

**Medicaid Fraud & Elder Abuse & Neglect**  
**Reporting Form**

State of New Jersey  
Division of Criminal Justice  
**Medicaid Fraud Control Unit**  
P.O. Box 094  
Trenton, New Jersey 08625

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Please complete this form as accurately as possible.

Your Name (optional): \_\_\_\_\_

Your Daytime Telephone # (optional): \_\_\_\_\_

Your E-mail (optional): \_\_\_\_\_

Your County or Zip Code (optional): \_\_\_\_\_

Name of Person or Organization Committing Medicaid : \_\_\_\_\_

Their Date of Birth: \_\_\_\_\_

Their Social Security #: \_\_\_\_\_

Their Address: \_\_\_\_\_

Their Telephone #: \_\_\_\_\_

Their E-mail: \_\_\_\_\_

Their Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Location of Fraudulent Activity: \_\_\_\_\_

Date(s) of Fraud: \_\_\_\_\_

Time(s) of Fraud: \_\_\_\_\_

List Any Conspirators: \_\_\_\_\_

In your own words, describe in as much detail as possible, what a person or business did to commit Medicaid fraud. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This form will be kept confidential, however, any information submitted can be intercepted by a third party over the internet. If you feel uncomfortable about submitting this form online, please return to the Report Fraud page and either contact us by mail or by phone.