Form for Reporting Fraud
Committed by a Provider or Vendor

Your name and phone number is optional, but it would be helpful to us in case we need to contact you for additional or clarifying information.

How do you want to report this?

☐ I am willing to identify myself. ☐ I wish to remain anonymous.

Please be advised that by remaining anonymous you may become exempt from any future claim to a financial incentive as stated in Connecticut Statue:
17b-102 Regulations providing a financial incentive for reporting vendor fraud. The commissioner of social services shall adopt regulations in accordance with the provisions of chapter 54 to provide a financial incentive for reporting of vendor fraud in the medical assistance program by offering a person up to fifteen percent of any amounts recovered by the state as a result of such person's report.

Note: Fields marked with * must be completed.

YOUR PERSONAL INFORMATION

YOUR NAME:	
YOUR ADDRESS:	
YOUR E-MAIL ADDRESS:	
YOUR AREA CODE + PHONE NUMBER:	

PROVIDER / VENDOR INFORMATION

* PROVIDER / VENDOR NAME:	
* PROVIDER / VENDOR MAILING ADDRESS:	
* PROVIDER / VENDOR CITY:	
* PROVIDER / VENDOR STATE:	
PROVIDER / VENDOR ZIP:	
BUSINESS TYPE:	

Please enter ALL the information you have regarding the allegation or suspicion of how the above individual(s) or Company(s) is defrauding the department:

State of Connecticut Department of Social Services, Medical Audits Division
25 Sigourney Street, Hartford, Connecticut 06106-5033
Phone: 1-800-842-2155 or 860-424-5923 Fax: (860) 424-5900