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Brent D. Sherard, M.D., M.P.H., Director and State Health Officer

Governor Dave Freudenthal

EXHIBIT 4.1

REPORT OF SUSPECTED ABUSE OF THE EQUALITYCARE HEALTH CARE SYSTEM

NAME(S) OF EQUALITYCARE CLIENT/
PROVIDER: _____

ADDRESS OF EQUALITYCARE CLIENT/
PROVIDER: _____

TELEPHONE NUMBER OF EQUALITYCARE CLIENT/ PROVIDER:

Please give a brief description of how the EqualityCare client/provider is abusing the EqualityCare health care system. (If possible give dates of occurrence.)

PLEASE CHECK ONE: EMERGENCY CARE _____ NON-EMERGENCY CARE _____

Signature of Person Reporting Abuse

Date

ADDRESS: _____ Telephone # _____

The above confidential information shall only be used to determine what action is necessary by the Wyoming Department of Health Care Financing, Office of EqualityCare.

RETURN THIS FORM TO:

**Program Integrity Unit
Office of Health Care Financing
6101 Yellowstone Rd.
Suite 210
Cheyenne, WY 82002**