

REPORT INPUT FORM

NOLO CONTENDERE (NO CONTEST) PLEA**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

Public Burden Statement: 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)
<input type="text" value="SMITH"/>	<input type="text" value="JOHN"/>	<input type="text"/>	<input type="text"/>

[Add another name used](#)**Gender**

Male Female Unknown

Birth Date (MMDDYYYY)**Is Subject Deceased?**

No Unknown Yes

Home Address/Address of Record

Street Address:

Address Line 2:

City:

State:

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:

Type:

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

Address

Street Address:

Address Line 2:

City:

State:

ZIP Code: -

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

Social Security Numbers (SSN)

[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: OR No License
- State of Licensure:
- Occupation/Field of Licensure:
- Specialty:

[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  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:

ZIP Code: -

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

Nature of Subject's Relationship to Affiliate:

[Add another Affiliate](#)

INFORMATION DESCRIBING ACTION

[Help ?](#)

Jurisdiction Information

Jurisdiction:

- Federal
- State/Local

Venue:
(Court Name)

City:

State:

Docket/Court File Number:

Prosecuting Agency or Civil Plaintiff:

Prosecuting Agency or Plaintiff Case Number:

Investigating Agencies

Name	Case Number
<input type="text" value="investigating agency"/>	<input type="text" value="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)
<input type="text" value="18 usc 287"/>	<input type="text" value="false claim"/>	<input type="text" value="2"/>

[Add another Statutory Offense](#)

Act or Omission Codes

Act or Omission

Code:

[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:
(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:

Authorized Submitter's Title:

Authorized Submitter's Phone: 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](#)

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REPORT INPUT FORM

NOLO CONTENDERE (NO CONTEST) PLEA**Report Correction**

To submit a **correction** to previously submitted report DCN 7930000076905966, 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.

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

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PRACTITIONER INFORMATION[Help ?](#)**Personal Information****Practitioner Name**

Last Name	First Name	Middle Name	Suffix (Jr, III)
<input type="text" value="SMITH"/>	<input type="text" value="JOHN"/>	<input type="text"/>	<input type="text"/>

[Add another name used](#)**Gender**

Male Female Unknown

Birth Date (MMDDYYYY)**Is Subject Deceased?**

No Unknown Yes

Home Address/Address of Record

Street Address:

Address Line 2:

City:

State:

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:

Type:

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

Address

Street Address:

Address Line 2:

City:

State:

ZIP Code: -

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

Social Security Numbers (SSN)

[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: OR No License


State of Licensure:

Occupation/Field of Licensure:

Specialty:

[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  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:

ZIP Code: -

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

Nature of Subject's Relationship to Affiliate:

[Add another Affiliate](#)

INFORMATION DESCRIBING ACTION



Jurisdiction Information

Jurisdiction:

- Federal
- State/Local

Venue:
(Court Name)

City:

State:

Docket/Court File Number:

Prosecuting Agency or Civil Plaintiff:

Prosecuting Agency or Plaintiff Case Number:

Investigating Agencies

Name	Case Number
<input type="text" value="INVESTIGATING AGENCY"/>	<input type="text" value="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)
<input type="text" value="18 USC 287"/>	<input type="text" value="FALSE CLAIM"/>	<input type="text" value="2"/>

[Add another Statutory Offense](#)

Act or Omission Codes

Act or Omission

Code:

[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:
(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

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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:

Authorized Submitter's Title:

Authorized Submitter's Phone:

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](#)

[Return to Options](#)

REPORT INPUT FORM

NOLO CONTENDERE (NO CONTEST) PLEA**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**[Add another name used](#)

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

Address

Street Address:

Address Line 2:

City:

State:

ZIP Code: -

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

Type

Organization Type:

Federal Employer Identification Numbers (FEIN)

[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: OR No License

State of Licensure:


[Add another License](#)

Principal Officers and Owners

Last Name	First Name	Middle Name	Suffix	Title
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

[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  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:

ZIP Code: -

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

Nature of Subject's Relationship to Affiliate:

[Add another Affiliate](#)

INFORMATION DESCRIBING ACTION



Jurisdiction Information

Jurisdiction:

- Federal
- State/Local

Venue: (Court Name)

City:

State:

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)
<input type="text"/>	<input type="text"/>	<input type="text"/>

[Add another Statutory Offense](#)

Act or Omission Codes

Act or Omission Code:

[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 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

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:

Authorized Submitter's Title:

Authorized Submitter's Phone: 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.



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REPORT INPUT FORM

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SUBJECT INFORMATION[Help ?](#)**Organization Information****Organization Name**[Add another name used](#)

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

Address

Street Address:

Address Line 2:

City:

State:

ZIP Code: -

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

Type

Organization Type:

Federal Employer Identification Numbers (FEIN)

[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: OR No License

State of Licensure:


[Add another License](#)

Principal Officers and Owners

Last Name	First Name	Middle Name	Suffix	Title
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

[Add another Principal Officer or Owner](#)

Health Care Entities With Which the Subject is Affiliated or Associated

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Name of Affiliated/Associated Health Care Entity:

Address

Street Address:

Address Line 2:

City:

State:

ZIP Code: -

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

Nature of Subject's Relationship to Affiliate:

[Add another Affiliate](#)

INFORMATION DESCRIBING ACTION



Jurisdiction Information

Jurisdiction:

- Federal
- State/Local

Venue:
(Court Name)

City:

State:

Docket/Court File Number:

Prosecuting Agency or Civil Plaintiff:

Prosecuting Agency
or Plaintiff Case
Number:

PROSECUTING CASE NUMBER

Investigating Agencies

Name

INVESTIGATING AGENCY

Case Number

123ABC

[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: 220 Unbundling of Services

Code:

[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: 01082012
(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

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:

Authorized Submitter's Title:

Authorized Submitter's Phone: Ext.

Date: 02/01/2013

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

[Return to Options](#)