



Fraud, Waste and Abuse Report Form

Please complete this form, include copies of any bills, and mail to:

Physicians United Plan
Attention: Compliance Department
9102 Southpark Center Loop
Orlando, FL 32765

PERSON OR COMPANY SUSPECTED OF FRAUD/WASTE/ABUSE

Name (Individual or Company)

Address

City

State

Zip

Telephone Number

Profession

Professional License # (if known)

LIST VICTIM(S) OTHER THAN YOURSELF

Name

Address

City

State

Zip

Daytime Telephone Number

COMPLAINANT (Yourself)

Name

Address

City

State

Zip

Daytime Telephone Number

E-mail Address

Have you attempted to contact the person/company listed above or any government authority?

Yes No

If Yes, Whom did you contact and when?

WITNESSES (Please Provide Full Name, Address and Phone Number)

Witness Name

Address

City

State

Zip

Daytime Telephone Number

Witness Name

Address

City

State

Zip

Daytime Telephone Number

DESCRIPTION OF SUSPECTED FRAUD/WASTE/ABUSE

Please include all details such as dates, times, where it occurred, etc.