PROVIDER INITIATED SELF DISCLOSURE REPORT FORM

Please complete and return this form along with your self audit refund check. You should also submit documentation explaining the reason for the self audit and indentify the results. If you choose to do on-line claims adjustments in lieu of sending a check (or in conjunction with a check), the adjustment information needs to be reported using this form. Please submit all documents or checks related to any self disclosure to:

MO HealthNet Division
Attn: Program Integrity Unit – SELF DISCLOSURE
P.O. Box 6500
615 Howerton Ct.
Jefferson City, MO. 65102-6500

Provider Name:_____ **NPI #:**_____

PARTICIPANT NAME/ ID (DCN)	DATE OF SERVICE	ICN (CLAIM NUMBER)	AMOUNT PAID	REFUND AMOUNT	DATE ADJUSTMENT SUBMITTED (IF APPLICABLE)	PROCEDURE CODE AND/OR REASON FOR REFUND
DCN:						
DCN:						
DCN:						
DCN:						
DCN:						
DCN:						
DCN:						
DCN:						
DCN:						
DCN:						

TOTAL REFUND $_____

Print Form