CONFIDENTIAL

Suspected Fraud/Abuse Referral

Date Complaint Received: Investigation Unit Case #:

Source of Complaint

____ Hotline
____ Telephone
____ Written
____ Internal Referral
____ Employee
____ Other _____

Line of Business

____ Blue Cross
____ Blue CHiP
____ Major Medical
____ F.E.P.
____ Dental
____ Other _____

COMPLAINANT: ____ Subscriber ____ Provider ____ Employee ____ Other _____

NAME _____ SUBSCRIBER LID #:

ADDRESS _____ _____

_____ NAME OF PATIENT:

_____

TELEPHONE ( ) _____

COMPLAINT AGAINST: ___ Physician ___ Facility ___ Subscriber ___ Other _____

NAME _____ PROVIDER/SUBSCRIBER #:

ADDRESS _____ _____

_____ DATE(S) OF SERVICE:

_____

TELEPHONE ( ) _____

NATURE OF COMPLAINT: _____

_____

_____

_____

Is there anyone else that you are aware of that can substantiate?: _____

_____

_____

_____

COMPLETED BY: DATE RECEIVED IN INVESTIGATIONS:

DEPARTMENT: ASSIGNED TO:

TELEPHONE: DATE: DATE CLOSED:

Guidelines for Completing

Suspected Fraud/Abuse Referral Form

The Suspected Fraud/Abuse Referral form is to be used for all complaints or inquiries alleging possible fraud and/or abuse. It is necessary to secure the proper information from the complainant when he/she is reporting an allegation of fraud or abuse. Therefore, this form is to be completed following the instructions below. All applicable sections should be completed prior to submission. Once completed, attach any pertinent documentation and forward this form and attachments immediately to the Investigations Unit. The Investigations Unit is located at 500 Exchange St, Providence RI, 02903.

1. ***Date Complaint Received*** - Enter the date the complaint/inquiry was received (i.e., the day of the phone call or the day the letter was received.)

2. ***Investigation Unit Case #*** - DO NOT COMPLETE - FOR INVESTIGATIONS UNIT USE ONLY.

3. ***Source of Complaint*** - Enter how the complaint/inquiry was received (i.e., telephone call, letter, employee, etc.)

4. ***Line of Business*** - Indicate the line or lines of business involved in this complaint/inquiry. If not listed, explain in "other".

5. ***Complainant*** - Who is making the complaint/inquiry? Indicate if it is the subscriber, provider or other. Obtain the complete name (first and last), address and telephone number of the individual making the complaint/inquiry. If the complainant will not provide identification print, "anonymous". Enter the subscriber's LID (membership number) and the name of the patient. If the patient is different from the complainant, enter the patient's address in the same block as the patient's name.

6. ***Complaint Against*** - Who is the complaint against? Indicate whether it is a physician, facility, subscriber or other (list who). Obtain the complete name (first and last), address and telephone number. Enter the provider or subscriber number and the date(s) of service.

7. ***Nature of Complaint*** - List as much information as possible as to what the complaint is about.

8. ***Completed By*** - The name of the person who received the complaint/inquiry. Enter your name, department, phone number and the date you completed the referral form.

9. ***Date Received in Investigations*** - DO NOT COMPLETE - FOR INVESTIGATIONS UNIT USE ONLY.