

HEALTH PLAN ACTION

Public Burden Statement ✕

OMB # 0915-0126 expiration date MM/DD/YY

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 this form, 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 14N-39, Rockville, Maryland, 20857.

Close

1. Subject Information

Please fill out

Personal Information

Last Name

Last Name

+ Additional name (

Gender

Male Female Unknown

HEALTH PLAN ACTION: Initial Report

Public burden statement

1. Subject Information

Please fill out as much information as possible to help entities find your report when they query.

Personal Information

Last Name **First Name** **Middle Name** **Suffix (Jr, III)**

+ Additional name (e.g. maiden name)

Gender
 Male Female Unknown

Birthdate

Is this person deceased?
 No Yes Unknown

Date of Death

Home Address/Address of Record

Country

Address Entering a military address?

Address Line 2

City **State**

ZIP

+ Additional address

Work Information

Use our information as the practitioner's work information.

Organization Name

Organization Type

Organization Description

Country

Address Entering a military address?

Address Line 2

City **State**

ZIP

Profession and Licensure

License 1

Profession or Field of Licensure
Specialty

Does the subject have a license for the selected profession or field of licensure?
 Yes No / Not sure

License Number
State

+ Additional license

Professional Schools Attended

Enter the schools or institutions the practitioner attended for their professional degree, training or certification (e.g. medical school, certification program). If the practitioner attended medical school, enter the medical school first, then add the school where they completed their residency and other degrees.

Name of School or Institution **Completion Year**

+ Additional school or institution

Identification Numbers

SSN or ITIN (Social Security Number or Individual Taxpayer Identification Number)

+ Additional SSN or ITIN

NPI (National Provider Identifier)
 To help queriers find your report, add the practitioner's NPI number if you know it.

+ Additional NPI

DEA (Drug Enforcement Agency) Number

+ Additional DEA

Does the subject have an FEIN or UPIN identification number?

FEIN (Federal Employer Identification Number)

+ Additional FEIN

UPIN (Unique Physician Identification Numbers)

+ Additional UPIN

Health Care Entity Affiliation

Is the practitioner affiliated with a health care entity?

Type of Affiliation

Entity Name

Country

Address Entering a military address?

Address Line 2

City **State**

ZIP

+ Additional affiliate

Add this subject to my subject database
 What is a subject database?

Save and finish later Continue to next step

2. Action Information

3. Certifier Information

Return to Options

Select an Occupation or Field of Licensure



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

Search

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

Don't see what you're looking for?

HEALTH PLAN ACTION: Initial Report

Public burden statement

1. Subject Information

Edit

2. Action Information

Select up to 5 actions

Find an Action

- Contract termination
- Denial of contract renewal
- Denial of initial contract application
- Employment suspension
- Employment termination
- Suspension of contract
- Other health plan action, (Specify)

Selected Action(s): 1

Clear All

- Other health plan action (Specify)

Basis for Action(s)

Description

+ Additional basis for action

Adverse Action Information

What is the name of the agency or program that took the action?

Date the action was taken

The date the decision for the action was issued, filed or signed.

Date the action went into effect

The starting date for the action. This may be the same as the date the action was taken or it may be different.

How long will it remain in effect?

- A specific period of time Permanently Unknown / Indefinite

Days

Is reinstatement automatic after this period of time?

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

Total monetary penalty, assessment, restitution or fine

Is the action on appeal?

- No Yes Unknown

Date of Appeal

Describe the subject's acts or omissions that caused the action to be taken

Do not include any personally identifying information, such as names, for anyone other than this practitioner.

Your narrative description helps querying organizations understand more about the action and why it was taken.

4000 characters remaining

Optional Reference Numbers

Entity Report Reference is an optional field that allows entities to add their own internal reference number to the report, such as a claim number. The reference number is available to all queriers.

Entity Report Reference

Customer Use is an optional field for you to create an identification for internal use. Your customer use number is only available to your organization.

Customer Use

Save and finish later

Continue to next step

3. Certifier Information

Return to Options

Select a Basis for Action



Enter a keyword or phrase to find a basis. (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

Default on Health Education Loan or Scholarship Obligations

Exclusion or Suspension from a federal or state health care program

Failure to maintain adequate or accurate records

Failure to maintain records or provide medical, financial or other required information

Failure to perform contractual obligations

Practicing beyond the scope of practice

Practicing with an expired license

Practicing without a license

Don't see what you're looking for?

HEALTH PLAN ACTION: Initial Report

Public burden statement

1. Subject Information

 Edit

2. Action Information

 Edit

3. Certifier Information

Review your entries to be sure they are correct before you Submit to the NPDB.

