

REPORT INPUT FORM

CRIMINAL CONVICTION (GUILTY PLEA OR TRIAL): Initial Report

[Hide Public Burden Statement](#)

OMB # 0915-0126 expiration date 05/31/16

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 0915-0126. 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 10-29, Rockville, Maryland, 20857.

1. Subject Information

2. Action Information

3. Certification

PRACTITIONER INFORMATION

[Help ?](#)

Please provide as much information as possible to make your report easier for other registered organizations to find. Your report may help inform decisions about practitioners under consideration for actions such as employment, licensing or privileging.

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

MANN

First Name

ANITTA

Middle Name

Suffix (Jr, III)

[Add another name used](#)

Gender

 Male Female Unknown

Birth Date

01 / 01 / 1982

Is Subject Deceased?

 No Unknown Yes

REPORT INPUT FORM

Home Address/Address of Record

Street Address: 5600 FISHERS LN
Address Line 2:
City: ROCKVILLE
State: MD Maryland
ZIP Code: 20852 - 1750 ✓
Country:
(if U.S., leave blank)

Work Information

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

Organization

Name: LICENSING BOARD
Type: CHOOSE ONE FROM LIST

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

Address

Street Address: 123 CEDAR LANE
Address Line 2:
City: ROCKVILLE
State: MD Maryland
ZIP Code: 20857 - 0001 ✓
Country:
(if U.S., leave blank)

Social Security Numbers (SSN)

*****1111 [Edit](#)
[Add another SSN](#)

Individual Taxpayer Identification Numbers (ITIN)

[Add another ITIN](#)

REPORT INPUT FORM

Federal Employer Identification Numbers (FEIN)

[Add another FEIN](#)

National Provider Identifiers (NPI)

[Add another NPI](#)

Drug Enforcement Administration (DEA) Numbers

AM111111111

[Add another DEA Number](#)

Unique Physician Identification Numbers (UPIN)

[Add another UPIN](#)

Occupation And State Licensure Information

Add information for at least one state license.

License 1

Occupation/Field of Licensure

Podiatrist

Other Name for Occupation
(Optional)

State

MD Maryland

License Number

SL56

 Unlicensed / No license number for
this occupation[Add](#) occupation/field of licensure

REPORT INPUT FORM

[Add another UPIN](#)

Occupation And State Licensure Information

Add information for at least one state license.

License 1

Occupation/Field of Licensure

Podiatrist

Other Name for Occupation
(Optional)

State

MD Maryland

License Number

SL56

 Unlicensed / No license number for
this occupation

Select an Occupation or Field of Licensure

Enter a keyword or phrase to find matching occupations. (Example: "counselor")

Search

Recently Used

Podiatrist ✕

Physician

Physician (MD)

Physician Resident (MD)

Osteopathic Physician (DO)

Osteopathic Physician Resident (DO)

Nurse - Advanced, Registered, Vocational or Practical

Registered Nurse

Nurse Anesthetist

Nurse Midwife ✓

Nurse Practitioner

Licensed Practical or Vocational Nurse

Clinical Nurse Specialist

Other Nurse Occupation - Not Classified, Specify

[Don't see what you're looking for?](#)

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.

REPORT INPUT FORM

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)

How is the subject of this report related to the affiliated entity?

The subject is a

[Add another Affiliate](#)

- 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 ?](#)[Continue to Action Information →](#)[Store as a Draft →](#)[Return to Options](#)

REPORT INPUT FORM

CRIMINAL CONVICTION (GUILTY PLEA OR TRIAL): Initial Report

[Show Public Burden Statement](#)

1. Subject Information

2. Action Information

3. Certification

INFORMATION DESCRIBING ACTION

[Help ?](#)

Jurisdiction Information

Jurisdiction:

 Federal State/LocalVenue:
(Court Name)

Court of the Foot

City:

Any City

State:

MD Maryland

Docket/Court File
Number:

ABCDEFGH

Prosecuting Agency
or Civil Plaintiff:

AB

Prosecuting Agency
or Plaintiff Case
Number:

CD

Investigating Agencies

Name

Case Number

[Remove](#)[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)[Remove](#)[Add another Statutory Offense](#)

REPORT INPUT FORM



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.

