HEALTH CLAIM FRAUD REFERRAL / NOTIFICATION FORM - OIFP/BFD-3 (04/13)

State of New Jersey
Insurance Fraud Referral/Notification
P.O. Box 094
Trenton, NJ 08625-0094

BFD Case #: / /
OIFP #:
Investigator:

☐ REFERRAL ☐ NOTIFICATION

PART I

INSURANCE CO.:
ADDRESS:
TELEPHONE #:
CONTACT PERSON:
E-MAIL ADDRESS:

DATE REPORTED:
NAIC COMPANY #:
D.O.L.:
POLICY#:
CLAIM #:
SIU #:

TYPE OF COVERAGE (check appropriate box)

Health (Indemnity) ☐ Health (Medicaid) ☐
Health (HMO) ☐ Dental ☐
OTHER

STATUS (indicate as appropriate)

PENDING ☐ PAID - IN FULL ☐
DENIED ☐ PAID - IN PART ☐
AMT. PAID: $ DATE / RANGE PD.:
CLAIM: $ FRAUD: $

☐ INSURED ☐ SUBJECT ☐ CLAIMANT (check appropriate title)

LAST NAME | FIRST NAME | MIDDLE
STREET ADDRESS | CITY | STATE / ZIP CODE
HOME PHONE | WORK PHONE | DOB
S.S. / T.I.N.# | D.L. # | D.L. STATE
BUSINESS NAME | ADDRESS | TIN #

☐ INSURED ☐ SUBJECT ☐ PROVIDER (check appropriate title)

LAST NAME | FIRST NAME | MIDDLE
DBA, LLC, PA OR GROUP PRACTICE NAME
STREET ADDRESS | CITY | STATE / ZIP CODE
TELEPHONE # | DOB | SS #
PROFESSIONAL LICENSE # | STATE

TYPE OF PROVIDER (check appropriate box)

- ☐ MD
- ☐ DMD
- ☐ MD/CHIRO PRACTICE
- ☐ SURGI-CENTER
- ☐ DO
- ☐ HOSPITAL
- ☐ DME SUPPLIER
- ☐ MSW
- ☐ PHD
- ☐ OUTPATIENT FACILITY
- ☐ HOME HEALTH
- ☐ OTHER _____
- ☐ DDS
- ☐ PHYSICAL THERAPY
- ☐ PHARMACIST

TAX ID #S USED: _____

SPECIALTY (Check appropriate box)

- ☐ ALLERGIST
- ☐ DERMATOLOGY
- ☐ ENT
- ☐ GENERAL PRACTICE
- ☐ NEONATOLOGY
- ☐ OPHTHALMOLOGY
- ☐ ORTHOPEDICS
- ☐ PERIODONTIST
- ☐ RADIOLOGY
- ☐ OTHER:
- ☐ ANAESTHESIOLOGY
- ☐ EMERGENCY MEDICINE
- ☐ EPIDEMIOLOGY
- ☐ IMMUNOLOGY
- ☐ NEUROLOGY
- ☐ OPTOMETRY
- ☐ OTOLARYNGOLOGY
- ☐ PLASTIC SURGERY
- ☐ SURGERY
- ☐ CARDIOLOGY
- ☐ ENDOCRINOLOGY
- ☐ FAMILY MEDICINE
- ☐ INFECTIOUS DISEASE
- ☐ OBSTETRICS/GYNECOLOGY
- ☐ ORAL SURGEON
- ☐ PEDIATRICS
- ☐ PROSTIDONTIST
- ☐ UROLOGY
- ☐ CHIROPRACTIC
- ☐ ENDODONTIST
- ☐ GASTROINTEROLOGY
- ☐ INTERNAL MEDICINE
- ☐ ONCOLOGY
- ☐ ORTHODONTIST
- ☐ PODIATRY
- ☐ PSYCHIATRY
- ☐ WEIGHT LOSS

PROVIDER

LAST NAME _____ FIRST NAME _____ MIDDLE _____

DBA, LLC, PA OR GROUP PRACTICE NAME _____

STREET ADDRESS _____ CITY _____ STATE / ZIP CODE _____

TELEPHONE # _____ DOB _____ SS # _____

PROFESSIONAL LICENSE # _____ STATE _____

DOES THIS CLAIM FORM PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. 17:33A-4? YES ☐ NO ☐

IF YES, LIST OTHER RELATED CLAIM NUMBERS, INDICATE STATUS OF OTHER RELATED CLAIMS, AND ATTACH COPIES OF OTHER REFERRALS, IF APPLICABLE:

ARE YOU AWARE OF ANY OTHER COMPANIES PURSUING RECOVERIES AGAINST THIS SUBJECT? YES ☐ NO ☐

IF YOU CHECKED "YES", PLEASE COMPLETE THE FOLLOWING:

NAME OF OTHER COMPANY _____ INVESTIGATOR _____

CONTACT NUMBER _____ EMAIL _____

IS ANY OTHER GOVERNMENT AGENCY INVESTIGATING THIS MATTER, OR HAS THIS MATTER BEEN REFERRED TO ANY OTHER GOVERNMENT AGENCY?

☐ YES ☐ NO

IF YES, PROVIDE AGENCY NAME & ADDRESS, CONTACT NAME, PHONE NUMBER, EMAIL, AGENCY CASE NUMBER.

PART II

PROVISIONS OF N.J.S.A. 17:33A-4 RELATING TO FALSE CLAIMS THAT MAY HAVE BEEN VIOLATED: (CHECK APPROPRIATE BOX OR BOXES)

☐ a(1) - presents false information: KNOWINGLY PRESENTS OR CAUSES TO BE PRESENTED ANY WRITTEN OR ORAL STATEMENT CONTAINING ANY FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO THE CLAIM. N.J.S.A. 17:33A-4A(1)

☐ a(2) - makes a false statement: KNOWINGLY PREPARES OR MAKES ANY WRITTEN OR ORAL STATEMENT CONTAINING ANY FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO THE CLAIM. N.J.S.A. 17:33A-4A(2)

☐ a(3)-conceals relevant information: CONCEALS OR KNOWINGLY FAILS TO DISCLOSE THE OCCURRENCE OF AN EVENT WHICH AFFECTS ANY PERSON'S INITIAL OR CONTINUED RIGHT OR ENTITLEMENT TO PAYMENT OF A CLAIM. N.J.S.A. 17:33A-4A(3)

☐ b-conspires with another: KNOWINGLY ASSISTS, CONSPIRES WITH OR URGES ANY PERSON OR PRACTITIONER TO VIOLATE ANY PROVISION(S) OF THIS ACT. N.J.S.A. 17:33A-4B. (IF SO, SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED). _____

☐ c-knowingly benefits from insurance fraud: DUE TO THE ASSISTANCE, CONSPIRACY OR URGING OF ANOTHER KNOWINGLY BENEFITS, DIRECTLY OR INDIRECTLY, FROM THE PROCEEDS DERIVED FROM A VIOLATION OF THIS ACT. N.J.S.A. 17:33A-4C. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED). _____

☐ d-involvement of hospital: AN OWNER, ADMINISTRATOR OR EMPLOYEE OF ANY HOSPITAL WHO KNOWINGLY ALLOWS THE USE OF THE FACILITIES OF THE HOSPITAL BY ANY PERSON IN FURTHERANCE OF A SCHEME OR CONSPIRACY TO VIOLATE ANY OF THE PROVISION(S) OF THE ACT. N.J.S.A. 17:33A-4C. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED). _____

☐ e-using or being a runner: A PERSON OR PRACTITIONER FOR PECUNIARY GAIN, DIRECTLY OR INDIRECTLY SOLICITS:

- ☐ ANY PERSON OR PRACTITIONER TO ENGAGE , EMPLOY OR RETAIN A PERSON TO MANAGE, ADJUST OR PROSECUTE, ANY CLAIM OR CAUSE OF ACTION FOR DAMAGES.
- ☐ ANY PERSON TO BRING CAUSES OF ACTION TO RECOVER DAMAGES FOR PERSONAL INJURIES/DEATH.
- ☐ ANY PERSON TO MAKE A CLAIM FOR PERSONAL INJURY PROTECTION BENEFITS. N.J.S.A. 17:33A-4E.

NOTE: IF THE INSURANCE COMPANY PAID MONEY FOR THE CLAIM(S), OBTAIN ALL CLAIMS CHECKS AND SUBMIT TO OIFP AS SOON AS PRACTICABLE AFTER SUBMISSION OF THIS REFERRAL FORM.

PART III

1. INDICATE THE PARTICULAR FACTS AND CIRCUMSTANCES, INCLUDING WHAT THAT CLAIMANT DID AND FRAUD INDICATORS, WHICH LED YOU TO SUSPECT THAT THE ACT WAS VIOLATED, AS CHECKED ABOVE: (MERELY STATING "SEE ATTACHED" FILE OR DOCUMENT IS NOT ACCEPTABLE WITHOUT SPECIFIC DESIGNATION OF PAGE AND LINE REFERENCED, BUT EXTRA SHEETS MAY BE USED TO MORE COMPLETELY EXPLAIN.)*

2. LIST ALL FALSE OR MISLEADING STATEMENTS MADE TO INSURANCE CARRIER, OR INFORMATION OMITTED, AND INDICATE ON WHICH CLAIM DOCUMENT EACH STATEMENT OR OMISSION IS MADE: (FOR EXAMPLE, ACORD FORM, AFFIDAVIT OF VEHICLE THEFT, APPRAISAL, AFFIDAVIT OF NO INSURANCE, RECORDED STATEMENT, POLICE ACCIDENT REPORT, RECEIPT, ETC.)*

3. INDICATE THE EVIDENCE WHICH CORROBORATES THE SUSPICIOUS FACTS AND CIRCUMSTANCES INDICATED IN PARAGRAPH 1. ABOVE: (FOR EXAMPLE, WITNESS STATEMENT, DOCUMENTARY EVIDENCE WHICH DIRECTLY CONTRADICTS A STATEMENT OR OMISSION MADE IN THE CLAIM PROCESS, AN EXPERT REPORT, OTHER APPARENT MISREPRESENTATIONS MADE TO SUPPORT THE CLAIM WHICH TEND TO INDICATE THAT THE MISREPRESENTATION OR OMISSION WAS NOT MERELY A MISTAKE.)*

4. SPECIFY ANY EVIDENCE WHICH WOULD TEND TO INDICATE THAT A LICENSED PROFESSIONAL MAY HAVE KNOWINGLY PARTICIPATED IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AND HIS EMPLOYER: (FOR EXAMPLE, POLICE OFFICER, MEDICAL SERVICE PROVIDER, ATTORNEY, INSURANCE PRODUCER/AGENT, INSURANCE CARRIER EMPLOYEE, AUTO REPAIR FACILITY EMPLOYEE, APPRAISER, OR CLAIMS ADJUSTER.)*

* For each document listed in support of the allegation of fraud, please attach an exact copy or the original. In addition, as to all documents attached to this form, please complete the attached Certification of Custodian of Records.

PART IV

CERTIFICATION OF CUSTODIAN OF RECORDS

I certify that the records identified herein are originals or exact copies of the records made by a person with actual knowledge in the regular course of business at the time the activity took place.

(List each document in this space or reference a separate attached listing)

I CERTIFY THAT THE FOREGOING STATEMENTS MADE BY ME ARE TRUE. I AM AWARE THAT IF ANY OF THE FOREGOING STATEMENTS MADE BY ME ARE WILLFULLY FALSE, I AM SUBJECT TO PUNISHMENT.

DATED:

SIGNATURE OF CUSTODIAN

PRINT FULL NAME AND TITLE

PART V

COMPLETE THE FOLLOWING ONLY IF THERE ARE ADDITIONAL SUBJECTS, CLAIMANTS OR INSUREDS OF THE INVESTIGATION:

☐ SUBJECT ☐ CLAIMANT ☐ INSURED

LAST NAME	FIRST NAME	MIDDLE
STREET ADDRESS	CITY	STATE / ZIP
HOME PHONE	WORK PHONE	DOB
S.S. #	D.L. #	

☐ SUBJECT ☐ CLAIMANT ☐ INSURED

LAST NAME	FIRST NAME	MIDDLE
STREET ADDRESS	CITY	STATE / ZIP
HOME PHONE	WORK PHONE	DOB
S.S. #	D.L. #	

☐ SUBJECT ☐ CLAIMANT ☐ INSURED

LAST NAME	FIRST NAME	MIDDLE
STREET ADDRESS	CITY	STATE / ZIP
HOME PHONE	WORK PHONE	DOB
S.S. #	D.L. #	

☐ SUBJECT ☐ CLAIMANT ☐ INSURED

LAST NAME	FIRST NAME	MIDDLE
STREET ADDRESS	CITY	STATE / ZIP
HOME PHONE	WORK PHONE	DOB
S.S. #	D.L. #	

PART VI

COMPLETE THE FOLLOWING ONLY IF ADDITIONAL LICENSED PROFESSIONALS ARE SUBJECTS OF THE INVESTIGATION

LAST NAME _____ FIRST NAME _____ MIDDLE _____

DBA, LLC, PA OR GROUP PRACTICE NAME _____

STREET ADDRESS _____ CITY _____ STATE / ZIP CODE _____

TELEPHONE # _____ DOB _____ SS # _____

PROFESSIONAL LICENSE # _____ STATE _____

TYPE OF PROVIDER (check appropriate box)

- ☐ MD
- ☐ DMD
- ☐ MD/CHIRO PRACTICE
- ☐ SURGI-CENTER
- ☐ DO
- ☐ HOSPITAL
- ☐ DME SUPPLIER
- ☐ MSW
- ☐ PHD
- ☐ OUTPATIENT FACILITY
- ☐ HOME HEALTH
- ☐ OTHER _____
- ☐ DDS
- ☐ PHYSICAL THERAPY
- ☐ PHARMACIST

TAX ID #S USED: _____

LAST NAME _____ FIRST NAME _____ MIDDLE _____

DBA, LLC, PA OR GROUP PRACTICE NAME _____

STREET ADDRESS _____ CITY _____ STATE / ZIP CODE _____

TELEPHONE # _____ DOB _____ SS # _____

PROFESSIONAL LICENSE # _____ STATE _____

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- ☐ PHARMACIST

TAX ID #S USED: _____

LAST NAME	FIRST NAME	MIDDLE

DBA, LLC, PA OR GROUP PRACTICE NAME

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PROFESSIONAL LICENSE #	STATE

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TAX ID #S USED: _____