

HEALTH PLAN ACTION

Individual Subject: Initial Report

Please provide as much of the following information as possible. Failure to provide sufficient information to permit identification of a single subject will result in the report being rejected, necessitating resubmission.

Do not print this page. A printable copy of your report submission will be provided after submission.

OMB # 0915-0239 expiration date 05/31/14

OMB # 0915-0126 expiration date 12/31/13

OMB # 0915-0331 expiration date 12/31/13

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239, 0915-0126 and 0915-0331. Public reporting burden for this collection of information is estimated to average 45 minutes to complete the forms, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

PRACTITIONER INFORMATION



Personal Information	n			
Practitioner Name				
Last Name	First Name	Middle Name	Suffix (Jr, III)	
SMITH	JOHN			
Add another nam	<u>e used</u>			
Gender				
Gender © Male © Fema	le © Unknown			
	le ○ Unknown			
○ Male ○ Fema				
○ Male ○ Fema				
○ Male ○ Fema				
© Male © Fema	YYYY)			
○ Male ○ Fema	YYYY) ed?			

Home Address/Address of Record		
Home Address/Address of Necold		
Chroat Address.		
Street Address:		

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Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	
Country:	
(if U.S., leave blar	ık)
Work Information ☐ Check here if the property of the propert	actitioner's work information is the same as your organization.
Organization	
Name:	
Type:	CHOOSE ONE FROM LIST
Click Help ? for	information on filling out non-U.S. and military addresses.
Address	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	-
Country: (if U.S., leave blar	nk)
Social Security Num	phore (SSN)
Oocial Security Num	
Add another SSN	
Individual Taxpaver	Identification Numbers (ITIN)
	• •
Add another ITIN	
Federal Employer Id	lentification Numbers (FEIN)

Add another FEIN			
National Provider Ide	entifiers (NPI)		
	, ,		
Add another NPI			
Drug Enforcement A	dministration (DEA) Numbers		
Add another DEA	Number		
			1
Unique Physician Ide	entification Numbers (UPIN)		
Add another UPIN			
Professional Schools	s Attended		
	chools as you type. Please choo	se the ma	tching school or enter the
complete school name.			Year of
School Name:			Graduation (YYYY)
Add another Profes	ssional School		
Occupation And Stat	e Licensure Information		
	ense. Check 'No License' if the		
Up to 60 licenses may l	Additional License/Occupation be provided.)	i bullon lo	provide more than one license.
•			
 State License Number: 		OR	☐ No License
State of Licensure:	CHOOSE ONE EDOM LIST		
Occupation/Field of			
Licensure:	Physician (MD)		
Specialty:	CHOOSE ONE FROM LIST		_
Add Additional Lice	,	_	

Health Care Entities With Which the Subject is Affiliated or Associated Inclusion of an affiliated/associated health care entity in this report does not imply complicity in the reported action. Click Help ? for information on filling out non-U.S. and military

addresses. Name of Affiliated/Associate Health Care Entity:		
Address Street Address: Address Line 2: City: State:	CHOOSE ONE FROM LIST	
ZIP Code: Country: (if U.S., leave blank		
Nature of Subject's Relationship to Affiliate: Add another Affiliat	CHOOSE ONE FROM LIST	V



Basis for Action

Select a category and then choose a basis for action code that best describes the reason for the action. Click **Add Additional Basis For Action** to provide up to 5 basis for action selections. View a complete basis for action list.

