UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO.

UNITED STATES OF AMERICA,

Plaintiff,

v.

APPROXIMATELY $6,396,531.56 IN U.S. CURRENCY SEIZED FROM ACCOUNT NO. 898156399068 AT BANK OF AMERICA, N.A. IN THE NAME OF CRC MANAGEMENT, CORP., and

APPROXIMATELY $567,398.59 IN U.S. CURRENCY SEIZED FROM ACCOUNT NO. 898158830716 AT BANK OF AMERICA, N.A. IN THE NAME OF CRC MANAGEMENT, CORP.

Defendants *In Rem*.

VERIFIED COMPLAINT FOR FORFEITURE *IN REM*

Plaintiff, the United States of America, by and through its undersigned counsel, alleges as follows:

I. NATURE OF THE ACTION

1. This is a civil action *in rem*, pursuant to 18 U.S.C. § 981(a)(1)(C) and the procedures set forth in Rule G of the Supplemental Rules for Admiralty or Maritime Claims and Asset Forfeiture Actions, the Federal Rules of Civil Procedure, to forfeit seized funds, more fully described as (collectively, the "Defendant Assets"):

(i) Approximately [1] $6,396,531.56 in U.S. currency seized from account no. 898156399068 at Bank of America, N.A. in the name of CRC Management Corp. ("Account 9068"), and

(ii) Approximately $567,398.59 in U.S. currency seized from account no. 898158830716 at Bank of America, N.A. in the name of CRC Management Corp. ("Account 0716").

II. JURISDICTION AND VENUE

2. This Court has jurisdiction over this subject matter. *See* 28 U.S.C. §§ 1345, 1355(a); 18 U.S.C. § 981(a)(1).

3. This Court has *in rem* jurisdiction over the Defendant Assets. *See* 28 U.S.C. §§ 1345, 1355(b).

4. Venue for this action is proper in this District because acts or omissions giving rise to the forfeiture occurred in the Southern District of Florida, and because this is the same District where the Defendant Assets were brought upon seizure. *See* 28 U.S.C. §§ 1355(b)(1), 1395; 18 U.S.C. § 981(h).

III. FACTUAL ALLEGATIONS

At all times material to this Action:

A. The Medicare Program

5. The Medicare Program ("Medicare") was a federal health care program that provided free or below-cost health care benefits to individuals who are 65 years of age or older or disabled.

6. The United States Department of Health and Human Services, through its agency,

[1] All dates and amounts referenced in this Verified Complaint are approximate.

the Center for Mediare and Medicaid Services ("CMS"), oversaw and administered Medicare.

7. Individuals who received benefits under Medicare were commonly referred to as "Medicare beneficiaries."

8. Medicare was a "health care benefit program," as defined by 18 U.S.C. § 24(b).

9. Medicare was subdivided into four parts: hospital insurance (Part A); medical insurance (Part B); Medicare Advantage (Part C); and prescription drug benefits (Part D).

10. Medicare Part B covered, among other things, skin substitutes, skin grafts, and surgical dressings. According to the CMS website, CMS.gov, Amnioamp-MP falls under "Skin Substitutes."

11. Medicare claims for Part B items and services were processed and paid by Medicare Administrative Contractors ("MAC[s]"), which contracted with CMS to administer parts of Medicare in specific jurisdictions.

12. First Coast Service Options, Inc. was the MAC that covered Florida.

13. Health care providers seeking to bill Medicare for the cost of related benefits, items, and services were required to apply for and receive a "provider number." As part of the enrollment application, the provider agreed to abide by Medicare's policies, procedures, rules and regulations governing reimbursement.

14. Providers with a Medicare provider number could file claims with Medicare to obtain reimbursement for services provided on behalf of Medicare beneficiaries.

15. Providers were given access to Medicare manuals and services bulletins describing billing procedures, rules, and regulations.

16. To receive payment for a covered service from Medicare, providers had to submit a claim, either electronically or using a form, to the MAC. The claim had to contain the required

information, including the provider's identifying information such as a Medicare-assigned Provider Transaction Access Number, the patient's information, the services rendered, the name of the provider who rendered or provided the billed-for item or service, the name of the beneficiary, a medical diagnosis, the date the billed-for service was rendered or the items was provided, and the type of service rendered and/or item provided.

