FRAUD, WASTE, & ABUSE REFERRAL FORM

NOTICE: RED BOLDED TITLE FIELDS ARE *REQUIRED* TO BE POPULATED FOR REFERRAL SUBMISSION ACCEPTANCE

Todays Date	
Date First Discovered	
Date First Reported to Client/Plan Sponsor	

Client Name	

What Line of Business does this involve?

Commercial | Exchanges	Medicaid	Med D / MMP
N/A	N/A	N/A
Mark X for each all that apply		

List all client Carrier(s)#'s that are being impacted/involved/included in this FWA Referral

Commercial	Medicaid	Med-D	CMS Contract#

Has this referral been reported to any other internal *or* external team or source?

INTERNAL	Acct Mngt	Customer CARE	Salesforce#	RXTicket #	PharmProfile#
	NO	NO	NO	NO	NO
EXTERNAL	Local Police	State Authorities	HHS|OIG	MEDIC	RXO Case #
	NO	NO	NO	NO	NO

Is there an Open or Existing FWA Case Referral activities or cross reference related to any contact in this referral?

Grievance #	CFWA #	RXTicket#	Salesforce#	RXO Case#	PharmProfile#

Suspect Name: *Allegation being made against whom*

Victim Name: *Victim of allegation*

Allegation Short Description:

Allegation Summary:

Claims Information:	
Insurance Company	
Date(s) of Service | Date(s) of Fill	
Amount Paid to Provider	
Claim Number(s)	

**** All referrals should include a separate claims detail file that represents claims involved in allegation or sampling**

Your Contact Information	
Name	
Email	
Phone	
Department	
Title	
Company of Submitter	
Supervisor Name	
Supervisor Email	
Have you reported this matter to customer Service? Y or N	** Selection Required **

*** Enter all necessary contact information needed to research suspect activities further*

Pharmacy Information (Only 1 NPI allowed per referral)	
Pharmacy Name	
NPI	
NCPDP	
Type (Retail/Mail/LTC)	
Address	
City	
County	
State	
Zip	
Phone	
Email	

Provider Information (MD, NP, PA, RN, RPh)	
Last Name	
First Name	
NPI#	
Credentials	
Specialty	
Address	
City	
County	
State	
Zip	
Phone Number	
Email	

Beneficiary / Patient Information	
Last Name	
First Name	
DOB	
Member ID/MBI	
Carrier #	
Address	
City	
County	
State	
Zip	
Phone Number	
Email	

Medical Other: Clinic / Imaging / Laboratory / Medical	
Name	
Name-DBA	
NPI#	
Specialty	
Credentials	
Address	
City	
County	
State	
Zip	
Phone Number	
Email	