General Information

Date of Request: Focus: ☐ Civil ☐ Criminal

I-MEDIC referral? ◯ Yes ◯ No Law Enforcement Case #: Enter number

Requestor's Information

First and Last Name: Enter first and last name **Mobile:** Format as 555-555-5555

Date Required: Enter as MM/DD/YYYY **Fax:** Format as 555-555-5555

Organization: Choose one **Email (Required):** Enter email address

If Other Organization: Enter other **Physical Address:** Enter street, suite/No., City, State, ZIP

Phone (Required): Format as 555-555-5555

Request Details

Select all criteria in this section that apply to your request.

Meeting Type: Choose one

Request for Assistance with:

☐ **Pharmacist Review**

Choose one

☐ **Invoice Reconciliation** ***(ALL associated wholesaler invoices and [if applicable] Medicaid and/ or third-party pharmacy data must be submitted as attachments with request.)***

Choose one

Trial Preparation

☐ **Trial Preparation/Testimony**

Trial Date:

Trial Location (City and State): Enter city and state

☐ **Indictment**

Trial Date:

Prosecutor Name (First/Last): Enter first and last name

Prosecutor Email: Enter email address

Seeking Testimony

Subject has been indicted: ◯ **Yes** ◯ **No**

Witness(es) Type (Select all that apply):

- ☐ **Clinical – Invoice Review**
- ☐ **Clinical – Medical Records Review**
- ☐ **Clinical – Pharmacist Review**
- ☐ **Data**
- ☐ **Payment**
- ☐ **Policy***

***If Policy selected, list the Program:** Enter Program name

Investigative Findings Synopsis:

Enter information

Subject Information

Subject Name (Required) *(Submit multiple subjects as an attachment)*: Enter first and last name

Subject Type (Part C) *(Select all that apply)*:

- ☐ **Beneficiary**
- ☐ **DME Supplier**
- ☐ **Provider**
- ☐ **Other** Enter details

Subject Type (Part D) *(Select all that apply)*:

- ☐ **Beneficiary**
- ☐ **Drug**
- ☐ **Pharmacy**
- ☐ **Prescriber**
- ☐ **Other** Enter details

Subject Address: Enter Street, Suite/No., City, State, ZIP

Identification Numbers Related to Request *(Provide for all applicable)*

(Beneficiary) MBI or HICN: Enter ID number

Medicaid ID: Enter ID number

DEA: Enter ID number

Pharmacy (NCPDP): Enter ID number

Group NPI: Enter ID number

Tax ID: Enter ID number

Group Tax ID: Enter ID number

Other: Enter ID number

Individual NPI: Enter ID number

Reason for Request (Allegations) *(Submit additional information as an attachment)*:

Enter information

Date(s) of Service:* Format as MM/DD/YYYY

**Part D data available beginning 1/1/2006. Part C encounter data available beginning 1/1/2012.*

HIPAA Compliant Statement

Important: This form must be signed by the requestor prior to the request being accepted for fulfillment.

Office of Inspector General, Office of Investigations

The information sought in the request is required to be produced to the Office of Investigations pursuant to the Inspector General Act of 1978, 5 U.S.C. App. The information is also sought by the Office of Inspector General in its capacity as a health oversight agency, and this information is necessary to further health oversight activities. Disclosure is therefore permitted under the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information, 45 CFR 164.501; 164.512(a); and 164.512(d).

Department of Justice (DOJ/FBI/AUSA)

The information is sought by the Department of Justice in its capacity as a health oversight agency, and this information is necessary to further health oversight activities. Disclosure is therefore permitted under the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information, 45 CFR 164.501; 164.512(a); and 164.512(d).

Other Federal, State, or Local Governmental Agency

The information is sought by this organization under (b)(3) of the Privacy Act (5 U.S.C 552a, as amended. The requestor is a Federal agency or instrumentality of a governmental jurisdiction within or under the control of the United States (including any state or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste, or abuse, in a health benefits program funded in whole or in part by Federal funds. This organization is required to comply with the HIPAA Privacy Rule.

Other CMS/Medicare Contractor

The information is sought by this organization as a contractor of the Department of Health and Human Services for the purposes of conducting oversight and enforcement under Title XVIII of the Social Security Act. (Reference SSA 1560D-15(f)(2).) This organization is required to comply with the HIPAA Privacy Rule.

Requestor Signature

First/Last Name (Required):

Enter first and last name

Signature (Required):

Title (Required):

Enter professional title

Date:

Organization:

Enter organization name

Submission Instructions

All information can be submitted by fax, email, or U.S. Postal Service.

I-MEDIC RFI Secure Fax

(410) 819-8698

I-MEDIC RFI Email

Email must be encrypted.

MEDICRFITEAM@qlarant.com

I-MEDIC RFI Postal Address

Bette Wood, Operations Coordinator
c/o Qlarant, Inc. – I-MEDIC
28464 Marlboro Avenue
Easton, MD 21601-2732

Questions

For questions about this form, please contact:
Lora Elliott Newnam, Data Analytics Manager
c/o Qlarant, Inc. – I-MEDIC
Phone: (866) 886-2658, Ext. 11029
28464 Marlboro Avenue
Easton, MD 21601-2732

Data Analysis Request for Information

I-MEDIC

Fax Cover Sheet

To: Bette Wood, Operations Coordinator	
Fax: (410) 819-8698	**Phone: (866) 886-2658, Ext. 11193**
From: Enter first and last name	**Agency:** Enter agency name
Fax: Format as 555-555-5555	**Phone:** Format as 555-555-5555, Ext. 12
Notes:	
Enter information	

Once received an email will be sent within 3 business days confirming receipt.

Please ensure the HIPAA form is signed as we are unable to complete unsigned requests.

Questions regarding the data should be addressed to Lora Elliott Newnam at (410) 770-3025.

Questions regarding receipt of the request may be directed to Bette Wood at (410) 819-3555.