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)