## UNIFORM SUSPECTED INSURANCE FRAUD REPORTING FORM

### Case Details (check all that apply)

- **Is there any reason to believe that this incident is related to other suspected fraudulent activity?**
  - [ ] Yes
  - [ ] No

- **Statements (Witness / Insured / Subject)**
  - [ ] Sworn
  - [ ] Recorded

- **Proof of Loss**

- **Continuance of Disability Forms**

- **Medical Records**

- **Other**

- **EUO / Deposition**

- **Copies of Receipts**

- **Expert Reports**

- **Videos / Photos**

- **Claim Information**

- **Other**

- **Law Enforcement / Other Agency Reports**

- **Claim History Extracts**

- **IME Reports**

- **Investigative Reports**

- **External Database results**

- **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**:  
  - [ ] Other State Fraud Bureau
  - [ ] Law Enforcement
  - [ ] Other Insurance Company
  - [ ] Regulatory Agency
  - [ ] Other

### Additional Party Involved (check all that apply)

- **See Additional Party Involved/AKA Information**

### Subject Information

- **Type**:  
  - [ ] Name (Last / Business):
  - [ ] (First):
  - [ ] (Middle):
  - [ ] Date of birth:
  - [ ] Age:
  - [ ] SSN:

- **Street Address (include P.O. Box and apartment #’s)**:
  - [ ] Address Type:  
    - [ ] Res.
    - [ ] Bus.
  - [ ] Maildrop
  - [ ] Other

- **City**:  
  - [ ] State:
  - [ ] Zip:

- **Driver’s License #**:  
  - [ ] State:
  - [ ] VIN:

- **Vehicle Year**:  
  - [ ] Make:
  - [ ] Model:
  - [ ] License Plate #:
  - [ ] Reported Injuries:

### Case History Extracts

- **SIU Investigation Completed**
  - [ ] Yes
  - [ ] No
  - [ ] Date Completed:

### Comments:

- **Employer**:
  - [ ] Address & Phone #:

### Telephone No.:

- [ ] Home
  - [ ] Cell
  - [ ] Business

### Driver’s License #:

- [ ] State:

### Other Information:

- **Contact Person**:
  - [ ] Case/Claim No.
Suspected Fraud Types (check all that apply)

- □ Arson
- □ home □ vehicle □ business
- □ Fictitious loss □ damages □
- □ Fictitious theft
- □ vehicle □ property
- □ Inflated inventory
- □ Inflated loss □ damages □
- □ Inflated theft
- □ vehicle □ property
- □ Double-dipping
- □ Exaggerated injuries
- □ Injuries not related to work
- □ Malingerers
- □ Misappropriated vehicle salvage
- □ Premium avoidance
- □ Prior injuries
- □ Slip and fall
- □ Staged injury / accident at work
- □ Staged collisions
- □ Paper accidents
- □ Other

- □ Agent fraud
- □ Application fraud
- □ Billing for services/products not provided
- □ Failure to disclose multiple insurance companies
- □ False claims
- □ Illegal solicitation (cappers)
- □ Issued fraudulent insurance policies, certificates, binders, ID cards
- □ Misrepresentation of services / products provided
- □ Kickbacks/bribery
- □ Money laundering
- □ Multiple claims
- □ Possession/sold fraudulent insurance policies, certificates, binders, ID cards
- □ Questioned documents
  - altered □ forged □ falsified □ duplicated
- □ Received compensation for referral to health care provider or attorney
- □ Ring / organized activity type

- □ Duplicate billing for same service
- □ Forged prescriptions
- □ Fraudulent death claims
- □ Over-utilization of services
- □ Prescription abuse / doctor shopping
- □ Prescriptions issued for non-medical purposes
- □ Unbundling
- □ Upcoding
- □ Misrepresented non-covered services as covered
- □ Changing dates of service, CPT/CDT/diagnostic codes
- □ Charges inconsistent with services provided
- □ Products billed are inconsistent with the products
- □ Using unqualified/unlicensed persons to perform billable services
- □ Other

Subject / Additional Party Types

<table>
<thead>
<tr>
<th>CL</th>
<th>Claimant</th>
<th>PH</th>
<th>Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN</td>
<td>Insured</td>
<td>CHI</td>
<td>Chiropractor</td>
</tr>
<tr>
<td>WT</td>
<td>Witness</td>
<td>NP</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>LC</td>
<td>Lawyer for Claimant</td>
<td>LPN</td>
<td>Licensed Practical Nurse</td>
</tr>
<tr>
<td>LI</td>
<td>Lawyer for Insured</td>
<td>PT</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>INS</td>
<td>Insurer</td>
<td>PA</td>
<td>Physician’s Assistant</td>
</tr>
<tr>
<td>SI</td>
<td>Self-Insured</td>
<td>OP</td>
<td>Optometrist</td>
</tr>
<tr>
<td>IY</td>
<td>Insurance Company Employee</td>
<td>PO</td>
<td>Podiatrist</td>
</tr>
<tr>
<td>IB</td>
<td>Agent/Broker</td>
<td>RD</td>
<td>Radiologist</td>
</tr>
<tr>
<td>IS</td>
<td>Adjuster</td>
<td>MT</td>
<td>Massage Therapist</td>
</tr>
<tr>
<td>IR</td>
<td>Appraiser</td>
<td>AMB</td>
<td>Ambulance Service Employee</td>
</tr>
<tr>
<td>BS</td>
<td>Body Shop</td>
<td>DME</td>
<td>DME Supplier</td>
</tr>
<tr>
<td>SY</td>
<td>Salvage Yard Owner / Employee</td>
<td>HHA</td>
<td>Home Health Agency</td>
</tr>
<tr>
<td>TY</td>
<td>Tow Yard Owner / Employee</td>
<td>MR</td>
<td>Laboratory</td>
</tr>
<tr>
<td>MD</td>
<td>Medical Doctor</td>
<td>MH</td>
<td>Medical Clinic/Hospital</td>
</tr>
<tr>
<td>DO</td>
<td>Doctor of Osteopathic Medicine</td>
<td>MZ</td>
<td>Office Administrator</td>
</tr>
<tr>
<td>DEN</td>
<td>Dentist</td>
<td>BS</td>
<td>Billing Services</td>
</tr>
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</table>

TPA | Third Party Administrator
FP | False Provider
UP | Unlicensed Provider
MN | Other Medical Personnel
MS | Medical Specialist
DS | Dental Specialist
NS | Nurse Specialist
OT | Other

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

<table>
<thead>
<tr>
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<th>Name (Last):</th>
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<td>Occupation:</td>
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