MCO PROGRAM INTEGRITY RECIPIENT REFERRAL FORM

Report 308

Health Plan ID/NPI: _____ Report Date: _____
Health Plan Name: _____ DHCFP Unit: _____
Prepared by: _____ Reviewed by: _____
Email: _____ Reviewed on: _____

1. RECIPIENT INFORMATION

Recipient Name	DOB	Med ID	Eligibility Period (if known)	Type of Referral
				☐ Credible Allegation of Fraud (CAF) ☐ If CAF, attach complete file to form ☐ Non-CAF Referral
Address		**Telephone number**		**Email Address**

2. ALLEGATION INFORMATION

Date of original complaint	Source of original complaint	Date(s) of conduct involved	Provider Type	Approx. value of improper payments	Procedure Code/Modifier
Citations of specific laws or Medicaid/MCO policies violated				**Date referral reported to SUR**	

Summary of Allegation

Description of alleged improper activity or billing errors. Provide names of any individual employees involved. If relevant, provide recipient name and Medicaid number (required for CAF referrals). Include findings from the preliminary investigation and proposed actions. Use additional sheet(s) if necessary.

Please specify any source of authority (other than Medicaid Services Manual) used in your investigation.

Current status of the investigation and any action(s) taken, or notification made to other agencies or entities (e.g. MFCU, DWSS, professional boards, etc.) and any subsequent action(s) taken.

3. INSTRUCTIONS

- Complete & send ALL referrals forms to **NPI@DHCFP.nv.gov**
- Referrals should be encrypted and password protected, as appropriate, to comply with federal HIPAA regulations
- CAF Referrals due two (2) business days after determination
- Non-CAF Referrals due ten (10) days after opening an investigation