

Investigation Form

Name of reporter _____

Anonymous

Date of report _____

Report method In person to _____
 Hotline
 In writing

Details of report _____

Additional interviews warranted
 Formal report prepared

Details of interview with reporter
 (if identified) _____

Details of interview with
 supervisor/manager _____

Details of interview with
 colleagues/peers _____

Scope of issue	
<input type="checkbox"/> Medicaid impacted	<input type="checkbox"/> Identified risk area
<input type="checkbox"/> Medicare impacted	<input type="checkbox"/> Less 6 mo.
<input type="checkbox"/> Systemic	<input type="checkbox"/> Multiple issues
<input type="checkbox"/> 6 mo. or longer	<input type="checkbox"/> Fraud/abuse
<input type="checkbox"/> Single issue	<input type="checkbox"/> Limited, how? _____

Corrective measure recommended	
<input type="checkbox"/> Employee discipline	<input type="checkbox"/> Corrective billing
<input type="checkbox"/> Training/education	<input type="checkbox"/> Repayment
<input type="checkbox"/> Change policies/procedures	<input type="checkbox"/> Self-disclosure (state or federal)

Notification	
<input type="checkbox"/> Audit committee, Date _____	<input type="checkbox"/> Outside counsel, Date _____
<input type="checkbox"/> Exec. Dir./CEO, Date _____	<input type="checkbox"/> Regulatory agencies, Date _____
<input type="checkbox"/> Board, Date _____	

Corrective measures taken	
_____	Date _____
_____	Date _____
_____	Date _____