

UNIFORM SUSPECTED INSURANCE FRAUD REPORTING FORM

State of _____
 Division of Insurance – Fraud Bureau

For State Use Only

Case No. _____ Status _____ FYI _____

Reporting Person:	Insurance Company:	NAIC#
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Mailing address:	Phone number: ()
	Fax number: ()
	E-mail address:

Detailed synopsis. Attach additional pages, if necessary.

Date of Loss / Injury:	Dates of Service: _____ to _____
Address of Loss / Injury: (City) _____ (State) _____ (Zip) _____	Description of Service:

Claim #	Policy #
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Reserve Amount \$	Amount Paid \$	Date Paid	Procedure Code #'s: <input type="checkbox"/> CPT <input type="checkbox"/> CDT	Insurance Type <input type="checkbox"/> PC <input type="checkbox"/> WC <input type="checkbox"/> HC <input type="checkbox"/> Auto <input type="checkbox"/> Life <input type="checkbox"/> Disability
Loss Amount \$	Settlement Amt. \$	Date Paid	Civil Litigation Pending: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Subject Information

Type:	Name (Last / Business):	(First):	(Middle):	Date of birth:	Age:	SSN:
Street Address (include P.O. Box and apartment #'s):		Address Type: <input type="checkbox"/> Res. <input type="checkbox"/> Bus. <input type="checkbox"/> Maildrop <input type="checkbox"/> Other		Fed. TIN <input type="checkbox"/>	EIN <input type="checkbox"/>	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
City:	State:	Zip:	County:	Telephone No.: ()	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.	
Driver's License #:	State:	VIN:		Telephone No.: ()	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.	
Vehicle Year:	Make:	Model:	License Plate #:	Reported Injuries:		
Employer:		Address & Phone #:		Occupation:		

Additional Party Involved <input type="checkbox"/> See Additional Party Involved/AKA AKA Information: <input type="checkbox"/> Information	Comments:
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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

<input type="checkbox"/> Statements (Witness / Insured / Subject) <input type="checkbox"/> Sworn <input type="checkbox"/> Recorded	<input type="checkbox"/> EUO / Deposition <input type="checkbox"/> Copies of Receipts <input type="checkbox"/> Expert Reports <input type="checkbox"/> Videos / Photos <input type="checkbox"/> Claim Information <input type="checkbox"/> Other	<input type="checkbox"/> Law Enforcement / Other Agency Reports <input type="checkbox"/> Claim History Extracts <input type="checkbox"/> IME Reports <input type="checkbox"/> Investigative Reports <input type="checkbox"/> External Database results <input type="checkbox"/> Other
<input type="checkbox"/> Proof of Loss	<input type="checkbox"/> Continuation of Disability Forms	<input type="checkbox"/> Medical Records
<input type="checkbox"/> Other		

Identify Other Agency You Have Contacted Regarding This Referral

Agency Type: Other State Fraud Bureau Law Enforcement Other Insurance Company Regulatory Agency Other

Agency: _____ Contact Person: _____
 (Address) _____ (City) _____ (State) _____ (Zip) _____
 Telephone () _____ Fax () _____ Case/Claim No. _____

