SPECIAL INVESTIGATION FORM

Samaritan Health Plans COMPLIANCE

For help with completing this form, please call:
541-768-4550 or toll-free at 1-800-832-4580, M - F,
8 AM to 8 PM. TTY users should call 1-800-735-2900.

FOR OFFICE USE ONLY:

TELL US ABOUT YOU:

I would like to (check all that apply):
❑ Remain anonymous ❑ Report Confidentially ❑ Get a Notice of Resolution

Today's date:

First name:

Last name:

Address:

City:

State:

Zip:

Email address:

Phone number:

I am (select one):
❑ Member ❑ Provider ❑ Supplier ❑ SHS employee ❑ SHP employee ❑ Friend/relative of Member
❑ Other: _____

TELL US THE NAME OF THE INSURANCE PLAN:

❑ IHN-CCO ❑ Samaritan Advantage ❑ Samaritan Choice ❑ Samaritan Employer Group Plans

TELL US ABOUT THE MEMBER:

Member's first name:

Member's last name:

Member's insurance ID #:

TELL US ABOUT YOUR CONCERN:

Date of service: _____ ICD-9/10: _____ CPT/HCPC Code: _____

Has anyone else previously contacted our office regarding this matter? ❑ Yes ❑ No ❑ Unknown

Did the Member (check all that apply):
❑ Receive a bill and pay for services that the plan already paid for?
❑ Receive an item/service no longer in use.
Date stopped: _____
❑ Cancel or Refuse the item/service.
Date: _____
❑ Return the item being billed for.
Date returned: _____
❑ Use the item or accept the service?
❑ Other: _____
❑ N/A

Reason for the complaint (check all that apply):
❑ Inappropriate equipment
❑ Improper fitting equipment
❑ Unable to use in the home
❑ Billed for a specific item, yet supplied with a different item.
❑ My physician never ordered the services/equipment
❑ Not Needed
❑ Knowledge of bribes, kickbacks, or rebates to supplier or physician.
❑ Other: _____

TELL US ABOUT THE SUPPLIER/ PROVIDER:		
Supplier or Provider's name (first, last):	Is this a Contracted Provider: ❑ Yes ❑ No ❑ Unknown	
Hospital / facility / clinic address:	Phone:	
City:	State:	Zip:

TELL US ABOUT THE SITUATION
Please provide as much detail as you can (Who, What, When, Where). Include the date of service, claim number, or other identifying details if possible, if not already given in this report:

TELL US HOW YOU BECAME AWARE OF THIS CONCERN:

FAX COMPLETED FORM TO 541-768-9791

COMPLETED FORM
MAY BE MAILED TO:

Samaritan Health Plans
Compliance Department
PO Box 1310
Corvallis, OR 97339

COMPLETED FORM MAY BE
PRESENTED IN PERSON TO:

Samaritan Health Plans
Compliance Department
2300 NW Walnut Blvd.
Corvallis, Oregon
M - F, 8:30 AM to 5 PM

FOR PROVIDER QUESTIONS
CONTACT:

Corvallis 541-768-5207
Toll-free 1-888-435-2396
TTY users should call 1-800-735-2900
M - F, 8 AM to 5 PM