DWC Medical Unit
P.O. Box 420603
San Francisco, CA 94142
Report of Suspected Medical Care Provider Fraud

Labor Code section 3823 requires any insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person that believes that a fraudulent claim has been made by any person or entity providing medical care, as described in Labor Code section 4600, to report the apparent fraudulent claim in the manner prescribed by the reporting protocols adopted by the administrative director of the Division of Workers' Compensation.

Complaining party (Please check the box that best describes you. Insurers, self-insured employers or third-party administrators should not use this form. These entities should use the Department of insurance suspected fraudulent claim referral form (FD-1).):

Person submitting the complaint:

☐ Injured worker ☐ Attorney ☐ Physician ☐ Other

Name: _____

Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home telephone number: ( ) _____

Work telephone number: ( ) _____

E-mail: _____

Preferred place to contact you: (check one) Work _____ Home _____

Complaint against (If more than one provider is involved, please attach additional sheets identifying each one):

Name: _____

Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Type of health care provider: _____

Description of the alleged fraudulent activity: Please provide as much detail as possible, including the nature of the unlawful act, why you believe that the activity you are reporting constitutes fraud, names, dates and documents. Please attach additional sheets if necessary and provide a copy of any relevant documentation you have. ***PLEASE DO NOT ATTACH ORIGINAL DOCUMENTS***

Claim information (If more than one injured worker's care is involved, please attach additional sheets):

Date of injury: 03/15/2001

WCAB case number(s) (if known): _____

Name of injured worker: Deborah Medina

Address: P.O. Box 2333

City: Whittier State: CA Zip Code: 90602

Injured worker's Social Security number (if known): 111111111

Injured worker's date of birth (if known): 10/12/1956

Name of employer at date of injury: PIH Health Hospital

Address: _____

City: _____ State: _____ Zip Code: _____

Location where injury occurred: 12401 Washington Blvd Whittier CA 90602

Name of insurer or third party administrator: PIH Health

Address: 12401 Washington Blvd

City: Whittier State: CA Zip Code: 90602

Claims administrator's claim number (if known): 8330-01-0038

Reports to other agencies Has the suspected fraudulent activity been reported to any law enforcement or professional licensing board? If so, please identify the agency, contact person and telephone number.

Report submitted by

Signature: _____ Date: 08/01/2022

Please print your name: _____

Where to report (Send this completed form and photocopies of relevant supporting documents to):

Division of Workers' Compensation-Medical Unit
P.O. Box 420603
San Francisco, CA 94142