



Fraud Investigation Referral Form

Member, Provider, or Health Care Facility Information

First Name:	Last Name:
Street 1:	Street 2:
City:	State:
Zip Code:	Telephone Number:
Patient First Name:	Patient Last Name:
Member Number:	Provider Number:
Claim Number:	

Suspected Fraudulent or Abusive Activity

What are they doing?

Reporting Entity (leave blank for anonymous referrals)

First Name:	Last Name:	Phone #:
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Complete and send to:

**Fraud Investigator
Rocky Mountain Health Plans
PO Box 10600
Grand Junction, CO 81502-5600**