SUSPECTED FRAUD REFERRAL

DEPARTMENT OF HUMAN SERVICES
SFN 20 (Rev. 9-2017)

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
Medicaid Amount Owed	SNAP Amount Owed	TANF Amount Owed	SPED Amount Owed	Child Care Assistance Owed

Tell us what happened. For client referral, please attach additional documentation to include signed applications or signed reviews acknowledging reporting requirements. Also add any wage matches or other wage information applicable to the referral. For provider referral, attach any supporting referral information.

Has Intentional Program Violation (IPV) been pursued? ☐ Yes ☐ No If no, do you intend to pursue an IPV? ☐ 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 information on any applications or reviews during the timeframe(s) listed above? ☐ Yes ☐ No **(attach applications/reviews)**

When have you spoken to this client? (mark all that apply) ☐ before issue ☐ after issue ☐ never

V. SIGNATURES

Signature of Lead Worker/Supervisor	Date Signed
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