



North Carolina Department of Health and Human Services
Division of Medical Assistance

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Director, Division of Medical Assistance

Voluntary Provider Self-Audit Form

I. Prepare and send the following documents to **DMA Third Party Recovery (TPR) Accounts Receivable:**

A. Cover letter on your business letterhead that summarizes:

- overview of the issues identified
- time period covered by the review (evaluate the problem for the full time period for which it occurred)
- type of sampling (100%, random, etc.)
- error percentage rate

B. Chart of Audit Findings

C. Provider Plan of Correction

D. Copy of the completed Provider Refund Attachment

E. Copy of the refund check (if applicable)

Send items A-E to the following address:

DMA Third Party Recovery
2508 Mail Service Center
Raleigh, North Carolina 27699-2508
Attention: Accounts Receivable Section

II. Prepare and send the following documents to the **Office of Controller:**

A. Refund check (if applicable)

B. Provider Refund Attachment

C. Copy of the cover letter that summarizes:

- overview of the issues identified
- time period covered by the review (please evaluate the problem for the full time period for which it occurred)
- type of sampling (100%, random, etc.)
- error percentage rate



Location: 1985 Umstead Drive • Dorothea Dix Hospital Campus • Raleigh, N.C. 27603

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Send items A-C to the following address:

Office of Controller
DMA Accounts Receivable
2022 Mail Service Center
Raleigh, North Carolina 27699-2022

Completed forms may be sent electronically to providerselfaudit@dhhs.nc.gov in lieu of mailing.

Call TPR Accounts Receivable at (919)814-0000 if you have any questions regarding the Provider Self-Audit forms.

PROVIDER REFUND ATTACHMENT

Provider Name	Legacy Provider Number	NPI #	Overpayment Amount
PAYMENT OPTIONS – CHECK ONE			
<input type="checkbox"/> Attached is a check for the full amount of overpayment. Make check payable to: N.C. Division of Medical Assistance.			
<input type="checkbox"/> Withhold overpayment amount from future Medicaid / Health Choice Payments.			
PROVIDER CONTACT INFORMATION			
Name:		Phone Number:	
Signature:		Date:	
Mail this form to: Office of Controller DMA - Accounts Receivable 2022 Mail Service Center Raleigh, NC 27699-2022			

PROVIDER PLAN OF CORRECTION Self-Audit

Complete all requested information and mail completed Plan of Correction form to:
 DMA Third Party Recovery
 2508 Mail Service Center
 Raleigh, North Carolina 27699-2508

In lieu of mailing the form, the completed electronic form may be e-mailed to:
providerselfaudit@dhhs.nc.gov

Provider Name:		NPI #:	Phone:
Provider Contact Person for follow-up:			Fax:
			Email:
Address:			Legacy Provider #

Finding	Corrective Action Steps	Responsible Party	Time Line
			Implementation Date:
			Projected Completion Date:
			Implementation Date:
			Projected Completion Date:
			Implementation Date:
			Projected Completion Date:
			Implementation Date:
			Projected Completion Date:
			Implementation Date:
			Projected Completion Date: