Instructions for
Uniform Suspected Insurance Fraud Reporting Form

The *Uniform Suspected Insurance Fraud Reporting Form* was adopted by the NAIC Antifraud Task Force on Mar. 11, 2003. This form will replace the prior form adopted by the Antifraud Task Force. The purpose of the form is to provide a standardized reporting platform for use by the insurance industry. It is the hope of the task force that by changing the existing format, insurance fraud data will not only be easier to report but also easier to track.

These directions will provide a general explanation of the information that should be contained in each data field of the form. You will find that some data fields could have multiple entries, such as phone number, driver's license number, address, etc. The easiest way for the insurance fraud division to track the information is to complete the form as it relates to the person/business mentioned in the Subject section. If the subject has an alias with different dates of birth, etc., please complete this information in the Additional Parties section of the form so investigators can differentiate between which personal data is connected to each subject name.

Reporting Person and Insurance Company Information	
State of ___________	**Fill in the name of the state that the referral should be sent to. If the referral should be sent to more than one state because of jurisdiction, please send a separate referral to each affected state and complete the "Other Agency" portion of the referral form to alert the state fraud agencies so that they may coordinate their investigations.**
Reporting Person	**Name of the person who is completing the referral and can be contacted for additional information if necessary.**
Insurance Company	**Use the name of the insurance company that is the victim of the suspected fraud. Avoid using a "group" name.**
NAIC #	**The insurance company's 5-digit number issued by the National Association of Insurance Commissioners.**
Mailing address	**The mailing address of the person sending the referral**
Phone number	**Telephone number of the person sending the referral**
Fax number	**Fax number of the person sending the referral**
E-mail address	**E-mail address of the person sending the referral**
Loss and Suspected Fraud Information	
Detailed Synopsis	**A report of the suspected insurance fraud. Please provide enough information to clearly indicate what the fraudulent activity is and any persons involved. Attach additional pages, if necessary. If you mention a person in this section, you should also provide more information about that person in either the "Subject Information" area or the "Additional Party Involved" area.**
Date of Loss / Injury	**Enter the date that the loss, claim, or injury occurred**
Address of Loss	**Address where the loss, claim, or injury occurred**
Dates of Service	**The date(s) of the health-related services that were provided to the insured or patient that are in question. Complete this section if the health-related services are in question.**
Description of Service	**Description of medical or dental service or procedure**
Claim #	**Claim number of the suspected fraudulent claim. If there are additional claim numbers that relate to the same investigation,**

	please complete an additional referral form to capture the information as it relates to each individual claim.	
Policy #	Policy number related to suspected fraud. If there is more than one policy number that relates to the investigation, please complete an additional referral form to capture the information as it relates to each individual policy.	
Reserve Amount $	Dollar amount held in reserve related to the fraud referral	
Amount Paid $	Dollar amount currently paid related to the fraud referral	
Date Paid	Date that the payment was made	
Loss Amount $	Dollar amount of the loss related to the fraud referral	
Settlement Amount $	Dollar amount of any settlement paid related to the fraud referral. If applicable, complete parties to all settlements in the "Additional Parties" section.	
Date Paid	Date that the settlement was paid	
Procedure Code #'s: ☐ CPT ☐ CDT	Use the five- digit CPT Codes or the CDT codes for the mental or dental services related to the referral.	
Insurance Type	Check off the type of insurance policy or policies that are related to the suspected fraud.	
	PC	property & casualty (includes homeowners, farm, general liability, commercial property, commercial liability, inland marine)
	WC	workers' compensation
	HC	health care (includes health, HMO's, dental, vision)
	Auto	personal auto, commercial auto
	Life	life insurance (including credit life)
	Disability	disability insurance (including credit disability)
Civil Litigation Pending ☐ Yes ☐ No	If "Yes" is checked, please indicate any pertinent dates related to the litigation., such as a trial date.	
Subject Information		
Type	Indicate the role the subject had in this referral. "Type" codes are on page 2 of the referral form. If you do not find a "type" that is appropriate, use OT for "other" and fill in a description of the role in the space provided below OT.	
Name (Last/Business), (First), (Middle)	The subject's name, or the subject business name, if the subject is a business name, and the subject is unknown.	
Date of Birth	Date of birth of the subject. You may list multiple dates of birth if the dates of birth are used by the subject's name used in the referral. If the subject uses an alias, match the aliases with the dates of birth used with the alias.	
Age	Age of the subject	
SSN	Social Security Number of the subject	
Street Address (Include PO Box and apartments #'s), City, State, Zip, County	Address of the subject. You may list multiple addresses if the subject uses multiple addresses using the subject's name.	
Address Type: ☐Res. ☐ Bus. ☐ Maildrop ☐ Other	Indicate if the subject's address is a residence, business, mail drop, or other. type	
Fed. TIN☐ EIN☐ Number:	Subject's Federal Tax Identification Number or Employer Identification Number	

