Washington State Department of Social & Health Services
Transforming lives

Medicaid Provider Fraud Referral

(Represents Loss to Medicaid program)

1. PROVIDER NAME If multiple entities are suspected, complete a referral for each one separately.	2. PROVIDERONE ID NUMBER

3. OTHER PROVIDERS

4. PROVIDER ADDRESS: THE INDIVIDUAL, AGENCY, OFFICE OR FACILITY SUSPECTED	PROVIDER PHONE NUMBER (IF KNOWN)

5. Is Electronic Visit Verification Data Available? ☐ Yes ☐ No ☐ N/A

6. PROVIDER TYPE

- ☐ CDE Individual In-Home Provider
- ☐ Agency In-Home Provider
- ☐ DDA Residential
- ☐ Adult Family Home (AFH)
- ☐ Enhanced Services Facility
- ☐ Assisted Living Facility
- ☐ Professional Contractor (counselor, trainer, etc.)
- ☐ Medical Professional (doctor, nurse, OT, PT, etc.)
- ☐ Hospital
- ☐ Nursing Home
- ☐ Other:

7. TYPE OF FRAUD SUSPECTED

Check all that apply.

- ☐ Billing for a service / item that was not provided
- ☐ Billing for service / item the client does not need
- ☐ Charging a rate higher than contracted for service / item
- ☐ Billing more than once for the same service / item
- ☐ Billing for service that is actually provided by unlicensed or unqualified personnel
- ☐ Billing for more service than was provided
- ☐ Making a client pay more than a Medicaid approved co-payment for service / item
- ☐ Resale of item(s) purchased with Medicaid funds
- ☐ Other:

8. SUMMARY OF ALLEGED ILLEGAL ACT

Describe the nature of suspected fraud, including the **dates / date range** each incident(s) occurred. Attach any available supporting documents (timesheets, bills, client statement, provider contract, etc.).

9. CLIENT NAME	ADSA ID (SIX DIGIT)	CLIENT ACES ID	CLIENT P1 ID

10. OTHER CLIENTS INVOLVED

Use this format: “Client name, ID number” i.e. “J Doe, ADSA ID 123456, ACES ID 9876543”

11. OTHER CONTACTS

12. ESTIMATED FINANCIAL IMPACT OR LOSS	13. PAYMENT SUSPENSION Has ProviderOne authorization been end dated? ☐ Yes ☐ No

14. OVERPAYMENT

Has an overpayment been initiated? ☐ Yes ☐ No

If yes, please attach a copy of the overpayment paperwork.

15. CONTRACT ACTION (FOR TRACKING PURPOSES ONLY)

Have concerns about the individual provider been communicated with CDE (CDE In-home providers only)?
☐ Yes ☐ No

Have concerns about the provider's contract been staffed with supervisor and/or contracts staff? ☐ Yes ☐ No ☐ N/A

Is a contract action being considered? ☐ Yes ☐ No ☐ Unknown ☐ N/A

If yes, what action is being considered:

Is a contract action being considered? ☐ Yes ☐ No ☐ Unknown ☐ N/A

If yes, date:

16. NOTIFICATION (PLANNED ACTION NOTICE OR IP NOTICE) (THIS DOES NOT INCLUDE CLIENTS WHO USE CDE INDIVIDUAL PROVIDERS)

Have notifications been sent to any parties involved in the suspected fraudulent activity? ☐ Yes ☐ No ☐ Unknown

If yes, list what notification was sent, date sent, and to whom:

17. OTHER INDIVIDUALS / AGENCIES INFORMED OF THIS SUSPECTED FRAUDULENT ACTIVITY

Check all that apply.

