REPORT INPUT FORM

the DataBank
NATIONAL PRACTITIONER
HEALTHCARE INTEGRITY & PROTECTION

DEFERRED CONVICTION or PRE-TRIAL DIVERSION

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

<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 number for this project is 0915-0239 (HIPDB). 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   Help   ?

> **We have pre-populated the practitioner information from the most recent report. Please review all pre-populated information for accuracy.**

Personal Information

Practitioner Name

Last Name	First Name	Middle Name	Suffix (Jr, III)
SMITH	JOHN		

Add another name used

Gender
⦿ Male   ◯ Female   ◯ Unknown

Birth Date (MMDDYYYY)
05051950

Is Subject Deceased?
⦿ No   ◯ Unknown   ◯ Yes

Home Address/Address of Record

Street Address: [   ]

Address Line 2: [   ]

City: [   ]

State: [CHOOSE ONE FROM LIST ▼]

ZIP Code: [   ] - [   ]

Country:
(if U.S., leave blank) [   ]

Work Information

☐ Check here if the practitioner's work information is the same as your organization.

Organization

Name: [GENERAL HOSPITAL]

Type: [301 General/Acute Care Hospital ▼]

Click [Help ?] for information on filling out non-U.S. and military addresses.

Address

Street Address: [123 FAKE STREET]

Address Line 2: [   ]

City: [FAIRFAX]

State: [VA Virginia ▼]

ZIP Code: [22030] - [   ]

Country:
(if U.S., leave blank) [   ]

Social Security Numbers (SSN)

[*****2333]   Edit

Add another SSN

Individual Taxpayer Identification Numbers (ITIN)

[   ]

Add another ITIN

Federal Employer Identification Numbers (FEIN)

[_____]

[Add another FEIN](#)

National Provider Identifiers (NPI)

[_____]

[Add another NPI](#)

Drug Enforcement Administration (DEA) Numbers

[_____]

[Add another DEA Number](#)

Unique Physician Identification Numbers (UPIN)

[_____]

[Add another UPIN](#)

Occupation And State Licensure Information

(Provide at least one license. Check **'No License'** if the subject does not have a State License Number. Use the **Add Additional License/Occupation** button to provide more than one license. Up to 60 licenses may be provided.)

1. State License Number: [123ABC_____]   OR   ☐ No License

   State of Licensure: [AL Alabama ▼]

   Occupation/Field of Licensure: [Physician (MD) ▼]

   Specialty: [Aerospace Medicine ▼]

   [Add Additional License/Occupation](#)

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/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: [CHOOSE ONE FROM LIST ▼]

[Add another Affiliate]

INFORMATION DESCRIBING ACTION   [Help ?]

Jurisdiction Information

Jurisdiction:

○ Federal

○ State/Local

Venue:
(Court Name) [   ]

City: [   ]

State: [CHOOSE ONE FROM LIST ▼]

Docket/Court File
Number: [   ]

Prosecuting Agency
or Civil Plaintiff: [   ]

Prosecuting Agency
or Plaintiff Case
Number: [   ]

Investigating Agencies

Name   Case Number
[   ]   [   ]

[Add another Investigating Agency]

Statutory Offenses

Statute Title and Section (e.g., 18 USC. 287)	Statutory Offense (e.g., False Claim)	Count (e.g., 2)
[ ]	[ ]	[ ]

[Add another Statutory Offense]

Act or Omission Codes

Act or Omission
Code: CHOOSE ONE FROM LIST ▼

[Add another Act or Omission Code](#)

Narrative Description of Act(s) or Omission(s)
Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

There are **4000** characters remaining for the description.

Spell Check

Sentence/Judgment Information

Date of Sentence or Judgment:
(MMDDYYYY)

Is the Action on Appeal?

○ Yes

○ No

○ Unknown

Restitution Amount: $
(Format NNNNN.NN)

Other Sentence/Judgment
Amount Ordered: $
(Format NNNNN.NN)

Incarceration: Years   Months   Days

Suspended Sentence: Years   Months   Days

Home Detention: Years   Months   Days

Probation: Years   Months   Days

Community Service: Hours

Other Court Orders:
(Describe)

[More Sentence/Judgment Information](#)

Entity Internal Report Reference

This optional field allows your entity to include an internal file number or other reference information to help you identify this report in your files. This information is not used by the Data Bank, but it will be provided on copies of the report sent to queriers.

Entity Internal Report
Reference:
(e.g., claim number)

Customer Use

This optional field may be used by the submitter to identify this transaction. This information is returned without modification and only appears on the response returned to your organization.

Customer Use:

Certification

I certify that I am authorized to submit this transaction and that all information is true and correct to the best of my knowledge.

Authorized Submitter's Name: DEVELOPER

Authorized Submitter's Title: DEVELOPER

Authorized Submitter's Phone: 7035551212   Ext.

Date: 02/01/2013

☐ Send e-mail notification when this and any future responses are available.

☐ Check this box if you wish to add/update this subject in your subject database for use in future queries and/or reports. Duplicate entries in your subject database may result in duplicate queries. You will be notified of potential duplicate entries prior to completing this subject entry.

Help ?

Submit to Data Bank   **Validate Without Submitting**   **Store as a Draft**

Return to Options

REPORT INPUT FORM

the DataBank
NATIONAL PRACTITIONER
HEALTHCARE INTEGRITY & PROTECTION

DEFERRED CONVICTION or PRE-TRIAL DIVERSION

Report Correction

To submit a **correction** to previously submitted report DCN 7930000076905965, 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   Help ?

Personal Information

Practitioner Name

Last Name	First Name	Middle Name	Suffix (Jr, III)
SMITH	JOHN		

Add another name used

Gender
⦿ Male   ◯ Female   ◯ Unknown

Birth Date (MMDDYYYY)
05051950

Is Subject Deceased?
⦿ No   ◯ Unknown   ◯ Yes

Home Address/Address of Record

Street Address: [ ]

Address Line 2: [ ]

City: [ ]

State: [CHOOSE ONE FROM LIST ▼]

ZIP Code: [ ] - [ ]

Country:
(if U.S., leave blank) [ ]

Work Information
☐ Check here if the practitioner's work information is the same as your organization.

Organization
Name: [GENERAL HOSPITAL]

Type: [301 General/Acute Care Hospital ▼]

Click [Help ?] for information on filling out non-U.S. and military addresses.

Address
Street Address: [123 FAKE STREET]

Address Line 2: [ ]

City: [FAIRFAX]

State: [VA Virginia ▼]

ZIP Code: [22030] - [ ]

Country:
(if U.S., leave blank) [ ]

Social Security Numbers (SSN)
[*****2333]   Edit
Add another SSN

Individual Taxpayer Identification Numbers (ITIN)

[ ]

Add another ITIN

Federal Employer Identification Numbers (FEIN)

[_____]

[Add another FEIN](#)

National Provider Identifiers (NPI)

[_____]

[Add another NPI](#)

Drug Enforcement Administration (DEA) Numbers

[_____]

[Add another DEA Number](#)

Unique Physician Identification Numbers (UPIN)

[_____]

[Add another UPIN](#)

Occupation And State Licensure Information
(Provide at least one license. Check **'No License'** if the subject does not have a State License Number. Use the **Add Additional License/Occupation** button to provide more than one license. Up to 60 licenses may be provided.)

1. State License
   Number: [123ABC_____]   OR   ☐ No License

   State of Licensure: [AL Alabama ▼]

   Occupation/Field of
   Licensure: [Physician (MD) ▼]

   Specialty: [Aerospace Medicine ▼]

   [Add Additional License/Occupation](#)

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/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 CHOOSE ONE FROM LIST ▾
Affiliate:

[Add another Affiliate](#)

INFORMATION DESCRIBING ACTION   Help ?

Jurisdiction Information

Jurisdiction:

⦿ Federal

○ State/Local

Venue:
(Court Name) FEDERAL COURT

City: FAIRFAX

State: VA Virginia ▾

Docket/Court File
Number: 123 ABC

Prosecuting Agency
or Civil Plaintiff: AGENCY

Prosecuting Agency
or Plaintiff Case
Number: 123 ABC

Investigating Agencies

Name	Case Number
INVESTIGATING AGENCY	123

[Add another Investigating Agency](#)

Statutory Offenses

Statute Title and Section (e.g., 18 USC. 287)	Statutory Offense (e.g., False Claim)	Count (e.g., 2)
18 USC 287	FALSE CLAIM	2

[Add another Statutory Offense](#)

Act or Omission Codes

Act or Omission Code: `200 Fraudulent Billing/Cost Reporting` ▼

[Add another Act or Omission Code](#)

Narrative Description of Act(s) or Omission(s)
Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

```
NARRATIVE DESCRIPTION
```

There are **3979** characters remaining for the description.

[Spell Check]

Sentence/Judgment Information

Date of Sentence or Judgment: `01012013`
(MMDDYYYY)

Is the Action on Appeal?

