OMB Control No. 2900-XXXX
Estimated Burden: 10 Minutes
Expiration Date: XX/XX/20XX

Department of Veterans Affairs

VHA FRAUD, WASTE, AND ABUSE COMPLAINT FORM

INSTRUCTIONS: Use this form to report potential health-care fraud, waste, or abuse in VA programs.

Submit form via Email or Fax:

- Email: VHAOICHelpline@va.gov. Note: if submitting via email, please do not include sensitive information like Social Security Number or bank account information.
- Secure Fax to 303-398-5295

You may also call the VHA Integrity and Compliance Helpline: 866-842-4357 (VHA-HELP)

BACKGROUND

FRAUD, WASTE, AND ABUSE COMPLAINT - What is fraud, waste, and abuse?

Fraud is the intentional misrepresentation of information to gain undeserved payment for a claim.

Waste involves spending federal healthcare dollars on services that are unnecessary.

Abuse involves a questionable practice, which is inconsistent with accepted medical or business policies.

SECTION I: SUBMITTER INFORMATION

1. HOW DO YOU WANT TO SUBMIT THIS COMPLAINT?

☐ **Confidential Complaint:** The information submitted on this form is considered confidential and may be disclosed outside VA only if the disclosure is authorized under the Privacy Act. VA will make every effort to protect your confidentiality. However, in some situations, it may still be necessary to disclose your identity to entities outside of VA, including (1) if necessary to research and resolve an issue with your benefits, (2) a referral to law enforcement is appropriate, or (3) otherwise required by law.

☐ **Anonymous:** You are not required to provide your name, patient name, or contact information (if different). You may choose not to provide any identifying information (address, DOB, etc.) with this complaint. However, providing this information helps VA to thoroughly research the issue; withholding this information could limit the review.

COMPLETE AS MUCH AS POSSIBLE

2. NAME *(First, Last)*:

3. ADDRESS *(Street, City, State, Zip, Country)*:

4. TELEPHONE:	5. EMAIL:

6. SUBMITTER *(Select one)*:

☐ VETERAN ☐ BENEFICIARY ☐ PROVIDER ☐ VA EMPLOYEE *(Location, Department)*: _____

☐ OTHER *(Specify)*: _____

SECTION II: VETERAN, PATIENT, OR BENEFICIARY INFORMATION

☐ 7. I DO NOT KNOW ANY PATIENT INFORMATION

COMPLETE AS MUCH AS POSSIBLE

☐ 8. SAME INFORMATION AS SUBMITTER

9. NAME *(First, Last)*:

10. ADDRESS *(Street, City, State, Zip, Country)*:

11. TELEPHONE:	12. EMAIL:

SECTION III: PROVIDER INFORMATION

☐ 13. I DO NOT KNOW ANY PROVIDER INFORMATION

COMPLETE AS MUCH AS POSSIBLE

14. NAME OF PROVIDER, BUSINESS, FACILITY, OR PRACTICE:

15. PROVIDER NPI OR NATIONAL PROVIDER ID *(If known)*:

16. ADDRESS *(Street, City, State, Zip, Country)*:

SECTION IV: COMPLAINT

COMPLETE AS MUCH AS POSSIBLE

17. PROGRAM TYPE *(Select one)*:

☐ CHAMPVA ☐ CHAMPVA FOREIGN ☐ CHILDREN OF WOMEN VIETNAM VETERANS *(CWVV)* ☐ VA COMMUNITY CARE

☐ FOREIGN MEDICAL PROGRAM *(FMP-Vets only)* ☐ SPINA BIFIDA HEALTH CARE BENEFITS PROGRAM ☐ CAMP LEJEUNE FAMILY MEMBER PROGRAM

☐ STATE VETERAN HOMES ☐ VA MEDICAL CENTER ☐ UNSURE/DO NOT KNOW

18. IS THERE A RELATED MEDICAL CLAIM OR BILL? *(Select one)*:

☐ YES *(If "YES," provide the medical claim numbers and dates of services in Item 23 below)* ☐ NO ☐ UNSURE

19. TYPE OF FRAUD, WASTE, OR ABUSE *(May select more than one)*:

☐ BILLING FOR SERVICES OR SUPPLIES NOT PROVIDED ☐ CRIME/MISCONDUCT BY A HEALTH CARE PROVIDER OR THEIR STAFF

☐ CRIME/MISCONDUCT BY A MEDICAL FACILITY ☐ KICKBACKS, INCENTIVES, OR BRIBES BY HEALTH CARE PROVIDERS ☐ IDENTITY THEFT

☐ BALANCE BILLING ☐ POOR QUALITY OF CARE ☐ OVERUTILIZATION OF CONTROLLED SUBSTANCES ☐ ELIGIBILITY

☐ OTHER *(Specify)*: _____

20. PROVIDE A LIST OF ALL PARTIES INVOLVED:

21. PLEASE PROVIDE A DETAILED DESCRIPTION OF THE SUSPECTED FRAUD, WASTE OR ABUSE AND A HISTORY OF WHAT HAPPENED. IF AVAILABLE, INCLUDE THE CLAIM NUMBER(S) AND DATES OF SERVICE HERE

22. DOCUMENTATION/ATTACHMENTS: YOU MAY SUBMIT MULTIPLE ATTACHMENTS *(Copies only). (Examples include Complaints, Bills, EOBs, Correspondence)*

PRIVACY ACT INFORMATION: The authority for collection of the requested information on this form is 38 U.S.C. 501 and 1781. The purpose of collecting this information is to process fraud, waste and abuse complaints for the VA Veteran Community Care Program and other family healthcare programs. You do not have to provide the requested information but if any of the requested information is not provided, it may significantly delay processing of your complaint. Failure to furnish the requested information will have no adverse impact on any VA benefit to which you may be entitled. The responses you submit are considered confidential and may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records governing Compliance Inquiry Reporting & Tracking System (CIRTS), CIRTS, 110VA17 "Compliance Record, Response, and Resolution of Reports of Persons Allegedly Involved in Compliance Violations --VA" as set forth in the Compilation of Privacy Act Issuances via online GPO access at http://www.gpoaccess.gov/privacyact/index.html. For example, information on this form may be disclosed to VA OIG, FBI and other law enforcement agencies involved in actions related to or affected by health care services rendered, medical benefits or payment for services. Use of Social Security Numbers for the identification of veterans or persons claiming or receiving VA benefits and their records and other purposes is authorized by Title 38, U.S.C., and the Privacy Act of 1974 (5 U.S.C. 552a) or where required by other statute.

VA BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-XXXX, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 10 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-XXXX in any correspondence. Do not send your completed VA Form 10-390 to this email address