

NOTICE OF RECIPIENT FRAUD/NON-FRAUD OVERISSUANCE

DATE: ____/____/____

**TO: DIVISION OF PROGRAM OPERATIONS
RECIPIENT AUDIT UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VA 23219**

Recipient Name: _____

Recipient Address: _____

Recipient Social Security #: _____

Recipient Medicaid ID#: - - -

Dates of Ineligibility for Medicaid/LTC: _____

Reason for Ineligibility for Medicaid/LTC:

Eligibility Worker/Medicaid Technician

() _____
Telephone Number

Address

City/County Code (FIPS)

If additional information is required, you will be contacted by the Recipient Audit Unit.