Suspected Fraud Types (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Arson
<input type="checkbox"/> home <input type="checkbox"/> vehicle <input type="checkbox"/> business | <input type="checkbox"/> Agent fraud | <input type="checkbox"/> Duplicate billing for same service |
| <input type="checkbox"/> Fictitious loss <input type="checkbox"/> damages <input type="checkbox"/> | <input type="checkbox"/> Application fraud | <input type="checkbox"/> Forged prescriptions |
| <input type="checkbox"/> Fictitious theft
<input type="checkbox"/> vehicle <input type="checkbox"/> property | <input type="checkbox"/> Billing for services/products not provided | <input type="checkbox"/> Fraudulent death claims |
| <input type="checkbox"/> Inflated inventory | <input type="checkbox"/> Failure to disclose multiple insurance companies | <input type="checkbox"/> Over-utilization of services |
| <input type="checkbox"/> Inflated loss <input type="checkbox"/> damages <input type="checkbox"/> | <input type="checkbox"/> False claims | <input type="checkbox"/> Prescription abuse / doctor shopping |
| <input type="checkbox"/> Inflated theft
<input type="checkbox"/> vehicle <input type="checkbox"/> property | <input type="checkbox"/> Illegal solicitation (cappers) | <input type="checkbox"/> Prescriptions issued for non-medical purposes |
| <input type="checkbox"/> Double-dipping | <input type="checkbox"/> Issued fraudulent insurance policies, certificates, binders, ID cards | <input type="checkbox"/> Unbundling |
| <input type="checkbox"/> Exaggerated injuries | <input type="checkbox"/> Misrepresentation of services / products provided | <input type="checkbox"/> Upcoding |
| <input type="checkbox"/> Injuries not related to work | <input type="checkbox"/> Kickbacks/bribery | <input type="checkbox"/> Misrepresented non-covered services as covered |
| <input type="checkbox"/> Malingerers | <input type="checkbox"/> Money laundering | <input type="checkbox"/> Changing dates of service, CPT/CDT/diagnostic codes |
| <input type="checkbox"/> Misappropriated vehicle salvage | <input type="checkbox"/> Multiple claims | <input type="checkbox"/> Charges inconsistent with services provided |
| <input type="checkbox"/> Premium avoidance | <input type="checkbox"/> Possession/sold fraudulent insurance policies, certificates, binders, ID cards | <input type="checkbox"/> Products billed are inconsistent with the products |
| <input type="checkbox"/> Prior injuries | <input type="checkbox"/> Questioned documents
<input type="checkbox"/> altered <input type="checkbox"/> forged <input type="checkbox"/> falsified
<input type="checkbox"/> duplicated | <input type="checkbox"/> Using unqualified/unlicensed persons to perform billable services |
| <input type="checkbox"/> Slip and fall | <input type="checkbox"/> Received compensation for referral to health care provider or attorney | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Staged injury / accident at work | <input type="checkbox"/> Ring / organized activity type | |
| <input type="checkbox"/> Staged collisions | | |
| <input type="checkbox"/> Paper accidents | | |
| <input type="checkbox"/> Other _____ | | |

Subject / Additional Party Types

CL	Claimant	PH	Pharmacist	TPA	Third Party Administrator
IN	Insured	CHI	Chiropractor	FP	False Provider
WT	Witness	NP	Nurse Practitioner	UP	Unlicensed Provider
LC	Lawyer for Claimant	LPN	Licensed Practical Nurse	MN	Other Medical Personnel
LI	Lawyer for Insured	PT	Physical Therapist	MS	Medical Specialist
INS	Insurer	PA	Physician's Assistant		_____
SI	Self-Insured	OP	Optometrist	DS	Dental Specialist
IY	Insurance Company Employee	PO	Podiatrist		_____
IB	Agent/Broker	RD	Radiologist	NS	Nurse Specialist
IS	Adjuster	MT	Massage Therapist		_____
IR	Appraiser	AMB	Ambulance Service Employee	OT	Other
BS	Body Shop	DME	DME Supplier		_____
SY	Salvage Yard Owner / Employee	HHA	Home Health Agency		
TY	Tow Yard Owner / Employee	MR	Laboratory		
MD	Medical Doctor	MH	Medical Clinic/Hospital		
DO	Doctor of Osteopathic Medicine	MZ	Office Administrator		
DEN	Dentist	BS	Billing Services		

This grey box is for each state to add unique statement or warnings for their reporting forms such as immunity language, special instructions, confidentiality disclaimer, etc.

Additional Party Involved / AKA Information

Type:	Name (Last):	(First):	(Middle):	Date of birth:	Age:	SSN:
Street Address (include P.O. Box and apartment #'s):			Address Type: <input type="checkbox"/> Res. <input type="checkbox"/> Bus. <input type="checkbox"/> Maildrop <input type="checkbox"/> Other		Fed. TIN <input type="checkbox"/> EIN <input type="checkbox"/>	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
City:		State:	Zip:	County:	Telephone No.: ()	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.
Driver's License #:		State:	VIN:		Telephone No.: ()	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.
Vehicle Year:	Make:	Model:		License Plate #:	Reported Injuries:	
Employer:		Address & Phone #:			Occupation:	
Involvement in referral:						

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Vehicle Year:	Make:	Model:		License Plate #:	Reported Injuries:	
Employer:		Address & Phone #:			Occupation:	
Involvement in referral:						