

UNIFORM SUSPECTED INSURANCE FRAUD REPORTING FORM

State of Kentucky
Division of Insurance Fraud Investigation

For State Use Only

Case No.

Status

FYI

Reporting Person:	Insurance Company:	NAIC#
-------------------	--------------------	-------

Mailing address:	Phone number: ()
	Fax number: ()
	E-mail address:

Detailed synopsis. Attach additional pages, if necessary.

Date of Loss / Injury:	Dates of Service: to
Address of Loss / Injury:	Description of Service:
(City) (State) (Zip)	

Claim #	Policy #
---------	----------

Reserve Amount \$	Amount Paid \$	Date Paid	Procedure Code #'s: ☐ CPT ☐ CDT	Insurance Type ☐ PC ☐ WC ☐ HC ☐ Auto ☐ Life ☐ Disability
Loss Amount \$	Settlement Amt. \$	Date Paid	Civil Litigation Pending: ☐ Yes ☐ No	

Subject Information

Type:	Name (Last / Business):	(First):	(Middle):	Date of birth:	Age:	SSN:
-------	-------------------------	----------	-----------	----------------	------	------

Street Address (include P.O. Box and apartment #'s):	Address Type: ☐ Res. ☐ Bus. ☐ Maildrop ☐ Other	Fed. TIN ☐ EIN ☐	Sex: M ☐ F ☐
--	---	--	--

City:	State:	Zip:	County:	Telephone No.: ()	Phone Type: ☐ home ☐ cell ☐ bus.
-------	--------	------	---------	--------------------------	--

Driver's License #:	State:	VIN:	Telephone No.: ()	Phone Type: ☐ home ☐ cell ☐ bus.
---------------------	--------	------	--------------------------	--

Vehicle Year:	Make:	Model:	License Plate #:	Reported Injuries:
---------------	-------	--------	------------------	--------------------

Employer:	Address & Phone #:	Occupation:
-----------	--------------------	-------------

Additional Party Involved ☐ See Additional Party Involved/AKA AKA Information: ☐ Information	Comments:
---	-----------

Case Details (check all that apply)

SIU Investigation Completed ☐ Yes ☐ No Date Completed:

Is there any reason to believe that this incident is related to other suspected fraudulent activity? ☐ Yes ☐ No

☐ Statements (Witness / Insured / Subject) ☐ Sworn ☐ Recorded ☐ Proof of Loss ☐ Continuance of Disability Forms ☐ Medical Records ☐ Other	☐ EUO / Deposition ☐ Copies of Receipts ☐ Expert Reports ☐ Videos / Photos ☐ Claim Information ☐ Other	☐ Law Enforcement / Other Agency Reports ☐ Claim History Extracts ☐ IME Reports ☐ Investigative Reports ☐ External Database results ☐ Other
---	---	--

Identify Other Agency You Have Contacted Regarding This Referral

Agency Type: ☐ Other State Fraud Bureau ☐ Law Enforcement ☐ Other Insurance Company ☐ Regulatory Agency ☐ Other

Agency: _____ Contact Person: _____
 (Address) _____ (City) _____ (State) _____ (Zip) _____
 Telephone () _____ Fax () _____ Case/Claim No. _____

Suspected Fraud Types (check all that apply)

- | | | |
|--|---|--|
| ☐ Arson
☐ home ☐ vehicle ☐ business
☐ Fictitious loss ☐ damages ☐
☐ Fictitious theft
☐ vehicle ☐ property
☐ Inflated inventory
☐ Inflated loss ☐ damages ☐
☐ Inflated theft
☐ vehicle ☐ property
☐ Double-dipping
☐ Exaggerated injuries
☐ Injuries not related to work
☐ Malingerers
☐ Misappropriated vehicle salvage
☐ Premium avoidance
☐ Prior injuries
☐ Slip and fall
☐ Staged injury / accident at work
☐ Staged collisions
☐ Paper accidents
☐ Other _____ | ☐ Agent fraud
☐ Application fraud
☐ Billing for services/products not provided
☐ Failure to disclose multiple insurance companies
☐ False claims
☐ Illegal solicitation (cappers)
☐ Issued fraudulent insurance policies, certificates, binders, ID cards
☐ Misrepresentation of services / products provided
☐ Kickbacks/bribery
☐ Money laundering
☐ Multiple claims
☐ Possession/sold fraudulent insurance policies, certificates, binders, ID cards
☐ Questioned documents
☐ altered ☐ forged ☐ falsified
☐ duplicated
☐ Received compensation for referral to health care provider or attorney
☐ Ring / organized activity type | ☐ Duplicate billing for same service
☐ Forged prescriptions
☐ Fraudulent death claims
☐ Over-utilization of services
☐ Prescription abuse / doctor shopping
☐ Prescriptions issued for non-medical purposes
☐ Unbundling
☐ Upcoding
☐ Misrepresented non-covered services as covered
☐ Changing dates of service, CPT/CDT/diagnostic codes
☐ Charges inconsistent with services provided
☐ Products billed are inconsistent with the products
☐ Using unqualified/unlicensed persons to perform billable services
☐ Other _____ |
|--|---|--|

Subject / Additional Party Types

CL Claimant IN Insured WT Witness LC Lawyer for Claimant LI Lawyer for Insured INS Insurer SI Self-Insured IY Insurance Company Employee IB Agent/Broker IS Adjuster IR Appraiser BS Body Shop SY Salvage Yard Owner / Employee TY Tow Yard Owner / Employee MD Medical Doctor DO Doctor of Osteopathic Medicine DEN Dentist	PH Pharmacist CHI Chiropractor NP Nurse Practitioner LPN Licensed Practical Nurse PT Physical Therapist PA Physician's Assistant OP Optometrist PO Podiatrist RD Radiologist MT Massage Therapist AMB Ambulance Service Employee DME DME Supplier HHA Home Health Agency MR Laboratory MH Medical Clinic/Hospital MZ Office Administrator BS Billing Services	TPA Third Party Administrator FP False Provider UP Unlicensed Provider MN Other Medical Personnel MS Medical Specialist DS _____ Dental Specialist NS _____ Nurse Specialist OT _____ Other
--	--	---

Under KRS 304-47-050(2), The following individuals having knowledge or believing that a fraudulent insurance act or any other act or practice which may constitute a felony or misdemeanor under this subtitle is being or has been committed shall send to the division a report or information pertinent to the knowledge or belief and additional relevant information that the commissioner or his employees or agents may require: (a) Any professional practitioner licensed or regulated by the Commonwealth, except as provided by law; (b) Any private medical review committee; (c) Any insurer, agent, or other person licensed under this chapter; and (d) Any employee of the persons named in paragraphs (a) to (c) of this subsection.

Under KRS 304.47-060(1), In the absence of malice, fraud, or gross negligence, a person shall not be subject to civil liability for libel, slander, or any other relevant tort by virtue of filing reports or furnishing other information required by this chapter or requested by the division or its authorized representative.

The Kentucky insurance market is regulated by KRS Chapter 304 and the regulations promulgated thereunder. Artificial Intelligence (“AI”) generated outputs are for informational purposes and do not replace professional advice and consultation. Skepticism is warranted when relying on AI-generated conclusions regarding insurance questions.

Additional Party Involved / AKA Information

Type:	Name (Last):	(First):	(Middle):	Date of birth:	Age:	SSN:
Street Address (include P.O. Box and apartment #'s):			Address Type: ☐ Res. ☐ Bus. ☐ Maildrop ☐ Other		Fed. TIN ☐ EIN ☐ Number:	Sex: M ☐ F ☐
City:		State:	Zip:	County:	Telephone No.: ()	Phone Type: ☐ home ☐ cell ☐ bus.
Driver's License #:		State:	VIN:		Telephone No.: ()	Phone Type: ☐ home ☐ cell ☐ bus.
Vehicle Year:	Make:	Model:		License Plate #:	Reported Injuries:	
Employer:		Address & Phone #:			Occupation:	
Involvement in referral:						

Additional Party Involved / AKA Information

Type:	Name (Last):	(First):	(Middle):	Date of birth:	Age:	SSN:
Street Address (include P.O. Box and apartment #'s):			Address Type: ☐ Res. ☐ Bus. ☐ Maildrop ☐ Other		Fed. TIN ☐ EIN ☐ Number:	Sex: M ☐ F ☐
City:		State:	Zip:	County:	Telephone No.: ()	Phone Type: ☐ home ☐ cell ☐ bus.
Driver's License #:		State:	VIN:		Telephone No.: ()	Phone Type: ☐ home ☐ cell ☐ bus.
Vehicle Year:	Make:	Model:		License Plate #:	Reported Injuries:	
Employer:		Address & Phone #:			Occupation:	
Involvement in referral:						

Additional Party Involved / AKA Information

Type:	Name (Last):	(First):	(Middle):	Date of birth:	Age:	SSN:
Street Address (include P.O. Box and apartment #'s):			Address Type: ☐ Res. ☐ Bus. ☐ Maildrop ☐ Other		Fed. TIN ☐ EIN ☐ Number:	Sex: M ☐ F ☐
City:		State:	Zip:	County:	Telephone No.: ()	Phone Type: ☐ home ☐ cell ☐ bus.
Driver's License #:		State:	VIN:		Telephone No.: ()	Phone Type: ☐ home ☐ cell ☐ bus.
Vehicle Year:	Make:	Model:		License Plate #:	Reported Injuries:	
Employer:		Address & Phone #:			Occupation:	
Involvement in referral:						

Additional Party Involved / AKA Information

Type:	Name (Last):	(First):	(Middle):	Date of birth:	Age:	SSN:
Street Address (include P.O. Box and apartment #'s):			Address Type: ☐ Res. ☐ Bus. ☐ Maildrop ☐ Other		Fed. TIN ☐ EIN ☐ Number:	Sex: M ☐ F ☐
City:		State:	Zip:	County:	Telephone No.: ()	Phone Type: ☐ home ☐ cell ☐ bus.
Driver's License #:		State:	VIN:		Telephone No.: ()	Phone Type: ☐ home ☐ cell ☐ bus.
Vehicle Year:	Make:	Model:		License Plate #:	Reported Injuries:	
Employer:		Address & Phone #:			Occupation:	
Involvement in referral:						