- 1. O Non-Compliance With Requirements
 - Criminal Conviction or Adjudication
 - Confidentiality, Consent or Disclosure Violations
 - Misconduct or Abuse
 - © Fraud, Deception, or Misrepresentation
 - Unsafe Practice or Substandard Care
 - Improper Supervision or Allowing Unlicensed Practice
 - Improper Prescribing, Dispensing, Administering Medication/Drug Violation
 - Other

Clear

	se Action Information
the	me of Agency or Program that Took Adverse Action Specified in This port:
	te Action Was Taken: MDDYYYY)
	te Action Became Effective: MDDYYYY)
Lei	ngth of Action:
	© Permanent
	○ Indefinite/Unspecified
	© Specific Period
ls l	Reinstatement Automatic at Completion of Adverse Action Period? © Yes © Yes, with conditions (requires a Revision to Action Report when status changes) © No
Ass	ral Amount of Monetary Penalty, sessment and/or Restitution or fine: Note: If no amount, leave this field blank.
ls t	he Action on Appeal?
	○ Yes
	○ No
	○ Unknown
and No	scription of Subject's Act(s) or Omission(s) or Other Reasons for Action(s) Taken d Description of Action(s) Taken by Reporting Entity te: Do not reference any personal identification information (e.g., names) of anyone er than the subject of this report. The description must include sufficient specificity to able a knowledgeable reviewer to determine clearly the circumstances of the action(s) or the content of the action of the ac

There are 4000 characters remaining for the description.

Spell Check

information to help you not be been been been in the second to the secon	lows your entity to include an internal file number or other reference rou identify this report in your files. This information is not used by the I be provided on copies of the report sent to queriers.	;
Entity Internal Repor Reference: (e.g., claim number)		
Customer Use		
	ay be used by the submitter to identify this transaction. This information dification and only appears on the response returned to your organization.	
Customer Use:		
Certification I certify that I am aut correct to the best of	thorized to submit this transaction and that all information is true and f my knowledge.	
Authorized Submitter	•	
Authorized Submitter	r's Title:	
Authorized Submitter	er's Phone: Ext.	
Date:	12/12/2012	
use in future queries and/	n to add/update this subject in your subject database for /or reports. Duplicate entries in your subject database may s. You will be notified of potential duplicate entries prior to ntry.	?
Submit to Data Bank	Validate Without Submitting Store as a Draft	



HEALTH PLAN ACTION

Report Correction

To submit a **correction** to previously submitted report DCN 7930000076906049, complete all necessary modifications in the form below, and press **Submit to Data Bank**.

The report entered here will replace the original report, so please ensure that all known data is entered in its entirety. Failure to provide sufficient information to permit identification of a single subject may result in the report being rejected, necessitating resubmission.

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OMB # 0915-0239 expiration date 05/31/14

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PRACTITIONER INFORMATION



Last Name	First Name	Middle Name	Cuffix / Ir III)
WHITE	JOE	Wilddie Name	Suffix (Jr, III)
Add another name u	<u>used</u>		
ender			
• Male	○ Unknown		
rth Date (MMDDYY)	(Y)		
01011970			
01011970			
Subject Deceased?	,		

Street Address:	1 MAIN ST
Address Line 2:	
City:	FAIRFAX
State:	VA Virginia
ZIP Code:	22033 -
Country: (if U.S., leave blank)	

─Work Information ——	
\square Check here if the pra	ctitioner's work information is the same as your organization.
Organization	
Name:	
Туре:	CHOOSE ONE FROM LIST
Click Help ? for in	nformation on filling out non-U.S. and military addresses.
Address	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	-
Country: (if U.S., leave blank)	
*****6789 Add another SSN	<u>Edit</u>
∼Individual Taxpayer Id	entification Numbers (ITIN)
Add another ITIN	
Federal Employer Ider Add another FEIN	ntification Numbers (FEIN)
National Provider Iden	itifiers (NPI)
Add another NPI	
Drug Enforcement Ad	ministration (DEA) Numbers
Add another DEA N	<u>lumber</u>

