MARYLAND MEDICAL ASSISTANCE PROGRAM
INVESTIGATION REFERRAL

To: DHMH Medicaid Program Integrity Recipient Fraud and Abuse Unit 201 West Preston Street, Room 520 Baltimore, Maryland 21201 FAX: 410-333-5326 410-333-7194	From: ______________________________ DSS Case Manager: ______________________________ Telephone: ______________________________

Re: ______________________________
Case Name

____
Address

____

Case Status:
☐ Open, effective: ____________
☐ Change, effective: ____________
☐ Closed Effective: ____________

Case #/Category: ______________________________

Representative/Address: ______________________________

A. Request for an investigation involving an unreported or untimely reporting of:

( ) Resources ( ) Income/Increase in Income ( ) A Change in Circumstance

( ) A Disposal of Non-Excluded Resources for Less than Fair Market Value

( ) A Request for More than 1 Duplicate Card in a 12 Month Period

( ) Other ______________________________

B. (Complete if known) Had the information now known been reported in a timely manner, the recipient would have been :

( ) Ineligible effective from ____________to______________ (Excess Income/Resource: $______________)

( ) Eligible with Spend-Down amount from $_____________ to _______________ beginning_____________ to ______________.

Total Due State: $ ______________________________

( ) Eligible with Monthly Available Income increased (Long Term Care recipient only):
from $ _____________ to $ _____________ beginning _______________ to _________________.
from $ _____________ to $ _____________ beginning _______________ to _________________.

Total Due State: $ ______________________________

C. Comments:______________________________

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(Use separate sheets for additional information and check here ☐)
NOTE: Attach one copy of all documents relevant to the referral.

D. Checklist for Completion: Ensure the following are completed before sending this form.

_____ Completed Referral signed by a supervisor citing the case circumstance as well as suspected period of ineligibility.

_____ Copy of application for eligibility period of suspected fraud.

_____ Copy of all other pertinent documents (i.e. bank statements, life insurance policies, etc.) relevant to suspected fraud.

______________________	______________________	__________	______________________
Supervisor's Name	Signature	Date	Telephone Number

DHMH 4243 (REVISED 10/06)
WHITE-INVESTIGATOR COPY YELLOW-CASE RECORD
RFAS CASE FILE