



**DWC Medical Unit  
P.O. Box 71010  
Oakland, CA 94612**

**Report of Suspected Medical Care Provider Fraud**

Labor Code section 3823 requires any insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person that believes that a fraudulent claim has been made by any person or entity providing medical care, as described in Labor Code section 4600, to report the apparent fraudulent claim in the manner prescribed by the reporting protocols adopted by the administrative director of the Division of Workers' Compensation.

**Complaining party** (Please check the box that best describes you. Insurers, self-insured employers or third-party administrators should not use this form. These entities should use the Department of insurance suspected fraudulent claim referral form (FD-1).):

**Person submitting the complaint:**

Injured worker       Attorney       Physician       Other

Name: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home telephone number: (      ) \_\_\_\_\_

Work telephone number: (      ) \_\_\_\_\_

E-mail: \_\_\_\_\_

Preferred place to contact you: (check one) Home \_\_\_\_\_ Work \_\_\_\_\_

**Complaint against** (If more than one provider is involved, please attach additional sheets identifying each one):

Name: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Type of health care provider: \_\_\_\_\_

**Description of the alleged fraudulent activity:** Please provide as much detail as possible, including the nature of the unlawful act, why you believe that the activity you are reporting constitutes fraud, names, dates and documents. Please attach additional sheets if necessary and provide a copy of any relevant documentation you have. ***PLEASE DO NOT ATTACH ORIGINAL DOCUMENTS.***

**Claim information** (If more than one injured worker's care is involved, please attach additional sheets):

Date of injury: \_\_\_\_\_ WCAB case number(s) (if known): \_\_\_\_\_

Name of injured worker: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Injured worker's Social Security number (if known): \_\_\_\_\_

Injured worker's date of birth (if known): \_\_\_\_\_

Name of employer at date of injury: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Location where injury occurred: \_\_\_\_\_

Name of insurer or third party administrator: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Claims administrator's claim number (if known): \_\_\_\_\_

**Reports to other agencies** Has the suspected fraudulent activity been reported to any law enforcement or professional licensing board? If so, please identify the agency, contact person and telephone number.

**Report submitted by**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please print your name: \_\_\_\_\_

**Where to report** (Send this completed form and photocopies of relevant supporting documents to):

Division of Workers' Compensation-Medical Unit  
P.O. Box 71010  
Oakland, CA 94612