Security Health Plan

Fraud, Waste & Abuse Investigation Form

1. Tell us about the situation you're reporting

Is the member involved a Medicare member? ☐ Yes ☐ No ☐ I don't know

Is the member involved a Medicaid member? ☐ Yes ☐ No ☐ I don't know

Subject to be investigated:

☐ Provider Name(s): _____

☐ Patient Name(s): _____

☐ Agent Name(s): _____

☐ Other person or group Name(s): _____

Describe the situation using as much detail as you can. Include the date of service, claim number, or other identifying details if possible:

_____

_____

_____

Describe how you become aware of this issue:

_____

_____

If others may have information about this situation, please provide their names:

_____

2. Tell us about you (if you want investigation follow-up)

Date you're filling out this form: _____

First name: _____ Middle initial: _____ Last name: _____

Address: _____

City, State, ZIP Code: _____

Telephone number: _____ E-mail address: _____

3. Send by Routing/Mail/Fax to:

Security Health Plan of Wisconsin, Inc.
Attention: Compliance Department
1515 N Saint Joseph Avenue
Marshfield, WI 54449
Fax is 715-221-9500

Feel free to attach other information, such as correspondence. Thank you.