**Referral of Suspected Provider Fraud**

**This form is to be used to make referrals of suspected Medicaid provider fraud to the Department of Medical Assistance Services (DMAS), which will be forwarded on to the Virginia Medicaid Fraud Control Unit (MFCU) for investigation and potential prosecution. This notification should be sent to DMAS via email at**

[**MCOhelp@dmas.virginia.gov**](mailto:MCOhelp@dmas.virginia.gov)**.**

Submission of this form indicates that your organization has investigated this provider and found evidence of provider fraud. All referrals shall be submitted to the Department via ManagedCare.Reporting@dmas.virginia.gov and shall include a detailed account of the incident, including names, dates, places, and suspected fraudulent activities. If an investigation of this provider has not yet been conducted, please notify DMAS of your planned investigation through the **Notification of Provider Investigation** form. If, during the course of that investigation, evidence of fraudulent activity is uncovered, an MCO should report this case to DMAS within 48 hours on this form. Any case sent to DMAS as a **Referral of Suspected Provider Fraud** will be forwarded on to the MFCU. Please be sure to note this case as a fraud referral on your organization’s quarterly fraud, waste and abuse tracking spreadsheet.

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| Referred by |
| Name:  Title:  Phone:  Email: |
| Referring Organization Name (i.e. MCO name, DMAS division/unit, contractor name) |
|  |
| Address |
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| Date referred to DMAS Program Integrity and contact person referred to. |
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**Fraud Referral Detail**

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| Provider name | | |
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| Medicaid ID (NPI) | | |
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| Tax Identification Number (TIN) – if available | | |
|  | | |
| Address | | |
|  | | |
| City or County | | |
|  | | FIPS: |
| Provider type/specialty | | |
|  | | |
| Source/origination of allegation (If QMR or UR, please note date of review) | | |
|  | | |
| Date reported to State | | |
|  | | |
| Description of suspected misconduct | | |
| Category of service/procedure code(s) | | |
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| Factual explanation of the allegation | | |
|  | | |
| Specific Medicaid statutes, rules, regulations, and/or policies violated (federal and/or state) | | |
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| Date(s) of conduct | | |
|  | | |
| Amount paid to provider during the past 3 years or during the period of the alleged misconduct, whichever is greater | | |
|  | | |
| Sample/exposed dollar amount (Amount reviewed/improper payments identified) | | |
|  | | |
| Contact information for State agency staff person with practical knowledge of workings of the relevant program | | |
| Name:  Title:  Phone:  Email: | | |
| Please note any attachments you are sending with this referral | | |
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| **Referral Documentation can be in the form of a CD.** | | |
| **Please label the attachments as indicated by the chart below.** | | |
| **Referral Documentation** | **Label as Attachment** | |
| Provider Findings Letter and Correspondence | **A** | |
| List of Specific recipients Reviewed | **B** | |
| Copies of Records Reviewed | **C** | |
| Specific Review Period | **D** | |
| Regulation Citing For Each Overpayment | **E** | |
| Overpayments | **F** | |
| Additional Documentation Submitted by Provider | **G** | |
| Previous Reviews/Retractions (Last three years) | **H** | |

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| **DMAS Program Integrity Use Only** | |
| **Date Referral Received by Provider Integrity Unit: and name of person receiving**  **\_\_\_/\_\_\_/\_\_\_** | **Comments: (Please use this section for additional comments regarding the referral assignment)** |
| **Referral Assigned to (please check one):**  **Analyst\_\_ \_**  **Contractor \_\_\_\_**  **Other\_\_\_**  **Name of Analyst, Contractor or Other referral assigned to**:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date Assigned**: **\_\_\_/\_\_\_/\_\_\_** |
| **Referred to MFCU (Y/N)**:  **If “Y”, Date Referred to MFCU**: **\_\_\_/\_\_\_/\_\_\_** |
| **Referred to LTC QMR for Health, Safety or Welfare (HSW) issue (Y/N)**\_\_\_\_  **If “Y”,** **Date Referred to LTC QMR for HSW Issue**: \_\_/\_\_/\_\_ |
| **Reason referred to LTC QMR for Health, Safety or Welfare (HSW) issue. (Please include member(s) Medicaid ID number(s):** | **Comments: (Please use this section for additional comments regarding the referral to LTC QMR)** |

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| **1099 Documentation** |
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