ALABAMA MEDICAID AGENCY
Program Integrity Division

PROVIDER SELF-AUDIT NOTIFICATION OF INTENT

SPR#: _____

Provider Name: _____

Billing NPI: _____ Medicaid Provider Number: _____

Contact Person for Your Office: _____

Phone Number: _____ Fax Number: _____

Email: _____

Type of self-disclosure method to be completed (select one):

____ **Option 1:** 100 percent claim review

____ **Option 2:** Provider-Developed Disclosure Work Plan for Medicaid Approval

____ **Option 3:** Medicaid Pre-Approved Disclosure Work Plan with Statistically Valid Random Sample

Estimated Completion Date: _____

Signature: _____ Date: _____

Title: _____

Complete and return in within 10 business days to:

Alabama Medicaid Agency
Attention: Self Audit Program, Suite 6042
501 Dexter Avenue
P. O. Box 5624
Montgomery, AL 36103-5624
Fax: 334-353-5778