VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Health Care Fraud & Abuse
Referral Form

Your Information

Name:		Date:	
Address:	City:	State:	Zip:
Email:	Telephone:		
Are you a Medicaid provider? ☐ Yes ☐ No	Provider ID (if applicable):		
Do you have state funded health care? ☐ Yes ☐ No	Medicaid ID (if applicable):		
Are you employed by the State of Vermont? ☐ Yes ☐ No	Department/Unit (if applicable):		

Reporting a Provider

Provider and/or Facility Name:			
Address:	City:	State:	Zip:
Provider ID:	Telephone:		

Reason for Referral

Please give as much detail as possible about your concern. Include copies of any documents you are willing to share.

(please continue on another page if necessary)