SURVEILLANCE AND UTILIZATION REVIEW SECTION (SURS) REFERRAL

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 20 (Rev. 8-2016)

This form is to be used by a provider, individual, or State/County staff to report suspected fraud, waste, or abuse of the North Dakota Medicaid & Healthy Steps Programs. Please provide as much detail as possible; there are no mandatory fields for submission. Additional comments or supporting documents can be attached if necessary.

I. CONTACT INFORMATION OF PERSON COMPLETING THE FORM

Name:	Title/Position:		Relationship to Provider/Recipient:	
Address:	City:	State:	ZIP Code:	Telephone Number:

II. NAME OF PROVIDER SUSPECTED OF FRAUD, WASTE, OR ABUSE

Provider Name:	Provider Type:			Provider ID:
Address:	City:	State:	ZIP Code:	Telephone Number:

III. NAME OF CLIENT SUSPECTED OF FRAUD, WASTE, OR ABUSE (If a family, please list parent or primary caregiver)

Client Name:			Client Date of Birth or Medicaid ID:	
Address:	City:	State:	ZIP Code:	Telephone Number:

IV. SUSPECTED FRAUD/ABUSE BEING REPORTED

Dates of Suspected Fraud or Abuse:		Total Potential Amount of Overpayment/Error:		Date Reported:
Medicaid Amount Owed	SNAP Amount Owed	TANF Amount Owed	SPED Amount Owed	Child Care Assistance Owed

Tell Us What Happened: Please attach additional documentation to include signed applications or reviews acknowledging reporting requirements as well as any notices sent to the recipient regarding reporting requirements.

Is any of the overpayment amount listed above due to agency/worker error? ☐ Yes ☐ No

Coverage Type? ☐ Traditional ☐ Expansion ☐ Both

Recoupment Type? ☐ Claims ☐ Recipient Liability ☐ Clawback ☐ Premiums

Do you believe information was being hidden on purpose in order to receive benefits? ☐ Yes ☐ No Why? or Why not?

Did the client falsify income information on any application during the timeframe listed above? ☐ Yes ☐ No **(attach application)**

Have you ever spoken to this client prior to this discovered issue? ☐ Yes ☐ No

Have you spoken to this client regarding this current issue? ☐ Yes ☐ No

Signature of Person Completing the Form:	Date Signed:

Please send form to: Medical Services Division
600 East Boulevard Ave. - Dept. 325
Bismarck, ND 58505

Fax: 701-328-1544
email: medicaidfraud@nd.gov