Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid and Long-Term Care

Nebraska Medicaid Provider Self-Disclosure Statement

Date Form Completed ______________________________

Type of Self-Report Issue (Select one of more)

- ☐ Billing Issue
- ☐ Documentation/Records Issue
- ☐ Quality of Care
- ☐ Cost Report Issue
- ☐ Claims for Services Not Provided
- ☐ Reporting Health Insurance
- ☐ Facility Licensing
- ☐ Falsification/Alteration of Records/Documents
- ☐ Employee Licensure and/or Credentialing
- ☐ Other ______________________________

Facility Information

Facility Name

Provider First Name | Last Name

Provider Type | Provider Speciality

NE Medicaid provider number | NPI | License #

Street Address | City | State | Zip

Mailing/Alternate Address | City | State | Zip

Office Phone | Fax | Alternate Phone

Contact information - person completing form. Leave fields blank if not applicable

First Name | Last Name

Job Title | Employer/Agency/Company | Division

Relationship to Provider

☐ Employee ☐ Attorney ☐ Consultant ☐ Staff ☐ Other

Street Address | City | State | Zip

Office Phone | Fax | Alternate Phone

E-mail Address

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State/Federal Agency or Law Enforcement Notification. Leave fields blank if not applicable

Agency Notified	Date Notified
Contact First Name	**Last Name**
Job Title	**Phone**

Self-Disclosure Details

You must provide written, detailed information about your self-disclosure in the space below. This must include a description of the facts and circumstances surrounding the errors and inappropriate payments, the time period involved, the person(s) involved, claim details (procedure codes, diagnoses, place of service, etc), relevant Medicaid regulations and estimate of the overpayment. Please provide specific Medicaid claim numbers.

If you have a spreadsheet or listing of the claim details, please send a copy in a secure manner (encrypted as an e-mail attachment with password under separate cover or on a CD).

Certification Statement

Self-disclosure offers providers the opportunity to minimize the potential cost and disruption of a full scale audit and investigation and to negotiate a fair monetary settlement. 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 Department will be forwarded to the appropriate agency.

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 Nebraska Medicaid Program Integrity in its inquiry and verification of this disclosed matter.

____
Print Name

______________________________ ______________
Signature Date

____
Job Title