Medicaid/Healthcare Fraud Complaint Form

ANDREW BAILEY

ago.mo.gov 573-751-3321

If you believe you know of an individual or company that is abusing a MO HealthNet participant, please complaint and mail this form to: Missouri Attorney General's Office • P.O. Box 899 • Jefferson City, MO 65102

Consumer Information			
YOUR NAME First	Last		
ADDRESS Street	City	State Zip	County
E-MAIL			
PRIMARY PHONE NO.			
SECONDARY PHONE NO. () - [
Complaint Information			
Complaint Information			
MY COMPLAINT IS AGAINST A: (CHECK ONE) Ocompany	O Agency	Individual	
NAME OF COMPANY/AGENCY/INDIVIDUAL			
ADDRESS Street	City	State Zip	County
PHONE NO. ()	WEB SITE		
E-MAIL			
Describe in detail the information you have relating to any all and contact information of individual(s) involved, dates of all relates to MO HealthNet Provider fraud. Attach additional she	eged occurrence(s), and		

ANDREW BAILEY MISSOURI ATTORNEY GENERAL

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Complaint Information (Con't)							
If you have any materials or documents relating to your allegation(s), please attach to this complaint.							
If you do not have material(s) relating to your allegation(s), but know that such material(s) exist(s), describe it and where it may be found, including who many have possession or control over it and how that person or entity may be reached.							
Employer Information							
NAME OF COMPANY/AGENCY/INDIVIDUAL							
ADDRESS Street City State Zip County							
EMPLOYER'S PHONE NO. (
EMPLOYER'S E-MAIL							
ARE YOU EMPLOYED HERE NOW? (CHECK ONE) O Yes O No MAY WE CONTACT YOU AT WORK? O Yes O No							

Your Verification

BY FILING THIS COMPLAINT, I UNDERSTAND THAT:

The Medicaid Fraud Control Unit ("MFCU") has authority to investigate and prosecute allegations of fraud against Missouri's Medicaid program. Specifically, the MFCU investigates individuals and companies that provide health care services to MO HealthNet participants.

If you wish to participate in the whistleblower program described in Section 191.907, RSMo, you must complete and return a Whistleblower Application. You will not be entitled to any proceeds of a recovery by this office if you do not do so. To request this application, please select the box below and we will mail the application to the address you provided on page one of this form.

	I wish to receive a Whistleblower Application Form.
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I ATTEST TO THE ACCURACY OF STATEMENTS MADE IN THIS COMPLAINT:

YOUR SIGNATURE	DATE			/		/	2	0		
	MM / DD/ YYYY									