

## REPORT INPUT FORM



## DEFERRED CONVICTION or PRE-TRIAL DIVERSION: 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.

**We have pre-populated the practitioner information from the most recent report. Please review all pre-populated information for accuracy.**

## Personal Information

## Practitioner Name

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

[Add another name used](#)

## Gender

 Male  Female  Unknown

## Birth Date

## Is Subject Deceased?

 No  Unknown  Yes

## 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](#)

### Occupation And State Licensure Information

Add information for at least one state license.

#### License 1

Occupation/Field of Licensure

Other Name for Occupation  
(Optional)

State

License Number

Unlicensed / No license number for  
this occupation

[Add](#) occupation/field of licensure

## REPORT INPUT FORM



[Add another DEA Number](#)

### Unique Physician Identification Numbers (UPIN)

[Add another UPIN](#)

#### Select an Occupation or Field of Licensure

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

Search

##### Recently Used

Podiatrist ✕

##### 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
- Clinical Nurse Specialist
- Other Nurse Occupation - Not Classified, Specify
- Nurse Aide, Home Health Aide And Other Aide

[Don't see what you're looking for?](#)

## REPORT INPUT FORM



### Home Address/Address of Record

Street Address:   
Address Line 2:   
City:   
State:   
ZIP Code: -   
Country:   
(if U.S., leave blank)

### 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)

[Edit](#)  
[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](#)

### Occupation And State Licensure Information

Add information for at least one state license.

#### License 1

Occupation/Field of Licensure	Other Name for Occupation (Optional)
<input type="text" value="Podiatrist"/>	<input type="text"/>
State	License Number
<input type="text" value="MD Maryland"/>	<input type="text" value="SL56"/>
<input type="checkbox"/> Unlicensed / No license number for this occupation	

[Add](#) occupation/field of licensure

## REPORT INPUT FORM



### Occupation And State Licensure Information

Add information for at least one state license.

#### License 1

Occupation/Field of Licensure	Other Name for Occupation (Optional)
<input type="text" value="Podiatrist"/>	<input type="text"/>
State	License Number
<input type="text" value="MD Maryland"/>	<input type="text" value="SL56"/>
<input type="checkbox"/> 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:	Year of Graduation (YYYY)
<input type="text"/>	<input type="text"/>

[Add another Professional School](#)

## 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

License Number

#### Select an Occupation or Field of Licensure

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

Search

Recently Used

Podiatrist ✖

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

Clinical Nurse Specialist

Other Nurse Occupation - Not Classified, Specify

Nurse Aide, Home Health Aide And Other Aide

[Don't see what you're looking for?](#)

## 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

## INJUNCTION: Initial Report

[Show Public Burden Statement](#)

1. Subject Information

2. Action Information

3. Certification

## INFORMATION DESCRIBING ACTION

Help ?

## Jurisdiction Information

Jurisdiction:

- Federal  
 State/Local

Venue: (Court Name) City: State: Docket/Court File Number: Prosecuting Agency or Civil Plaintiff: Prosecuting Agency or Plaintiff Case Number: 

## Investigating Agencies

Name	Case Number
<input type="text"/>	<input type="text"/>

[Add another Investigating Agency](#)

## Statutory Offenses

Statute Title and Section (e.g., 18 USC. 287)	Statutory Offense (e.g., False Claim)	Count (e.g., 2)
<input type="text" value="18 USC. 287"/>	<input type="text" value="False Claim"/>	<input type="text" value="4"/>

[Add another Statutory Offense](#)

## REPORT INPUT FORM



### DEFERRED CONVICTION or PRE-TRIAL DIVERSION: Initial Report

[Show Public Burden Statement](#)

1. Subject Information	2. Action Information	3. Certification
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#### INFORMATION DESCRIBING ACTION

[Help ?](#)

##### Jurisdiction Information

Jurisdiction:

- Federal
- State/Local

Venue: (Court Name)

City:

State:

Docket/Court File Number:

Prosecuting Agency or Civil Plaintiff:

Prosecuting Agency or Plaintiff Case Number:

##### Investigating Agencies

Name	Case Number
<input type="text"/>	<input type="text"/>

[Add another Investigating Agency](#)

##### Statutory Offenses

Statute Title and Section (e.g., 18 USC. 287)	Statutory Offense (e.g., False Claim)	Count (e.g., 2)
<input type="text" value="18 USC 287"/>	<input type="text" value="False Claim"/>	<input type="text" value="2"/>

[Add another Statutory Offense](#)

## REPORT INPUT FORM



### Act or Omission Codes

Act or Omission Code:

[Add another Act or Omission Code](#)

Narrative Description of Act(s) or Omission(s)

**Note:** Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Doctor did not provide services to patient.

There are **3957** characters remaining for the description.

[Spell Check](#)

## REPORT INPUT FORM



or Civil Plaintiff:

Prosecuting Agency  
or Plaintiff Case  
Number:

### Investigating Agencies

✕

**Select an Act or Omission Code**  
Enter a keyword or phrase to find matching act or omission codes. (Example: "failure")

**Search**

Billing/Cost Reporting	
<input type="checkbox"/>	Billing For Medically Unnecessary Services
<input type="checkbox"/>	Billing For Services Not Rendered/supplies Not Provided
<input type="checkbox"/>	Duplicate Billing
<input type="checkbox"/>	Failure To Pay Non-assigned Claim
<input type="checkbox"/>	Fraudulent Billing/cost Reporting
<input type="checkbox"/>	Fraudulent Cost Reporting
<input type="checkbox"/>	Medicare/medicaid Secondary Payer Fraud
<input type="checkbox"/>	Misrepresentation Of Services/supplies Provided
<input type="checkbox"/>	Overcharging
<input type="checkbox"/>	Submitting Claims After Sanctions
<input type="checkbox"/>	Unbundling Of Services
<input type="checkbox"/>	Upcoding Of Services
Patient Care/Property	
<input type="checkbox"/>	Failure To Provide Medically Necessary Care
<input type="checkbox"/>	Patient Abuse

[Don't see what you're looking for?](#)

## REPORT INPUT FORM



### Sentence/Judgment Information

Date of Sentence or Judgment:

Is the Action on Appeal?

- Yes
- No
- Unknown

Date of Appeal:

Restitution Amount:   
(Format NNNNN.NN)

Other Sentence/Judgment Amount Ordered:   
(Format NNNNN.NN)

Incarceration:      Years       Months       Days

Suspended Sentence:      Years       Months       Days

Home Detention:      Years       Months       Days

Probation:      Years       Months       Days

Community Service:      Hours

Other Court Orders:   
(Describe)

[More Sentence/Judgment Information](#)

### 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



### INJUNCTION: 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:

Authorized Submitter's Title:

Authorized Submitter's Phone:  Ext.

Date:

[Submit to Data Bank →](#)

[Store as a Draft →](#)

**MANN, ANITTA**

**LICENSING BOARD**

**JUDGMENT OR CONVICTION REPORT**

**Date of Action: 02/14/2014**

**Initial Action**

**Basis for Initial Action**

- INJUNCTION

- FRAUDULENT BILLING/COST REPORTING

**A. REPORTING ENTITY**

Entity Name: LICENSING BOARD  
Address: 123 CEDAR LANE  
City, State, Zip: ROCKVILLE, MD 20857-0001  
Country:  
Name or Office: JANET DOE  
Title or Department: BOARD OFFICIAL  
Telephone: (555) 555-5555  
Entity Internal Report Reference:  
Type of Report: INITIAL

