



SURVEILLANCE AND UTILIZATION REVIEW SECTION (SURS) REFERRAL

DEPARTMENT OF HUMAN SERVICES

MEDICAL SERVICES DIVISION

SFN 20 (3-2013)

Clear Fields

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:	IPV Completed: ☐ Yes-Include a copy ☐ No
Medical Amount Owed	SNAP Amount Owed	TANF Amount Owed	SPED Amount Owed

Tell Us What Happened:

Signature of Person Completing the Form:	Date Signed:
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Please send form to: Medical Services Division
c/o SURS Administrator
600 East Boulevard Ave-Dept. 325
Bismarck, ND 58505
Fax: 701-328-1544
email: medicaidfraud@nd.gov