NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

# Nebraska Department of Health and Human Services
# Referral for Investigation

See Instructions on Reverse Side

Central Office Use Only

1. Date Completed

## RECIPIENT/PROVIDER INFORMATION

| 2. Last Name | First Name(s) and Initial(s) | 3. MC# |
|---|---|---|
| 4. Street and Mailing Address | | 3a. Social Security Number or Provider Number |
| Street and Mailing Address | | 5. Telephone (Include Area Code) ( ) |
| 6. City State | Zip Code | 7. Social Services Provider Program |

## DEPARTMENT CONTACT INFORMATION

| 8. Last Name | First Name(s) and Initial(s) | 9. Position Title | 10. Worker Number |
|---|---|---|---|
| 11. Office or Division | 12. Local Office/Division Number | 13. Telephone (Include Area Code) ( ) | |
| 14. Street and Mailing Address | City | State | Zip Code |

## COMPLAINT INFORMATION

| 15. Last Name | First Name(s) and Initial(s) | 16. Telephone (Include Area Code) ( ) |
|---|---|---|
| 17. Street and Mailing Address | City | State Zip Code |

## DETAILS OF ALLEGED OVERPAYMENT

| 18a. Program Area | Period of Time | Amount |
|---|---|---|
| Program Area | Period of Time | Amount |
| Program Area | Period of Time | Amount |

18b. Brief Description:

Email the form and all attachments to:
DHHS.InvestigationsSIU@nebraska.gov and place a copy in the file

# INSTRUCTIONS

Please provide the following information:

## RECIPIENT/PROVIDER REFERRALS

1. Complete parts 1 thru 6 for Recipient Referrals/Complete parts 1 thru 7 for Provider Referrals.

2. Complete parts 8 thru 14 with information of the Department of Health and Human Services employee who has knowledge of the details of the complaint.

3. Complete parts 15 thru 17 with information of the complainant if different than the contact person.

4. Complete part 18.

| | | |
|---|---|---|
| a. IN PART 18a., | COMPLETE | the program area(s) involved,<br>the overpayment period(s) and,<br>the amount of the overpayment. |
| b. IN PART 18b., | STATE | briefly the facts you believe establish<br>the act of fraud; |
| | STATE | whether client/provider continues to receive<br>benefits/payments, and if so what kind; |
| | STATE | whether client/provider has been involved<br>in any prior recipient/provider fraud case(s). |

**NOTE:** Only one ASD-63 form is to be completed covering all programs involved (ADC, AABD, Food Stamps, Medical, Social Services, etc.). Coordinate with appropriate workers before submission to the Investigation Unit.

## DISTRIBUTION

By Email: send the form and all attachments to: DHHS.InvestigationsSIU@nebraska.gov

By Mail: submit in an envelope marked ‘CONFIDENTIAL, DO NOT OPEN’ and mail to DHHS, Attention: Special Investigations Unit, 1215 S 42nd St, Omaha NE 68105