MEDICARE FYI

FRAUD AND ABUSE REFERRAL FORM Date:

☐ Blue Cross Blue Shield of MN Medicare Part A Anti-Fraud Unit PO Box 64357 St. Paul, MN 55164-0357 (651) 456-8000 Fax: (651) 456-1050	☐ United Healthcare Ins. Co. Medicare Part B Anti-Fraud Unit 8120 Penn Avenue South Bloomington, MN 55431 (612) 885-2921 Fax: (612) 885-2900	☐ AdminaStar Federal, Inc. DMEFC Region B Clearinghouse Unit PO Box 6128 Indianapolis, IN 46206 (800) 270-8313 Fax: (317) 841-4600	☐ United Government Services Beneficiary Services 1515 N Rivercenter Drive Milwaukee, WI 53212-3953 (414) 226-5000 Fax: (414) 226-5226	☐ Office of the Attorney General Medicaid Fraud Division 445 Minnesota Street St. Paul, MN 55101 (651) 296-7575 Fax: (651) 297-4139	☐ Other

From: (Name of Person Filling Out Form) Organization:

Address: City State Zip

Phone (inc. area code) Fax # Email:

Contact me at: between: a.m. and p.m.

Regarding: (Beneficiary Name) Medicare #:
Medicaid #:

Address: Phone (inc. area code)

City: State County Zip

Ethnicity: Gender:
This information is voluntary for internal reporting purposes only.

Contact me at: between: a.m. and p.m.

Complaint Against: (Name of facility, Provider, physician, lab, supplier, etc.)
Date(s) of Service:

Business Name Phone (inc. area code)

Address:

City State Zip

What prompted you to make a referral:
- ☐ Medicare FYI Fraud & Abuse Forum
- ☐ Health Insurance Counseling Program
- ☐ Outreach (radio, brochure, TV ad etc.)
- ☐ Own initiative
- ☐ Other

Describe your complaint. If known, include procedure code and/or description of service, amounts billed, amount you paid, etc. You may continue on the next page, if there is insufficient room on this page.
*If service(s) were allegedly not provided, please complete the non-rendered service questionnaire in the following area.

Description of Complaint (continued)

***Non-rendered Services Questionnaire:**

Did you see anyone else for service that day? _____ If yes, who? (Physician's Assistance, Nurse, Lab/X-ray)

Technician, etc. _____

_____

Was the service(s) done on another day? _____ If yes, on what day? _____

_____

Did you have any other services that day? _____ If yes, what type of service and where?

_____

_____

Did you already contact the provider/supplier regarding your complaint? _____ Yes _____ No
If yes, who did you speak to and what did he/she say?

Do you have a copy of the Medicare Benefit Notice and/or bill relating to this incident? _____ Yes _____ No
If yes, please send a copy with this report.

Please attached any information pertaining to this complaint. A completed authorization to release information is necessary to provide information to anyone other than the beneficiary or his/her Representative Payee.

For Agency Use Only: