

Fraud Referral Form

**Patient Information**

Name: \_\_\_\_\_ ID/Certificate Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date(s) of Incident(s): \_\_\_\_\_

**Provider Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Tax ID Number: \_\_\_\_\_ License Number: \_\_\_\_\_

NPI Number: \_\_\_\_\_

**Details of Suspected Fraud (Use additional paper if necessary.)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reporting Party: \_\_\_\_\_ Phone: \_\_\_\_\_

Reporting Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: Be sure to attach to this form any document (claims, correspondence, medical records, etc.) that you may have.

Send completed form to: **BlueChoice HealthPlan of South Carolina  
PO Box 9054, Mail Stop CACC01-055D  
Oxnard, CA 93031-9054**

Or fax to: **1-866-454-3990**