HEALTH CARE FRAUD & ABUSE REFERRAL FORM

Date________________

Please attach all necessary documentation

Name of Beneficiary ____

Address____ **Zip**____________

Phone#(________**)**____________________________

Medicare #__________________________ **Medicaid#**__________________________

Provider ____

Provider Address ____

Phone #(____**)**________________________________

Date(s) of Service ____

Nature of Complaint____

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Attachments:

[ ] EOMB Explanation of Medical Benefits
[ ] Medicare Summary Notice
[ ] Bills or statements
[ ] Consent Form

Mail or Fax:

[ ] Medicare A
[ ] Medicare B
[ ] Medicaid Fraud Unit
[ ] Durable Medical Eqmt.

Name of Counselor____

Site Address____

Phone # (________**)**__________________________ **Fax#**____________________________

[ ] Copy to:

Protecting Quality Health Care-***New Hampshire Senior Advocacy Program***

2 Industrial Park Drive ♦ Concord, NH 03301 ♦ 228-0223/1-877-228-0223