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