



ID

Oklahoma Attorney General's Office
Medicaid Fraud Control Unit
313 NE 21st Street, Oklahoma City, OK 73105

Complaint Form

Your Information:

Last Name:	First Name:	DOB:
Address		City, State
		Zip
Contact Phone:	Alternate Phone:	
Email:	Fax:	

Please complete if you are reporting abuse, neglect, or financial exploitation.

(Please provide details on next page)

Victim's Last Name:	Victim's First Name:
Suspect's Last Name:	Suspect's First Name:
Amount of Loss (Exploitation only):	
Suspect Phone:	
Facility Name:	
Address	
City, State	Zip
Facility Phone:	
Witness Last Name:	Witness First Name:
Witness Phone:	

Please complete if reporting Medicaid fraud.

(Please provide details on next page)

Medicaid Provider:	Type (e.g. doctor, counselor):
Address	
City, State	Zip
Phone Number:	

If you have contacted any other agencies, please provide names and case numbers:

DECLARATION: By submitting this form, I declare under penalty of perjury under the laws of the State of Oklahoma that the information in this Complaint is true and accurate to the best of my knowledge.

Name: _____ Date: _____

After completion, this form may be mailed to the address listed above to Medicaid Fraud Control Unit, Office of the Attorney General, or faxed to: (405) 522-4875 or emailed to: mfcu.referral@oag.ok.gov

The filing of this Complaint does not ensure an investigation will be initiated.
Thank you for completing this form.

ID

(Office Use Only) Case Type:

Abuse

Neglect

Financial Exploitation

Medicaid Fraud

In the space below, please provide as much detail as possible, such as names, dates, times, places, and actions, and any applicable documents:

The filing of this Complaint does not ensure an investigation will be initiated.
Thank you for completing this form.