Subject Information

Name:	Test Practioner
Gender:	Male
DOB:	01-01-1960
Practitioner Deceased:	No
Home Address:	555 Cabin Rd Chantilly, VA 20111
Work Address:	<i>None/NA</i>
Profession/Field of Licensure:	Physician (MD)
Specialty:	General Surgery
License Info:	111111 (VA)
SSN/ITIN:	555555555
NPI:	<i>None/NA</i>
DEA:	<i>None/NA</i>
FEIN:	<i>None/NA</i>
UPIN:	<i>None/NA</i>
Health Care Entity Affiliation:	<i>None/NA</i>

Action Information

Adverse action(s) taken:	Contract termination
Basis of action(s):	Failure to maintain adequate financial records
Agency or program taking the action:	Test Agency
Date the action was taken:	05-20-2017
Date the action became effective:	05-20-2017
Length of time the action will be in effect:	Indefinite/unspecified
Total monetary penalty, assessment, restitution, or fine:	<i>None/NA</i>
Action is on appeal?:	No
Description:	Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aenean laoreet. Proin gravida dolor sit amet lacus accumsan et viverra justo sodales pulvinar tempor. Cum sociis natoque penatibus et magnis nascetur ridiculus mus. Nam fermentum, nulla luctus pharetra vulputate, orci, sed rhoncus sapien nunc eget.

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.

Your Name

TEST USER

Title

ADMIN

Phone

0005551111

Extension (optional)

Ext.

WARNING:

Any person who knowingly makes a false statement or misrepresentation to the National Practitioner Data Bank (NPDB) is subject to a fine and imprisonment under federal statute.

Save and finish later

Submit to the NPDB

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[Close](#)

1. Subject Information

Please fill out

Personal Information

Last Name

+ Additional name (f

Gender

Male Female Unknown

HEALTH PLAN ACTION: Initial Report

Public burden statement

1. Subject Information

Please fill out as much information as possible to help entities find your report when they query.

Organization Information

Organization Name

- Include a store number or other identifier for a location in the organization name (e.g. XYZ Pharmacy # 123)
- Add any previous names or other names used by the organization, such as a "doing business as" name (dba).

+ Additional name

Organization Type

Organization Description

Location Address

Enter the physical address for this location.

Country

Street Address Entering a military address?

Street Address Line 2

City

State

ZIP

Principal Officers and Owners

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

+ Additional principal officer or owner

Identification Numbers

NPI (National Provider Identifier)

To help queriers find your report, add the organization's NPI number if you know it.

+ Additional NPI

FEIN (Federal Employer Identification Number)

+ Additional FEIN

SSN or ITIN (Social Security Number or Individual Taxpayer Identification Number)

+ Additional SSN or ITIN

DEA (Drug Enforcement Agency) Number

+ Additional DEA

MPN/MSN (Medicare Provider/Supplier Number)

+ Additional MPN/MSN

 Does the subject have a FDA or CLIA identification number?

FDA (Federal Food and Drug Administration)

+ Additional FDA

CLIA (Clinical Laboratory Improvement Act)

+ Additional CLIA

Organization State Licensure Information

License 1	
Does the organization have a license?	
<input checked="" type="radio"/> Yes <input type="radio"/> No / Not sure	
License Number	State
<input type="text"/>	<input type="text"/>

+ Additional license

Health Care Entity Affiliation

 Is the organization affiliated with a health care entity?

Type of Affiliation

Description

Entity Name

Street Address Entering a military address?

Street Address Line 2

City

State

ZIP

+ Additional affiliate

 Add this subject to my subject database

[What is a subject database?](#)

Save and finish later

Continue to next step

2. Action Information

3. Certifier Information

Return to Options

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Edit

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Select up to 5 actions

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Basis for Action(s)

Description

+ Additional basis for action

Adverse Action Information

What is the name of the agency or program that took the action?

Date the action was taken

The date the decision for the action was issued, filed or signed.

Date the action went into effect

The starting date for the action. This may be the same as the date the action was taken or it may be different.

How long will it remain in effect?

- A specific period of time
 Permanently
 Unknown / Indefinite

Days

Is reinstatement automatic after this period of time?

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

Total monetary penalty, assessment, restitution or fine

Is the action on appeal?

- No
 Yes
 Unknown

Date of Appeal

Describe the subject's acts or omissions and reason the action was taken

Do not include any personally identifying information, such as names.

Your narrative description helps querying organizations understand more about the action and why it was taken.

