

APPENDIX 12 – Form for Submitting Semiannual Reports of Debarment and Suspension Activity to OIG

Plan _____

Code _____

Period Covered by this Report _____

A. *On initial review of your provider/claims database, please indicate:*

- _____ 1. Number of OPM debarred/suspended providers identified.
- _____ 2. Number of enrollees notified of their association with an OPM debarred/suspended provider (no future claims will be paid or for HMO's provider cannot be utilized).

B. *After the effective date of OPM's debarment/suspension:*

- _____ 1. Number of notices sent to enrollees.
- _____ 2. Number of notices sent to debarred/suspended providers.
- _____ 3. Number of claims denied (does not apply to prepaid plans).

C. *Claims paid after the debarment/suspension date (describe circumstances of payment)*

- _____ 1. Number of enrollees receiving payment
- _____ 2. Number of providers receiving payment
- _____ 3. Number of claims paid
- _____ 4. Dollar amount of claims paid