Incident Report/ Case Referral

PLEASE PROVIDE AS COMPLETE INFORMATION AS POSSIBLE.

OFFICE OF ATTORNEY GENERAL
MEDICAID FRAUD CONTROL UNIT
Division Director - Assist Attorney General Paul Cremer
1302 E Hwy 14, Suite 4
Pierre, South Dakota 57501-8504
PHONE: 605-773-4102 FAX: 605-773-6279
EMAIL: ATGMedicaidFraudHelp@state.sd.us

1. Reporting Party:

Name: _____

Address: _____

City: _____ State & Zip: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

When & where would be the best time for an investigator to contact you?

2. Victim/Patient:

Name: _____

Address: _____

City: _____ State & Zip: _____

Home Phone: _____ Work Phone: _____

Date of Birth:_____ SSN: _____ Medicaid # _____

3. Facility/Provider:

Name: _____

Address: _____

City: _____ State & Zip: _____

Home Phone: _____ Work Phone: _____

Date of Birth:_____ SSN: _____ Medicaid # _____

4. Alleged Perpetrator:

Name: _____

Address: _____

City: _____ State & Zip: _____

Date of Birth:_____ SSN: _____

5. Other Parties Involved:

Name: _____

Address: _____

City: _____ State & Zip: _____

Home Phone: _____ Work Phone: _____

6. Allegation/Concern:

Summary of your Complaint: (Describe briefly your complaint. Give specific details in the order they occurred including dates. Please include us copies of any paperwork involved in your complaint. (Cancelled checks, statements, etc). Attach extra pages if necessary.