

PROVIDER FRAUD COMPLAINT FORM

- 1. Please complete all fields in the form below to the best of your ability.**
- 2. Submit the form by:**
 - Fax: 208/334-2026; or**
 - Mail: Medicaid Fraud & Program Integrity Unit
P. O. Box 83720
Boise, ID 83720-0036**

Your Name (optional):

Your contact information (daytime phone, address):

Provider's Name:

Name of Provider's Business:

Provider's Business Address:

Provider's Telephone Number:

Provider's Type of Business (Dentist, Physician, Pharmacist, etc):

Complaint (Describe in detail what you suspect is wrong):