Iowa Medicaid
IOWA HHS

Iowa Medicaid Program Integrity Tip Form

Complete and Email to: fwa_audits@dhs.state.ia.us

Date: Click or tap to enter a date.

Source (Informant) Information:

Please provide information as we may reach out for additional information if it is needed. Your information will remain confidential if you select to remain anonymous.

First Name: Click or tap here to enter text. **Last Name:** Click or tap here to enter text.
Street Address: Click or tap here to enter text.
City: Click or tap here to enter text.
State: Click or tap here to enter text. **Zip Code:**Click or tap here to enter text.
Phone: Click or tap here to enter text.
Phone Type: Choose an item.
Email: Click or tap here to enter text.
Preferred Contact Method: Choose an item.
Do you want to remain anonymous? Choose an item.
Are you a HHS employee? Choose an item.

Subject Information:

Please provide as much information as possible about the Iowa Medicaid provider issue and member/recipient information.

Name: Click or tap here to enter text.
Street Address: Click or tap here to enter text.
City: Click or tap here to enter text.
State: Click or tap here to enter text.
Zip Code: Click or tap here to enter text.
Subject Type: Choose an item.
Subject NPI, TIN, or SSN: Click or tap here to enter text.
Subject DOB: Click or tap to enter a date.

Suspected Activity Information:

Complaint (Please provide as much detailed information as possible about the suspected activity.):

Click or tap here to enter text.

☐ YES ☐ NO All-related information, documentation and/or provider education has been included. If NO, please provide explanation below.
Click or tap here to enter text.