Medicaid Fraud & Elder Abuse & Neglect Reporting Form

State of New Jersey
Office of the Attorney General
Medicaid Fraud Control Unit
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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.