Billed for foot care and didn't give foot care.

There are 3953 characters remaining for the description.

[Spell Check](#)

Content / Judgment Information

REPORT INPUT FORM



Act or Omission Codes

Act or Omission Code:

[Add another Act or Omission Code](#)

Select an Act or Omission Code

Enter a keyword or phrase to find matching act or omission codes. (Example: "failure")

Search

Billing/Cost Reporting

Billing For Medically Unnecessary Services
Billing For Services Not Rendered/supplies Not Provided
Duplicate Billing
Failure To Pay Non-assigned Claim
Fraudulent Billing/cost Reporting
Fraudulent Cost Reporting
Medicare/medicaid Secondary Payer Fraud
Misrepresentation Of Services/supplies Provided
Overcharging
Submitting Claims After Sanctions
Unbundling Of Services
Upcoding Of Services

Patient Care/Property

Failure To Provide Medically Necessary Care

[Don't see what you're looking for?](#)

NO

Unknown

Date of Appeal:

REPORT INPUT FORM

Sentence/Judgment Information

Date of Sentence or Judgment:

Is the Action on Appeal?

- Yes
 No
 Unknown

Date of Appeal: 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) 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](#)

REPORT INPUT FORM

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:

[Continue to Certification →](#)[Store as a Draft →](#)[Return to Options](#)

REPORT INPUT FORM



CRIMINAL CONVICTION (GUILTY PLEA OR TRIAL): Initial Report

[Show Public Burden Statement](#)

1. Subject Information

2. Action Information

3. Certification

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:

[Submit to Data Bank →](#)

[Store as a Draft →](#)

[Return to Options](#)

MANN, ANITTA

LICENSING BOARD

JUDGMENT OR CONVICTION REPORT

Date of Action: 11/25/2014

Initial Action

Basis for Initial Action

- CRIMINAL CONVICTION (GUILTY PLEA OR TRIAL)

- BILLING FOR MEDICALLY UNNECESSARY SERVICES

A. REPORTING ENTITY

Entity Name: LICENSING BOARD
Address: 123 CEDAR LANE
City, State, Zip: ROCKVILLE, MD 20857-0001
Country:
Name or Office: JANET DOE
Title or Department: BOARD OFFICIAL
Telephone: (555) 555-5555
Entity Internal Report Reference:
Type of Report: INITIAL

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name: MANN, ANITTA
Other Name(s) Used:
Gender: FEMALE
Date of Birth: 01/01/1982
Organization Name: LICENSING BOARD
Work Address: 123 CEDAR LANE
City, State, ZIP: ROCKVILLE, MD 20857-0001
Organization Type: CHIROPRACTIC GROUP/PRACTICE (361)
Home Address: 5600 FISHERS LN
City, State, ZIP: ROCKVILLE, MD 20852-1750
Deceased: NO
Federal Employer Identification Numbers (FEIN):
Social Security Numbers (SSN): ***-**-1111
Individual Taxpayer Identification Numbers (ITIN):
National Provider Identifiers (NPI):
Occupation/Field of Licensure (Code): PODIATRIST
State License Number, State of Licensure: SL56, MD
Drug Enforcement Administration (DEA) Numbers: AM111111111
Unique Physician Identification Numbers (UPIN):
Name(s) of Health Care Entity (Entities) With Which Subject Is Affiliated or Associated (Inclusion Does Not Imply Complicity in the Reported Action.):
Business Address of Affiliate:
City, State, ZIP:
Nature of Relationship(s):

C. INFORMATION REPORTED

Venue (Court): COURT OF THE FOOT
Jurisdiction: FEDERAL COURT
City, State of Court: ANY CITY, MD
Docket/Court File Number: ABCDEFG
Prosecuting Agency or Civil Plaintiff: AB

Case Number Used by Prosecuting Agency: CD
Type of Action: CRIMINAL CONVICTION (GUILTY PLEA OR TRIAL) (10)
Investigating Agency(Agencies):
Case Number(s) Used by Investigating Agency(Agencies):
Statutory Offense(s) and Count(s): , ()
Act or Omission Code(s): BILLING FOR MEDICALLY UNNECESSARY SERVICES (310)
Narrative Description of Act(s) or Omission(s): BILLED FOR FOOT CARE AND DIDN'T GIVE FOOT CARE.
Date of Judgment/Sentence: 11/25/2014