⊂Unique Physician Ide	ntification Numbers (UPIN)		
Add another UPIN			
			-
∼Professional Schools	Attended —		
The form will suggest s complete school name.	chools as you type. Please c	hoose the ma	atching school or enter the
			Year of
School Name:			Graduation (YYYY)
Add another Profes	sional School		
Coccupation And State	Licensure Information—		
(Provide at least one lic	ense. Check 'No License' if	the subject d	oes not have a State License
Number. Use the Add AUD to 60 licenses may be	•	i on button to	provide more than one license.
 State License Number: 		OR	✓ No License
State of Licensure:	CHOOSE ONE FROM LIST		
Occupation/Field of	f		
Licensure:	Physician (MD)		
Specialty:	CHOOSE ONE FROM LIST		
Add Additional Lice	nse/Occupation		

Health Care Entities V	Vith Which the Subject is Affiliated or Associated
Address	
Street Address: Address Line 2: City: State: ZIP Code: Country: (if U.S., leave	CHOOSE ONE FROM LIST
blank)	
Nature of Subject's Relationship to Affiliate: Add another Affiliat	CHOOSE ONE FROM LIST



Basis for Action

Select a category and then choose a basis for action code that best describes the reason for the action. Click **Add Additional Basis For Action** to provide up to 5 basis for action selections. View a complete basis for action list.

1. • Non-Compliance With Requirements

- Clinical Privileges Restricted, Suspended or Revoked by Another Hospital or Health Care Facility
- O Debarment From Federal or State Program
- Employing or Contracting With Individuals or Entities Excluded From a Federal or State Health Care Program
- © Exclusion or Suspension From a Federal or State Health Care Program
- C Failure to Comply With Corrective Action Plan
- C Failure to Maintain Adequate or Accurate Records
- C Failure to Maintain Records or Provide Medical, Financial or Other Required Information
- C Failure to Meet or Comply With Contractual Obligations, Participation Requirements, or Credentialing Standards
- C License Revocation, Suspension or Other Disciplinary Action Taken by a Federal, State or Local Licensing Authority
- Practicing Beyond the Scope of Practice
- O Practicing With an Expired License
- O Practicing Without a License
- Practicing Without a Valid License
- O Surrendered License to Practice
- Criminal Conviction or Adjudication
- Confidentiality, Consent or Disclosure Violations
- Misconduct or Abuse
- Fraud, Deception, or Misrepresentation
- Unsafe Practice or Substandard Care
- Improper Supervision or Allowing Unlicensed Practice
- Improper Prescribing, Dispensing, Administering Medication/Drug Violation
- Other

Clear

	ne
Adverse Action Specified in This Report:	BBB
Date Action Was Taken: (MMDDYYYY)	01012010
Date Action Became Effective: (MMDDYYYY)	01012010
Length of Action:	
Permanent	
○ Indefinite/Unspecified	
C Specific Period	
Is Reinstatement Automatic at Completio O Yes	on of Adverse Action Period?
Yes, with conditions (requires a RNo	Revision to Action Report when status changes)
Total Amount of Monetary Penalty, Assessment and/or Restitution or fine: ((Format NNNNN.NN)	Note: If no amount, leave this field blank.
Is the Action on Appeal?	
○ Yes	
No	
○ Unknown	
and Description of Action(s) Taken by Re	•
and Description of Action(s) Taken by Re Note : Do not reference any personal id other than the subject of this report. The enable a knowledgeable reviewer to determine the Refer to Reporting, Submitting	eporting Entity entification information (e.g., names) of anyone e description must include sufficient specificity to
and Description of Action(s) Taken by Re Note : Do not reference any personal id other than the subject of this report. The enable a knowledgeable reviewer to determine the surrender. Refer to Reporting, Submitting information.	eporting Entity entification information (e.g., names) of anyone e description must include sufficient specificity to ermine clearly the circumstances of the action(s)
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Data Bank, but it will be provide Entity Internal Report	ed on copies of the report sent to queriers.
Reference:	
(e.g., claim number)	
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	by the submitter to identify this transaction. This information and only appears on the response returned to your
Customer Use:	
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HEALTH PLAN ACTION