17. Providers could only submit reimbursement claims to Medicare for items provided and/or services rendered that were reasonable and medically necessary.

18. Reimbursement payments under Mediare were often made directly to a provider for the goods or services, rather than to a Medicare beneficiary.

19. Medicare sent reimbursement payments directly to a provider's financial institution whether claims were filed electronically or on paper. Medicare required all providers to submit an electronic funds transfer agreement and a voided check or letter from their financial institution with their enrollment application to receive payments electronically.

B. CRC Management, Corp.

20. CRC Management, Corp. ("CRC Management") was an enrolled Medicare provider that purportedly provided services through Medicare Part B to Medicare beneficiaries.

21. CRC Management was a Florida corporation located in North Miami Beach, Florida, which is within the Southern District of Florida.

22. CRC Management's Bank of America Account 9068 was opened on or about October 21, 2024, using an address at CRC Management's purported office in North Miami Beach.

23. CRC Management's Bank of America Account 0716 was opened on or about February 7, 2025, using that same purported office in North Miami Beach.

24. Co-conspirators submitted and caused CRC Management to submit false and

fraudulent claims to Medicare totaling $10,538,950.00 in U.S. currency for Amnioamp-MP skin substitutes that were medically unnecessary and not provided as represented.

25. Alleged beneficiaries of CRC Management's Medicare claims stated in interviews with law enforcement agents that they did not receive, request, or need any of the Amnioamp-MP that was billed for them and had never heard of CRC Management.

26. The alleged provider and prescriber of Amnioamp-MP identified in CRC Management's Medicare claims stated in an interview with law enforcement agents that he or she had never heard of CRC Management, and he or she had not prescribed Amnioamp-MP to the identified beneficiaries. This provider stated that the identified Medicare beneficiaries were not his or her patients. This provider's prescriptions accounted for 100% CRC Management's total billed Medicare claims.

27. On March 3, 2025, law enforcement agents also visited CRC Management's purported office in North Miami Beach, which they found was another business, and CRC Management was not located there. There were no signs indicating CRC Management was an active business.

C. Defendant Assets

i. Account 9068

28. From February 4, 2025, through March 6, 2025, as a result of claims for reimbursements, Medicare deposited $7,164,619.62 in U.S. currency into Account 9068 in the name of CRC Management.

29. This $7,164,619.62 in U.S. currency constituted almost all of Account 9068's total deposits during that time period. There was only one non-Medicare proceeds deposit of $60 cash

into Account 9068 account between February 4, 2025, through March 6, 2025.

30. There were no additional deposits into Account 9068 after March 6, 2025.

31. Analysis of Account 9068 revealed that $6,958,827.61 in U.S. currency on deposit on or about March 12, 2025, which was entire balance of the account at the time, was traceable to Medicare reimbursements.

ii. Account 0716

32. On or about February 7, 2025, Account 0716, a savings account also in the name of CRC Management, was opened with two transfers from Account 9068, totaling $5,100.

33. Before those transfers on or about February 7, 2025, Account 0716 had a zero balance.

34. On or about March 12, 2025, Account 9068 transferred approximately $562,296.05 to Account 0716.

35. Bank statements reflect that Account 0716 earned $2.54 in interest between February 7, 2025, and March 31, 2025.

36. Analysis of Account 0716 traced all funds on deposit to Medicare reimbursements.

iii. Seizure Warrant

37. On or about April 7, 2025, law enforcement agents served a federal seizure warrant on Bank of America N.A. for all funds on deposit in the following Bank of America Accounts: Account no. 898156399068 in the name of CRC Management, Corp., and Account no. 898158830716 in the name of CRC Management, Corp. *See* Case No. 25-MJ-02659-Sanchez (S.D. Fla.).

38. Pursuant to that seizure warrant, Bank of America remitted a total of $6,963,930.15 in U.S. currency, comprised of $6,396,531.56 from Account 9068 and $567,398.59 from Account

0716.

