Investigations MEDIC Complaint Form

Instructions

The purpose of this form is to report complaints of fraud, waste, and abuse in the Medicare Parts C and D programs. A representative from Qlarant may contact you upon receipt of this complaint. Please furnish sufficient contact information. Instructions for submitting by fax, email, or US Postal Service are on page 4.

Note: Descriptions of findings/allegations must be provided as a separate attachment.

General Information

Date of Referral:

Area(s) of Concern *(Select all that apply)*:

Medicare Advantage (Part C)   Prescription Drug Benefit (Part D)   Both Parts C and D

Complainant Contact Information

Name:

Phone:

Fax:

Email:

Request for Information (RFI) POC Name:

RFI POC Email:

Submitted By *(Select one)*:

- Plan
- Pharmacy Benefit Manager (PBM)
- UPIC
- Other (On behalf of)
- Other *(If applicable)*:

Complainant Organization:

Address:

Plan Name *(If applicable)*:

Plan Contract Number *(If applicable)*:

Plan Tracking Number *(If applicable)*:

Parent Organization *(If applicable)*:

To ensure compliance with all applicable laws, do not send Protected Health Information (PHI) via email.

PBM Information *(If applicable)*

PBM Case or Tracking Number:

Was information contained in complaint submitted by your PBM?

Yes No

Is referral considered preliminary?

Yes *(If Yes, report outcome upon conclusion)*

No

(Plan sponsors) Did you conduct additional investigative steps beyond the information supplied by the PBM?

Yes *(If Yes, information developed independently from PBM should be clearly delineated)*

No

Are there additional details or information not provided here available to the I-MEDIC upon official RFI?

Yes No

Subject/Suspect of Fraud Information

(Include any additional information as an attachment.)

Provider Network Status:

In Network Out of Network

Name:

Tax ID (TIN):

NPI:

DEA Number:

Medicare Provider Number:

Business Name (DBA):

Phone:

Address:

Describe type of business or physician specialty:

Beneficiary Information

Name:

Phone:

HICN:

MBI:

Address:

Date of Birth:

Primary Language (If other than English):

Medicare Plan Name:

Plan Member ID Number:

Is the Beneficiary a Subject?

Yes No Unknown

Do you have any Contact Reports on the Beneficiary?

Yes No Unknown

To ensure compliance with all applicable laws, do not send Protected Health Information (PHI) via email.

Complaint Information

Prior MEDIC Case Number *(If applicable)*:

Period of Review:

Was matter forwarded to Law Enforcement?

Yes No

If Yes, who was sent the issue?

OIG FBI Local

Was HPMS FWA used?

Yes No

Potential Medicare Part C Program Exposure:

Paid $:

Potential Medicare Part D Program Exposure:

Paid $:

Were Medical Records received?

Yes No

If Yes, has a Medical Record Review been completed?

Yes No

Has Patient Harm in this matter been reported to another agency?

Yes No

If Yes, which agency received the report of Patient Harm?

Description of Findings/Allegations

Please attach a detailed description of the nature of the fraud issue including the following:

- Description of fraudulent activity;
- Current Procedural Terminology (CPT®) codes involved;
- States where the fraud activity took place;
- Description of individuals and/or businesses involved in the alleged illegal activity;
- Dates that the fraud occurred;
- Names and contact information for victims; and
- Copies of documentation regarding the fraudulent activity, including letters, advertising, etc.

Submission Information

Submit information by fax, email, or U.S. Postal Service.

Fax

410-819-8698

Email

I-MEDICComplaints@qlarant.com

US Postal Service

Qlarant, Inc.

Attention: I-MEDIC

28464 Marlboro Avenue

Easton, MD 21601-2732

Questions?

Call **877-7SAFERX (1-877-772-3379)** with any questions.