Judgment/Sentence

Restitution Amount: \$ 1.00
Other Sentence/Judgment Amount: \$ 1.00
Incarceration: Years: 1 Months: 1 Days: 1
Suspended Sentence: Years: Months: Days:
Home Detention: Years: Months: Days:
Probation: Years: Months: Days:
Community Service: Hours:
Other:

Judgment/Sentence

Restitution Amount: \$ 1.00
Other Sentence/Judgment Amount: \$ 1.00
Incarceration: Years: Months: Days:
Suspended Sentence: Years: Months: Days:
Home Detention: Years: 1 Months: 1 Days: 1
Probation: Years: Months: Days:
Community Service: Hours:
Other:

Subject identified in Section B has appealed the reported adverse action.
Date of Appeal: 11/25/2014

D. SUBJECT STATEMENT

If the subject identified in Section B of this report has submitted a statement, it appears in this section.

E. REPORT STATUS

Unless a box below is checked, the subject of this report identified in Section B has not contested this report.

- This report has been disputed by the subject identified in Section B.
- At the request of the subject identified in Section B, this report is being reviewed by the Secretary of the U.S. Department of Health and Human Services to determine its accuracy and/or whether it complies with reporting requirements. No decision has been reached.
- At the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services and a decision was reached. The subject has requested that the Secretary reconsider the original decision.
- At the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services. The Secretary's decision is shown below:

Date of Original Submission: 11/25/2014
Date of Most Recent Change: 11/25/2014

This report is maintained under the provisions of: Section 1921

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Section 1921 of the Social Security Act, and 45 CFR Part 60. All information is confidential and may be used only for the purpose for which it was disclosed. Disclosure or use of confidential information for other purposes is a violation of federal law. For additional information or clarification, contact the reporting entity identified in Section A.

END OF REPORT

REPORT INPUT FORM

CRIMINAL CONVICTION (GUILTY PLEA OR TRIAL): Initial Report

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OMB # 0915-0126 expiration date 05/31/16

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 0915-0126. 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 10-29, Rockville, Maryland, 20857.

1. Subject Information

2. Action Information

3. Certification

SUBJECT INFORMATION

Help ?

Organization Information

Organization Name

FOOTCAREINC.

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

Address

Street Address: 5600 Fishers Ln

Address Line 2:

City: Rockville

State: MD Maryland

ZIP Code: 20852 - 1750

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

Type

Organization Type: 381 Chiropractic Group/Practice

REPORT INPUT FORM

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

[Add another Principal Officer or Owner](#)

REPORT INPUT FORM

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)

How is the subject of this report related to the affiliated entity?

The subject is a

[Add another Affiliate](#)

- 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 ?](#)[Continue to Action Information →](#)[Store as a Draft →](#)[Return to Options](#)

REPORT INPUT FORM

CRIMINAL CONVICTION (GUILTY PLEA OR TRIAL): Initial Report

[Show Public Burden Statement](#)

1. Subject Information

2. Action Information

3. Certification

INFORMATION DESCRIBING ACTION

[Help ?](#)

Jurisdiction Information

Jurisdiction:

- Federal
 State/Local

Venue:
(Court Name) FOOTCARECOURT

City: Any City

State: MD Maryland ▼

Docket/Court File
Number: ABProsecuting Agency
or Civil Plaintiff: CDProsecuting Agency
or Plaintiff Case
Number: EF

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](#)

REPORT INPUT FORM

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.

Didn't provide quality foot care.

There are 3967 characters remaining for the description.