**B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)**

Subject Name: MANN, ANITTA  
Other Name(s) Used:  
Gender: FEMALE  
Date of Birth: 01/01/1982  
Organization Name: GENERAL HOSPITAL  
Work Address: 123 CEDAR LANE  
City, State, ZIP: ROCKVILLE, MD 20857-0001  
Organization Type: GENERAL/ACUTE CARE HOSPITAL (301)  
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):  
Occupation/Field of Licensure (Code): PODIATRIST  
State License Number, State of Licensure: SL56, MD  
Drug Enforcement Administration (DEA) Numbers: AM111111111  
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.):  
Business Address of Affiliate:  
City, State, ZIP:  
Nature of Relationship(s):

**C. INFORMATION REPORTED**

Venue (Court): COURT  
Jurisdiction: FEDERAL COURT  
City, State of Court: ROCKVILLE, MD  
Docket/Court File Number: ABC1234  
Prosecuting Agency or Civil Plaintiff: CIVIL WRIGHT

Case Number Used by Prosecuting Agency: DEF1234  
Type of Action: INJUNCTION (50)  
Investigating Agency(Agencies):  
Case Number(s) Used by Investigating Agency(Agencies):  
Statutory Offense(s) and Count(s): 18 USC. 287, FALSE CLAIM (4)  
Act or Omission Code(s): FRAUDULENT BILLING/COST REPORTING (200)  
Narrative Description of Act(s) or Omission(s): DOCTOR DID NOT PROVIDE SERVICES TO PATIENT.  
Date of Judgment/Sentence: 02/14/2014

**Judgment/Sentence**

Restitution Amount: \$ 20,000.00  
Other Sentence/Judgment Amount:  
Incarceration: Years: Months: Days:  
Suspended Sentence: Years: Months: Days:  
Home Detention: Years: Months: Days:  
Probation: Years: 1 Months: Days:  
Community Service: Hours:  
Other:

Subject identified in Section B has appealed the reported adverse action.  
Date of Appeal: 12/01/2014

**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: 12/04/2014  
Date of Most Recent Change: 12/04/2014

**This report is maintained under the provisions of:** Section 1921

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Section 1921 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:** 5950000090960773  
**Process Date:** 12/04/2014  
**Page:** 3 of 3  
MANN, ANITTA  
For authorized use by:  
LICENSING BOARD

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END OF REPORT

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## REPORT INPUT FORM



### DEFERRED CONVICTION or PRE-TRIAL DIVERSION: 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

#### SUBJECT INFORMATION

[Help ?](#)

**We have pre-populated the practitioner information from the most recent report. Please review all pre-populated information for accuracy.**

##### 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)

###### Type

Organization Type: 361 Chiropractic Group/Practice

## REPORT INPUT FORM



### 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](#)

### 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](#)

## REPORT INPUT FORM

## Principal Officers and Owners

Last Name	First Name	Middle Name	Suffix	Title
MANN	ANITTA			

[Add another Principal Officer or Owner](#)

## 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



### INJUNCTION: Initial Report

[Show Public Burden Statement](#)

1. Subject Information

2. Action Information

3. Certification

#### INFORMATION DESCRIBING ACTION

[Help ?](#)

##### Jurisdiction Information

Jurisdiction:

- Federal
- State/Local

Venue:   
(Court Name)

City:

State:

Docket/Court File Number:

Prosecuting Agency or Civil Plaintiff:

Prosecuting Agency or Plaintiff Case Number:

##### Investigating Agencies

Name	Case Number
<input type="text"/>	<input type="text"/>

[Add another Investigating Agency](#)

##### Statutory Offenses

Statute Title and Section (e.g., 18 USC. 287)	Statutory Offense (e.g., False Claim)	Count (e.g., 2)
<input type="text" value="18 USC. 287"/>	<input type="text" value="False Claim"/>	<input type="text" value="3"/>

[Add another Statutory Offense](#)

## REPORT INPUT FORM



### Act or Omission Codes

Act or Omission Code:

[Add another Act or Omission Code](#)

Narrative Description of Act(s) or Omission(s)

**Note:** Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

There are **3949** characters remaining for the description.

