COALITION OF WISCONSIN AGING GROUPS

CID#_____

FRAUD AND ABUSE REFERRAL FORM

DATE:

[] Medicaid (MA) Fraud Unit	[] Medicare Part A	[] Medicare Part B	[] DMERC Region B	[] Other:
Dept. of Justice	United Gov. Services	WPS	AdminaStar Federal	_____
P.O. Box 7857	1515 N. Rivercenter Dr.	P.O. Box 1787	P.O. Box 6128	_____
Madison, WI 53707-7857	Milwaukee, WI 53212	Madison, WI 53701	Indianapolis, IN 46206	_____

From: (Your Name)	Organization:	County:	
Address:	City:	State:	Zip:
Phone: (With Area Code)	Fax #	E-Mail (If Applicable)	

Beneficiary Name:	Medicare #:	Medicaid #:
Address:	Phone #: (With Area Code)	
City:	State:	Zip:
Beneficiary Can Be Contacted at:		Between _____ a.m. and _____ p.m.

Complaint Against: (Name of facility, provider, physician, lab, supplier, etc.)	Claim # (If appropriate)
	Date(s) of Service:
Business Address:	Phone: (With Area Code)
	Provider Number:
City: State:	Zip:

Please 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 you need more room. If you feel you were billed for services or supplies that were not provided, continue on with the non-rendered service section below.

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Description of Complaint (Continued)

Non-rendered Services Section:

Did you see any provider that day? _____ If yes, who? (Physician's Assistant, Nurse, Lab, X-ray Technician)

Was the service(s) provided on another day? _____ If yes, when? _____

Have you ever seen the provider listed?_____ If yes, when? _____

Have you contacted the provider/supplier regarding this billing? _____ Yes _____ No

If yes, to whom did you speak and what was the result of the conversation?

Release of Information: Please read carefully and sign where indicated

I, _____, hereby authorize _____ and

The Coalition of Wisconsin Aging Groups to discuss my complaint with _____ for the purpose of investigating possible fraud or abuse.

I understand that, except for action already taken, I may revoke this authorization at any time. I also understand that a photocopy of this authorization has the same effect as the original. I further understand that the parties named above will not disclose this information to anyone else without my consent. This authorization expires one (1) year from the date on which it is signed.

_____ _____

Signature **Date**

Important: Please attach the appropriate Medicare and/or Medicaid Explanation of Benefits relating to this incident. Also attach any other information you feel may be important to this complaint. When completed mail to: CWAG, 5900 Monona Drive Suite 400, Madison, WI 53716.