STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

SEND TO: *DIRECTOR, DIVISION OF PROGRAM INTEGRITY, DEPARTMENT OF HEALTH AND HUMAN SERVICES P.O. BOX 8206, 1801 MAIN STREET, SUITE M 112, COLUMBIA, SOUTH CAROLINA 29202-8206*

PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

Suspected Individual(s)

Suspect I - ID Number **Recipient Number** **Suspect II - ID Number**

Suspect I - Address **Suspect II - Address**

Location of Incident **Date of Incident**

Complaint

Reporter's Name **Date of Report**

Reporter's Address **Reporter's Phone**

Date Assigned

Resolution **For DHHS Use Only**

Complaint Log Number **Complaint Reviewer**

Supervisor Approval **Date (Supervisor Approval)**

Division Director Approval **Date (Division Director Approval)**

☐ **Close** ☐ **Perform full Review** ☐ **Referral** ☐ **Other**

Requesters Signature: **DATE:**