



**Fraud, Waste or Abuse Complaint Form**

**Name (optional)** \_\_\_\_\_ **Phone Number (optional)** \_\_\_\_\_  
*If you provide your name and phone number, Priority Health will keep your information anonymous.*

**Would you like to remain anonymous?** Yes \_\_\_\_\_ No \_\_\_\_\_

**May Priority Health contact you?** *(Note: You may remain anonymous.)* Yes \_\_\_\_\_ No \_\_\_\_\_

**Your Status:** *(Check all that apply)*

Member \_\_\_\_\_ Physician \_\_\_\_\_ Employer \_\_\_\_\_ Hospital \_\_\_\_\_ Law Enforcement \_\_\_\_\_ Other \_\_\_\_\_

**Your complaint is against:** *(Check all that apply)*

Member \_\_\_\_\_ Physician \_\_\_\_\_ Employer \_\_\_\_\_ Hospital \_\_\_\_\_ Law Enforcement \_\_\_\_\_ Other \_\_\_\_\_

**Summary of complaint and individuals involved**

*(Please list details of complaint including: Names, contact information including: address and phone number, details of incident or services such as date of service/incident, copay, etc. You can also include support materials such as Explanation of Benefits (EOB) that provide examples of your concern.)*

Signed By \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Mail:**

Fraud and Abuse Program, Finance Department  
Priority Health, MS 2305  
1231 East Beltline NE  
Grand Rapids, MI 49525-4501

**Fax:**

Fraud and Abuse Program, Finance Department  
616 942-7916

**Email:**

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