

**COMMUNITY FIRST HEALTH PLANS  
Suspicious Activity Report (SAR) - RECIPIENT**

**Part I – General Contact Information**

Date Completed					
<b>Person Providing Information</b>					
First Name			Last Name		
Department					
Street Address					
City			State		Zip Code
E-mail Address					
Work Telephone			Fax Number		

**Part II – Recipient Report**

*Please provide detailed information about your fraud, waste, and abuse concern. Attach any additional documentation with this complaint.*

Type of Complaint (check one or more)		Program	
Dual Participation	<input type="checkbox"/>	CHIP	<input type="checkbox"/>
Falsification/Alteration of Application	<input type="checkbox"/>	Medicaid Program	<input type="checkbox"/>
Misuse or Abuse of Medical Benefits	<input type="checkbox"/>	Other	<input type="checkbox"/>
Other	<input type="checkbox"/>		

Recipient/Client Information					
Suspect/Client First Name			Last Name		
SSN			Date of Birth		
Client Medicaid/CHIP Number					
Residence Address					
City		State		Zip Code	
Mailing/Alternate Address					
City		State		Zip Code	
<i>Telephone numbers must include the area code.</i>					
Work Telephone			Extension		
Home Telephone					
Cell Telephone					
List Children in Family (3 children or less)					
1. Child Name			DOB		
2. Child Name			DOB		
3. Child Name			DOB		

For SIU Use Only	Date	Case Number Assigned
Received By		Revised 01/2010