Voluntary Provider Self-Audit Form

NC Medicaid recommends providers conduct periodic, voluntary self-audits to identify instances where services reimbursed by Medicaid are not in compliance with program requirements. Self-auditing is a critical component which can mitigate potential risks and facilitate resolution of matters that potentially violate state or federal administrative rules, regulation, or policy governing Medicaid. This includes matters exclusively involving overpayments or errors that do not suggest violations of the law.

Instructions:

1. Complete and prepare:
   a. Cover letter on the business letterhead summarizing:
      i. Overview of the identified issues
      ii. Period covered by the review (evaluate the problem for the full period for which it occurred)
      iii. Type of sampling (I.e., 100%, random, etc.)
      iv. Error percentage rate
   b. Chart of Self-Audit Findings
   c. Provider Plan of Correction
   d. Provider Refund Attachment
   e. Refund Check (if applicable)

2. Prepare and mail the listed documents to each address:

Address	Original	Copy
DHHS Office of the Controller **Accounts Receivable – Health Benefits** 2022 Mail Service Center Raleigh, North Carolina 27699-2022	Provider Refund Attachment Refund Check	Cover letter
Office of Compliance and Program Integrity **Business Intake Center** Division of Health Benefits 2501 Mail Service Center Raleigh, NC 27699-2501	Cover letter Chart of Self-Audit Findings Provider Plan of Correction	Provider Refund Attachment Refund Check

Contact the Office of Compliance and Program Integrity at Medicaid.OCPI.InvestigationsUnit@dhhs.nc.gov with any questions regarding this form.

Chart of Self-Audit Findings

Use this form as a guide when creating a spreadsheet containing the findings of the self-audit. Include additional columns (I.e., modifier, units, tooth numbers, etc.) depending on the specialty.

Provider Name ____

Provider Address ____

Provider Address 2 ____

NPI Number ____

Legacy Provider Number ____

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	**$**	

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 • FAX: 919-733-6608

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Revised 1/13/2025

Provider Plan of Correction

Provider Name ____

Provider Address ____

Provider Address 2 ____

NPI Number ____

Legacy Provider Number ____

Finding	Corrective Action Plan	For Each Finding and Plan
		Individual's Name Responsible for Implementing: Direct Telephone: Email: Implementation Date: Projected Completion Date:
		Individual's Name Responsible for Implementing: Direct Telephone: Email: Implementation Date: Projected Completion Date:

Provider Signature_______________________________________ Date______________

LOCATION: 1985 Umstead Drive, Kirby Building, Raleigh NC 27603
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Provider Refund Attachment

Attach this form to the refund check.

Provider Name ____

Provider Address ____

Provider Address 2 ____

NPI Number ____

Legacy Provider Number ____

Overpayment Amount $_____________

Repayment Options:
Check one

____ Withhold overpayment amount from future Medicaid payments.

____ Attached is a check for the full amount of overpayment. The check is payable to "NC Division of Health Benefits" and includes the Legacy Provider Number.

Contact Information for Follow-Up:

Individual's Name ____

Direct Telephone ____

Email ____

Provider Signature_____________________________________ Date______________