



California Department of Justice  
Bureau of Medi-Cal Fraud & Elder Abuse

State of California  
Attorney General  
Bill Lockyer

COMPLAINT FORM

I want to report suspected Medi-Cal fraud or elder abuse. I understand that the Attorney General does not represent private citizens seeking private remedies. I submit my allegations for review to determine if law enforcement or statewide legal action is warranted.

**Complaining Party**

Name \_\_\_\_\_

Street Address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

e-mail address \_\_\_\_\_

Preferred method of contact:  Home  Work  e-mail

**Complaint Against**

Name \_\_\_\_\_

Street Address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_

**THREE WAYS TO FILE YOUR COMPLAINT**

**(1) Submit On-line Using This Form**

**(2) OR Print Complaint Form To Mail**

Mail to:  
California Department of Justice  
Bureau of Medi-Cal Fraud & Elder Abuse  
P.O. Box 944255  
Sacramento, CA 94244-2550

**(3) OR Call Toll-Free Hotline**

**1-800-722-0432**  
ATTORNEY GENERAL'S BUREAU OF  
MEDI-CAL FRAUD & ELDER ABUSE

**1-800-822-6222**  
DEPARTMENT OF HEALTH SERVICES

Have you contacted your local law enforcement agency?  Yes  No

If yes, name of agency

Have you contacted another state agency?  Yes  No

If yes, name of agency

Have you contacted an attorney?  Yes  No

If yes, name of attorney

Is there court action pending?  Yes  No

If yes, name of court

Have you lost a lawsuit in this matter?  Yes  No

Please provide a factual statement that clearly describes the date, place and nature of the incident or issue that you are reporting.

Briefly describe how you believe this office can be of assistance.

I will sign a sworn statement if requested.  Yes  No

**By submitting this form, I certify that I understand that the Attorney General does not represent private citizens seeking the return of money or other personal remedies.**

---