Sex: M ☐ F ☐	**If unknown, do not complete the box.**
Telephone No.	**The subject's telephone number. There are boxes to enter two phone numbers.**
Phone Type **☐ home ☐ cell ☐ bus.**	**Check off the type of phone number, if known.**
Driver's License #	**Subject's driver's license number.**
State	**State that the driver's license was issued in**
VIN	**The Vehicle Identification Number of the vehicle involved in the referral**
Vehicle Year	**The year that the vehicle was manufactured**
Make	**The vehicle manufacturer or brand**
Model	**The specific type or style of vehicle**
License Plate #	**The license plate number of the subject's vehicle.**
Reported Injuries	**A general overview of the subject's injuries**
Employer	**The name of the subject's employer**
Address & Phone #	**The address and phone number of the subject's employer**
Occupation	**The subject's job title and/or profession**
Additional Party Involved ☐ **AKA Information ☐**	**If other persons are involved with this referral such as a witness, co-conspirator, etc., please complete a section about them on the "Additional Parties" section. Check off the box if the Subject is known by a different name. Please complete a section in the "Additional Parties" area as well.**
Comments	**Any information that is relevant to the case, not covered on the form.**
Case Details (check all that apply)	
SIU Investigation Completed ☐ Yes ☐ No	
Date Completed	

Is there any reason to believe that this incident is related to other suspected fraudulent activity? ☐ Yes ☐ No	
☐ Statements (Witness / Insured / Subject) ☐ Sworn ☐ Recorded	
☐ Proof of Loss	
☐ Continuance of Disability Forms	
☐ Medical Records	
☐ Other	
☐ EUO / Deposition	
☐ Copies of Receipts	
☐ Expert Reports	
☐ Videos / Photos	
☐ Claim Information	
☐ Other	
☐ Law Enforcement / Other Agency Reports	
☐ Claim History Extract	
☐ IME Reports	
☐ Investigative Reports	
☐ External Database results	
☐ Other	
Identify Other Agency You Have Contacted Regarding This Referral	
Agency Type	**If you have contacted another agency regarding this referral, check off the type of agency.**
☐ **Other State Fraud Bureau**	
☐ **Law Enforcement**	
☐ **Other Insurance Company**	
☐ **Regulatory Agency**	
☐ **Other**	
Agency	**Name of the agency you contacted**
Contact Person	**The person who received or is investigating your referral**
Address/City/State/Zip	
Telephone	
Fax	
Case/Claim No.	**The agency's case number or claim number**
Suspected Fraud Types	
Suspected Fraud Types	**Check all boxes that apply to your referral. The first column relates mostly to Property/Casualty referrals. The second column relates mostly to Fraud Types that could be found in any lie of insurance. The last column refers mostly to Health Care fraud referrals.**

Subject / Additional Party Types	
Subject/Additional Party Types	**Use the abbreviations to indicate which role that the Subject and/or Additional Parties played in the investigation. You may use more than one type per person.**
Grey Box at the end of Referral Form	**Additional information that the reporting state would like to inform the sender about. Each grey box will be specific to the state that will be receiving the referral.**
Additional Party Involved / AKA Information	
Please use the directions in the Subject Information area to help you complete the Additional Parties section. This section was designed to assist investigators with identifying personal information that belongs to all parties of an investigation or the personal information associated with each alias used by a subject.	

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