Affiliated Computer Services
Surveillance and Utilization Review (SUR)
P.O. Box 240808
Anchorage, AK 99524-0808

Fraud Hotline: (800) 256-0930
Fax: (907) 644-8128
Email: SURS-AK@acs-inc.com

Suspected Fraud/Abuse Complaint Form

This is a confidential complaint/report of suspected abuse/fraud involving the Alaska Medical Assistance Program (State of Alaska Medicaid).

Name of the person or entity suspected of abuse and/or fraud:

____

This person or entity is a:

- ☐ Medicaid Recipient
- ☐ Medicaid Provider
- ☐ Other

Identifying Information: ____
ID number, date of birth, or other identifying information of suspected person or entity.

Reason for complaint/report:

Please continue on back of form if additional space is required

You may remain anonymous. However, we encourage you to provide your name and contact information in the event more information is needed to investigate this report. If you choose to do so, your identity will be kept confidential.

Your name: ____

Your telephone number (or other contact information): ________________________________

Date: __________________ Signature:____

INTERNAL USE ONLY

DATE AND METHOD OF RECEIPT:____

Case #/Entry Date:_____________________ Received by: ___________________________ Disposition: _____________________________

Reason for complaint/report (continued):