39. The $6,396,531.56 in U.S. currency from Account 9068 and $567,398.59 in U.S. currency from Account 0716, which constitute the Defendant Assets, were seized by the Federal Bureau of Investigation.

IV. BASIS FOR FORFEITURE

40. Pursuant to 18 U.S.C. § 981(a)(1)(C), any property, real or personal, which constitutes or is derived from proceeds traceable to a specified unlawful activity or a conspiracy to commit such offense is subject to civil forfeiture.

41. Pursuant to 18 U.S.C. § 1956(c)(7)(F), any act or activity constituting an offense involving a "Federal health care offense" constitutes a specified unlawful activity.

42. Pursuant to 18 U.S.C. § 1347, health care fraud is a "Federal health care offense."

FIRST CLAIM
Proceeds of Health Care Fraud
18 U.S.C. § 981(a)(1)(C)

43. The factual allegations in paragraphs 1 through 39 are re-alleged and incorporated by reference as if fully set forth herein.

44. As set forth above, the Defendant Assets are property that constitute or are derived from proceeds traceable to health care fraud in violation of 18 U.S.C. § 1347, which is a specified unlawful activity pursuant to 18 U.S.C. § 1956(c)(7)(F).

45. Accordingly, the Defendant Assets are subject to forfeiture pursuant to 18 U.S.C. § 981(a)(1)(C).

WHEREFORE, Plaintiff, the United States of America, requests that the Clerk of the Court issue a warrant for the arrest *in rem* of the Defendant Assets; that notice of this action be provided to persons known or thought to have an interest in or right against the Defendant Assets;

that the Defendant Assets be forfeited and condemned to the United States of America; and for such other and further relief as may be deemed just, necessary and proper.

Respectfully submitted,

JASON A. REDING QUIÑONES
UNITED STATES ATTORNEY

By: *s/ G. Raemy Charest-Turken*

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VERIFICATION

I, Anthony Lam, hereby verify and declare, under penalty of perjury, that I am a Special Agent with the United States Department of Health and Human Services, Office of Inspector General, Office of Investigations, and that the foregoing factual allegations are true and correct to the best of my knowledge and belief.

The sources of my knowledge and information and the grounds of my belief are the official files and records of the United States, information supplied to me by other law enforcement agents, as well as my investigation of this case, together with others, as a Special Agent of HHS-OIG.

Executed on this 17 of June 2026.

Anthony Lam

Anthony Lam
Special Agent, United States Department of Health and Human Services, Office of Inspector General

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO.

UNITED STATES OF AMERICA,

Plaintiff,

v.

APPROXIMATELY $4,306,826.95 IN U.S. CURRENCY SEIZED FROM ACCOUNT NO. 1100033166565 AT TRUIST BANK IN THE NAME OF STEEL DISTRIBUTION SERVICES INC;

and

APPROXIMATELY $60,679.17 IN U.S. CURRENCY SEIZED FROM ACCOUNT NO. 1100033170465 AT TRUIST BANK IN THE NAME OF NAKELLY MEDICAL CENTER CORP.

Defendants *In Rem*.

VERIFIED COMPLAINT FOR FORFEITURE *IN REM*

Plaintiff, the United States of America, by and through its undersigned counsel, alleges as follows:

I. NATURE OF THE ACTION

1. This is a civil action *in rem*, pursuant to 18 U.S.C. § 981(a)(1)(C) and the procedures set forth in Rule G of the Supplemental Rules for Admiralty or Maritime Claims and Asset Forfeiture Actions, the Federal Rules of Civil Procedure, to forfeit seized funds, more fully described as (collectively, the "Defendant Assets"):

(i) Approximately[1] $4,306,826.95 in U.S. currency formerly on deposit in account number 1100033166565 held at Truist Bank in the name of Steel Distribution Services Inc. (the "Steel Distribution Account"), which was seized on or about February 13, 2026, to include accrued interest; and

(ii) Approximately $60,679.17 in U.S. currency formerly on deposit in account number 1100033170465 held at Truist Bank in the name of Nakelly Medical Center Corp. (the "Nakelly Account"), which was seized on or about February 13, 2026, to include accrued interest.

