



Instruction: The purpose of this form is to report complaints of fraud, waste, and abuse in the Medicare Parts C & D Programs. A representative from Qlarant may contact you upon receipt of this complaint, so please be sure to furnish sufficient contact information. **Please enter description of findings/allegations as a separate attachment.**

Date of Referral: _____

Please designate as a Part C or Part D issue:

- Medicare Advantage Issue (Part C)
- Prescription Drug Benefit Issue (Part D)
- Both Part C and Part D Issue

Complainant Contact Information:

Name: _____ Phone: _____ Fax: _____

Email: _____

Submitted By (Select One) Plan PBM UPIC Other on behalf of (if applicable):

Complainant Organization Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Plan Name/Contract # (if applicable): _____

Plan Tracking # (if applicable): _____

Parent Organization (if applicable): _____

Pharmacy Benefit Manager (if applicable): _____

Beneficiary Information:

Name: _____ Phone: _____

HICN#: _____ MBI #: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Primary language (if other than English): _____

Medicare Plan Name: _____ Member ID#: _____

Is the Beneficiary a Subject? No Yes Unknown

Do you have any Contact Reports on the beneficiary? No Yes Unknown

To ensure compliance with all applicable laws, do not send Protected Health Information (PHI) via email.

Please fax this form to 410-819-8698, email to I-MEDICComplaints@qlarant.com, call 877-7SAFERX, or mail to Qlarant, Inc., 28464 Marlboro Avenue, Easton, MD 21601-2732, Attn: I-MEDIC



Description of Subject/Suspect of Fraud:

Please put one subject/suspect at a time.

Name: _____ Tax ID (TIN): _____ NPI: _____

DEA#: _____ Medicare Provider #: _____

Business (DBA): _____ Phone#: _____ ext. _____

Address: _____ City: _____ State: _____ Zip: _____

Please describe type of business or physician specialty: _____

Complaint Details:

Prior MEDIC Case Number (if applicable): _____

Potential **MEDICARE** program exposure:

Part C program exposure: _____ Paid \$

Part D program exposure: _____ Paid \$

Period of Review: _____

Was this matter forwarded to Law Enforcement?

No Yes If yes, type: OIG FBI Local

Did you receive Medical Records? No Yes

If yes, have you completed a Medical Record Review? No Yes

Was PLATO used? No Yes

Have you reported Patient Harm in this matter to another agency? No Yes

Description of Findings/Allegations: **(Please attach** a detailed description of the nature of the fraud issue including the following: description of fraudulent activity; CPT codes involved; states where the fraud activity took place, description of individuals and/or businesses involved in the alleged illegal activity; dates that the fraud occurred; names and contact information for victims; and copies of documentation regarding the fraudulent activity including letters, advertising, etc.)

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