Oklahoma Health Care Authority
Provider Self Disclosure Form

Provider Information	
Provider Name	
Provider ID	
Address	

Contact Information	
Contact Person	
Phone Number	

Description of matter being disclosed:

Date discovered:	_____

How it was discovered:

Summary of provider's review of the overpayment:

Amount of Overpayment:	_____

It should be noted that participation in the self disclosure program does not alleviate the possibility of further review of the OHCA in this or future reviews, and does not affect in any manner the government's ability to pursue criminal, civil or administrative remedies for the matters which are the subject of the self disclosure.

I certify that the information submitted on this form and any other documentation related to this disclosure submitted to OHCA is based upon a good faith effort to disclose a billing inaccuracy and is true and correct.

Signature_____ **Date**_____

Mail this form to: Oklahoma Health Care Authority, Program Integrity & Accountability Unit, 4345 N. Lincoln Blvd., Oklahoma City, OK 73105