II. JURISDICTION AND VENUE

2. This Court has jurisdiction over this subject matter. *See* 28 U.S.C. §§ 1345, 1355(a); 18 U.S.C. § 981(a)(1).

3. This Court has *in rem* jurisdiction over the Defendant Assets. *See* 28 U.S.C. §§ 1345, 1355(b).

4. Venue for this action is proper in this District because acts or omissions giving rise to the forfeiture occurred in the Southern District of Florida, and because this is the same District where the Defendant Assets were brought upon seizure. *See* 28 U.S.C. § 1355(b)(1).

III. FACTUAL ALLEGATIONS

At all times material to this Action:

A. The Medicare Program and Skin Substitutes

[1] All dates and amounts referenced in this Verified Complaint are approximate.

5. The Medicare Program ("Medicare") was a federal health care program that provided free or below-cost health care benefits to individuals who are 65 years of age or older or disabled. The benefits available under Medicare were governed by federal statutes and regulations.

6. The United States Department of Health and Human Services ("HHS"), through its agency the Center for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare.

7. Individuals who received benefits under Medicare were commonly referred to as "Medicare beneficiaries."

8. Medicare was a "health care benefit program," affecting interstate commerce as defined by 18 U.S.C. § 24(b).

9. Medicare was subdivided into multiple program "parts." Medicare Part B covered, among other things, physician services and outpatient care, including medically necessary skin substitute and skin graft products applied to beneficiaries in non-facility settings, such as a beneficiary's home.

10. Skin substitutes, also referred to as cellular and/or tissue-based products or skin grafts, were products that included amniotic-tissue-based allografts such as Simplimax used to aid in the closure of certain chronic, non-healing wounds, such as diabetic ulcers and pressure ulcers. Medicare reimbursed skin substitute products under product-specific Healthcare Common Procedure Coding System ("HCPCS") codes on a per-square-centimeter basis, together with associated application procedure codes.

11. Health care providers that provided items or services to Medicare beneficiaries were referred to as Medicare "providers." To participate in Medicare, providers were required to submit an enrollment application in which the providers agreed to comply with all Medicare-related laws and regulations. If Medicare approved a provider's application, Medicare assigned the enrolled provider a Medicare provider number.

12. A provider with a Medicare provider number could file claims with Medicare to obtain reimbursement for items and services rendered to Medicare beneficiaries. Enrolled Medicare providers agreed to abide by the policies, procedures, rules, and regulations governing reimbursement, and were given access to Medicare manuals and services bulletins describing billing procedures, rules, and regulations.

13. To receive payment from Medicare, providers submitted or caused the submission of claims to Medicare, either directly or through a billing company. A Medicare claim for a skin substitute product was required to set forth, among other things, the name and unique Medicare identification number of the beneficiary, the product provided and its size, the date of service, the place of service, the diagnosis, and the identity of the rendering provider.

14. A claim for a skin substitute product submitted to Medicare qualified for reimbursement only if the product was medically necessary for the treatment of the beneficiary's illness or injury, was ordered by a licensed physician or other qualified health care practitioner and was actually provided to the beneficiary as billed.

B. NAKELLY, STEEL DISTRIBUTION, and the Fraudulent Billing Scheme

15. As further discussed below, between May and July of 2025, NAKELLY electronically submitted $17,663,992 in fraudulent claims to Medicare as reimbursements for skin substitutes and skin grafts, that were not requested, delivered, or medically necessary for the beneficiaries. Data provided by the Center for Medicare & Medicaid Services ("CMS") shows that between May 2025 and July 2025, Medicare disbursed $7,440,483.46 to the Nakelly Account before the account was voluntarily frozen by Truist. From the Nakelly Account, which was solely funded by Medicare funds during the relevant time period, $6,309,976 was transferred into the Steel Distribution Account. Pursuant to the seizure warrant signed by the Honorable Magistrate Elfenbein, the United States seized $4,306,826.95 in Medicare fraud proceeds from both the Nakelly and the Steel Distribution Accounts.

16. Nakelly Medical Center Corp. ("NAKELLY") was a Florida corporation, with its principal office address in Miami, FL, which is within the Southern District of Florida.

