PriorityHealth
THINK SMART. LIVE SMART.

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, copayment, etc. You can also include support materials such as Explanation of Benefits (EOB) that provide examples of your concern.)

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Signed By_____ Date _____ / _____ /_____

Mail:
Fraud and Abuse Program
Priority Health, MS 3175
1231 East Beltline NE
Grand Rapids, MI 49525-4501

Fax:
Fraud and Abuse Program
616 942-7916

Email:
SIU@priorityhealth.com