

INDIVIDUAL INTERACTION: COMPLEX INTERACTION FORM

*** Items marked with asterisk (*) indicate required fields**

Type of Interaction*: Individual Interaction

Session Conducted By*: _____
Date of Interaction (MM/DD/YYYY)*: _____

Title of Interaction: _____

End Date (if applicable): _____

Time Spent in Minutes*: _____

Zip code*: _____ State*: _____

Reference Number: *Auto-Populated*

County: _____

Organization: *Auto-Populated*

Notes:

Beneficiary Name and Contact Information

Beneficiary First Name: _____
Beneficiary Last Name: _____

Beneficiary Address: _____

Beneficiary Phone: (_____) - _____ - _____

Beneficiary City: _____

Beneficiary Email: _____

Beneficiary State: _____

Beneficiary Zip Code: _____

Beneficiary Demographic Information

Race
(Multiple selections
allowed):

- | | |
|--|--|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Not Collected |
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Other |

Gender (Select only one):

- | | |
|---------------------------------|--|
| <input type="checkbox"/> Female | <input type="checkbox"/> Other |
| <input type="checkbox"/> Male | <input type="checkbox"/> Not Collected |

Date of Birth (MM/DD/YYYY): _____

Medicare Number: _____

Medicaid Number: _____

Other Information:

Topic(s) Discussed:

- Conditional Payments
- Consumer Protection
- Durable Medical Equipment (DME)
- Employer Health Plan
- General Fraud, Errors, and Abuse
- Genetic/DNA Testing
- Home Health Care
- Hospice
- Medicaid
- Medical Identity Theft
- Medicare Advantage
- Medicare Card
- Medicare Part A and B
- Medicare Part D
- Medicare Summary Notice
- Medigap or Supplemental Insurance
- Opioid Fraud and Abuse
- SMP Program Information
- SMP Volunteer Recruitment
- Social Security
- TRICARE
- Veteran's Health Benefits (VA)
- Other

Other Topics Discussed Details:

Additional Information

Issue(s):

- Beneficiary Perpetrated Fraud
- Billing Error
- Billing for Services Different From Received
- Billing for Services Not Provided
- Compromised Medicare Number
- Compromised Social Security Number
- Double Billing
- Enrollment / Disenrollment Issues
- Kickbacks
- Marketing Fraud
- Quality of Care Issues
- Scams
- Other Fraud, Error, or Abuse

Other Fraud, Error, or Abuse Details:

Is the Complainant different from the Beneficiary? Yes No

Complainant Name and Contact Information

Complainant First Name: _____ Complainant Address: _____

Complainant Last Name: _____

Complainant Phone: (____) - _____ - _____ Complainant City: _____

Complainant Email: _____ Complainant State: _____

Complainant Zip Code: _____

Complainant Relationship to Beneficiary:

- Spouse
- Family Member/Caregiver
- Health Care Provider
- Other

Permission to contact Complainant: Yes No

Recoveries Information	
Cost Avoidance on behalf of Medicare, Medicaid, Beneficiaries, or others (xxxx.xx) :	_____
Expected Medicare Recoveries (xxxx.xx):	_____
Additional Expected Medicare Recoveries (xxxx.xx) :	_____
Expected Medicaid Recoveries (xxxx.xx) :	_____
Additional Expected Medicaid Recoveries (xxxx.xx) :	_____
Actual Savings to Beneficiaries (xxxx.xx) :	_____
Other Savings (xxxx.xx):	_____
Explanation:	
SMP Action(s):	
<input type="checkbox"/> SMP contacted 1-800-Medicare <input type="checkbox"/> SMP contacted CMS Liaison <input type="checkbox"/> SMP contacted CMS Regional Office <input type="checkbox"/> SMP contacted Federal Trade Commission <input type="checkbox"/> SMP contacted Medicare Advantage Plan or Part D Plan <input type="checkbox"/> SMP contacted Medicare PSC or MEDIC Contractor <input type="checkbox"/> SMP contacted MFCU or Medicaid Office <input type="checkbox"/> SMP contacted OIG <input type="checkbox"/> SMP contacted Other CMS Contractor <input type="checkbox"/> SMP contacted Provider/Practitioner	<input type="checkbox"/> SMP contacted Quality Improvement Organization (QIO) <input type="checkbox"/> SMP contacted Secondary Insurer/Plan <input type="checkbox"/> SMP contacted SHIP <input type="checkbox"/> SMP contacted SMP Resource Center <input type="checkbox"/> SMP contacted State Insurance Department <input type="checkbox"/> SMP contacted UPIC <input type="checkbox"/> SMP sent Release of Information Form and Request Documents <input type="checkbox"/> SMP reviewed Guidelines, Policies, or Procedures <input type="checkbox"/> Other SMP Action
Other SMP Action Details:	
Referred Beneficiary to Action(s):	
<input type="checkbox"/> Referred beneficiary to 1-800-Medicare <input type="checkbox"/> Referred beneficiary to an Ombudsman <input type="checkbox"/> Referred beneficiary to contact Medicare Advantage Plan or Part D Plan <input type="checkbox"/> Referred beneficiary to contact MFCU or Medicaid Office <input type="checkbox"/> Referred beneficiary to contact Provider/Practitioner	<input type="checkbox"/> Referred beneficiary to contact Quality Improvement Organization (QIO) <input type="checkbox"/> Referred beneficiary to contact Secondary Insurer/Plan <input type="checkbox"/> Referred beneficiary to Federal Trade Commission <input type="checkbox"/> Referred beneficiary to SHIP
Appeal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Attach File 1	
Attach File 2	
Attach File 3	
Attach File 4	
Attach File 5	

Case Notes:	
Refer to OIG Hotline via ACL:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date Submitted to ACL:	<i>Auto-Populated after saving</i>
Date ACL Submitted to OIG (MM/DD/YYYY):	
ACL Comments:	
SMP Representative Name and Contact Information	
SMP Representative Name: _____	SMP Representative Phone Number: (_____) - _____ - _____
SMP Representative Mailing Address: _____ _____	SMP Representative Fax Number: (_____) - _____ - _____
	SMP Representative Email Address: _____
Status of Interaction:	<input type="checkbox"/> Open – Research in progress by SMP, less than one year <input type="checkbox"/> Open – Awaiting Response to Referral <input type="checkbox"/> Closed – Reviewed Internally, no issue identified <input type="checkbox"/> Closed – Resolved by SMP <input type="checkbox"/> Closed – Referral No Action Required <input type="checkbox"/> Closed – Action Taken By Referent <input type="checkbox"/> Closed – Handled by SHIP <input type="checkbox"/> Closed – Other <input type="checkbox"/> Suspended
Date of Last Status Update (MM/DD/YYYY):	

Subject Name and Contact Information

Organization Name: _____

Subject Address: _____

Subject First Name: _____

Subject City: _____

Subject Last Name: _____

Subject State: _____

Subject Phone: (_____) - _____ - _____

Subject Zip Code: _____

Provider Number: _____

Subject Email: _____

Subject Website: _____

Subject Other Information:Public Burden Statement:

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