17. Florida Department of State Division of Corporations records reflected that NAKELLY was incorporated on October 25, 2022.

18. According to Florida Department of State Division of Corporations records, on March 19, 2025, NAKELLY's Articles of Incorporation were amended to add Humberto Perez Rodriguez ("PEREZ RODRIGUEZ") as NAKELLY's Vice President with an address in the Southern District of Florida. On April 8, 2025, NAKELLY's Articles of Incorporation were amended once again, to list PEREZ

RODRIGUEZ as NAKELLY's President.

19. Steel Distribution Services Inc. ("STEEL DISTRIBUTION") was a Florida corporation incorporated on or about May 7, 2025 that listed PEREZ RODRIGUEZ as its President.

20. According to Medicare enrollment records, on April 8, 2025, NAKELLY enrolled in Medicare as a Clinic/Practice Group, listing PEREZ RODRIGUEZ as its Authorized Official and identifying the Nakelly Account as the account into which Medicare was to deposit reimbursement payments.

21. As part of its Medicare provider enrollment application, NAKELLY submitted a voided check and an electronic funds transfer ("EFT") Authorization Agreement for the Nakelly Account. The EFT agreement bore a signature purporting to be that of PEREZ RODRIGUEZ as NAKELLY's authorized official.

C. <u>The Nakelly Account and the Steel Distribution Account</u>

22. According to bank records obtained from Truist, on March 28, 2025, PEREZ RODRIGUEZ opened the Nakelly Account in NAKELLY's name at Truist Bank, in Miami, FL.

23. According to the signature cards obtained from the bank records, the Nakelly Account's opening documents listed PEREZ RODRIGUEZ as NAKELLY's President and sole authorized signer.

24. According to bank records obtained from Truist, on May 16, 2025, PEREZ RODRIGUEZ opened the Steel Distribution Account in STEEL DISTRIBUTION's name at Truist Bank, in Miami, FL.

25. According to the signature cards obtained from the bank records, Steel

Distribution Account's opening documents listed PEREZ RODRIGUEZ as its President and sole authorized signer.

D. The Medicare Fraud Scheme

26. As described further below, from May 2025 through July 2025 — beginning approximately one month after NAKELLY's Medicare enrollment — NAKELLY submitted false and fraudulent claims to Medicare totaling $17,663,992 for skin substitutes and skin grafts that were medically unnecessary.

27. All claims submitted by NAKELLY to Medicare during this period included the same two types of diagnoses: (1) PRESSURE ULCER OF RIGHT HEEL, STAGE 3 and (2) PRESSURE ULCER OF LEFT HIP, STAGE 3.

28. All claims submitted by NAKELLY to Medicare during this period listed Physician 1 as the referring provider.

29. Law enforcement interviewed Physician 1. Physician 1 told law enforcement that at all times relevant to this Complaint, Physician 1: (a) was an accredited plastic surgeon, (b) never heard of NAKELLY, (c) never treated any of NAKELLY's claimed beneficiaries, (d) never prescribed wound skin substitutes, such as Simplimax, for NAKELLY, and (e) never authorized NAKELLY to use his/her NPI for Medicare billing.

30. Law enforcement interviewed five of the Medicare beneficiaries whose Medicare identification numbers PEREZ RODRIGUEZ through NAKELLY, used to bill Medicare.

31. Each interviewed beneficiary stated that he or she was not familiar with NAKELLY, did not receive and did not need the skin substitutes, skin grafts, or

Simplimax, billed to Medicare using his or her Medicare identification number, and was not familiar with Physician 1, who appears in Medicare claims data as the rendering provider on NAKELLY's claims.

E. The Defendant Assets

32. The United States obtained bank records for the Nakelly Account, which showed that on July 7, 2025, when Medicare disbursements into the Nakelly Account began, the account had a balance of $364.86.

33. Bank records also showed that between July 7, 2025, through July 21, 2025, as a result of NAKELLY's claims for reimbursement, Medicare deposited a$7,440,483.46 in U.S. currency into the Nakelly Account, as reflected below.

