INSTRUCTIONS FOR COMPLETING THE
OPPC SELF-REPORTING FORM

Please complete the OPPC Self-Reporting Form any time that an Other Provider-Preventable Condition occurs.

NOTE: A separate form must be completed for each procedure.

ACN - Enter the Attachment Control Number (ACN) if this is an attachment for an electronically submitted institutional claim.

Provider PROMISe Number - Enter the facility’s 9-digit provider number.

Service Location Number - Enter the facility’s 4-digit service location number.

Recipient Name - Enter the recipient’s full name.

Recipient ID - Enter the recipient’s 10-digit identification number.

Date of Birth - Enter the recipient’s date of birth (MMDDCCYY).

Admission Date - Enter the date of admission (MMDDCCYY).

Discharge Date - Enter the date of discharge (MMDDCCYY).

Was this an operation/invasive procedure - Enter an X for yes or no for line a), b), and c).

ICD-PCS Procedure Code, Description and Date - Enter the ICD-PCS procedure code, description and date.

NOTE: A separate form must be completed for each procedure.

Were any of the following involved - Enter an X for each provider type.

Name, Position, Title and License/Certification/NPI Number - Enter the name, position, title and License/Certification/ NPI Number as applicable for each provider type. If more space is needed, see Attachments described below.

Details - Enter the specifics pertaining to this procedure. If more space is needed, see Attachments described below.

Charges Related to the OPPC - Use this section to identify any charges that are being reported for non-payment.

Attachments - If more space is needed, attach an 8 ½” x 11” sheet of paper. Include all of the following at the top of each page: the ACN, Provider PROMISe Number, Service Location, Recipient Name, Recipient ID, Admission Date and Discharge Date.
OPPC Self-Reporting Form

ACN: _______________________________

Provider PROMIsSe Number: _______________________________ Service Location Number: _______________________________

Provider Name: __________________________________________________________________________________________________________________________

Recipient Name: __________________________________________ Recipient ID: _______________________________ DOB: _______________________________

Admission Date: _______________________________ Discharge Date: _______________________________

Was this:

a) the wrong operation/invasive procedure on correct patient (Y65.51)?  □ Yes □ No

b) operation/invasive procedure on patient not scheduled (Y65.52)?  □ Yes □ No

c) the correct operation/invasive procedure on wrong side/body part (Y65.53)?  □ Yes □ No

ICD-PCS Procedure Code: _________________________ Description: _____________________________________________ Date: ______________________

Were any of the following involved:

- [ ] Anesthesiologist
- [ ] Nurse (RN or LPN)
- [ ] Certified Registered Nurse Anesthetist (CRNA)
- [ ] Assistant surgeon
- [ ] OR Technician
- [ ] Physician Assistant (PA)
- [ ] Physician/surgeon
- [ ] Radiologist
- [ ] Certified Registered Nurse Practitioner (CRNP)
- [ ] Dentist
- [ ] Podiatrist
- [ ] Other (Specify) ____________________________

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<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Title</th>
<th>License/Cert./NPI Number</th>
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Details:
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Charges Related to the OPPC:

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<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Service Date(s)</th>
<th>Service Units</th>
<th>Charges</th>
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