



CONFIDENTIAL

FOR REPORTING BY INSURANCE COMPANIES ONLY

INVESTIGATION REQUEST PER NRS 686A
 INSURANCE FRAUD UNIT
 Bureau of Criminal Justice
 555 E. Washington Avenue, Suite 3900
 Las Vegas, NV 89101
 (702) 486-3420

Date: _____

Please send referrals to sholiday@ag.nv.gov

Referring Person	Name of Insurance Co.
Signature of Referring Person	Address
Telephone No.	City/State Zip
Email	

CLAIM NO. _____ POLICY NO. _____

WHERE WAS CLAIM FILED? _____

TYPE OF COVERAGE: ___ AUTO ___ HEALTH ___ RENTAL
 ___ BUSINESS ___ HOMEOWNER ___ SELF-INSURED
 ___ DISABILITY ___ LIFE ___ OTHER

DATE OF LOSS _____ LOCATION OF LOSS _____

CLAIM AMOUNT _____ AMOUNT PAID _____ AMOUNT DENIED _____

REASON FOR REFERRAL

PLEASE BE SPECIFIC (Print or Type)

POSSIBLE RING / ORGANIZED ACTIVITY YES NO

CHECK HERE IF FOR INFORMATION ONLY

LAW ENFORCEMENT AGENCY:	REPORTING OFFICER:
DATE OF REPORT:	REPORT NO.:

<i>CLAIMANT INFORMATION</i>		<i>CLAIM HISTORY</i> <input type="checkbox"/> YES <input type="checkbox"/> NO	
Name of INSURED		Social Security No.	
Address		Date of Birth	
City/State/Zip		Occupation	
Telephone No.			
Name of CLAIMANT		Social Security No.	
Address		Date of Birth	
City/State/Zip		Occupation	
Telephone No.			
<u>OTHER PARTIES INVOLVED:</u>		<u>OTHER PARTIES INVOLVED:</u>	
Name		Name	
Address		Address	
City/State/Zip		City/State/Zip	
Telephone No.	SS#	Telephone No.	SS#

USE BACK OF FORM IF ADDITIONAL SPACE IS NEEDED

PLEASE INCLUDE ANY ADDITIONAL INFORMATION OR DOCUMENTS THAT MAY SUPPORT THIS REQUEST.