OFFICE OF THE GOVERNOR
AMERICAN SAMOA MEDICAID STATE AGENCY
AMERICAN SAMOA 96799

Medicaid Program Integrity Division Referral Form

Please attach copies of all relevant documents. This may include, but not be limited to: case history, file documents, notes of provider education/training, provider questions, and relevant policy & procedure documentation. Communication sources may be letters, emails and phone logs. Submit your referral form via email to: pi@medicaid.as.gov. If the amount of documentation is too great to be emailed, please mail to the address listed below.

American Samoa Medicaid State Agency
ATTN: Program Integrity Division
P.O. Box 6101
Pago Pago, AS 96799

Phone: (684) 699-4777

Medicaid Program Integrity Division cannot comment on the status of any referral once received other than to acknowledge receipt of the referral. All information regarding this referral will be treated as confidential within the American Samoa Medicaid State Agency.

ALLEGED VIOLATOR

Subject's Name (Rendering/Servicing/Prescribing Provider Name)	*Provider Type*	*Rendering/Servicing/Prescribing NPI*	
Subject/Provider Address	*City*	*State*	*Zip Code*
Pay-To Name (if Different)	*Provider Type*	*Pay-To NPI (if Different)*	
Subject/Individual's Name (if Different from Provider)	*Subject/Individual's Job Position or Duties (if applicable)*		

SOURCE OF THE REFERRAL

Source Name/Origin of Complaint	*Medicaid Employee?* ☐ Yes ☐ No	*Date Reported to Medicaid*	
Source Address	*City*	*State*	*Zip Code*
Source Phone	*Source Email*		

ALLEGATION INFORMATION

Chronology of Events (Only Applicable Events) (Expand section, if necessary)

Factual Explanation of Allegation

Dates of Allegation	*Type of Service (Code & Procedure Description)*

Specific Medicaid Statutes, Rules and/or Policies Allegedly Violated (include attachments or web link)

Are there any additional comments you wish to make or any additional information you wish to give about this referral?