34. These Medicare deposits constituted approximately 99.71% of all deposits into the Nakelly Account, as shown below:

EFT Check Date	EFT Amount	EFT Trace No.	Deposited Account No.
7/7/2025	$141,372.72	817234917	1100033170465
7/8/2025	$373,229.18	817234917	1100033170465
7/9/2025	$229,054.35	817234917	1100033170465
7/10/2025	$698,017.32	817234917	1100033170465
7/11/2025	$1,766,917.33	817234917	1100033170465
7/15/2025	$1,003,423.12	817234917	1100033170465
7/16/2025	$1,308,828.92	817234917	1100033170465
7/17/2025	$610,811.60	817234917	1100033170465
7/21/2025	$1,308,828.92	817234917	1100033170465
TOTAL	**$7,440,483.46**		

35. The United States obtained bank records for the Steel Distribution Account, which showed that on July 9, 2025, when transfers of Medicare proceeds

from the Nakelly Account to the Steel Distribution Account began, the Steel Distribution Account had a balance of $144.21.

36. Bank records further showed that beginning on or about July 9, 2025 — two days after the first Medicare deposit — and continuing through on or about July 21, 2025, $6,309,976 in funds traceable to the Medicare deposits were transferred from the Nakelly Account to the Steel Distribution Account.

37. The transfers from the Nakelly Account constituted 100% of all deposits into the Steel Distribution Account from its date of opening on March 28, 2025 through the date of the seizure on February 13, 2026.

38. On July 29, 2025, Truist Bank closed the Nakelly Account and transferred its entire balance of $60,679.17 into a hold harmless account.

39. Similarly, on or about July 29, 2025, Truist Bank closed the Steel Distribution Account and transferred its entire balance of $4,306,826.95 into a hold harmless account.

40. An analysis conducted in accordance with generally accepted accounting principles demonstrated that, as of July 29, 2025, the Nakelly Account's entire balance of $60,679.17 was fully traceable to Medicare reimbursements.

41. An analysis conducted in accordance with generally accepted accounting principles demonstrated that, as of July 29, 2025, the Steel Distribution Account's entire balance of $4,306,826.95 was fully traceable to Medicare reimbursements.

42. On or about February 18, 2026, law enforcement agents served a federal seizure warrant on Truist Bank for the balance of the Nakelly Account and the Steel

Distribution Account. *See* Case Nos. 26-MJ-02321-ELFENBEIN; 26-MJ-02322-ELFENBEIN (S.D. Fla.).

43. Pursuant to those seizure warrants, Truist Bank remitted to the Federal Bureau of Investigation ("FBI") $4,306,826.95 in U.S. currency from the Steel Distribution Account and $60,679.17 in U.S. currency from the Nakelly Account.

44. In total, the FBI seized $4,367,506.12 in U.S. currency (collectively, the "Defendant Assets").

IV. BASIS FOR FORFEITURE

45. Pursuant to 18 U.S.C. § 981(a)(1)(C), any property, real or personal, which constitutes or is derived from proceeds traceable to a specified unlawful activity or a conspiracy to commit such offense is subject to civil forfeiture.

46. Pursuant to 18 U.S.C. § 1956(c)(7)(F), any act or activity constituting an offense involving a "Federal health care offense" constitutes a specified unlawful activity.

47. Pursuant to 18 U.S.C. § 1347, health care fraud is a "Federal health care offense."

FIRST CLAIM
Proceeds of Health Care Fraud
18 U.S.C. § 981(a)(1)(C)

48. The factual allegations in paragraphs 1 through 47 are re-alleged and incorporated by reference as if fully set forth herein.

49. As set forth above, the Defendant Assets are property that constitute or are derived from proceeds traceable to health care fraud in violation of 18 U.S.C.

§ 1347, which is a specified unlawful activity pursuant to 18 U.S.C. § 1956(c)(7)(F).

50. Accordingly, the Defendant Assets are subject to forfeiture pursuant to 18 U.S.C. § 981(a)(1)(C).

WHEREFORE, Plaintiff, the United States of America, requests that the Clerk of the Court issue a warrant for the arrest *in rem* of the Defendant Assets; that notice of this action be provided to persons known or thought to have an interest in or right against the Defendant Assets; that the Defendant Assets be forfeited and condemned to the United States of America; and for such other and further relief as may be deemed just, necessary and proper.

