



## COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

### Report Suspected Provider Fraud, Waste and/or Abuse

Please answer the questions below to the best of your ability.

**Part 1 – Your information. Please tell us how we can reach you in case we need more information.**

Today's Date:

Last Name:

First Name:

Telephone number:

Email Address:

**Part 2 – What do you want to report?**

Please describe the suspected fraud, waste and/or abuse you would like to report:

**When did the event occur?**

**Part 3 – Provider Information. Tell us about the provider(s) committing potential fraud, waste and/or abuse.**

Name of the Provider:

Provider ID, if known:

Business address of the Provider:

City:

Zip code:

Telephone Number:

Email address of the Provider, if known:

Name of Administrator/CEO/Owner, if known:

**Part 4 - The Client affected by the suspected fraud/waste and/or abuse.**

Name of the client involved, if known, enter First and Last Name:

Medicaid/Client ID number, if known:

Client street address:

Client telephone number:

Client email address, if known:

City:

Zip Code:

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**READ THE STATEMENT BELOW BEFORE SUBMITTING THE REPORT!**

**By pressing the “Submit Now” button, I acknowledge that the information I am submitting is accurate and complete to the best of my knowledge.**

**Press the “SUBMIT NOW” button, if you agree with the statement.**



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