

MEDIC Complaint Form

Instruction: The purpose of this form is to report complaints of 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: National BI MEDIC, Health Integrity 410-819-8698 or call 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:

Provide a detailed description of the nature of the 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: _____