OKLAHOMA HEALTH CARE AUTHORITY
PROGRAM INTEGRITY AUDIT APPEAL FORM

In order to process your audit appeal request, all of the requested information must be supplied. Failure to provide all of the information may result in a denial/dismissal of your audit appeal. (O.A.C. 317:2-1-7)

Provider Information:

Company Name (if any):____________________________ Provider ID#: _____________

Individual Name (if any):____________________________ Federal Tax ID#____________

Mailing Address: ____
NUMBER STREET

____
CITY STATE ZIP CODE

Phone Number: (___) _________________________ E-mail: _____________________

Date of Audit Findings Letter: ________________________

Legal Representative Information (If any):

Name: ____ OK Bar No.: _________

Mailing Address: ____
NUMBER STREET

____
CITY STATE ZIP CODE

Phone Number: (___) ______________________ E-mail: _________________________

Provider or Legal Representative Signature: __________________________________

Pursuant to O.A.C. 317:2-1-7, please attach a statement that specifies what findings and/or claims are being appealed, as well as all factual and legal bases for the appeal.

Please return the completed form and attachments to:

Oklahoma Health Care Authority
Legal Docket Clerk
Legal Division
P.O. Drawer 18497
Oklahoma City, OK 73154-0497
(405) 530-3444 (Fax)
(405) 522-7217 (Phone)