AO 91 (Rev. 11/11) Criminal Complaint

UNITED STATES DISTRICT COURT

for the

District of Vermont

United States of America
v.
Evelyn Herrera

Case No. 2:25-mj-81-1

Defendant(s)

CRIMINAL COMPLAINT

I, the complainant in this case, state that the following is true to the best of my knowledge and belief.

On or about the date(s) of October 13, 2021 to July 21, 2022 in the county of _____ in the _____ District of Vermont, the defendant(s) violated:

Code Section	*Offense Description*
18 U.S.C. § 1349	Conspiracy to Commit Health Care Fraud

This criminal complaint is based on these facts:

See attached affidavit.

☑ Continued on the attached sheet.

Complainant's signature

Robert Ames, Special Agent

Printed name and title

Attested to by the applicant in accordance with the requirements of Fed. R. Crim. P. 4.1 by telephone.

Date: June 12, 2025

Judge's signature

City and state: Burlington, Vermont

Hon. Kevin J. Doyle, U.S. Magistrate Judge

Printed name and title

AFFIDAVIT IN SUPPORT OF CRIMINAL COMPLAINT

I, Robert Ames, being first duly sworn, hereby depose and state as follows:

Introduction and Agent Background

1. I am a Special Agent with the Department of Health and Human Services, Office of Inspector General (HHS-OIG), Boston Regional Office, Office of Investigations. I have been employed in this capacity since December 2021. I am presently assigned to investigate a wide variety of health care fraud matters, including schemes to defraud Medicare and Medicaid. In this capacity, I am authorized to conduct investigations into criminal violations committed against the United States, including, but not limited to, health care fraud, payment and receipt of illegal health care kickbacks, making false statements in connection with a health care benefit program, money laundering, and related conspiracies. I am authorized to apply for and execute arrest warrants for offenses enumerated in Titles 18 and 42 of the United States Code, and to execute search warrants. I have received extensive training in investigations of fraud related to the United States health care system.

2. I make this affidavit in support of an application for a criminal complaint alleging that EVELYN HERRERA ("HERRERA") has committed the offense of conspiracy to commit health care fraud, in violation of Title 18, United States Code, Section 1349.

3. Title 18, United States Code, Section 1349, prohibits a person from knowingly and willfully conspiring to execute and attempt to execute a scheme and artifice to defraud and to obtain, by means of materially false and fraudulent pretenses, representations, or promises, money and property owned by and under the custody and control of Medicare, a "health care benefit program," as that term is defined in Title 18, United States Code, Section 24(b), in connection with the delivery of and payment for health care benefits, items, and services.

4. The investigation of HERRERA is being conducted jointly by HHS-OIG and the Federal Bureau of Investigation ("FBI"). Because this affidavit is being submitted for the limited purpose of establishing probable cause in support of a criminal complaint charging HERRERA with conspiracy to commit health care fraud, it does not include everything I have learned during my investigation. The facts in this affidavit come from my training and experience, my personal knowledge and observations, information provided to me by other law enforcement officers, law enforcement officers' review of financial and banking records, information I have received from various business records and searches of public and governmental databases, and other documents and records gathered in the investigation.

Facts Supporting Probable Cause

A. Background and Overview of Investigation

5. This investigation began in approximately October 2024 and concerns a Medicare-enrolled durable medical equipment company, Merida Medical Supplies Inc. ("Merida"). The investigation determined that Merida submitted false and fraudulent claims to Medicare for durable medical equipment, or "DME," purportedly provided to beneficiaries nationwide, including beneficiaries located across New England, including in Vermont.

6. HERRERA, a resident of Loxahatchee, Florida, incorporated Merida and was its sole owner and managing employee. After obtaining payment from Medicare for the false and fraudulent claims, financial records show HERRERA siphoned off some of the funds to benefit herself and others, including her family members.

7. Publicly available records from the Florida Secretary of State Division of Corporations demonstrate that HERRERA incorporated Merida on December 21, 2020. The

incorporation paperwork identifies HERRERA as the registered agent, incorporator, and the initial officer and/or director.

8. On or about January 8, 2021, HERRERA opened a deposit account with Bank 1 in the name of Merida ("Bank 1 Account"). HERRERA was the only authorized signer on the Bank 1 Account. In the Bank 1 Account opening documentation, HERRERA identified herself as Merida's President and the "100.0" percent owner.

9. On or about February 24, 2021, HERRERA signed a contract with an outside billing company on behalf of Merida. The contract provided that the outside billing company would regularly process claims it received from Merida, and Merida represented "that neither it nor any person or firm connected with it has knowingly participated in any act that violates any state or federal law." The contract also stated that the company would "have the exclusive billing rights for all of [Merida's] health care service claims and [Merida] shall not do business with any other billing company or process its own billing."

10. On or about March 8, 2021, Merida enrolled with Medicare as a medical supply company located in Greenacres, Florida. Medicare records identify HERRERA as the owner, managing employee, authorized official, and director/officer. No other individuals are listed for those roles.

11. On or about April 9, 2021, HERRERA directed Medicare to deposit reimbursements for claims submitted into the Bank 1 Account.

12. In addition to HERRERA, Co-Conspirator 1, Individual-1, and Individual-2 were employees of Merida, according to Florida Department of Revenue records. Upon information and belief, all are relatives and close associates of HERRERA.

13. As outlined in greater detail below, Merida fraudulently billed Medicare for DME that was never provided to beneficiaries, not prescribed by their medical providers, and not medically necessary.

14. Medicare data reflects that from approximately July 27, 2021, to August 11, 2022, Merida submitted claims for reimbursement for DME that was alleged to be provided to approximately 2,330 Medicare beneficiaries throughout the United States, including in New England. In total, Merida billed Medicare approximately $6.5 million in claims.

15. Medicare, in fact, paid approximately $2.8 million for those claims. The funds were deposited into the Bank 1 Account controlled by HERRERA. There were no other signatories on the Bank 1 Account.

16. As described in more detail below, after obtaining payment for the claims into the Bank 1 Account, HERRERA withdrew large sums of cash and transferred funds to benefit herself and others, including relatives.

B. Medicare

17. The Medicare Program ("Medicare") is a federally-funded program that provides free and below-cost health care benefits to people aged 65 years or older, the blind, and the disabled. The Centers for Medicare and Medicaid Services ("CMS") is responsible for the administration of Medicare.

18. Medicare is a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

19. Individuals who receive benefits under Medicare are referred to as Medicare "beneficiaries." Beneficiaries are eligible to receive a variety of services, including hospital services ("Part A"), physician services ("Part B"), and prescription drug coverage ("Part D"). Part

B covers outpatient physician services, such as office visits, minor surgical procedures, laboratory services, and DME when certain criteria are met.

20. "Providers" include independent clinical laboratories, physicians, DME suppliers, and other health care providers who provide services to beneficiaries. To bill Medicare, a provider must submit a Medicare Enrollment Application Form CMS-855 ("Provider Enrollment Application") to Medicare. The Provider Enrollment Application contains certification statements that the provider must agree to before enrolling with Medicare. Specifically, the certification statement sets forth, in part, that the provider agrees to abide by the Medicare laws, regulations, and program instructions, including the Federal Anti-Kickback Statute, and will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare.

21. Medicare will not pay claims for services or supplies that are not provided, not medically necessary, or not authorized by an ordering physician.

22. A Medicare "provider number" is assigned to a provider upon approval of the provider's Medicare application. A provider may use that provider number to file claims with, or "bill," Medicare to obtain reimbursement for services rendered to beneficiaries. When submitting claims to Medicare for reimbursement, providers certify that: (1) the contents of the forms are true, correct, and complete; (2) the forms are prepared in compliance with the laws and regulations governing Medicare; and (3) the services purportedly provided, as set forth in the claims, are medically necessary.

23. Medicare, in receiving and adjudicating claims, acts through fiscal intermediaries called Medicare administrative contractors ("MACs"), which are statutory agents of CMS for Medicare Part B. The MACs are private entities that review claims and make payments to providers for services rendered to beneficiaries. The MACs are responsible for processing

Medicare claims arising within their assigned geographical area, including determining whether the claim is for a covered service.

24. Additionally, when initially enrolling or updating ownership or management information, the Provider Enrollment Application requires that the provider disclose all owners and any individuals or businesses with managing control over the provider. This includes any individual or entity with 5 percent or more ownership, managing control, or a partnership interest regardless of the percentage of ownership the partner has.

