REPORT INPUT FORM

the DataBank NATIONAL PRACTITIONER

HEALTH PLAN ACTION: 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.

Personal Information

Practitioner Name

Last Name	First Name	Middle Name	Suffix (Jr, III)
MANN	Annita		

Add another name used

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Gender

○ Male ◉ Female ○ Unknown

Birth Date

11 / 01 / 1982

Is Subject Deceased?

◉ No ○ Unknown ○ Yes

Home Address/Address of Record

Street Address:	5600 Fishers Lane
Address Line 2:	
City:	Rockville
State:	MD Maryland
ZIP Code:	20857 -
Country: (if U.S., leave blank)	

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Work Information

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

Organization

Name: FOOTCAREINC

Type: 361 Chiropractic Group/Practice

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 blank)

Social Security Numbers (SSN)

Add another SSN

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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

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Select an Occupation or Field of Licensure
Enter a keyword or phrase to find matching occupations. (Example: "counselor")

Search po

Podiatric Service Practitioner
- Podiatrist
- Podiatric Assistant
- Other Podiatric Service Occupation - Not Classified, Specify

Technologist/Technician
- Other Technologist/Technician - Not Classified, Specify

Other Occupation
- Corporate Officer

Don't see what you're looking for?

Name of

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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: CHOOSE ONE FROM LIST

License Number:

☐ Unlicensed / No license number for this occupation

Add occupation/field of licensure

Professional Schools Attended

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

School Name: University of the Foot

Year of Graduation (YYYY): 1996

Add another Professional School

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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: FOOTCAREINC

Address

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

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

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

The subject is a CHOOSE ONE FROM LIST

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 →

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HEALTH PLAN ACTION: Initial Report

Show Public Burden Statement

1. Subject Information | 2. Action Information | 3. Certification

ADVERSE ACTION INFORMATION

Help ?

Adverse Action Classification Codes

Select up to five adverse action classification codes from one of the action categories and click **Continue**.
Note: Any existing selections can be changed.

- [x] Contract Termination (1920)
- [ ] Suspension of Contract (1930)
- [ ] Contract Restriction (1931)
- [ ] Administrative Fine/Monetary Penalty (1932)
- [ ] Employment Termination (1941)
- [ ] Employment Suspension (1942)
- [ ] Denial of Initial Contract Application (1951)
- [ ] Denial of Contract Renewal (1952)
- [ ] Other Health Plan Action, Specify (1989)

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Choose a basis for action that best describes the reason for the action.

Select a Basis for Action

Enter a keyword or phrase to find matching bases. (Example: "failure")

Search C

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

Don't see what you're looking for?

Yes, with conditions (requires a Revision to Action Report when status changes)

No

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Choose a basis for action that best describes the reason for the action.

Basis for Action 1

Basis for Action

Clinical Privileges Restricted, Suspended or Revoked by Another Hospital or Health Care Facility

Add basis for action

Adverse Action Information

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

Date action was taken: 12 / 03 / 2014

Date action became effective: 12 / 03 / 2014

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) $ 1

Note: If no amount, leave this field blank.

Is the Action on Appeal?

- ◉ Yes
- ○ No
- ○ Unknown

Date of Appeal: 12 / 03 / 2014

REPORT INPUT FORM

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NATIONAL PRACTITIONER

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.

Provided bad foot care.

There are **3977** 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:

Continue to Certification → Store as a Draft →

REPORT INPUT FORM

the DataBank NATIONAL PRACTITIONER

HEALTH PLAN ACTION: 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:	DEVELOPER
Authorized Submitter's Title:	DEVELOPER
Authorized Submitter's Phone:	7035551212 Ext.
Date:	12/03/2014

Submit to Data Bank → | Store as a Draft →

Return to Options

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Chantilly, VA 20153-0832

http://www.npdb.hrsa.gov

MANN, ANNITA

WESTPORT HEALTHCARE

HEALTH PLAN ACTION

Date of Action: 12/03/2014

Initial Action	Basis for Initial Action
- CONTRACT TERMINATION	- CLINICAL PRIVILEGES RESTRICTED, SUSPENDED OR REVOKED BY ANOTHER HOSPITAL OR HEALTH CARE FACILITY

A. REPORTING ENTITY

Entity Name:	WESTPORT HEALTHCARE
Address:	12447 W CARVER ST
City, State, Zip:	DURHAM, NC 14052
Country:	
Name or Office:	DEVELOPER
Title or Department:	DEVELOPER
Telephone:	(703) 555-1212
Entity Internal Report Reference:	
Type of Report:	INITIAL

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name:	MANN, ANNITA
Other Name(s) Used:	
Gender:	FEMALE
Date of Birth:	11/01/1982
Organization Name:	FOOTCAREINC
Work Address:	
City, State, ZIP:	
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):	
Professional School(s) & Year(s) of Graduation:	UNIVERSITY OF THE FOOT (2002)
Occupation/Field of Licensure (Code):	PODIATRIST
State License Number, State of Licensure:	
Drug Enforcement Administration (DEA) Numbers:	
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.):	FOOTCAREINC
Business Address of Affiliate:	
City, State, ZIP:	
Nature of Relationship(s):	

C. INFORMATION REPORTED

Type of Adverse Action: HEALTH PLAN ACTION
Basis for Action: CLINICAL PRIVILEGES RESTRICTED, SUSPENDED OR REVOKED BY ANOTHER HOSPITAL OR HEALTH CARE FACILITY (A8)
Name of Agency or Program That Took the Adverse Action Specified in This Report: ABCD
Adverse Action Classification Code(s): CONTRACT TERMINATION (1920)
Date Action Was Taken: 12/03/2014
Date Action Became Effective: 12/03/2014
Length of Action: INDEFINITE
Total Amount of Monetary Penalty, Assessment and/or Restitution: $ 1.00
Is Subject Automatically Reinstated After Adverse Action Period Is Completed?: YES
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: PROVIDED BAD FOOT CARE.

