UniCare Health Plans of Texas, Inc.
State Sponsored Business

Fraud Referral Form

Patient/Member Information

Name: _____ ID/Certificate Number: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Date of Birth: _____

Date(s) of Incident(s): _____

Provider Information

Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____

NPI Number: _____

TPI Number: _____

Tax ID Number: _____

License Number: _____

Details of Suspected Fraud (Use additional paper if necessary)

_____

_____

_____

_____

_____

_____

Reporting Party: _____ Phone: _____

Reporting Party Signature: _____ Date: _____

Note: Be sure to attach to this form any documents (claims, correspondence, medical records, etc.) that you may have.

Send completed form to: **Attn: Fraud and Abuse Unit**
UniCare Health Plans of Texas, Inc.
P.O. Box 9054, Mail Stop CACC01-055D
Oxnard, CA 93031-9054

Or fax to: **1-866-454-3990**

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