Spell Check

REPORT INPUT FORM



Act or Omission Codes

Act or Omission Code:

[Add another Act or Omission Code](#)

Select an Act or Omission Code

Enter a keyword or phrase to find matching act or omission codes. (Example: "failure")

Search

Billing/Cost Reporting

Billing For Medically Unnecessary Services
Billing For Services Not Rendered/supplies Not Provided
Duplicate Billing
Failure To Pay Non-assigned Claim
Fraudulent Billing/cost Reporting
Fraudulent Cost Reporting
Medicare/medicaid Secondary Payer Fraud
Misrepresentation Of Services/supplies Provided
Overcharging
Submitting Claims After Sanctions
Unbundling Of Services
Upcoding Of Services

Patient Care/Property

Failure To Provide Medically Necessary Care

[Don't see what you're looking for?](#)

Unknown

Restitution Amount: \$
(Format NNNNN.NN)

Other Sentence/Judgment

REPORT INPUT FORM

Sentence/Judgment Information

Date of Sentence or Judgment:

Is the Action on Appeal?

- Yes
 No
 Unknown

Date of Appeal: 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 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 quierers.

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: [Continue to Certification →](#)[Store as a Draft →](#)

REPORT INPUT FORM



CRIMINAL CONVICTION (GUILTY PLEA OR TRIAL): Initial Report

[Show Public Burden Statement](#)

1. Subject Information

2. Action Information

3. Certification

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:

[Submit to Data Bank →](#)

[Store as a Draft →](#)

[Return to Options](#)

FOOTCAREINC.

LICENSING BOARD

JUDGMENT OR CONVICTION REPORT

Date of Action: 11/25/2014

Initial Action

Basis for Initial Action

- CRIMINAL CONVICTION (GUILTY PLEA OR TRIAL)

- BILLING FOR MEDICALLY UNNECESSARY SERVICES

A. REPORTING ENTITY

Entity Name: LICENSING BOARD
Address: 123 CEDAR LANE
City, State, Zip: ROCKVILLE, MD 20857-0001
Country:
Name or Office: JANET DOE
Title or Department: BOARD OFFICIAL
Telephone: (555) 555-5555
Entity Internal Report Reference:
Type of Report: INITIAL

B. SUBJECT IDENTIFICATION INFORMATION (ORGANIZATION)

Organization Name: FOOTCAREINC.
Other Organization Name(s) Used:
Business Address: 5600 FISHERS LN
City, State, ZIP: ROCKVILLE, MD 20852-1750
Organization Type: CHIROPRACTIC GROUP/PRACTICE (361)
Names and Titles of Principal Officers and Owners (POO): MANN, ANITTA
Federal Employer Identification Numbers (FEIN): 111111111
Social Security Numbers (SSN):
Individual Taxpayer Identification Numbers (ITIN):
State License Number, State of Licensure: SL89, MD
Drug Enforcement Administration (DEA) Numbers:
National Provider Identifiers (NPI):
Medicare Provider/Supplier Numbers:
Name(s) of Health Care Entity (Entities) With Which Subject Is Affiliated or Associated (Inclusion Does Not Imply Complicity in the Reported Action.): FOOTCAREINC2
Business Address of Affiliate:
City, State, ZIP:
Nature of Relationship(s): SUBJECT IS SUBSIDIARY OF AFFILIATE OR ASSOCIATE (600)

C. INFORMATION REPORTED

Venue (Court): FOOTCARECOURT
Jurisdiction: FEDERAL COURT
City, State of Court: ANY CITY, MD
Docket/Court File Number: AB
Prosecuting Agency or Civil Plaintiff: CD
Case Number Used by Prosecuting Agency: EF
Type of Action: CRIMINAL CONVICTION (GUILTY PLEA OR TRIAL) (10)
Investigating Agency(Agencies):
Case Number(s) Used by Investigating Agency(Agencies):
Statutory Offense(s) and Count(s): , ()
Act or Omission Code(s): BILLING FOR MEDICALLY UNNECESSARY SERVICES (310)

Narrative Description of Act(s) or Omission(s): DIDN'T PROVIDE QUALITY FOOT CARE.

Date of Judgment/Sentence: 11/25/2014

Judgment/Sentence

Restitution Amount: \$ 1.00

Other Sentence/Judgment Amount: \$ 1.00

Suspended Sentence: Years: 1

Months: 1

Days: 1

Probation: Years:

Months:

Days:

Community Service: Hours:

Other:

Subject identified in Section B has appealed the reported adverse action.

Date of Appeal: 11/25/2014

D. SUBJECT STATEMENT

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Date of Most Recent Change: 11/25/2014

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END OF REPORT