☐ My supervisor ☐ Residential Care Services
☐ Adult Protective Services ☐ Child Protective Services
☐ Law enforcement ☐ CDE
☐ Other:

REPORTER'S NAME	DATE FORM COMPLETED	REPORTER'S EMAIL ADDRESS	REPORTER'S PHONE NUMBER

REPORTER'S POSITION

☐ Case Manager / Social Worker ☐ Supervisor ☐ Manager / Administrator ☐ Support Staff ☐ APS
☐ CDWA ☐ Other:

AGENCY	REGION / AAA
Choose the agency you (the reporter) work for. ☐ AAA ☐ HCS ☐ DDA	Region where client is served. ☐ 1 ☐ 2 ☐ 3 ☐ AAA - PSA number: _____ ☐ HQ

Instructions for Completing Provider Fraud Referral

The Medicaid Provider Fraud Referral form is completed to report suspected Medicaid provider fraud. All instances of suspected fraud must be reported regardless of the alleged dollar amount involved. This form is completed by field staff and submitted to ALTSA and DDA headquarters at the email address listed below. Program headquarters staff will forward the reported information to the Medicaid Fraud and Control Unit (MFCU), and/or the DSHS Office of Fraud and Accountability (OFA), as appropriate, and will coordinate referrals with the Office of Program Integrity at Health Care Authority (HCA). All fields must be completed. If any fields are not applicable, indicate this with "N/A".

IMPORTANT: Suspected fraudulent activities must be staffed with your supervisor before submitting this form. Timelines for reporting suspected Medicaid provider fraud are different from mandatory reporting timelines for CPS / APS / RCS / law enforcement (which must be reported immediately.)

1. **Provider Name:** Enter the name of the individual, agency, or facility suspected of fraud. If multiple entities are suspected, complete a separate referral for each one.
2. **Provider's ProviderOne ID number:** Enter the provider's ProviderOne ID number if the allegation involves ProviderOne payments.
3. **Other Providers:** If there may be other providers involved, please list their names here AND complete a separate referral for each one.
4. **Provider Address:** Enter the address and phone number of the individual, agency or facility suspected of fraud.
5. **Electronic Visit Verification Data Available:** Check the box indicating availability (Yes, No, Not Applicable).
6. **Provider Type:** Check the box for the type of provider. If "other," indicate the provider type.
7. **Type of Fraud Suspected:** Check all boxes that apply to the type of fraud suspected. If "other," indicate in the type of fraud suspected.
8. **Summary of Alleged Illegal Act:** Describe the nature of the suspected fraud, including the dates / date range incidents occurred. Attach all available supporting documents (timesheets, bills, client statement, provider contract, etc.). Include the specific rules, regulations and/or policies violated wherever possible, any instruction provider received regarding incident/activities being reported, and a description of supporting documentation attached. If no documentation is attached, indicate reason. Avoid using program-specific abbreviations and use plain talk wherever possible.
9. **Client Name and ID Numbers:** Enter the client name, ADSA ID Number and the ACES ID, if available.
10. **Other Clients:** If this allegation involves more than one client, please list here using the following format:

    Client Name, ADSA ID 123456, ACES ID 9876543
11. **Other Contacts:** Provide names and contact information of others who may have information about this allegation. Also state the role or position of these other contacts in relation to the client or provider.
12. **Estimated Financial Impact or Loss:** Enter the approximate dollar amount involved in the fraudulent activity (if known).
13. **Payment Suspension:** Check the appropriate box to indicate if the payment authorization has been end dated.
14. **Overpayment:** Check the appropriate box for whether or not an overpayment has been initiated. If yes, attach a copy of the overpayment paperwork.
15. **Contract Action:** **This question is for tracking purposes only** A report of fraud does not always result in termination of the provider contract. Check the appropriate boxes to indicate if discussions have occurred regarding taking action on the provider's contract, with supervisor and/or contracts staff, and what action (if any) is being considered. If a contract action is being considered, please provide additional information in the text field. Check whether or not HCA has been notified; this only applies if provider has a Core Provider Agreement with HCA. If HCA has been notified list the date of notification.
16. **Notification:** Check the box to indicate if a Planned Action Notice was sent. If notice has been sent to the provider and/or client, please list who has been sent a notice and the date of mailing.
17. **Other individuals / agencies informed of this suspected fraudulent activity:** Check all boxes that apply. Suspected provider fraud MUST be staffed with your supervisor prior to submitting this form.

Email completed form to:

For ALTSA Home AND Community Services (HCS) Division Referrals, send referrals to this email address:

ProviderFraudHCS@dshs.wa.gov

For Development Disabilities Administration (DDA) Referrals, send referrals to this email address:

ProviderFraudDDA@dshs.wa.gov