Fraud and Abuse Complaint Form

Please check one: (REQUIRED) Date:

- [ ] Medicaid Provider
- [ ] Person on Medicaid

Type of Complaint (Required to select one or more)

- [ ] Use of Another's Medicaid Card
- [ ] Quality of Care
- [ ] Provider Furnishing Services not Medically Necessary
- [ ] Prescription Abuse / Doctor Shopping
- [ ] Beneficiary Living Out of State
- [ ] Beneficiary has unreported Spouse
- [ ] Beneficiary Over Reported Number of Household Members
- [ ] Provider Billing for Services Not Rendered
- [ ] Kickback/ Bribery
- [ ] Forged Prescriptions
- [ ] Beneficiary Has Unreported Income / Assets
- [ ] Beneficiary Has Private Insurance
- [ ] Beneficiary is Not Disabled
- [ ] Other - (If Other, Please Check and Specify Below)

Person Providing Information
Information about the person who is providing the information

Name

Employer / Agency / Company

Address

Street Address

Address Line 2

City

Postal / Zip Code

Email

Relationship to Beneficiary / Provider

Home Telephone

####

Work Telephone

####

May We Contact You?

- ◯ YES
- ◯ NO

Beneficiary Name

First Last

Medicaid Number

Social Security Number

Date of Birth

Address

Street Address

Address Line 2

City

Postal / Zip Code

Telephone

Gender

Race

Other Agencies You Have Notified (Optional)

- [ ] City Police
- [ ] County Sheriff
- [ ] Department of Health
- [ ] Department of Human Services
- [ ] Other

Please provide detailed information about your fraud and/ or abuse concern below: (REQUIRED)