4000 characters remaining

Optional Reference Numbers

Entity Report Reference is an optional field that allows entities to add their own internal reference number to the report, such as a claim number. The reference number is available to all queriers.

Entity Report Reference

Customer Use is an optional field for you to create an identification for internal use. Your customer use number is only available to your organization.

Customer Use

Save and finish later

Continue to next step

3. Certifier Information

Return to Options

Select a Basis for Action



Enter a keyword or phrase to find a basis. (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

Default on Health Education Loan or Scholarship Obligations

Exclusion or Suspension from a federal or state health care program

Failure to maintain adequate or accurate records

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 Edit

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 Edit

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Review your entries to be sure they are correct before you Submit to the NPDB.

Subject Information

Organization Name: **Test Entity #1234**
 Organization Type: **Clinic**
 Address: **555 Cabin Rd**
Chantilly, VA 20111
 Principal Officers and Owners: **John Jones**
 NPI: *None/NA*
 FEIN: **55-555555**
 SSN/ITIN: *None/NA*
 DEA: *None/NA*
 MPN/MSN: *None/NA*
 FDA: *None/NA*
 CLIA: *None/NA*
 License Info: **111111 (VA)**
 Health Care Entity Affiliation: *None/NA*

Action Information

Adverse action(s) taken: **Contract termination**
 Basis of action(s): **Failure to maintain adequate financial records**
 Agency or program taking the action: **Test Agency**
 Date the action was taken: **05-20-2017**
 Date the action became effective: **05-20-2017**
 Length of time the action will be in effect: **Indefinite/unspecified**
 Total monetary penalty, assessment, restitution, or fine: *None/NA*
 Action is on appeal?: **No**
 Description: Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aenean laoreet. Proin gravida dolor sit amet lacus accumsan et viverra justo sodales pulvinar tempor. Cum sociis natoque penatibus et magnis nascetur ridiculus mus. Nam fermentum, nulla luctus pharetra vulputate, orci, sed rhoncus sapien nunc eget.

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.

Your Name

TEST USER

Title

ADMIN

Phone

0005551111

Extension (optional)

Ext.

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Save and finish later

Submit to the NPDB

Return to Options

Non-visible Questions

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
Date of Death	Health Plan (1)	Below "Is this person deceased?"	Text Entry	The field is displayed if the user selects the "Yes" radio button for "Is this person deceased?"	
Organization Description	Health Plan (1)	Below Organization Type	Text Entry	The field is displayed if the user selects an organization type that requires a description.	
Name of Occupation	Health Plan (1)	Beside Profession or Field of Licensure	Text entry	The field is displayed if the user selects a profession or field of licensure that does not require information for a specialty.	"Specialty" is displayed in place of "Name of Occupation" if the selected profession or field of licensure requires specialty information.
Specialty	Health Plan (1)	Beside Profession or Field of Licensure	Drop List	The field is displayed if the user selects a profession or field of licensure that requires information for specialty.	"Name of Occupation" is displayed in place of "Specialty" if the selected profession or field of licensure does not require information for a specialty.

FEIN (Federal Employer Identification Number)	Health Plan (1)	Below checkbox "Does the subject have an FEIN, or UPIN identification number?"	Text Entry	The field is displayed in the individual report if the user selects the checkbox for "Does the subject have an FEIN, or UPIN identification number?"	Selecting the checkbox displays FEIN and UPIN text entry fields.
UPIN (Unique Physician Identification Numbers)	Health Plan (1)	Below FEIN text entry	Text Entry	The field is displayed in the individual report if the user selects the checkbox for "Does the subject have an FEIN, or UPIN identification number?"	Selecting the checkbox displays FEIN and UPIN text entry fields.
FDA (Federal Food and Drug Administration)	Health Plan (1)	Below checkbox "Does the subject have a FDA or CLIA identification number?"	Text Entry	The field is displayed in the organization report form if the user selects the checkbox for "Does the subject have a FDA or CLIA identification number?"	Selecting the checkbox displays FDA and CLIA, and text entry fields.
CLIA (Clinical Laboratory Improvement Act)	Health Plan (1)	Below text entry FDA (Federal Food and Drug Administration)	Text Entry	The field is displayed in the organization report form if the user selects the checkbox for "Does the subject have a FDA or CLIA identification number?"	Selecting the checkbox displays FDA and CLIA, and text entry fields.

