

**Provider Self-Audit and Referral Form**

Name	
Organization\Company	
Address	
Telephone#	Email

**Details of Self-Audit and Referral**

Date of Audit or Identification
Summary of Audit or Referral

**Please include a spreadsheet of the claims to be adjusted with the following information for each claim:**

- Member Name
- Medical Assistance #
- Date of Service
- Service Code
- Claim Number
- Paid Amount
- Units to be Recovered
- County (Member)

**Complete and Send Referral Form and Spreadsheet to the following:**

**Attention:** Sandra Leisifer, Compliance Auditor

**Telephone Number:** (724) 744-6527 **Fax Number:** (724) 744-6303

**Email Address:** [Sandra.Leisifer@valueoptions.com](mailto:Sandra.Leisifer@valueoptions.com)