



DATA ANALYSIS REQUEST FOR ASSISTANCE (RFA)

UPIC W – AK, AS, AZ, CA, GU, HI, ID, MP, MT, ND, NV, OR, SD, UT, WA, WY

Date of Request:		Civil	Criminal
Request Type:		Medicare	Medicaid Medicare & Medicaid
REQUESTOR'S INFORMATION			
Requestor Name:		Include all contact info and select preferred method of contact:	
Organization: OIG DOJ/FBI OAG/MFCU		Telephone:	
<input type="checkbox"/> Strike Force <input type="checkbox"/> Other:		Mobile Phone:	
Physical Address:		E-mail:	
		Facsimile:	
REQUIRED CRITERIA FOR CLAIMS REQUEST			
Reason for Request (Allegations):			
<p>Request Discussion with a Clinical Person or Medicare Subject Matter Expert (SME)</p> <p>Request for Assistance with Training/Presentation</p> <p>Request for Assistance with Interpretation of Policies</p> <hr/> <p>Request for Assistance with Trial Preparation:</p> <p> Trial Preparation/Testimony (if checked, trial date must be provided)</p> <p> For indictment (if checked, trial date must be provided)</p> <p> Prosecutor Name and Email</p> <hr/> <p>Request for Assistance with Medical Records/Review</p> <p> Medical Review with Report</p> <p> Medical Review Consult (five or less claims)</p>			



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Overpayment Calculation Needed

If any type of record review is requested, include the following:

Type of Service:

Specific HCPCS or CPT Code of Interest:

Number of Records:

Number of Beneficiaries:

Number of Claims:

Number of Pages to be:

Reviewed: Records Manifest: (see below)

The Manifest should be in an Excel format and include the following information:

File Name	Patient Identifier (i.e., HICN, MBI, Name, DOB)	Date(s) of Service (DOS) / Date Range

IMPORTANT: ANY DOCUMENTS CONTAINING PHI NEED TO BE SENT VIA AN ENCRYPTED METHOD

Electronic Records Should be Transmitted as PDF Files and Sent Via:

Kiteworks USAfx File Exchange Accellion Other

Part B	Part A - Inpatient	Home Health (Part A)	Skilled Nursing Fac. (Part A)
DME	Part A - Outpatient	Hospice (Part A)	Other:

Subject Name:	Subject Type	Provider	Beneficiary
		Other: _____	

Subject Address:

List **ALL** available identification numbers related to this request or attach spreadsheet:

Spreadsheet attached

Individual NPI:	Group NPI:	Tax ID:
Individual PIN:	Group PIN:	UPIN:
Medicaid ID:	HICN/MBI (if beneficiary):	



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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).

Signature of Requestor:

Date:

Title:

NOTE: This form must be signed by the requestor prior to the release of any data.

Submit via secure fax to the UPIC W Data Team at **855.420.8001** or via
email to **UPICWRFI@Qlarant.com** using a secure email system (e.g.
Kiteworks, USAfxFile Exchange, etc.)



DATA ANALYSIS REQUEST FOR ASSISTANCE (RFA)

UPIC W – AK, AS, AZ, CA, GU, HI, ID, MP, MT, ND, NV, OR, SD, UT, WA, WY

To: Norma Torres

Fax Number: 855.420.8001

Phone Number: 562.263.5279

From:

Phone Number:

Agency:

Fax Number:

Notes:

Once received an email will be sent within 24 hours confirming receipt.

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

This message is confidential and may contain information that is privileged or protected from disclosure under applicable law. It is intended solely for the individual or entity to whom it is addressed. If you receive this message in error, please notify the sender immediately, and delete and destroy the original message. This message does not necessarily express the corporate opinion of Qlarant Integrity Solutions, LLC and does not serve to bind Qlarant Integrity Solutions, LLC to any order or contract unless supported by an explicit written agreement.