

## MEDIC Complaint Form

The purpose of this form is to report complaints of potential fraud, waste and abuse in the Medicare Parts C & D Program. Health Integrity may contact you upon receipt of this complaint, so please be sure to furnish sufficient contact information. To ensure compliance with all applicable laws, please do not send Protected Health Information (PHI) via email.

**Please fax this form Attn: South MEDIC, Health Integrity, LLC 410-819-8698.**  
**You may also report your concern via phone by calling 877-7SAFERX**

### Complainant Contact Information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Organization: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Beneficiary Contact Information:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Medicare HICN#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Primary language, if other than English: \_\_\_\_\_ Best time to contact: AM PM

Medicare Plan Name: \_\_\_\_\_ Member ID Number: \_\_\_\_\_

### Description of Subject/Suspects of Fraud:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Business: \_\_\_\_\_ Email: \_\_\_\_\_

Address : \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Type of Business:  Plan  Pharmacy  Long-term Care  
 Beneficiary  Provider  Other \_\_\_\_\_

## Complaint Details:

Please provide a detailed description of the nature of the potential fraud and abuse issue including the following: Description of fraudulent activity; description of individuals and/or businesses involved in the alleged illegal activity; dates that the fraud occurred; names and contact information for victims, copies of documentation regarding the fraudulent activity including letters, advertising, etc.

States were occurring: \_\_\_\_\_ Total dollars at risk: \$ \_\_\_\_\_

Threat or danger of harm to beneficiaries: \_\_\_\_\_