ADVOCATE HEALTH ADVISORS

FRAUD, WASTE & ABUSE REPORTING FORM

DATE: _____

PERSON COMPLETING FORM (leave blank if you wish to remain anonymous):

_____

TELEPHONE: _____

EMAIL: _____

Please include the following about the alleged suspect and/or victim(s):

Does this involve a Medicare member?

☐ YES ☐ NO ☐ I don't know

CARRIER NAME: _____

AGENT NAME: _____

MEMBER NAME: _____

PROVIDER NAME: _____

OTHER PERSON OR GROUP: _____

Describe the situation:

_____

_____

_____

_____

Describe how you became aware of this issue:

_____

_____

_____

_____

Has this been reported to any other entity?

☐ YES Please provide what entity: _____ ☐ NO

Instructions:

Please provide as much detail as possible. This will help us in our investigation and reporting of the allegation.

If the suspected Fraud, Waste and/or Abuse involves a carrier, agent, member, or provider, please supply information in those fields.

Describe the situation in as much detail as possible. If you need additional room please add to the form.

If you have already reported the allegation to another entity (e.g., carrier or government agency) please provide who it was reported to and when.

You can also report any suspected Fraud, Waste & Abuse by emailing our compliance team:

compliance@advocatehealthllc.com

Or call our office at 1-800-709-5513

You can request to remain anonymous by any of these means.