[Spell Check](#)

## REPORT INPUT FORM



### Act or Omission Codes

Act or Omission Code:

[Add another Act or Omission Code](#)

#### Select an Act or Omission Code

Enter a keyword or phrase to find matching act or omission codes. (Example: "failure")

Search

#### Billing/Cost Reporting

Billing For Medically Unnecessary Services
Billing For Services Not Rendered/supplies Not Provided
Duplicate Billing
Failure To Pay Non-assigned Claim
Fraudulent Billing/cost Reporting
Fraudulent Cost Reporting
Medicare/medicaid Secondary Payer Fraud
Misrepresentation Of Services/supplies Provided
Overcharging
Submitting Claims After Sanctions
Unbundling Of Services
Upcoding Of Services

#### Patient Care/Property

Failure To Provide Medically Necessary Care
Patient Abuse

[Don't see what you're looking for?](#)

## REPORT INPUT FORM



### Sentence/Judgment Information

Date of Sentence or Judgment:

Is the Action on Appeal?

- Yes
- No
- Unknown

Date of Appeal:

Restitution Amount:   
(Format NNNNN.NN)

Other Sentence/Judgment Amount Ordered:   
(Format NNNNN.NN)

Suspended Sentence:      Years       Months       Days

Probation:                      Years       Months       Days

Community Service:      Hours

Other Court Orders:   
(Describe)

[More Sentence/Judgment Information](#)

### 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



### INJUNCTION: 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:

Authorized Submitter's Title:

Authorized Submitter's Phone:  Ext.

Date:

[Submit to Data Bank →](#)

[Store as a Draft →](#)

[Return to Options](#)

**FOOTCAREINC.**

**LICENSING BOARD**

**JUDGMENT OR CONVICTION REPORT**

**Date of Action: 03/30/2014**

**Initial Action**

**Basis for Initial Action**

- INJUNCTION

- FRAUDULENT BILLING/COST REPORTING

**A. REPORTING ENTITY**

Entity Name: LICENSING BOARD  
Address: 123 CEDAR LANE  
City, State, Zip: ROCKVILLE, MD 20857-0001  
Country:  
Name or Office: JANET DOE  
Title or Department: BOARD OFFICIAL  
Telephone: (555) 555-5555  
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, ANITTA  
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:  
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.): FOOTCAREINC2  
Business Address of Affiliate:  
City, State, ZIP:  
Nature of Relationship(s): SUBJECT IS SUBSIDIARY OF AFFILIATE OR ASSOCIATE (600)

**C. INFORMATION REPORTED**

Venue (Court): FEDERAL COURT  
Jurisdiction: FEDERAL COURT  
City, State of Court: ROCKVILLE, MD  
Docket/Court File Number: XYZ123  
Prosecuting Agency or Civil Plaintiff: CIVIL WRIGHTS  
Case Number Used by Prosecuting Agency:  
Type of Action: INJUNCTION (50)  
Investigating Agency(Agencies):  
Case Number(s) Used by Investigating Agency(Agencies):  
Statutory Offense(s) and Count(s): 18 USC. 287, FALSE CLAIM (3)  
Act or Omission Code(s): FRAUDULENT BILLING/COST REPORTING (200)

Narrative Description of Act(s) or Omission(s): DOCTOR BILLED FOR SERVICES THAT HE DID NOT PROVIDE.  
Date of Judgment/Sentence: 03/30/2014

**Judgment/Sentence**

Restitution Amount: \$ 1,000.00  
Other Sentence/Judgment Amount:  
Suspended Sentence: Years: Months: Days:  
Probation: Years: 2 Months: Days:  
Community Service: Hours:  
Other:

Subject identified in Section B has appealed the reported adverse action.

Date of Appeal: 11/30/2014

**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: 12/04/2014

Date of Most Recent Change: 12/04/2014

**This report is maintained under the provisions of: Section 1921**

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Section 1921 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**