

REPORT INPUT FORM

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

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 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[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)

[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](#)

Professional Schools Attended

The form will suggest schools as you type. Please choose the matching school or enter the complete school name.

School Name:

Year of
Graduation (YYYY)

[Add another Professional School](#)

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](#)

ADVERSE ACTION INFORMATION



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](#). 

- 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](#)

[Add Additional Basis for Action](#)

Adverse Action Information

Name of Agency or Program that Took the Adverse Action Specified in This Report:

Date Action Was Taken:
(MMDDYYYY)

Date Action Became Effective:
(MMDDYYYY)

Length of Action:

- Permanent
- Indefinite/Unspecified
- Specific Period

Is Reinstatement Automatic at Completion of Adverse Action Period?

- Yes
- Yes, with conditions (requires a Revision to Action Report when status changes)
- No

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

Description of Subject's Act(s) or Omission(s) or Other Reasons for Action(s) Taken and Description of Action(s) Taken by Reporting Entity

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report. The description must include sufficient specificity to enable a knowledgeable reviewer to determine clearly the circumstances of the action(s) or surrender. Refer to [Reporting](#), Submitting a Factually-Sufficient Narrative, for detailed information.

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

Spell Check

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: 12/12/2012

- 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

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.

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

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 numbers for this project are 0915-0239 (HIPDB), 0915-0126 (NPDB) and 0915-0331 (NPDB). Public reporting burden for this collection of information is estimated to average 15 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 ?](#)

Personal Information

Practitioner Name

Last Name

WHITE

First Name

JOE

Middle Name

Suffix (Jr, III)

[Add another name used](#)

Gender

Male Female Unknown

Birth Date (MMDDYYYY)

01011970

Is Subject Deceased?

No Unknown Yes

Home Address/Address of Record

Street Address:

1 MAIN ST

Address Line 2:

City:

FAIRFAX

State:

VA Virginia

ZIP Code:

22033

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)

****6789
[Add another SSN](#)

[Edit](#)

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](#)

Professional Schools Attended

The form will suggest schools as you type. Please choose the matching school or enter the complete school name.

School Name:

Year of
Graduation (YYYY)

[Add another Professional School](#)

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 [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:

ZIP Code: -

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

Nature of Subject's
Relationship to
Affiliate:

[Add another Affiliate](#)

ADVERSE ACTION INFORMATION

[Help ?](#)

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
- 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
- Failure to Comply With Corrective Action Plan
- Failure to Maintain Adequate or Accurate Records
- Failure to Maintain Records or Provide Medical, Financial or Other Required Information
- Failure to Meet or Comply With Contractual Obligations, Participation Requirements, or Credentialing Standards
- License Revocation, Suspension or Other Disciplinary Action Taken by a Federal, State or Local Licensing Authority
- Practicing Beyond the Scope of Practice
- Practicing With an Expired License
- Practicing Without a License
- Practicing Without a Valid License
- 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](#)

[Add Additional Basis for Action](#)

Adverse Action Information

Name of Agency or Program that Took the 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
 Specific Period

Is Reinstatement Automatic at Completion of Adverse Action Period?

- Yes
 Yes, with conditions (requires a Revision to Action Report when status changes)
 No

Total Amount of Monetary Penalty, Assessment and/or Restitution or fine: \$

Note: If no amount, leave this field blank.

Is the Action on Appeal?

- Yes
 No
 Unknown

Description of Subject's Act(s) or Omission(s) or Other Reasons for Action(s) Taken and Description of Action(s) Taken by Reporting Entity

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report. The description must include sufficient specificity to enable a knowledgeable reviewer to determine clearly the circumstances of the action(s) or surrender. Refer to [Reporting](#), Submitting a Factually-Sufficient Narrative, for detailed information.

TEST

There are **3996** characters remaining for the description.

Spell Check

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.

Submit to Data Bank

Validate Without Submitting

Store as a Draft

Return to Options

REPORT INPUT FORM

HEALTH PLAN ACTION

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
OMB # 0915-0126 expiration date 12/31/13
OMB # 0915-0331 expiration date 12/31/13

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 numbers for this project are 0915-0239 (HIPDB), 0915-0126 (NPDB) and 0915-0331 (NPDB). 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.

