FRAUD COMPLAINT

NORTH DAKOTA OFFICE OF ATTORNEY GENERAL
MEDICAID FRAUD CONTROL UNIT
SFN 61788 (02-2020)

Medicaid Fraud Control Unit
PO Box 2495
Bismarck, ND 58502-2495
(701) 328-5446

The Medicaid Fraud Control Unit investigates and prosecutes health care providers who defraud the Medicaid program and the abuse, neglect, or financial exploitation of a patient in any facility that accepts Medicaid funds. The Medicaid Fraud Control unit cannot accept or review anonymous complaints.

UNLESS OTHERWISE INDICATED, ALL INFORMATION IS REQUIRED

YOUR INFORMATION

Name	Daytime Telephone Number		
Address	City	State	ZIP Code
Email Address (required if the report is submitted electronically)			

COMPLAINT TYPE

Provider Fraud:

- ☐ Billing for services not rendered
- ☐ Double billing
- ☐ Providing and billing for unnecessary services
- ☐ Falsely diagnosing so Medicaid will pay for more services
- ☐ Billing for equipment/prescribed medications not received by patient
- ☐ Physical abuse of patient/resident
- ☐ Verbal abuse of patient/resident
- ☐ Neglect of patient/resident
- ☐ Financial exploitation of patient/resident
- ☐ Other Explain

FRAUD/ABUSE COMMITED BY

Facility or Provider Name	Telephone Number (if known)		
Address (if known)	City (required)	State	ZIP Code

VICTIM INFORMATION

Victim Name (required)			
Address	City (required)	State	ZIP Code

Victim Age (if known)

- ☐ Under 18
- ☐ 18-34
- ☐ 35-54
- ☐ 55-74
- ☐ Over 74

Other Parties Involved ☐ Yes ☐ No	If yes, provide name and contact information

ALLEGED FRAUD/ABUSE

Describe the Alleged Fraud/Abuse (provide as much detail as possible, including dates, locations, events, background, persons involved)

OTHER AGENCIES NOTIFIED (provide name of agency you contacted and, if known, the date of contact)

City Police (which city)	County Sheriff (which county)	ND Department of Health	Professional Licensing Entity (specify)	
ND Department of Human Services	ND Adult Protective Services	Federal Agency (specify)	Other (specify)	☐ None

I understand the Attorney General's Office is not my attorney and cannot provide legal advice to me. I understand that by submitting this complaint to the Medicaid Fraud Control Unit, my complaint will become public record under state law and may be subject to disclosure. I certify the information provided herein is true and correct to the best of my knowledge.

Signature	Date