Qlarant

Investigations MEDIC Complaint Form

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, please 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: _____ RFI POC and 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 (PBM) if applicable:

PBM Case or Tracking Number: _____

Was the information contained in this complaint supplied by your PBM? ◯ No ◯ Yes

Is this referral considered preliminary? ◯ No ◯ Yes (**If yes, you must report the outcome upon conclusion**.)

As a plan sponsor, did you conduct additional investigative steps beyond the information supplied by the PBM?

◯ No ◯ Yes (**If yes, the information developed independent from your PBM should be clearly delineated.**)

Are there additional details or information not provided herein which are available to the I-MEDIC upon request via official Request for Information (RFI)? ◯ No ◯ Yes

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

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Description of Subject/Suspect of Fraud:

Please put **one** subject/suspect at a time.

Is this Provider: ◯ In Network ◯ Out of Network

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

DEA#:_____ Medicare Provider #: _____

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

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

Please describe type of business or physician specialty: _____

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

Complaint Details:

Prior MEDIC Case Number (if applicable): _____

Period of Review: _____

Was this matter forwarded to Law Enforcement?

◯ No ◯ Yes

If yes, to whom: ◯ OIG ◯ FBI ◯ Local

Was HPMS FWA used? ◯ No ◯ Yes

Potential **MEDICARE** program exposure:

Part C program exposure:_____ Paid $ _____

Part D program exposure: _____ Paid $ _____

Did you receive Medical Records? ◯ No ◯ Yes

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

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

If yes, to whom: _____

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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