SUBJECT INFORMATION


Help



Organization Information

Organization Name

[Add another name used](#)

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)

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](#)

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](#)

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

[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:

ZIP Code: -

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

Nature of Subject's Relationship to Affiliate:

[Add another Affiliate](#)

ADVERSE ACTION INFORMATION

[Help ?](#)

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](#). 📄

- 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**
 - Improper Prescribing, Dispensing, Administering Medication/Drug Violation**
 - Other**

[Clear](#)

[Add Additional Basis for Action](#)

Adverse Action Information

Name of Agency or Program that Took the Adverse Action Specified in This Report:

Date Action Was Taken:
(MMDDYYYY)

Date Action Became Effective:
(MMDDYYYY)

Length of Action:

- Permanent
- Indefinite/Unspecified
- Specific Period

Is Reinstatement Automatic at Completion of Adverse Action Period?

- Yes
- Yes, with conditions (requires a Revision to Action Report when status changes)
- No

Total Amount of Monetary Penalty, Assessment and/or Restitution or fine: \$

Note: If no amount, leave this field blank.

Is the Action on Appeal?

- Yes
- No
- Unknown

Description of Subject's Act(s) or Omission(s) or Other Reasons for Action(s) Taken and Description of Action(s) Taken by Reporting Entity

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report. The description must include sufficient specificity to enable a knowledgeable reviewer to determine clearly the circumstances of the action(s) or surrender. Refer to [Reporting](#), Submitting a Factually-Sufficient Narrative, for detailed information.

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

Spell Check

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](#)

[Validate Without Submitting](#)

[Store as a Draft](#)

[Return to Options](#)

REPORT INPUT FORM

HEALTH PLAN ACTION

Report Correction

To submit a **correction** to previously submitted report DCN 7930000076906047, complete all necessary modifications in the form below, and press **Submit to Data Bank**.

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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

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 numbers for this project are 0915-0239 (HIPDB), 0915-0126 (NPDB) and 0915-0331 (NPDB). Public reporting burden for this collection of information is estimated to average 15 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.


SUBJECT INFORMATION

[Help](#)

Organization Information

Organization Name

[Add another name used](#)

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)

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](#)

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](#)

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

[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:

ZIP Code: -

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


Nature of Subject's
Relationship to
Affiliate:

[Add another Affiliate](#)

ADVERSE ACTION INFORMATION

[Help ?](#)

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
- Failure to Comply With Health and Safety Requirements
- Failure to Maintain Adequate or Accurate Records
- Failure to Maintain Equipment/Missing or Inadequate Equipment
- Failure to Maintain Records or Provide Medical, Financial or Other Required Information
- Failure to Perform Contractual Obligations
- Failure to Take Corrective Action
- Financial Insolvency
- Lack of Appropriately Qualified Professionals
- 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](#)

[Add Additional Basis for Action](#)

Adverse Action Information

Name of Agency or Program that Took the
Adverse Action Specified in This Report:

DDD

Date Action Was Taken:
(MMDDYYYY)

01012010

Date Action Became Effective:
(MMDDYYYY)

01012010

Length of Action:

- Permanent
 Indefinite/Unspecified
 Specific Period

Is Reinstatement Automatic at Completion of Adverse Action Period?

- Yes
 Yes, with conditions (requires a Revision to Action Report when status changes)
 No

Total Amount of Monetary Penalty,
Assessment and/or Restitution or fine: \$

\$

Note: If no amount, leave this field blank.

Is the Action on Appeal?

- Yes
 No
 Unknown

Description of Subject's Act(s) or Omission(s) or Other Reasons for Action(s) Taken
and Description of Action(s) Taken by Reporting Entity

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TEST

There are **3996** characters remaining for the description.

Spell Check

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

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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.

Submit to Data Bank

Validate Without Submitting

Store as a Draft

Return to Options