



Arkansas Department of Human Services Division of Medical Services

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Medicaid Fraud Control Unit Referral



TO: Attorney General, Medicaid Fraud Control Unit
ATTN:

FROM:

DATE:

- REVIEW**
- REFERRAL**
- OTHER**

Provider Name:	
Provider Number:	
Claim Number:	
Reviewer/Auditor:	
Phone # of Reviewer/Auditor:	

Please see attached documentation.

"Prohibition of Redisclosure: This information has been disclosed to you from records that are confidential. You are prohibited from using the information for other than the stated purpose; from disclosing it to any other party without the specific written consent of the person to whom it pertains; and are required to destroy the information after the stated need has been fulfilled, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose."