

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 complete form to: **[Anthem Blue Cross and Blue Shield
Special Investigations Unit - Medicaid
4425 Corporation Lane
Virginia Beach, VA 23462]**

Or fax to: **[1-866-494-8279]**

www.anthem.com