

UNIFORM SUSPECTED INSURANCE FRAUD REPORTING FORM

State of Kentucky
Division of Insurance Fraud Investigation

For State Use Only

Case No. Status FYI

Reporting Person:	Insurance Company:	NAIC#
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Mailing address:	Phone number: ()
	Fax number: ()
	E-mail address:

Detailed synopsis. Attach additional pages, if necessary.

Date of Loss / Injury:	Dates of Service: to
Address of Loss / Injury:	Description of Service:
(City) (State) (Zip)	

Claim #	Policy #			
Reserve Amount \$	Amount Paid \$	Date Paid	Procedure Code #'s: <input type="checkbox"/> CPT <input type="checkbox"/> CDT	Insurance Type <input type="checkbox"/> PC <input type="checkbox"/> WC <input type="checkbox"/> HC <input type="checkbox"/> Auto <input type="checkbox"/> Life <input type="checkbox"/> Disability
Loss Amount \$	Settlement Amt. \$	Date Paid	Civil Litigation Pending: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Subject Information

Type:	Name (Last / Business):	(First):	(Middle):	Date of birth:	Age:	SSN:
Street Address (include P.O. Box and apartment #'s):		Address Type: <input type="checkbox"/> Res. <input type="checkbox"/> Bus. <input type="checkbox"/> Maildrop <input type="checkbox"/> Other		Fed. TIN <input type="checkbox"/>	EIN <input type="checkbox"/>	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
City:	State:	Zip:	County:	Telephone No.: ()	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.	
Driver's License #:	State:	VIN:		Telephone No.: ()	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.	
Vehicle Year:	Make:	Model:	License Plate #:	Reported Injuries:		
Employer:		Address & Phone #:		Occupation:		
Additional Party Involved <input type="checkbox"/> See Additional Party Involved/AKA			Comments:			
AKA Information: <input type="checkbox"/> Information						

Case Details (check all that apply)

SIU Investigation Completed Yes No Date Completed: _____

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

<input type="checkbox"/> Statements (Witness / Insured / Subject)	<input type="checkbox"/> EUO / Deposition	<input type="checkbox"/> Law Enforcement / Other Agency Reports
<input type="checkbox"/> Sworn <input type="checkbox"/> Recorded	<input type="checkbox"/> Copies of Receipts	<input type="checkbox"/> Claim History Extracts
<input type="checkbox"/> Proof of Loss	<input type="checkbox"/> Expert Reports	<input type="checkbox"/> IME Reports
<input type="checkbox"/> Continuance of Disability Forms	<input type="checkbox"/> Videos / Photos	<input type="checkbox"/> Investigative Reports
<input type="checkbox"/> Medical Records	<input type="checkbox"/> Claim Information	<input type="checkbox"/> External Database results
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> 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: _____ Contact Person: _____

(Address) _____ (City) _____ (State) _____ (Zip) _____

Telephone () _____ Fax () _____ Case/Claim No. _____

Suspected Fraud Types (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Arson
<input type="checkbox"/> home <input type="checkbox"/> vehicle <input type="checkbox"/> business
<input type="checkbox"/> Fictitious loss <input type="checkbox"/> damages <input type="checkbox"/>
<input type="checkbox"/> Fictitious theft
<input type="checkbox"/> vehicle <input type="checkbox"/> property
<input type="checkbox"/> Inflated inventory
<input type="checkbox"/> Inflated loss <input type="checkbox"/> damages <input type="checkbox"/>
<input type="checkbox"/> Inflated theft
<input type="checkbox"/> vehicle <input type="checkbox"/> property
<input type="checkbox"/> Double-dipping
<input type="checkbox"/> Exaggerated injuries
<input type="checkbox"/> Injuries not related to work
<input type="checkbox"/> Malingerers
<input type="checkbox"/> Misappropriated vehicle salvage
<input type="checkbox"/> Premium avoidance
<input type="checkbox"/> Prior injuries
<input type="checkbox"/> Slip and fall
<input type="checkbox"/> Staged injury / accident at work
<input type="checkbox"/> Staged collisions
<input type="checkbox"/> Paper accidents
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Agent fraud
<input type="checkbox"/> Application fraud
<input type="checkbox"/> Billing for services/products not provided
<input type="checkbox"/> Failure to disclose multiple insurance companies
<input type="checkbox"/> False claims
<input type="checkbox"/> Illegal solicitation (cappers)
<input type="checkbox"/> Issued fraudulent insurance policies, certificates, binders, ID cards
<input type="checkbox"/> Misrepresentation of services / products provided
<input type="checkbox"/> Kickbacks/bribery
<input type="checkbox"/> Money laundering
<input type="checkbox"/> Multiple claims
<input type="checkbox"/> Possession/sold fraudulent insurance policies, certificates, binders, ID cards
<input type="checkbox"/> Questioned documents
<input type="checkbox"/> altered <input type="checkbox"/> forged <input type="checkbox"/> falsified
<input type="checkbox"/> duplicated
<input type="checkbox"/> Received compensation for referral to health care provider or attorney
<input type="checkbox"/> Ring / organized activity type | <input type="checkbox"/> Duplicate billing for same service
<input type="checkbox"/> Forged prescriptions
<input type="checkbox"/> Fraudulent death claims
<input type="checkbox"/> Over-utilization of services
<input type="checkbox"/> Prescription abuse / doctor shopping
<input type="checkbox"/> Prescriptions issued for non-medical purposes
<input type="checkbox"/> Unbundling
<input type="checkbox"/> Upcoding
<input type="checkbox"/> Misrepresented non-covered services as covered
<input type="checkbox"/> Changing dates of service, CPT/CDT/diagnostic codes
<input type="checkbox"/> Charges inconsistent with services provided
<input type="checkbox"/> Products billed are inconsistent with the products
<input type="checkbox"/> Using unqualified/unlicensed persons to perform billable services
<input type="checkbox"/> Other _____ |
|--|---|--|

Subject / Additional Party Types

CL Claimant IN Insured WT Witness LC Lawyer for Claimant LI Lawyer for Insured INS Insurer SI Self-Insured IY Insurance Company Employee IB Agent/Broker IS Adjuster IR Appraiser BS Body Shop SY Salvage Yard Owner / Employee TY Tow Yard Owner / Employee MD Medical Doctor DO Doctor of Osteopathic Medicine DEN Dentist	PH Pharmacist CHI Chiropractor NP Nurse Practitioner LPN Licensed Practical Nurse PT Physical Therapist PA Physician's Assistant OP Optometrist PO Podiatrist RD Radiologist MT Massage Therapist AMB Ambulance Service Employee DME DME Supplier HHA Home Health Agency MR Laboratory MH Medical Clinic/Hospital MZ Office Administrator BS Billing Services	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 _____
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Under KRS 304-47-050(2), The following individuals having knowledge or believing that a fraudulent insurance act or any other act or practice which may constitute a felony or misdemeanor under this subtitle is being or has been committed shall send to the division a report or information pertinent to the knowledge or belief and additional relevant information that the commissioner or his employees or agents may require: (a) Any professional practitioner licensed or regulated by the Commonwealth, except as provided by law; (b) Any private medical review committee; (c) Any insurer, agent, or other person licensed under this chapter; and (d) Any employee of the persons named in paragraphs (a) to (c) of this subsection.

Under KRS 304.47-060(1), In the absence of malice, fraud, or gross negligence, a person shall not be subject to civil liability for libel, slander, or any other relevant tort by virtue of filing reports or furnishing other information required by this chapter or requested by the division or its authorized representative.

Additional Party Involved / AKA Information

Type:	Name (Last):	(First):	(Middle):	Date of birth:	Age:	SSN:
Street Address (include P.O. Box and apartment #'s):			Address Type: <input type="checkbox"/> Res. <input type="checkbox"/> Bus. <input type="checkbox"/> Maildrop <input type="checkbox"/> Other		Fed. TIN <input type="checkbox"/> Number:	EIN <input type="checkbox"/> Sex: M <input type="checkbox"/> F <input type="checkbox"/>
City:		State:	Zip:	County:		Telephone No.: ()
Driver's License #:		State:	VIN:		Telephone No.: ()	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.
Vehicle Year:	Make:	Model:		License Plate #:	Reported Injuries:	
Employer:		Address & Phone #:			Occupation:	
Involvement in referral:						

Additional Party Involved / AKA Information

Type:	Name (Last):	(First):	(Middle):	Date of birth:	Age:	SSN:
Street Address (include P.O. Box and apartment #'s):			Address Type: <input type="checkbox"/> Res. <input type="checkbox"/> Bus. <input type="checkbox"/> Maildrop <input type="checkbox"/> Other		Fed. TIN <input type="checkbox"/> Number:	EIN <input type="checkbox"/> Sex: M <input type="checkbox"/> F <input type="checkbox"/>
City:		State:	Zip:	County:		Telephone No.: ()
Driver's License #:		State:	VIN:		Telephone No.: ()	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.
Vehicle Year:	Make:	Model:		License Plate #:	Reported Injuries:	
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City:		State:	Zip:	County:		Telephone No.: ()
Driver's License #:		State:	VIN:		Telephone No.: ()	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.
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Vehicle Year:	Make:	Model:		License Plate #:	Reported Injuries:	
Employer:		Address & Phone #:			Occupation:	
Involvement in referral:						