



## FRAUD, WASTE, ABUSE REFERRAL FORM

REFERRAL	
Date:	
Name of Person Making Referral:	
Contact Phone Number:	
Title:	
Department:	
Referral of Fraud, Waste, Abuse By:	<input type="checkbox"/> PROVIDER <input type="checkbox"/> MEMBER <input type="checkbox"/> OTHER

You may remain anonymous. However, we may need to talk with you to obtain additional information, so a contact number is helpful.

MEMBER	
Member Name:	
Member ID:	
Address:	
City:	
State & Zip Code:	
Date(s) of Suspected Fraud, Waste or Abuse:	
Describe the suspected fraud, waste, or abuse as clearly as possible and identify any individuals involved or who may have knowledge of the incident(s):	

PROVIDER	
Provider or Facility Name:	
Provider ID (if known):	
Address:	
City:	
State & Zip Code:	
Date(s) of Suspected Fraud, Waste or Abuse:	
Describe the suspected fraud, waste, or abuse as clearly as possible and identify any individuals involved or who may have knowledge of the incident(s):	

OTHER	
Name:	
Address:	
City:	
State & Zip Code:	
Date(s) of Suspected Fraud, Waste or Abuse:	
Describe the suspected fraud, waste, or abuse as clearly as possible and identify any individuals involved or who may have knowledge of the incident(s):	