Contractor Suspected Fraud Written Notice Form

Contractor Contact Information			
Contractor:		Contract Type:	
	1		
Primary Contact Name:	Primary Contact Ti	tle:	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 p	orovider suspec	ted of committing	g 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

- ModifiersFirst Date of Service
- End Date of Service
- Units
- Paid Amount
- Paid Date

- Procedure Code
- 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