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 identify 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 reporting using this form.

Please submit all documents or checks related to any self disclosure to:

Date:

Missouri Medicaid Audit and Compliance (MMAC)

Attn: Financial Section - SELF DISCLOSURE
P.O. Box 6500
Jefferson City, MO 65102-6500

Provider Name:

Name: NPI #:

Provider Type:

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

Total Refund:

Form Completed By:

Telephone Number: