Office of Compliance and Program Integrity – Business Intake
Division of Health Benefits
2501 Mail Service Center
Raleigh, NC 27699-2501

Finding	Corrective Action Plan	For each finding and plan
		Name of Individual Responsible for Implementing:
		Direct Telephone:
		Email Address:
		Implementation Date:
		Projected Completion Date:
		Name of Individual Responsible for Implementing:
		Direct Telephone:
		Email Address:
		Implementation Date:
		Projected Completion Date: