COMMUNITY HEALTH PLAN of Washington™

REPORT POTENTIAL FRAUD/ID THEFT

Use this form to report potential fraud, waste, abuse, and identity theft.

INSTRUCTIONS:

1. Please gather and enter all details about the incident. Thorough information will aid investigation.
2. Compile any relevant documentation.
3. Send your report and any documentation by any of the following methods:

Email: compliance.incident@chpw.org
Fax: (206) 521-8834
Mail: Compliance Officer
Community Health Plan of Washington
1111 3rd Ave, Suite 400
Seattle, WA 98101

Note: If you wish to make an anonymous report, please send this form by mail or from a proxy email address or fax number. No attempt will be made to discover the identity of someone making an anonymous.

SECTION 1 - REPORT PREPARED BY			
Your Name:		Phone:	
Business Name (if applicable):		Email:	
SECTION 2 - INCIDENT DETAILS			
Date of Report:		Incident Date:	
MEMBER INFORMATION		**INVOLVED PARTIES**	
Member First Name:		Name of Individual (if applicable):	
Member Last Name:		Name of Business or Provider: (if applicable)	
Member ID: (AND Provider One number, if applicable)		Member ID or Provider NPI: (if applicable)	
Member LOB:		Street Address (With City, State Zip):	
Member DOB:			
Member Street Address (With City, State Zip)::		Phone:	
Member Phone:		Email Address (not required):	
(if applicable) **MEMBER ELIGIBILITY DATE:**		**MEMBER TERMINATION DATE:**	
CLAIM INFORMATION *(if applicable)*			
Dates of Service:		Procedure Codes:	
Patient Name:		Claim Number(s):	
DESCRIPTION OF INCIDENT *(Please describe what happened. Include details, names and dates to aid investigation.)*			
Incident also reported to:			
SECTION 3 - CORRECTIVE ACTIONS *(Has anything been done to address the issue so far?)*			