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

Date of Appeal: 12/03/2014

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: 12/03/2014
Date of Most Recent Change: 12/03/2014

This report is maintained under the provisions of: Section 1128E

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Section 1128E 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

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HEALTH PLAN ACTION: 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

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)

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Type

Organization Type: 361 Chiropractic Group/Practice

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

REPORT INPUT FORM

the DataBank NATIONAL PRACTITIONER

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: SL89 OR ☐ No License

State of Licensure: CHOOSE ONE FROM LIST

Add another License

Principal Officers and Owners

Last Name	First Name	Middle Name	Suffix	Title
Mann	Annita			

Add another Principal Officer or Owner

REPORT INPUT FORM

the DataBank NATIONAL PRACTITIONER

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: FOOTCAREINC3

Address

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

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

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

The subject is a CHOOSE ONE FROM LIST

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

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HEALTH PLAN ACTION: Initial Report

Show Public Burden Statement

Select a Basis for Action
Enter a keyword or phrase to find matching bases. (Example: "failure")

Search

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

Don't see what you're looking for?

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HEALTH PLAN ACTION: Initial Report

Show Public Burden Statement

1. Subject Information | 2. Action Information | 3. Certification

ADVERSE ACTION INFORMATION

Help ?

Adverse Action Classification Codes

Select up to five adverse action classification codes from one of the action categories and click **Continue**.
Note: Any existing selections can be changed.

- [x] Contract Termination (3920)
- [ ] Suspension of Contract (3930)
- [ ] Administrative Fine/Monetary Penalty (3932)
- [ ] Denial of Initial Contract Application (3951)
- [ ] Denial of Contract Renewal (3952)
- [ ] Other Health Plan Action, Specify (3989)

Basis for Action

Choose a basis for action that best describes the reason for the action.

Basis for Action 1

Basis for Action
Debarment From Federal or State Program

Add basis for action

REPORT INPUT FORM

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Adverse Action Information

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

Date action was taken:

12 / 03 / 2014

Date action became effective:

12 / 03 / 2014

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)

$ 1

Note: If no amount, leave this field blank.

Is the Action on Appeal?

- (•) Yes
- ( ) No
- ( ) Unknown

Date of Appeal:

12 / 03 / 2014

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NATIONAL PRACTITIONER

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.

Provided bad foot care.

There are 3977 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:

Continue to Certification → Store as a Draft →

REPORT INPUT FORM

the DataBank NATIONAL PRACTITIONER

HEALTH PLAN ACTION: 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:	DEVELOPER
Authorized Submitter's Title:	DEVELOPER
Authorized Submitter's Phone:	7035551212 Ext.
Date:	12/03/2014

Submit to Data Bank → Store as a Draft →

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http://www.npdb.hrsa.gov

FOOTCAREINC

WESTPORT HEALTHCARE

HEALTH PLAN ACTION

Date of Action: 12/03/2014

Initial Action	Basis for Initial Action
- CONTRACT TERMINATION	- DEBARMENT FROM FEDERAL OR STATE PROGRAM

A. REPORTING ENTITY

Entity Name:	WESTPORT HEALTHCARE
Address:	12447 W CARVER ST
City, State, Zip:	DURHAM, NC 14052
Country:	
Name or Office:	DEVELOPER
Title or Department:	DEVELOPER
Telephone:	(703) 555-1212
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, ANNITA
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:	
Clinical Laboratory Act (CLIA) Numbers:	
Food and Drug Administration (FDA) 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.):	FOOTCAREINC3
Business Address of Affiliate:	
City, State, ZIP:	
Nature of Relationship(s):	

C. INFORMATION REPORTED

Type of Adverse Action:	HEALTH PLAN ACTION
Basis for Action:	DEBARMENT FROM FEDERAL OR STATE PROGRAM (82)
Name of Agency or Program That Took the Adverse Action Specified in This Report:	ABCD
Adverse Action Classification Code(s):	CONTRACT TERMINATION (3920)
Date Action Was Taken:	12/03/2014
Date Action Became Effective:	12/03/2014
Length of Action:	PERMANENT

Total Amount of Monetary Penalty, Assessment and/or Restitution: $ 1.00

Is Subject Automatically Reinstated After Adverse Action Period Is Completed?: YES

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: PROVIDED BAD FOOT CARE.

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

Date of Appeal: 12/03/2014

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: 12/03/2014

Date of Most Recent Change: 12/03/2014

This report is maintained under the provisions of: Section 1128E

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Section 1128E 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