FRAUD, WASTE & ABUSE REFERRAL FORM

RED BOLDED TITLE FIELDS ARE REQUIRED TO BE POPULATED FOR REFERRAL SUBMISSION ACCEPTANCE.
SEND COMPLETED FORM VIA EMAIL TO: COMPREHENSIVEFWA@CVSHEALTH.COM

Today's Date:	
Date Issue First Discovered:	

Client Name:	
Line of Business:	
Carrier #'s that are impacted in this referral:	

Please list any other internal or external teams this referral has been reported to:

Victim/Member Name:	
Suspect Name:	

Allegation Summary:

Claim information: List all that apply (provide RX#, DOF, Claim #, etc.)

Contact Information

Please fill–out all relevant boxes; however, 'Referral Submitter' and 'Beneficiary/Patient Information' are required.

Referral submitter	
Name:	
Email:	
Phone #:	
Department:	
Title:	
Company:	
Supervisor Name:	

Beneficiary/Patient Information	
Name:	
DOB:	
Member ID#:	
Carrier #:	
Address:	
City, State:	
Phone #:	

Pharmacy Information (list additional pharmacies in the Allegation Summary)	
Pharmacy Name:	
NPI# or NPCPD#:	
Address:	
City, State:	
Phone #:	
Contact Name:	

Provider Information (list additional providers in the Allegation Summary)	
Name:	
NPI#:	
Credentials:	
Specialty:	
Address:	
City, State:	
Phone #:	
Contact Name:	