

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

Part I – General Contact Information

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

Part II – Provider Report

Type of Complaint (check one or more)		Program	
Billing Issues	<input type="checkbox"/>	CHIP	<input type="checkbox"/>
Falsification/Alteration of Records	<input type="checkbox"/>	Medicaid Program	<input type="checkbox"/>
Licensing/Certification	<input type="checkbox"/>	Other	<input type="checkbox"/>
Other	<input type="checkbox"/>		

Provider Information					
Vendor/Facility Name					
Provider First Name			Last Name		
Provider Type			Provider Specialty		
TPI or Vendor Facility Number (if known)			License No.		
Physical Address					
City			State	Zip Code	
Mailing/Alternate Address					
City			State	Zip Code	
Telephone			Fax Number		

Please provide detailed information about your fraud, waste, and abuse concern

Attach any additional documentation with this complaint.

For SIU use only	Date	Case Number Assigned
Received By		Revised 01/2010