Organization Subject: Initial Report

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SUBJECT INFORMATION



BBB	
Add another name	<u>e used</u>
Click Help ?	for information on filling out non-U.S. and military addresses.
dress	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	-
Country: if U.S., leave blank)	
eral Employer Ide	entification Numbers (FEIN)
eral Employer Ide	
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Add another FEIN ial Security Num Add another SSN	
Add another FEIN al Security Num Add another SSN	bers (SSN)

Clinical Laboratory Improvement Act (CLIA) Numbers
Add another CLIA Number
Federal Food and Drug Administration (FDA) Numbers
Add another FDA Number
National Provider Identifiers (NPI)
Add another NPI
<u></u>
Medicare Provider/Supplier Numbers
Add another Medicare Provider/Supplier Number
Organization State Licensure Information
(If no State License, check the 'No License' box.)
State License Number: OR No License
State of Licensure: CHOOSE ONE FROM LIST
Add another License
Add another Electise
Principal Officers and Owners————————————————————————————————————
Last Name First Name Middle Name Suffix Title
Add another Principal Officer or Owner
<u> </u>

Health Care Entities V	Vith Which the Subject is Affiliated or Associated——————
Inclusion of an affil in the reported acti addresses. Name of Affiliated/Associate Health Care Entity:	d
Address	
Street Address: Address Line 2: City: State: ZIP Code: Country: (if U.S., leave blank)	CHOOSE ONE FROM LIST
Nature of Subject's Relationship to Affiliate: Add another Affiliat	CHOOSE ONE FROM LIST



Basis for Action-

Select a category and then choose a basis for action code that best describes the reason for the action. Click **Add Additional Basis For Action** to provide up to 5 basis for action selections. View a complete <u>basis for action list</u>.

- 1. O Non-Compliance With Requirements
 - Criminal Conviction or Adjudication
 - Confidentiality, Consent or Disclosure Violations
 - Conflict of Interest
 - Fraud, Deception or Misrepresentation
 - Substandard Care or Patient Neglect/Abuse
 - O Improper Prescribing, Dispensing, Administering Medication/Drug Violation
 - Other

Clear

Adverse Action	cy or Program that Specified in This			
Date Action W	·	toporti		1
(MMDDYYYY)	as lakeli.			
	ecame Effective:			
Length of Action	on:			
© Permar	nent			
Indefini	te/Unspecified			
 Specific 	Period			
Yes	ent Automatic at Co	•		
○ Yes, wi ○ No	th conditions (requ	res a Revision	to Action Rep	port when status changes)
Assessment a	of Monetary Penalt and/or Restitution of			
(Format NNNN	,	Note:	If no amount	, leave this field blank.
Is the Action of	n Appeal?			
© Yes				
○ No				
Unknow	vn			
and Descriptio	n of Action(s) Take	n by Reporting	Entity	ons for Action(s) Taken
and Descriptio Note : Do not other than the enable a know surrender. Ref	n of Action(s) Take reference any per subject of this rep ledgeable reviewe	n by Reporting conal identificat ort. The descrip to determine o	Entity ion information information must in learly the cir	on (e.g., names) of anyone clude sufficient specificity to
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Data Bank, but it will be provid	this report in your files. This information is not used by the led on copies of the report sent to queriers.
Entity Internal Report Reference:	
(e.g., claim number)	
Customer Use	
	d by the submitter to identify this transaction. This information and only appears on the response returned to your
Customer Use:	
correct to the best of my knowledge	submit this transaction and that all information is true and ledge.
Authorized Submitter's Name:	
Authorized Submitter's Name: Authorized Submitter's Title:	
	Ext.
Authorized Submitter's Title:	02/01/2013



