

## REPORT INPUT FORM

## 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

MANN

First Name

Annita

Middle Name

Suffix (Jr, III)

[Add another name used](#)

## REPORT INPUT FORM



### 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)

## REPORT INPUT FORM

**Work Information**

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

**Organization**

Name:

Type:

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)

**Social Security Numbers (SSN)**

[Add another SSN](#)

## REPORT INPUT FORM



### 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](#)

## REPORT INPUT FORM



### Select an Occupation or Field of Licensure

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

Search

#### 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

## REPORT INPUT FORM

**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](#)

## 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 →](#)

## REPORT INPUT FORM

## HEALTH PLAN ACTION: Initial Report

[Show Public Burden Statement](#)

1. Subject Information

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## 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.

- 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)



**REPORT INPUT FORM**

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 **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

## REPORT INPUT FORM

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

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

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**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

## 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](#)

**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):

DCN: 5950000090960769  
Process Date: 12/03/2014  
Page: 2 of 3  
MANN, ANNITA  
For authorized use by:  
WESTPORT HEALTHCARE

**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.

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.

**DCN:** 5950000090960769  
**Process Date:** 12/03/2014  
**Page:** 3 of 3  
MANN, ANNITA  
For authorized use by:  
WESTPORT HEALTHCARE

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**END OF REPORT**

## REPORT INPUT FORM

## HEALTH PLAN ACTION: Initial Report

[Hide Public Burden Statement](#)

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

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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)



## REPORT INPUT FORM

## 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](#)

## REPORT INPUT FORM

## 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

## 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

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## REPORT INPUT FORM

## 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.

- 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

## Adverse Action Information

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

Date action was taken:

Date action became effective:

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

Date of Appeal:

## REPORT INPUT FORM

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



## 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

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**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.

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**