Respectfully submitted,

JASON A. REDING QUIÑONES
UNITED STATES ATTORNEY

By: */s/ Sandra Demirci*

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Counsel for United States of America

VERIFICATION

Pursuant to 28 U.S.C. § 1746, I, Alexandria Davis, hereby verify and declare, under penalty of perjury, that I am a Special Agent with the Federal Bureau of Investigation and that I have read the foregoing Verified Complaint for Forfeiture In Rem and that the foregoing factual allegations are true and correct to the best of my knowledge and belief.

The sources of my knowledge and information and the grounds of my belief are the official files and records of the United States, information supplied to me by other law enforcement agents, as well as my investigation of this case, together with others, as a Special Agent of the Federal Bureau of Investigation.

Executed on this 18th of June 2026.

Alexandria Davis, Special Agent,
Federal Bureau of Investigation

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO.

UNITED STATES OF AMERICA,

Plaintiff,

v.

APPROXIMATELY $1,113,748.23 IN U.S. CURRENCY SEIZED FROM ACCOUNT NO. 898118513086 AT BANK OF AMERICA, N.A. IN THE NAME OF H SERVICES CORP.

Defendant *In Rem*.

VERIFIED COMPLAINT FOR FORFEITURE *IN REM*

Plaintiff, the United States of America, by and through its undersigned counsel, alleges as follows:

I. NATURE OF THE ACTION

1. This is a civil action *in rem*, pursuant to 18 U.S.C. § 981(a)(1)(C) and the procedures set forth in Rule G of the Supplemental Rules for Admiralty or Maritime Claims and Asset Forfeiture Actions, and the Federal Rules of Civil Procedure, to forfeit seized funds[1], more fully described as approximately $1,113,748.23 in U.S. currency seized formerly on deposit in account number 898118513086 held at Bank of America, N.A. in the name of H Services Corp. (the "H Services Account"), which

[1] All dates and amounts referenced in this Verified Complaint are approximate.

was seized on or about December 12, 2025, to include accrued interest.

II. JURISDICTION AND VENUE

2. This Court has jurisdiction over this subject matter. *See* 28 U.S.C. §§ 1345, 1355(a); 18 U.S.C. § 981(a)(1).

3. This Court has *in rem* jurisdiction over the Defendant Asset. *See* 28 U.S.C. §§ 1345, 1355(b).

4. Venue for this action is proper in this District because acts or omissions giving rise to the forfeiture occurred in the Southern District of Florida, and because this is the same District where the Defendant Asset were brought upon seizure. *See* 28 U.S.C. § 1355(b)(1).

III. FACTUAL ALLEGATIONS

At all times material to this Action:

A. The Medicare Program and Skin Substitutes

5. The Medicare Program ("Medicare") was a federal health care program that provided free or below-cost health care benefits to individuals who are 65 years of age or older or disabled. The benefits available under Medicare were governed by federal statutes and regulations.

6. The United States Department of Health and Human Services ("HHS"), through its agency the Center for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare.

7. Individuals who received benefits under Medicare were commonly referred to as "Medicare beneficiaries."

8. Medicare was a "health care benefit program," affecting interstate commerce as defined by 18 U.S.C. § 24(b).

9. Medicare was subdivided into four parts: hospital insurance (Part A); medical insurance (Part B); Medicare Advantage (Part C); and prescription drug benefits (Part D).

10. Medicare Part B covered, among other things, surgical dressings, such as collagen based wound filler.

11. Health care providers that provided items or services to Medicare beneficiaries were referred to as Medicare "providers." To participate in Medicare, providers were required to submit an enrollment application in which the providers agreed to comply with all Medicare-related laws and regulations. If Medicare approved a provider's application, Medicare assigned the enrolled provider a Medicare provider number.

12. A provider with a Medicare provider number could file claims with Medicare to obtain reimbursement for items and services rendered to Medicare beneficiaries. Enrolled Medicare providers agreed to abide by the policies, procedures, rules, and regulations governing reimbursement, and were given access to Medicare manuals and services bulletins describing billing procedures, rules, and regulations.