○ Yes
⦿ No
○ Unknown

Restitution Amount: $ [   ]
(Format NNNNN.NN)

Other Sentence/Judgment
Amount Ordered: $ [   ]
(Format NNNNN.NN)

Incarceration:	Years [ ]	Months [ ]	Days [ ]
Suspended Sentence:	Years [ ]	Months [ ]	Days [ ]
Home Detention:	Years [ ]	Months [ ]	Days [ ]
Probation:	Years [ ]	Months [ ]	Days [ ]
Community Service:	Hours `45`		

Other Court Orders:
(Describe) [   ]

[More Sentence/Judgment Information](#)

Entity Internal Report Reference

This optional field allows your entity to include an internal file number or other reference information to help you identify this report in your files. This information is not used by the Data Bank, but it will be provided on copies of the report sent to queriers.

Entity Internal Report
Reference:
(e.g., claim number)

Customer Use

This optional field may be used by the submitter to identify this transaction. This information is returned without modification and only appears on the response returned to your organization.

Customer Use:

Certification

I certify that I am authorized to submit this transaction and that all information is true and correct to the best of my knowledge.

Authorized Submitter's Name: DEVELOPER

Authorized Submitter's Title: DEVELOPER

Authorized Submitter's Phone: 7035551212   Ext.

Date: 02/01/2013

☐ Send e-mail notification when this and any future responses are available.

Submit to Data Bank   Validate Without Submitting   Store as a Draft

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REPORT INPUT FORM

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HEALTHCARE INTEGRITY & PROTECTION

DEFERRED CONVICTION or PRE-TRIAL DIVERSION

Organization 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.

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

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SUBJECT INFORMATION   Help   ?

We have pre-populated the practitioner information from the most recent report. Please review all pre-populated information for accuracy.

Organization Information

Organization Name

MEDICAL ORGANIZATION

Add another name used

Click   Help   ?   for information on filling out non-U.S. and military addresses.

Address

Street Address: 123 MAIN STREET

Address Line 2:

City: FAIRFAX

State: VA Virginia

ZIP Code: 22033   -

Country:
(if U.S., leave blank)

Type

Organization Type: [361 Chiropractic Group/Practice ▼]

Federal Employer Identification Numbers (FEIN)

[123456789]

Add another FEIN

Social Security Numbers (SSN)

[   ]

Add another SSN

Individual Taxpayer Identification Numbers (ITIN)

[   ]

Add another ITIN

Drug Enforcement Administration (DEA) Numbers

[   ]

Add another DEA Number

National Provider Identifiers (NPI)

[   ]

Add another NPI

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: [123ABC]   OR   ☐ No License

State of Licensure: [AL Alabama ▼]

Add another License

Principal Officers and Owners

Last Name	First Name	Middle Name	Suffix	Title

Add another Principal Officer or Owner

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/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: [CHOOSE ONE FROM LIST ▼]

Add another Affiliate

INFORMATION DESCRIBING ACTION   **Help ?**

Jurisdiction Information

Jurisdiction:
- ⦿ Federal
- ○ State/Local

Venue: (Court Name) [federal venue]

City: [fairfax]

State: [VA Virginia ▼]

Docket/Court File Number: [123 abc]

Prosecuting Agency or Civil Plaintiff: [prosecuting agency]

Prosecuting Agency or Plaintiff Case Number:

`case number 123`

Investigating Agencies

Name	Case Number
`investigating agency`	`123`

[Add another Investigating Agency](#)

Statutory Offenses

Statute Title and Section (e.g., 18 USC. 287)	Statutory Offense (e.g., False Claim)	Count (e.g., 2)
`18 usc 287`	`false claim`	`2`

[Add another Statutory Offense](#)

Act or Omission Codes

Act or Omission Code:

`205 Billing for Services not Rendered/Supplies not Provided` ▾

[Add another Act or Omission Code](#)

Narrative Description of Act(s) or Omission(s)
Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Narrative Description

There are **3979** characters remaining for the description.

Spell Check

Sentence/Judgment Information

Date of Sentence or Judgment: `01042013`
(MMDDYYYY)

Is the Action on Appeal?

○ Yes

● No

○ Unknown

Restitution Amount:
(Format NNNNN.NN)

$ [ ]

Other Sentence/Judgment
Amount Ordered:
(Format NNNNN.NN)

$ [ ]

Suspended Sentence: Years [ ]   Months [ ]   Days [ ]

Probation: Years [ ]   Months [ ]   Days [ ]

Community Service: Hours [44]

Other Court Orders:
(Describe)

[ ]

More Sentence/Judgment Information

Entity Internal Report Reference

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Entity Internal Report
Reference:
(e.g., claim number)

[ ]

Customer Use

This optional field may be used by the submitter to identify this transaction. This information is returned without modification and only appears on the response returned to your organization.

