

Complainant Information:

Name _____ Date _____

Address: Street & # _____

City _____ State _____ Zip _____

Email Address _____ Telephone (____) _____

• If you are a Medicaid **provider**: Provider ID _____

• If you are a Medicaid **recipient**: CID# _____ Case # _____

Summary of Complaint:

Complaint Against a Medicaid Provider

Provider or Facility Name _____

Address: Street & # _____

City _____ State _____ Zip _____

Provider ID (if known) _____ Telephone (____) _____

Complaint Against a Medicaid Client

Client First Name _____ Last Name _____

Address: Street & # _____

City _____ State _____ Zip _____

Telephone (____) _____

CID# _____ Case# _____

SSN _____ DOB/Age _____