



**Health Care Policy and Financing, Program Integrity Section  
Provider Overuse, Fraud and Abuse Referral Form**

<b>Today's Date:</b>	
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<b>Provider Information</b>	<i>Identify the provider(s) committing alleged overuse, fraud or abuse. (Attach Provider MMIS Screens.)</i>
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Provider ID:	Provider Phone #:
Provider Name:	
Provider Location Address:	
City, State, Zip:	
Provider Type:	

<b>Client Information</b>	<i>Identify the client involved in the alleged overuse, fraud or abuse incident. (Attach Client MMIS screens, if applicable.)</i>
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Client ID:	Client Date Of Birth:
Client Name:	
Client Address:	
City, State, Zip:	
Email Address:	

<b>Allegation</b>	<i>Clearly state the specific overuse, fraud or abuse allegations related to this referral. Include locations, times, dates, actions or pertinent statements. (Attach print out of claims including TCN numbers whenever possible.)</i>
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Describe alleged overuse, fraud or abuse incident:

Date Span(s) of alleged incident:
Medicaid rule allegedly violated. <i>(Provide citation of all rules violated) ( Attach a copy of the rule whenever possible.)</i>

<b>Witness(es) (If applicable)</b>	Phone #:
	Phone #:

<b>Complainant Information</b>	<i>Identify the person making the alleged overuse, fraud or abuse complaint.</i>
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Complainant Name:	Phone #:
Complainant Address:	
City, State, Zip:	
Email Address:	
Agency Name (if applicable):	
County:	
Other Contact Name and Phone # (if applicable):	

<b>Attachments? (please circle)</b>	<b>Yes</b>	<b>No</b>
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<b>Signature of person completing form:</b>	Date:
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