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DATA ANALYSIS REQUEST FOR ASSISTANCE (RFA)

Investigations MEDIC (IMEDIC)

Date of Request:	☐ Civil ☐ Criminal
Is this from an IMEDIC Referral? ☐ No ☐ Yes	Law Enforcement Case #:

REQUESTOR'S INFORMATION

Requestor Name:	Physical Address:
Organization: ☐ OIG ☐ DOJ/FBI ☐ OAG/MFCU ☐ Strike Force ☐ Other :	
Telephone:	E-mail:
Mobile Phone:	Facsimile:
Date Required:	

TYPE OF REQUEST AND CRITERIA

☐ Request discussion with a Clinical Person or Medicare Subject Matter Expert

☐ (SME) Face-to-Face meeting with SME

Request for Assistance with Pharmacist Review:

☐ Pharmacist Review with Report

☐ High-Level (limited) Pharmacist Review

Request for Assistance with Invoice Reconciliation:

☐ Invoice Reconciliation with Report – Part D PDE Records Only

☐ Invoice Reconciliation with Report - Incorporate provided Medicaid and/or third party pharmacy data

Trial Preparation

☐ Trial Preparation/Testimony (Trial date and location of trial must be provided):

City and State:

☐ For Indictment (If checked, trial date must be provided):

Prosecutor Name and Email:

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Seeking Testimony

Has the subject been indicted? ☐ Yes ☐ No

What type of witness(es) are you seeking?

- ☐ Data
- ☐ Clinical (Please specify)
  - ☐ Medical Records Review
  - ☐ Invoice Review
  - ☐ Pharmacist Review
- ☐ Payment
- ☐ Policy / Program

Synopsis of Investigative Findings

Subject Name:

(Note: *Multiple subjects may be submitted as an attachment*.)

Subject Type:

Part D:

- ☐ Prescriber
- ☐ Pharmacy
- ☐ Beneficiary
- ☐ Drug
- ☐ Other: _____

Part C:

- ☐ Provider
- ☐ DME Supplier
- ☐ Beneficiary
- ☐ Other: _____

Subject Address:

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List ALL available identification numbers related to this request:

- Individual NPI:
- DEA:
- If Pharmacy – NCPDP:
- Medicaid ID:
- If Beneficiary – MBI or HICN:
- If Group – Group NPI:
- If Group – Group Tax ID:
- Other:
- Tax ID:

Reason for Request (Allegations):

(Note: *Additional Information may be submitted as an attachment*.)

Date(s) of Service*:

**Part D data is available beginning 1/1/2006.*

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HIPAA Compliant Statement

(*Note: This form must be signed by the requestor prior to the request being accepted for fulfillment.*)

Office of Inspector General, Office of Investigations:
The information sought in the request is required to be produced to the Office of Investigations pursuant to the Inspector General Act of 1978, 5 U.S.C. App. The information is also sought by the Office of Inspector General in its capacity as a health oversight agency, and this information is necessary to further health oversight activities. Disclosure is therefore permitted under the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information, 45 CFR 164.501; 164.512(a); and 164.512(d).

Department of Justice (DOJ/ FBI/ AUSA):
The information is sought by the Department of Justice in its capacity as a health oversight agency, and this information is necessary to further health oversight activities. Disclosure is therefore permitted under the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information, 45 CFR 164.501; 164.512(a); and 164.512(d).

Other Federal , state or local governmental agency:
The information is sought by this organization under (b)(3) of the Privacy Act (5 U.S.C 552a, as amended. The requestor is a Federal agency or instrumentality of a governmental jurisdiction within or under the control of the United States (including any state or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste, or abuse, in a health benefits program funded in whole or in part by Federal funds. This organization is required to comply with the HIPAA Privacy Rule.

Other CMS/Medicare Contractor:
The information is sought by this organization as a contractor of the Department of Health and Human Services for the purposes of conducting oversight and enforcement under Title XVIII of the Social Security Act. (Reference SSA 1560D-15(f)(2).) This organization is required to comply with the HIPAA Privacy Rule.

Signature of Requestor:		**Title:**	
Organization:		**Date:**	

Submit via secure fax to the I-MEDIC RFI Team at (410) 819-8698 or E-mail as an **encrypted** file to:
MEDICRFITEAM@qlarant.com

Or mail to:

Bette Wood
Project Support
Qlarant, Inc. – I-MEDIC
28464 Marlboro Avenue
Easton, MD 21601-2732

Questions concerning the formulation of this request or any data related questions may be directed to:

Lora Elliott Newnam

Project Manager

Qlarant, Inc. – I-MEDIC

28464 Marlboro Avenue, Easton MD 21601-2732

Direct Dial: (410) 770-3025

Phone: (866) 886-2658 x 11029 elliottl@qlarant.com

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I-MEDIC

FAX COVER SHEET

To:	Bette Wood Project Support Phone Number: (866) 886-2658, ext. 11193	Fax Number:	(410) 819-8698
From:		Phone Number:	

Agency:	Fax Number:

Notes:

Once received an email will be sent within 3 business days confirming receipt.

Please ensure the HIPAA form is signed as we are unable to complete unsigned requests.

Questions regarding the data should be addressed to Lora Elliott Newnam at 410.770.3025.
Questions regarding receipt of the request may be directed to Bette Wood at 410.819.3555.

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