Type of Affiliation	Health Plan (1)	Below "Is the practitioner affiliated with a health care entity?" checkbox	Drop List	The field is displayed if the user selects the "Is the practitioner affiliated with a health care entity?" checkbox.	Selecting the checkbox displays Type of Affiliation, Entity Name, Country, Address, Address Line 2, City, State, and ZIP entries.
Entity Name	Health Plan (1)	Below Type of Affiliation	Text Entry	The field is displayed if the user selects the "Is the practitioner affiliated with a health care entity?" checkbox.	Selecting the checkbox displays Type of Affiliation, Entity Name, Country, Address, Address Line 2, City, State, and ZIP entries.
Country	Health Plan (1)	Below "Is the practitioner affiliated with a health care entity?" checkbox	Drop List	The field is displayed if the user selects the "Is the practitioner affiliated with a health care entity?" checkbox.	Selecting the checkbox displays Type of Affiliation, Entity Name, Country, Address, Address Line 2, City, State, and ZIP entries. United States is the default selection.
Address	Health Plan (1)	Below Country	Text Entry	The field is displayed if the user selects the "Is the practitioner affiliated with a health care entity?" checkbox.	Selecting the checkbox displays Type of Affiliation, Entity Name, Country, Address, Address Line 2, City, State, and ZIP entries.
Address Line 2	Health Plan (1)	Below Address	Text Entry	The field is displayed if the user selects the "Is the practitioner affiliated with a health care entity?" checkbox.	Selecting the checkbox displays Type of Affiliation, Entity Name, Country, Address, Address Line 2, City, State, and ZIP entries.

City	Health Plan (1)	Below Address Line 2	Text Entry	The field is displayed if the user selects the "Is the practitioner affiliated with a health care entity?" checkbox.	Selecting the checkbox displays Type of Affiliation, Entity Name, Country, Address, Address Line 2, City, State, and ZIP entries.
State	Health Plan (1)	Below City	Drop List	The field is displayed if the user selects the "Is the practitioner affiliated with a health care entity?" checkbox.	Selecting the checkbox displays Type of Affiliation, Entity Name, Country, Address, Address Line 2, City, State, and ZIP entries.
ZIP	Health Plan (1)	Below State	Text Entry	The field is displayed if the user selects the "Is the practitioner affiliated with a health care entity?" checkbox.	Selecting the checkbox displays Type of Affiliation, Entity Name, Country, Address, Address Line 2, City, State, and ZIP entries.
Description	Health Plan (2)	Below an action requiring a description	Text Entry	The field is displayed if the user selects an action that requires a description.	
Description	Health Plan (2)	Below Basis of Action(s)	Text Entry	The field is displayed if the user selects a basis of action that requires a description.	
Period of time number	Health Plan (2)	Below "How long will it remain in effect?"	Text Entry	The field is displayed if the user selects "A specific period of time" option for "How long will it remain in effect?"	Selecting the radio button displays the number text entry and type of time period drop list.

Period of time type	Health Plan (2)	Below "How long will it remain in effect?"	Drop List	The field is displayed if the user selects "A specific period of time" option for "How long will it remain in effect?"	Selecting the radio button displays the number text entry and type of time period drop list.
Is reinstatement automatic after this period of time?	Health Plan (2)	Below "How long will it remain in effect?"	Radio Buttons	The fields are displayed if the user selects "A specific period of time" for "Is reinstatement automatic after this period of time?"	Available options are "No," "Yes" and "Yes with conditions (Requires a Revision to Action report when status changes)
Date of Appeal	Health Plan (2)	Below Is the action on appeal?	Text Entry	The field is displayed if the user selects Yes option for "Is the action on appeal?"	

State Changes

Label	PDF Name	Item Type	Trigger
Public Burden Statement	Government Administrative	Modal	When the user selects the Public Burden Statement link the modal is displayed.
Select a Profession or Field of Licensure	Government Administrative	Modal	When the user sets focus on the Profession or Field of Licensure text entry, the modal to select a profession is displayed and focus is set on the Search text entry. The user can enter text in the Search text box to find a specific profession or select a profession from the list without searching. The modal is hidden once the user selects a profession from the list. The user's selection populates the Profession or Field of Licensure text entry.
Name of Occupation	Government Administrative	Text Entry	Text entry is disabled if the user does not select a profession or field of licensure requiring a description.
License Number	Government Administrative	Text Entry	Text entry is disabled if the user selects the "No/ Not sure" option for "Does the subject have a license for the selected profession or field of licensure?"
Select a Basis for Action	Government Administrative	Modal	When the user sets focus on the Basis for Action(s) text entry, the modal to select an act is displayed and focus is set on the Search text entry. The user can enter text in the Search text box to find a specific basis or select a basis from the list without searching. The modal is hidden once the user selects a basis from the list. The user's selection populates the Basis for Action(s) text entry.