Please complete this form with **as much information** and in **as detailed a manner** as possible. Upon receipt, your complaint will be reviewed by a member of our staff. A representative from the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section, may contact you if additional information is needed.

COMPLAINANT INFORMATION (REPORTING PERSON)

Your Name:

Email:

Daytime Phone:

Address:

City and Zip:

County:

Your Profession/ Occupation:

Date Submitted:

TYPE OF FRAUD/COMPLAINT

☐ Medicaid Fraud (Page 2)

☐ Abuse/Neglect/Mistreatment of Care-Dependent Persons (Page 4)

Have you contacted any law enforcement agency, insurance agency, or governmental agency regarding this complaint?

◯ No

◯ Yes If so, who?

SECTION I (MEDICAID FRAUD):

What type of Provider, Professional, or Facility is involved: (check all applicable)

- ☐ Assisted Living Facility
- ☐ Developmental Disability Facility
- ☐ Nursing Facility
- ☐ Hospital
- ☐ Hospice
- ☐ Personal Care Home
- ☐ In-Patient Mental Health Facility

- ☐ Physician
- ☐ Chiropractor
- ☐ Dentist
- ☐ Pharmacist
- ☐ Psychologist

- ☐ Nurse
- ☐ Nurse Practitioner
- ☐ Nurse's Aide
- ☐ Home Health Agency
- ☐ Personal Care Attendant (PCA)/ Direct Care Worker (DCW)

- ☐ Out-Patient Mental Health Facility
- ☐ Behavioral Specialist Consultant (BSC)
- ☐ Mobile Therapist (MT)
- ☐ Therapeutic Staff Support (TSS)
- ☐ Certified Peer Specialist
- ☐ Therapist (physical, speech, occupational)

- ☐ Ambulance
- ☐ Durable Medical Equipment
- ☐ Lab
- ☐ Pain Management Clinic
- ☐ Pharmacy
- ☐ Transportation Company
- ☐ Alcohol/Drug Treatment Facility

- ☐ Other:

Name of Provider/Professional/Facility:

Address of Provider/Professional/Facility:

Location of alleged fraudulent or criminal activity
(if different than the provider, professional, or facility address):

Date and time of alleged fraudulent or criminal activity:

Name of individuals with their job titles, if known, who were involved in fraudulent or criminal activity:

Name	Title

Describe, in as much detail as possible, what a provider, professional, or facility did to commit Medicaid Fraud.

SECTION II (ABUSE/NEGLECT/MISTREATMENT OF CARE-DEPENDENT PERSONS):

◯ Neglect ◯ Systemic Neglect ◯ Physical Abuse ◯ Sexual Abuse

Where did the alleged abuse/neglect/mistreatment of a care-dependent person occur?

Name of the facility/other location:

Address of the facility/other location:

Identify the type of facility, if known (check all applicable):

☐ Assisted Living Facility ☐ Developmental Disability Facility
☐ Nursing Facility ☐ Hospital
☐ Hospice ☐ Personal Care Home
☐ In-Patient Mental Health Facility
☐ Other:

Did the abuse/neglect/mistreatment of a care-dependent person happen in a home or residence?

◯ No ◯ Yes Address:

If so, was the care-dependent person receiving attendant and/or personal care services at the time of the alleged abuse/neglect/mistreatment?

◯ No ◯ Yes

Name of patient/resident:

Patient's/Resident's date of birth (if known):

Patient's/Resident's address (if known):

Patient's/Resident's contact information (if known):

Your relationship to the patient/resident:

Date and time of incident:

Injury to patient/resident:

Medical treatment, if any, required (include the name of any hospital where treatment was rendered):

Name and job title of the person who allegedly abused, neglected or mistreated the patient/resident:

Name Title

Describe the incident in as much detail as possible:

Note: After pressing the “Email Form” button below your email provider will be prompted (gmail, yahoo, outlook, etc). This form and the information you have completed will be provided in this email as a PDF attachment. If you would like to attach any additional documents to support this form, attach those documents as you would normally when drafting an email. Acceptable file types are images and PDFs. Max file size is 4MB and max total upload size is 10MB. **If the Submit button does not work correctly with your Internet Browser, please save the form and email it to mfcsintake@attorneygeneral.gov.**

Email Form