

Contractor Suspected Fraud Written Notice Form

Contractor Contact Information		
Contractor:	Contract Type:	
Primary Contact Name:	Primary Contact Title:	Primary Contact Telephone:
Primary Contact Email:		
Reporting Party information, if applicable		
Full Name:	Title:	Telephone:
Email:		
Agency:	Method of reporting (call, email, in person, etc.):	
Provider/Entity suspected (for provider suspected of committing fraud, one per referral)		
Business/Individual(s) Name:	Address:	City, State, Zip:
Telephone:	Provider NPI:	Provider Medicaid ID (if applicable):
Email:		
Does the offender have previous allegations, complaints, lawsuits or administrative action against them? (describe briefly):		
Description (describe the suspected fraud with as much detail as possible)		
Who (individual, multiple parties, business entity, etc.) do you believe may be committing fraud:		
What is the suspected fraudulent activity:		
Date range of suspected fraud and the basis for this range: From: To:		
The exposed dollar amount, if available:		
Which statute, rule, guidance, coding standard, etc. was violated (included description of any modifiers):		
What facts can be used towards proof of an allegation:		
The story of the suspected fraud, based on information and records available:		
When and how was the suspected fraud discovered:		
Has the provider had any previous training on issue(s) (describe or attach any documentation related to training):		
What actions have been taken or are planned by the Contractor:		
Is there any policy, guidance or informal communication that might be construed as making the conduct permissible (attach)?		
Other (provide any additional information you believe to be pertinent):		

Supporting Documentation

Along with the above information, include any *relevant* supporting documentation for an investigation, which may include:

- Encounter Data/Claims Data for date spans of suspected fraud (starting at first date of service for the period of time that the suspected fraud occurred, with 6 months of run-out after last date of service)
 - Ensure at least the following fields are included in the provided data:
 - ICN
 - Billing Provider NPI
 - Billing Provider ID
 - Rendering Provider Name
 - Rendering Provider ID
 - Client ID
 - Procedure Code
 - Modifiers
 - First Date of Service
 - End Date of Service
 - Units
 - Paid Amount
 - Paid Date
- Care plans for Medicaid clients involved (that were active during the suspected fraud)
- Agreement Between the Contractor and the Provider
- Relevant Medical Record(s)
- Relevant Prior Authorization(s)
- Any research or findings from your analysis that lead to this fraud referral
- Any other relevant documentation not listed here