

ZPIC/TX, OK, CO, & NM Complaint Form



Instructions: The purpose of this form is to report complaints of fraud and abuse in the Parts A, B, DME, Home Health, and Hospice Medicare Programs. Please furnish sufficient contact information should additional information be needed to process the complaint. See additional information - attached regarding "Referring Fraud, Waste, or Abuse Cases to the ZPIC."

Please fax this form attn: ZPIC, Health Integrity 410-819-8698.

Complainant Contact Information

Name _____ Phone _____ Fax _____

Organization _____ Email _____

Address _____ City _____ State _____ Zip _____

Date of Complaint Submission ____/____/____

Complainant Type: Beneficiary ___ Relative ___ Senior Medicare Patrol ___ Other/ Specify _____

Complaint Details

Provide a detailed description of the nature of the fraud and abuse issue including: 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. Attach extra sheet if necessary.

Date of Incidents: From ____/____/____ To ____/____/____

States where occurring: _____ Total dollars at risk: \$ _____

Threat or danger of harm to beneficiaries: _____

Description of Subject/Suspects of Fraud

Name _____ Phone _____ Fax _____

Business _____ Email _____

Address _____ City _____ State _____ Zip _____

Type of Business: Hospital DME Supplier Provider
 Beneficiary Long-term Care Home Health Agency

Other _____

Claim Information

Procedure Code _____ Type of Patient _____

Other _____