HEALTH PLAN ACTION

Report Correction

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SUBJECT INFORMATION



ABC	
Add another name	a used
Add another hame	5 4364
Click Help ?	for information on filling out non-U.S. and military addresses.
ddress	
Street Address:	1 MAIN ST
Address Line 2:	
City:	FAIRFAX
State:	VA Virginia
ZIP Code:	22033 -
Country:	
(if U.S., leave blank)	
deral Employer Id	entification Numbers (FEIN)
Add another FEIN	
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Add another SSN	
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ig Emoreement A	1
Add another DEA	

Clinical Laboratory Improvement Act (CLIA) Numbers
Add another CLIA Number
Federal Food and Drug Administration (FDA) Numbers
Add another FDA Number
National Provider Identifiers (NPI)
Add another NPI
<u></u>
Medicare Provider/Supplier Numbers
Add another Medicare Provider/Supplier Number
Organization State Licensure Information
(If no State License, check the 'No License' box.)
State License Number: OR No License
State of Licensure: CHOOSE ONE FROM LIST
Add another License
Add another Electise
Principal Officers and Owners————————————————————————————————————
Last Name First Name Middle Name Suffix Title
Add another Principal Officer or Owner
<u> </u>

Health Care Entities W	/ith Which the Subject is Affiliated or Associated
Inclusion of an affiliation in the reported action addresses. Name of Affiliated/Associated Health Care Entity:	
Address	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	-
Country: (if U.S., leave blank)	
Nature of Subject's Relationship to Affiliate: Add another Affiliate	CHOOSE ONE FROM LIST
	-



Basis for Action

Select a category and then choose a basis for action code that best describes the reason for the action. Click **Add Additional Basis For Action** to provide up to 5 basis for action selections. View a complete basis for action list.

1. • Non-Compliance With Requirements

- Debarment From Federal or State Program
- Employing or Contracting With Individuals or Entities Excluded From a Federal or State Health Care Program
- Exclusion or Suspension From a Federal or State Health Care Program
- C Failure to Comply With Health and Safety Requirements
- C Failure to Maintain Adequate or Accurate Records
- © Failure to Maintain Equipment/Missing or Inadequate Equipment
- C Failure to Maintain Records or Provide Medical, Financial or Other Required Information
- C Failure to Perform Contractual Obligations
- C Failure to Take Corrective Action
- C Financial Insolvency
- C Lack of Appropriately Qualified Professionals
- C License Revocation, Suspension or Other Disciplinary Action Taken by a Federal, State or Local Licensing Authority
- Violation of Federal or State Statutes, Regulations or Rules
- Violation of State Health Code
- Criminal Conviction or Adjudication
- Confidentiality, Consent or Disclosure Violations
- Conflict of Interest
- Fraud, Deception or Misrepresentation
- Substandard Care or Patient Neglect/Abuse
- Improper Prescribing, Dispensing, Administering Medication/Drug Violation
- Other

Clear

	t: DDD
Date Action Was Taken: (MMDDYYYY)	01012010
Date Action Became Effective: (MMDDYYYY)	01012010
Length of Action:	
Permanent	
O Indefinite/Unspecified	
Specific Period	
Is Reinstatement Automatic at Complet	
Yes, with conditions (requires aNo	Revision to Action Report when status changes)
Total Amount of Monetary Penalty, Assessment and/or Restitution or fine: (Format NNNNN.NN)	\$ Note: If no amount, leave this field blank.
Is the Action on Appeal?	
C Yes	
No	
○ Unknown	
and Description of Action(s) Taken by F	•
Note : Do not reference any personal other than the subject of this report. T enable a knowledgeable reviewer to de	Reporting Entity identification information (e.g., names) of anyone he description must include sufficient specificity to etermine clearly the circumstances of the action(s) of ing a Factually-Sufficient Narrative, for detailed
Note : Do not reference any personal other than the subject of this report. T enable a knowledgeable reviewer to desurrender. Refer to Reporting, Submittinformation.	identification information (e.g., names) of anyone he description must include sufficient specificity to etermine clearly the circumstances of the action(s)
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(e.g., claim number)	
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