

PROVIDER FRAUD COMPLAINT FORM

1. Please complete all fields in the form below to the best of your ability.

2. Submit the form by:

- Fax: (208) 334-2026
- Mail: Medicaid Program Integrity Unit
PO Box 83720
Boise, ID 83720-0036

Your Name (optional):

Your contact information (daytime phone/address):

PROVIDER INFORMATION

NAME:

BUSINESS NAME:

BUSINESS ADDRESS:

TELEPHONE NUMBER:

TYPE OF BUSINESS (DENTIST, PHYSICIAN, CLINIC):

COMPLAINT (DESCRIBE IN DETAIL WHAT YOU SUSPECT IS WRONG):

MEDICAID PROGRAM INTEGRITY UNIT HOTLINE # (208) 334-5754