Potential Fraud Report Form

Date of Incident(s) _____

Summary of Incident(s) (Provide as much detail as possible)

_____

_____

_____

_____

_____

Provider Information:

Name _____

Facility Name _____

Address _____

City/State/Zip _____

INTERNAL USE ONLY

Case #: _____

Method received: _____

Close date: _____

Policy Holder Information:

Name _____

Address _____

City/State/Zip _____

Phone number _____

Benefit Plan# _____

Patient's name (if different than policy holder) _____

Person making the report (if different from policy holder information): (OPTIONAL)

Name _____

Address _____

City/State/Zip _____

Phone number _____

Mail to: Compliance

P.O. Box 242, West Fargo, ND 58078-0242

****Please attach all supporting documentation.****

Thank you for taking the time to report your concerns.
It is our policy to keep the identity of the reporting party confidential to the extent possible.