



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) 527-7749 if you have any questions regarding the Voluntary Provider Self-Audit Forms.

NC MEDICAID

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH BENEFITS

LOCATION: 1985 Umstead Drive, Kirby Building, Raleigh NC 27603

MAILING ADDRESS: 2501 Mail Service Center, Raleigh NC 27699-2501

www.ncdhhs.gov • TEL: 919-855-4100

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

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: