

*Exhibit 33 – Harkin Grantee Model Form -- (Rev. 32, 10-25-02)*

*State (if not evident in name)*

*Grantee Name  
MODEL FORM*

*Grantee Phone #*

*FID # \_\_\_\_\_*

***HARKIN PROJECT FRAUD AND ABUSE COMPLAINT REFERRAL FORM  
DATE:***

*(insert information on contractors here)*

*From: (Your Name)*

*Organization:*

*County:*

*Address:*

*City:*

*State:*

*Zip:*

*Phone: (With Area Code)  
Applicable)*

*Fax #*

*E-Mail (If*

*Beneficiary Name:  
Date of Birth:*

*Medicare #:*

*Medicaid #:*

*Address:*

*Phone #: (With Area Code)*

*City:*

*State:*

*Zip:*

*Beneficiary Can Be Contacted at:*

*Between \_\_\_\_\_*

*a.m. and \_\_\_\_\_ p.m.*

*Name of Complainant (If Different From Beneficiary):*

*Address:*

*Phone #: (With Area Code)*

*City:*

*State:*

*Zip:*

*Complainant Can Be Contacted at:*

*Between \_\_\_\_\_*

*a.m. and \_\_\_\_\_ p.m.*

**Complaint Against:** (Name of facility, provider, physician, lab, supplier, etc.) **Claim #** (If appropriate)

**Date(s) of Service:**  
**Business Address:** \_\_\_\_\_ **Phone: (With Area Code)** \_\_\_\_\_

**Provider Number:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

*Please describe your complaint. If known, include procedure code and/or description of service, amounts billed, amount you paid, etc. You may continue on the next page if you need more room. If you feel you were billed for services or supplies that were not provided, continue with the non-rendered service section below.*

**Description of Complaint (Continued)**

**Non-rendered Services Section:**

**Did you see any provider that day?** \_\_\_\_\_ **If yes, who? (Physician's Assistant, Nurse, Lab, X-ray Technician)**

**Was the service(s) provided on another day?** \_\_\_\_\_ **If yes, when?**

\_\_\_\_\_

*Have you ever seen the provider listed? \_\_\_\_\_ If yes, when?*

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*Have you contacted the provider/supplier regarding this billing? Yes No*

*If yes, to whom did you speak and what was the result of the conversation?*

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***Release of Information: Please read carefully and sign where indicated***

*I, \_\_\_\_\_, hereby authorize  
\_\_\_\_\_ and*

*(insert name of project) to discuss my complaint with \_\_\_\_\_  
for the purpose of investigating possible fraud or abuse.*

*I understand that, except for action already taken, I may revoke this authorization at any time. I also understand that a photocopy of this authorization has the same effect as the original. I further understand that the parties named above will not disclose this information to anyone else without my consent. This authorization expires one (1) year from the date on which it is signed.*

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*Signature*

*Date*

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***Important: Please attach the appropriate Medicare and/or Medicaid Explanation of Benefits relating to this incident. Also attach any other information you feel may be important to this complaint. When completed mail to: (insert name of project)***