Customer Use: [ ]

Certification

I certify that I am authorized to submit this transaction and that all information is true and correct to the best of my knowledge.

Authorized Submitter's Name: [DEVELOPER]

Authorized Submitter's Title: [DEVELOPER]

Authorized Submitter's Phone: [7035551212]   Ext. [ ]

Date: 02/01/2013

☐ Send e-mail notification when this and any future responses are available.

☐ Check this box if you wish to add/update this subject in your subject database for use in future queries and/or reports. Duplicate entries in your subject database may result in duplicate queries. You will be notified of potential duplicate entries prior to completing this subject entry.

Help ?

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Return to Options

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HEALTHCARE INTEGRITY & PROTECTION

DEFERRED CONVICTION or PRE-TRIAL DIVERSION

Report Correction

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

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SUBJECT INFORMATION   [Help ?]

Organization Information

Organization Name

MEDICAL ORGANIZATION

Add another name used

Click [Help ?] for information on filling out non-U.S. and military addresses.

Address

Street Address: 123 MAIN STREET

Address Line 2:

City: FAIRFAX

State: VA Virginia

ZIP Code: 22033 -

Country:
(if U.S., leave blank)

Type

Organization Type: `361 Chiropractic Group/Practice ▼`

Federal Employer Identification Numbers (FEIN)

`123456789`

Add another FEIN

Social Security Numbers (SSN)

Add another SSN

Individual Taxpayer Identification Numbers (ITIN)

Add another ITIN

Drug Enforcement Administration (DEA) Numbers

Add another DEA Number

National Provider Identifiers (NPI)

Add another NPI

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: `123ABC` OR ☐ No License

State of Licensure: `AL Alabama ▼`

Add another License

Principal Officers and Owners

Last Name	First Name	Middle Name	Suffix	Title

[Add another Principal Officer or Owner](#)

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/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: CHOOSE ONE FROM LIST ▼

[Add another Affiliate](#)

INFORMATION DESCRIBING ACTION   **Help ?**

Jurisdiction Information

Jurisdiction:
- ⦿ Federal
- ○ State/Local

Venue: (Court Name) FEDERAL VENUE

City: FAIRFAX

State: VA Virginia ▼

Docket/Court File Number: 123 ABC

Prosecuting Agency or Civil Plaintiff: PROSECUTING AGENCY

Prosecuting Agency
or Plaintiff Case
Number:
CASE NUMBER 123

Investigating Agencies

Name
INVESTIGATING AGENCY

Case Number
123

[Add another Investigating Agency](#)

Statutory Offenses

Statute Title and Section
(e.g., 18 USC. 287)
18 USC 287

Statutory Offense
(e.g., False Claim)
FALSE CLAIM

Count
(e.g., 2)
2

[Add another Statutory Offense](#)

Act or Omission Codes

Act or Omission
Code:
205 Billing for Services not Rendered/Supplies not Provided ▾

[Add another Act or Omission Code](#)

Narrative Description of Act(s) or Omission(s)
Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

NARRATIVE DESCRIPTION

There are **3979** characters remaining for the description.

Spell Check

Sentence/Judgment Information

Date of Sentence or Judgment: 01042013
(MMDDYYYY)

Is the Action on Appeal?

○ Yes

Restitution Amount:
(Format NNNNN.NN)

$ [   ]

● No

○ Unknown

Other Sentence/Judgment
Amount Ordered:
(Format NNNNN.NN)

$ [   ]

Suspended Sentence: Years [   ]   Months [   ]   Days [   ]

Probation: Years [   ]   Months [   ]   Days [   ]

Community Service: Hours [44]

Other Court Orders:
(Describe)

[   ]

[More Sentence/Judgment Information](#)

Entity Internal Report Reference

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Entity Internal Report
Reference:
(e.g., claim number)

[   ]

Customer Use

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Customer Use: [   ]

Certification

I certify that I am authorized to submit this transaction and that all information is true and correct to the best of my knowledge.

Authorized Submitter's Name: [DEVELOPER   ]

Authorized Submitter's Title: [DEVELOPER   ]

Authorized Submitter's Phone: [7035551212   ]   Ext. [   ]

Date: 02/01/2013

☐ Send e-mail notification when this and any future responses are available.

[Submit to Data Bank]   [Validate Without Submitting]   [Store as a Draft]