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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: _____

