Arizona Attorney General's Office
Medicaid Fraud Control Unit Complaint Form

ID

Your Information (items in BLUE are required)

Last Name:	**First Name:**
Address:	**City, State:**
	Zip Code:
Contact Phone Number:	**Alternate Phone Number:**
Email Address:	**Fax Number:**

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

Victim's Last Name:	**Victim's First Name:**
Amount of Loss (if reporting Exploitation):	
Suspect Last Name:	**Suspect First Name:**
Suspect Phone Number:	
Facility Name:	
Address:	**City, State:**
	Zip Code:
Facility Phone Number:	
Facility Web Site:	
Details of Abuse/Neglect or Exploitation:	
Witness Last Name:	**Witness first Name:**
Witness Phone Number:	

Please complete if you are reporting Medicaid fraud.

Medicaid Provider:	
Address:	**City, State:**
	Zip Code:
Phone Number:	
Details of Medicaid Fraud:	

If you have contacted any other agencies, please include any names or case numbers:

DECLARATION: By submitting this form, I declare under penalty of perjury under the laws of the State of Arizona that the information in this Complaint is true and accurate:
Name:_____ **DATE:** _____

Please print out form, sign and date form where indicated, and mail completed form to:
Medicaid Fraud Control Unit, OFFICE OF THE ATTORNEY GENERAL, 2005 N. Central Ave., Phoenix, AZ 85004

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