DIVISION OF PROFESSIONAL LICENSURE
OFFICE OF INVESTIGATIONS
Application for Healthcare Fraud Complaint

617-727-7406

www.mass.gov/dpl

Date Received (stamp):

Entered into the Database (Date): _____/ _____/ _____ **Docket #:_____-_____-_____**

Acknowledgement letter sent (Date): _____/ _____/ _____ **Signature: _____**

Please complete this form as fully as possible. **(PLEASE DO NOT WRITE ABOVE LINE.)** Please type or print legibly in ink.

SUBMITTED BY (INCLUDE COMPANY NAME IF AN INSURANCE COMPANY, ETC.):

Name: _____ _____ / _____
Last Name First Name COMPANY

Address: _____ _____
Number Street Phone

_____ _____ _____ _____
City State Zip Code Alternate Phone (optional)

E-mail: _____

LICENSEE SEEKING COMPLAINT AGAINST (use separate form for each licensed individual/business AND if complaint involves multiple patients, you must submit a separate form for each patient):

Name: _____ _____ _____
Last Name First Name M.I.

Address: _____ _____
Number Street Daytime Phone

_____ _____ _____ _____
City State Zip Code License Number/Type Class

_____
Business Name

_____ _____
Business Address Daytime Phone

_____ _____ _____ _____
City State Zip Code Business License # / Type Class

Please check the trade or profession that this application for complaint pertains to:

____Audiologist/Speech Language Pathologist ____Chiropractor ____Occupational Therapist

____Optometrist ____Physical Therapist ____Podiatrist ____Psychologist

____Mental Health Counselor ____Social Worker ____OTHER: _____

Please check the alleged health-care violation(s) that led to your application for complaint:

Overutilization _____ Fraud (false claims) _____ Upcoding _____
Unjustified Referrals _____ Use of Runners _____
Improperly prescribing drugs _____ Misrepresentation of Services _____
Other (please explain):
_____
_____
_____

Incident data – See below for confidentiality of records

Patient Name: _____ Patient Year of Birth: _____

Date of Incident: _____ Total bills of patient: $_____

Independent Review(s): Y/N Date: _____

Dates of service (start date to end date) _____

Additional Practitioners/Referrals:
X-Rays ____ MRI _____ Fluoroscopy _____
Orthopedic Surgeon _____ Neurologist _____ Massage Therapist _____
Medical Doctor _____
Other (please state) _____

***Licensee status with your organization (if applicable)*:**
Licensee not facing any sanctions from your organization _____
Licensee's bills are accepted but face additional scrutiny (probationary status) _____
Your organization will not accept services/bills from the Licensee _____
Other (please explain) _____

To speed up application for complaint process, submit legible copies (not the originals) of all relative documents supporting your application (e.g. full medical file, contracts, bills for payment, IME, IMR, etc.). You will receive an acknowledgment letter notifying you if a complaint is issued based on your application. NOTE THAT INCOMPLETE DOCUMENTATION CAN DELAY OR PREVENT THE DOCKETING OF YOUR COMPLAINT.

AUTHORIZATION FOR RELEASE OF RECORDS AND FORM REFERRAL

Pursuant to 45 CFR 164.501 (HIPAA), the Division of Professional Licensure is a "health oversight agency" which is authorized to review unredacted patient medical records without prior approval or notice given to any patient. Further, under G.L. c. 175, §113V(e), no person filing this complaint (if in good faith) shall be subject to criminal or civil liability, and no civil cause of action of any nature shall arise against such person for making this complaint or providing records in support of said complaint. By signing this form (or a photocopy thereof), the person filing this complaint certifies that this complaint is being made with good faith and not for any fraudulent purpose. The Division of Professional Licensure may refer this complaint to other appropriate law enforcement authorities.

Please note that all applications for complaints are examined to determine their factual basis. Filing an application for complaint does not ensure or imply that disciplinary action will be taken against the licensee.

I attest that the information provided is true, correct, and complete to the best of my knowledge.

_____ _____
Signature Date

Mail this form to:
Division of Professional Licensure
Office of Investigations
1000 Washington Street, Suite 710
Boston, MA 02118

www.mass.gov/dpl