Self-Audit Worksheet

Provider Name: ____________________ Medicaid Provider Number: ____________________ Date: ____________________

Provider Type: ____________________ Contact Person: ____________________ Telephone Number: ____________________

Provider Address: ______________________________ Tax ID: ____________________ NPI Number: ____________________

Audit Period: ____________________ Audit Type (Comprehensive or Focus): ____________________ Code(s) Reviewed (Focus): ____________________

Did the audit involve the use of statistical sampling? (Yes or No): ____________________ If yes, was a sample received from DHCF? (Yes or No): ____________________

Description of Audit Methodology: ____

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Self-Audit Correspondence Address: Department of Health Care Finance, Division of Program Integrity, Attention: Special Audit Coordinator, 441 4th Street, NW, Washington, DC, 20001

Recipient ID	Recipient Full Name	Medicaid ICN	From Date of Service	To Date of Service	Date of payment	Procedure code/ Revenue Code	Units of service	Treating provider	Description of Non-Compliance	Overpayment Amount

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