MEDICAID FRAUD COMPLAINT FORM

To report Abuse, Neglect, or Exploitation of an individual(s): Contact Adult Protective Services and/or your local law enforcement. Español

What is Medicaid Provider Fraud?

Providing your information will allow us to contact you with questions and for further information.

Today's Date:	

Frequently Asked Questions

YOUR INFORMATION					
Last Name:		First Name:			
Address:					
City:		State:		Zip Code:	
Phone:		Alternate Phone:			
Email:					

INDIVIDUAL OR ORGANIZATION/COMPANY ALLEGEDLY COMMITING FRAUD					
Individual Name:					
Organization or Company Name:					
Address:					
City:		State:		Zip Code:	
Phone:		Are you an employee of this individual or organization/company? ☐ Yes ☐ No			

DESCRIPTION OF ALLEGED MEDICAID FRAUD. PLEASE BE AS THOROUGH AS POSSIBLE INCLUDING DATES AND TIMES.

HOW DID YOU LEARN OF THIS FRAUD?

Has this been reported to another agency? ☐ NO ☐ YES

Agency Name:		Contact:		Phone:	
Agency Name:		Contact:		Phone:	

Supporting documentation or materials you would like included with this complaint.

UPLOAD FILES:

Select Files

Add Another File

Acceptable file types include PDF, JPEG, WAV and MP3.

Thank you for completing this form.

The filing of this Complaint does not ensure that an investigation will be initiated.

SUBMIT