



Fraud Prevention Program Fraud, Abuse and Waste Referral Form

To report suspected health care fraud, abuse and waste, please complete the following form. Fields marked with an asterisk (*) are required. Once the form is complete, please send it to:

Internal Audit and Fraud Prevention
VISTA Fraud Prevention Program
1340 Concord Terrace
Sunrise, FL 33323

PERSON OR COMPANY SUSPECTED OF FRAUD, ABUSE, OR WASTE:

*Name (Individual/Company)

*Address 1

*Address 2

*City

*State

*Zip

*Telephone Number

LIST VICTIM(S); IF OTHER THAN YOURSELF:

Name

Address 1

Address 2

City

State

Zip

Daytime Telephone Number

VISTA Member # (if applicable)



NAME OF PERSON FILING THE COMPLAINT:

*Your Name

*Address 1:

Address 2:

*City

*State

*Zip

*Daytime Telephone Number

Email Address:

VISTA Member #
(if applicable)

WITNESSES:

Please list anyone else that can provide information relating to the potential fraud, abuse and waste. If you have more witnesses than the space allows, please use the description section of this form.

Witness Name 1:

Address 1:

Address 2:

City

State

Zip

Daytime Telephone Number



Witness Name 2:

Address 1:

Address 2:

City

State

Zip

Daytime Telephone Number



***DESCRIPTION OF SUSPECTED FRAUD, ABUSE, OR WASTE:**

Please include as much detail as possible.