C. Durable Medical Equipment

25. This investigation concerns claims submitted to Medicare for Part B DME supplies, namely orthotic devices.

26. Orthotic devices, or orthoses, are DME items that are applied to the outside of the body to support a body part. They are commonly referred to as "braces." Examples of orthotic devices include back braces, knee braces, ankle braces, wrist/hand supports, and arm/shoulder supports.

27. Before submitting a claim to Medicare, a DME supplier must have the following on file: a dispensing order, written order, some type of certificate of medical necessity, and information from the treating physician concerning the patient's condition and diagnosis. The documentation must be maintained in the supplier's files and pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Medicare providers are required to retain required documentation for six years from the date of its creation. A supplier must have a hard copy, faxed, or electronic order in their records before the supplier can submit a claim for payment to Medicare.

D. Claims Data Analysis

28. My review of the claims Merida submitted to Medicare identified several indicators of health care fraud.

29. Notably, the claims submitted to Medicare were almost exclusively for billing of certain orthotics. As shown in the chart below, the vast majority of claims billed were for only four Healthcare Common Procedure Coding System, or "HCPCS," codes: one code for a wrist brace, one code for a suspension sleeve, one code for a knee brace, and one code for a back brace.

Rank	HCPCS Code	HCPCS Code Description	Claim Lines	Benes	Percent of Benes	Total Billed	Total Paid
1	**L3916**	WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF	3,661	2,025	87%	$2,098,255	$1,034,526
2	**L2397**	ADDITION TO LOWER EXTREMITY ORTHOSIS, SUSPENSION SLEEVE	2,117	1,110	48%	$285,795	$142,828
3	**L1851**	KNEE ORTHOSIS (KO), SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, OFF-THE-SHELF	2,066	1,078	46%	$2,220,950	$873,440
4	**L0648**	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF	1,295	1,290	55%	$1,574,720	$600,749

30. Moreover, as shown in the chart above, those four codes represented approximately $2.6 million of the $2.8 million total paid by Medicare to Merida.

31. In addition, Merida billed Medicare for an average of 2.5 unique codes per beneficiary. Merida's billed claims often involved multiple braces on a single claim—such as double knee and/or double wrist braces, in addition to a back brace and/or suspension sleeves.

32. Based on my training and experience, the volume and pattern of billing is highly unusual for a legitimate provider.

E. Suspicious Payments to Company-1 for "Lead Generation"

33. Based on my review of the financial and accounting records, HERRERA regularly made large payments from the Bank 1 Account to Company-1, a Florida limited liability company. The payments were made electronically using Direct Pay and wire transfers and typically included a memo line, such as "for Leads the Week 03.14 to 03.18." In 2021, Merida spent approximately $270,300 for these payments, which were characterized as "advertising & lead generation." In 2022, Merida spent approximately $957,500 for "lead generation / marketing."

34. Merida's single largest business expense was "lead generation." In 2022, the amount Merida spent on leads was nearly three times the amount spent on DME supplies and materials. Specifically, in contrast to the $957,500 spent on leads in 2022, Merida spent $387,650 on DME supplies and materials.

35. Based on my training and experience, large expenses identified as "leads," "marketing," and "advertising" are often used to conceal payments for illegal health care kickbacks.

F. Medicare Beneficiary Complaints

36. Beginning on September 21, 2021, Medicare began receiving complaints from Medicare beneficiaries about Merida to Medicare's complaint telephone number, 1-800-Medicare. That number connects to a call center where Medicare-contracted employees receive complaints from the public regarding any Medicare-related issue, including Medicare fraud, waste, and abuse or quality of care issues.

37. Between September 21, 2021, and May 2, 2024, the Medicare hotline received approximately 269 complaints regarding Merida. Of those complaints, 90 reported that they did not receive services, 43 reported that they did not know the provider, and 83 reported that they returned equipment and no refund was given.

G. Medicare Contractor Reviews

38. Shortly after Merida began submitting bills to Medicare, several Medicare contractors began to identify concerns with Merida's billing practices.

39. CGS was a MAC for DME.

40. On or about November 25, 2021, CGS sent Merida a "Notice of Review – Targeted Probe and Educate." The letter explained that CGS would begin with a review of 10 claims and would continue for up to three rounds of additional review if errors were identified. On or about May 12, 2022, CGS responded with its findings on the "Round (1) Probe Review." Based on the medical records provided, 10 of the 40 claims in the sample did not support Medicare coverage.

41. As part of this investigation, I have reviewed documents produced by Merida's billing company regarding the records request from CGS and compared them with medical records obtained directly from the referring providers. The materials include recordings and transcripts of calls allegedly between Co-Conspirator-1, Individual-2, and others on behalf of Merida with

referring providers and beneficiaries. In my review, I have identified inconsistencies between the medical records obtained directly from the referring providers and the records from the biller. For example, physician notes for beneficiary R.M. from the biller include a diagnosis for back pain and state: "USE BACK BRACE L0648 FOR THE NEXT 99 MONTHS TO REDUCE PAIN BY RESTRICTING MOBILITY OF THE TRUNK AND SUPPORT WEAK SPINAL AND/OR A DEFORMED SPINE." However, the records obtained directly from the provider as part of this investigation do not include a diagnosis for back pain, do not refer to a back brace, and do not include the language quoted above.

42. To address the deficiencies identified by CGS, Merida submitted a Process Improvement Plan (PIP) on or about June 1, 2022, and it was accepted on or about June 2, 2022. The PIP listed Co-Conspirator-1 as the person accountable for several of the action items, including reviewing and becoming more familiar with Medicare coverage guidelines.

43. Each region of the country has a Unified Program Integrity Contractor ("UPIC") tasked with investigating fraud, waste, and abuse in Medicare. Qlarant Integrity Solutions, LLC ("Qlarant") was the UPIC for the Western region.

44. On or about August 11, 2022, Qlarant issued a letter to Merida notifying it of its decision "to suspend . . . Medicare payments in all jurisdictions." The letter stated that the "suspension [was] based on credible allegations of fraud" that Merida "submitted claims for services that were not rendered or medically unnecessary."

H. Vermont Medicare Beneficiary Interviews

45. As part of the investigation, I and other law enforcement officers conducted interviews of Medicare beneficiaries and providers in Vermont and other states in New England.

46. For example, officers interviewed R.C., a Medicare beneficiary purportedly residing in Cabot, Vermont, in October 2024. On or about October 26, 2021, Merida billed Medicare approximately $3,566 for multiple orthoses – two wrist braces, two knee braces, and two compression sleeves, claiming that those orthoses had all been provided to R.C. Medicare paid Merida $2,202.12 for the braces based on Merida's representation that the braces were prescribed to R.C., medically necessary, and provided to R.C. However, when interviewed, R.C. indicated that he/she did not receive any of the braces and has never been diagnosed with osteoarthritis, despite it being the diagnosis on each of the claims.

47. In March 2025, I interviewed J.S., a Medicare beneficiary residing in Saint Johnsbury, Vermont. On or about May 20, 2022, Merida billed Medicare $3,636 for a lumbar-sacral orthosis, two knee orthoses, and two suspension sleeves, claiming that those items had all been provided to J.S. Claims data shows no payment from Medicare. According to billing records, J.S. returned the items, and Merida submitted an overpayment request on or about November 9, 2022. J.S. said when interviewed that in approximately 2022, he/she received phone calls asking for personally identifiable information; however, he/she never provided the information and no longer answers the phone for those calls. J.S. said that he/she has not received any medical supplies or equipment at his/her residence and has never used any form of brace. J.S. also informed agents that his/her primary care physician, M.S., has never prescribed a brace for him/her.

48. I also interviewed M.C., a Medicare beneficiary residing in Irasburg, Vermont, in March 2025. On or about December 3, 2021, Merida billed Medicare $3,636 for a lumbar-sacral orthosis, two knee orthoses, and two suspension sleeves, claiming that those items had all been provided to M.C. Claims data shows no payment from Medicare. M.C. told us that he/she received three or four boxes of knee and back braces that he/she did not need several years ago in

approximately 2021 to 2023. M.C. told us that he/she returned the boxes to the sender and did not remember the name of the DME vendors. M.C. also said that he/she does not have any back, wrist, or knee pain and has not been prescribed a back, wrist, or knee brace.

49. Law enforcement officers also interviewed D.B., a Medicare beneficiary purportedly residing in Orleans, Vermont, in October 2024. On or about July 21, 2022, Merida billed Medicare $2,352.90 for two wrist orthoses and two elbow orthoses, claiming that the braces had all been provided to D.B. Claims data shows no payment from Medicare. D.B. told law enforcement officers that he/she never received any DME equipment, never was contacted regarding DME, and has never been diagnosed with osteoarthritis, despite it being the diagnosis on Merida's claim.

I. Vermont Medicare Provider Interviews

50. As part of the investigation, I and other law enforcement officers conducted interviews of the medical providers identified as referring providers for the Vermont beneficiaries described above and referring providers for other Vermont Medicare beneficiaries.

51. For example, we interviewed J.M, a physician, and L.S., a practice manager, at their medical clinic in Plainfield, Vermont in March 2025, regarding claims submitted by Merida for braces allegedly provided to beneficiary R.C. Contrary to Merida's representation to Medicare, J.M. and L.S. informed us that J.M. did not order or prescribe any DME for R.C. Indeed, medical records from the practice indicate that R.C. has not been seen or treated by J.M. because R.C. is solely a dental patient of the practice. J.M. also stated, in sum and substance, that the physician has never ordered anyone double knee or wrist braces before, and that it is suspicious for anyone to do so.

52. Similarly, we interviewed M.S., a physician, and H.M., an office manager and registered nurse, at their medical clinic in Lyndonville, Vermont in March 2025, regarding claims submitted by Merida for braces allegedly provided to beneficiary J.S. M.S. told us that he/she did not order any DME for J.S. in the relevant time period. M.S. also reviewed J.S.'s medical records and reported that J.S. did not have any knee, wrist, or back issues or complaints. Furthermore, notes in the medical practice's records indicate that on May 17, 2022, J.S.'s relative contacted the practice to report that J.S. received a phone call and may have provided protected health information to the caller. The medical practice's records reflect that another DME company requested information from the practice regarding J.S. via fax, and the practice wrote "Stop" and returned it to the other DME company.[1]

53. We also interviewed P.K., a physician, and K.S., a patient safety director, regarding Medicare beneficiary M.C. in April 2025. P.K. and K.S. work at a medical clinic in Newport, Vermont. P.K. reviewed electronic medical records for M.C. and explained that they did not reflect a prescription for a knee or back brace and did not reflect a diagnosis of osteoarthritis, despite that diagnosis being listed on Merida's claim for reimbursement. P.K. stated that he/she does not prescribe braces to individuals suffering from osteoarthritis. Although the diagnoses and prescriptions were not present in the medical records, what was present were notes indicating that M.C. called to complain about calls from medical supply companies. The medical records included faxes from providers seeking signatures and medical records for M.C. Both P.K. and K.S. stated that they either do not respond to the requests or respond by writing "stop requesting" and send it back to the sender.

[1] Based on my training and experience, DME fraud often involves networks of individuals and entities sharing protected health information about Medicare beneficiaries.

54. I and other law enforcement officers also interviewed additional Vermont providers listed by Merida as referring physicians.

55. We interviewed B.R., a physician, and L.S., a practice manager, at their medical clinic in Plainfield, Vermont in March 2025. We asked B.R. about Medicare beneficiary M.S. of Highgate Center, Vermont. B.R. reported that M.S. currently resides in an assisted living facility. B.R. did not recall prescribing braces for beneficiary M.S. L.S. reviewed the electronic medical records for M.S. and confirmed that M.S. has never been prescribed any wrist, knee, or back braces. L.S. said that the medical office receives a lot of high-pressure phone calls from unknown individuals trying to obtain patient information to order their patients DME. M.S.'s medical chart includes one example of this in a call to the practice on May 12, 2022. The recorded note in the medical record states:

> Call from a mail order vendor asking for our fax number in order to send us an order to complete. I did not give him the fax number—he was difficult to understand and would not confirm what the item was they were trying to get an order for. It was something to do with low back pain, I think. No info given.

Claims data shows Merida submitted a claim for $3,636 for several items for M.S. the very next day on May 13, 2022—two knee braces, two suspension sleeves, and a back brace, alleging that the items were provided to M.S. with referring provider B.R. Medicare paid Merida $2,191.36.

56. We also interviewed M.W., a family nurse practitioner in Randolph, Vermont, regarding Medicare beneficiary R.C. of White River Junction, Vermont in March 2025. M.W. recalled R.C. as a patient at M.W.'s former practice in White River Junction, Vermont. When M.W. asked us about the relevant time frame and we explained that we were inquiring about July 2022, M.W. stated that it was "impossible" to have prescribed any DME for R.C. then because M.W. was on maternity leave from May to August 2022. Nevertheless, on or about July 18, 2022, Merida

billed Medicare $2,362 for a back brace and two wrist braces allegedly provided to R.C. and allegedly prescribed by M.W. Medicare paid Merida $1,491.01.

J. Money Laundering Transactions

57. After funds were deposited into the Bank 1 Account from Medicare, HERRERA conducted financial transactions and attempted to conceal and disguise the source, origin, and control of the health care fraud proceeds generated by Merida.

58. On or about March 24, 2022, HERRERA sent an international wire from her Bank 1 Account for $58,100. The detail in the wire stated, "Ref Down Payment for Pent House Elements Tulum Mexico." She sent additional wires to the same recipient on or about May 4, 2022, August 9, 2022, November 17, 2022, and February 15, 2023, each in the amount of $16,885.71 with details stating, "Pago Elements 326 DK Unidad 315." In total, HERRERA wired more than $125,000 to this recipient. Based on my training and experience, these funds appear to be sent for a down payment and payments on the purchase of a residential property in Tulum, Mexico.

59. From approximately December 2021 to August 2022, HERRERA periodically transferred money from her Bank 1 Account to a cryptocurrency exchange ("Cryptocurrency Exchange 1") account in her name and another cryptocurrency exchange account in the name of Co-Conspirator-1.

60. Shortly after the payment suspension letter was issued on August 11, 2022, which notified HERRERA that CMS would no longer make any payments on Medicare claims, HERRERA swiftly attempted to withdraw large amounts of cash from the Bank 1 Account and transfer some of the funds to Co-Conspirator-1 and Individual-1.

61. On or about August 12, 2022, HERRERA went to three different Bank 1 locations in Florida. She withdrew $20,000 in cash at each location for a total of $60,000 in a single day from Merida's account at Bank 1.

62. Shortly thereafter, on or about August 15, 2022, HERRERA withdrew $100,000 in cash from the Bank 1 Account.

63. In addition to withdrawing cash from the accounts, HERRERA transferred funds from the Bank 1 Account to Co-Conspirator-1 and Individual-1. HERRERA made multiple payments in the amount of $25,000 to Co-Conspirator-1 and Individual-1 on or about August 16, 2022, August 18, 2022, and August 31, 2022. She also wrote two checks—one to Co-Conspirator-1 and one to Individual-1—both in the amount of $100,000 on or about September 3, 2022.

Conclusion and Request

64. In summary, according to witnesses and records obtained by law enforcement, HERRERA, through Merida, caused to be submitted false and fraudulent claims to Medicare for the purported supply of orthoses. To accomplish the scheme, HERRERA worked with Company-1, Co-Conspirator-1, and others.

65. Merida charged Medicare for supplying orthoses to beneficiaries throughout the nation who never requested nor received such items. The fraudulent claims include claims for the purported delivery of medical supplies to beneficiaries R.C., J.S., M.C., D.B., M.S., and R.C., all within the District of Vermont, between October 13, 2021, and July 21, 2022.

66. Based on the foregoing, I submit that there is probable cause to believe that EVELYN HERRERA committed the offense of conspiracy to commit health care fraud, in

violation of Title 18, United States Code, Section 1349. I therefore respectfully request that the Court issue a criminal complaint charging her accordingly.

ROBERT AMES
Special Agent, HHS-OIG

Attested to by the applicant in accordance with the requirements of Fed. R. Crim. P. 4.1 by telephone, this 12th day of June 2025.

Kevin J. Doyle
HON. KEVIN J. DOYLE
UNITED STATES MAGISTRATE JUDGE