13. To receive payment from Medicare, providers submitted or caused the submission of claims to Medicare, either directly or through a billing company. A Medicare claim for a surgical dressing was required to set forth, among other things, the name and unique Medicare identification number of the beneficiary, the product

provided and its size, the date of service, the place of service, the diagnosis, and the identity of the rendering provider.

14. A claim for a surgical dressings, such as collagen based wound filler product, submitted to Medicare qualified for reimbursement only if the product was medically necessary for the treatment of the beneficiary's illness or injury, was ordered by a licensed physician or other qualified health care practitioner and was actually provided to the beneficiary as billed.

B. H Services and the Fraudulent Billing Scheme

15. As further discussed below, during the month of February 2025, H Services electronically submitted $2,028,480.00 in fraudulent claims to Medicare as reimbursements for wound care dressings, including collagen-based fillers, that were not requested, delivered, or medically necessary for the beneficiaries. Data provided by CMS shows that between February and March of 2025, Medicare disbursed $1,113,763.38 to the H Services Account before the account was voluntarily frozen by Bank of America. Pursuant to the seizure warrant signed by the Honorable Magistrate Torres, the United States seized $1,113,748.23 in Medicare fraud proceeds from the H Services Account.

16. H Services Corp. ("H Services") was a Florida corporation, with its principal office address in Miami, FL, which is within the Southern District of Florida.

17. Florida Department of State Division of Corporations records reflected that H Services was incorporated on February 12, 2024.

18. At all times relevant to this Complaint, the only managing officer of H Services was Humberto Gonzalez Mora ("GONZALEZ MORA").

19. According to Medicare enrollment records, on September 23, 2024, H Services enrolled in Medicare as a Medical Supply Company, listing GONZALEZ MORA as its Authorized Official and identifying the H Services Account as the account into which Medicare was to deposit reimbursement payments.

20. According to Medicare enrollment records, as part of its Medicare provider enrollment application, on April 5, 2025, H Services submitted a voided check and an electronic funds transfer ("EFT") Authorization Agreement for the H Services Account.

C. The Medicare Fraud Scheme

21. As described further below, during February of 2025, H Services submitted false and fraudulent claims to Medicare totaling $2,028,480.00 for surgical dressings that were medically unnecessary.

22. According to Medicare records, all claims submitted by H Services to Medicare during this period included the same diagnosis code for an unspecified open wound on the claimed Medicare beneficiary's right knee.

23. Law enforcement interviewed five of the Medicare beneficiaries whose Medicare identification numbers H Services used to bill Medicare.

24. Each interviewed beneficiary stated that he or she was not familiar with H Services, did not receive and did not need collagen based wound fillers or dressings for wounds billed to Medicare using his or her Medicare identification number, and

was not familiar with either Physician 1, who appeared in the Medicare claims data as the rendering provider on H Services' claims

25. According to Medicare records, H Services listed Physician 1 on 74% of the claims it submitted to Medicare and listed Physician 2 on 26% of the claims it submitted to Medicare.

26. Law enforcement interviewed Physician 1, who confirmed that throughout this period, he/she: (a) specialized in cardiology, (b) never heard of H Services, (c) never treated any of H Services' claimed beneficiaries, (d) never prescribed wound care dressings, including collagen-based fillers, and (e) never authorized H Services to use his/her NPI for Medicare billing.

27. Law enforcement interviewed Physician 2, who confirmed that throughout this period, he/she: (a) was a nurse practitioner, (b) never heard of H Services, (c) never treated any of H Services' claimed beneficiaries, (d) never prescribed wound care dressings, including collagen-based fillers in Florida, and (e) never authorized H Services to use his/her NPI for Medicare billing.

D. <u>The Defendant Asset</u>

17. The United States obtained bank records for the H Services Account, which showed that February 1, 2025, when Medicare disbursements into the H Services Account began, the account had a balance of $1,823.67.

18. Between February 24, 2025, through March 3, 2025, as a result of H Services' claims for reimbursement, Medicare deposited $1,113,763.38 in U.S. currency into the H Services Account.

19. These Medicare deposits constituted approximately 98.20% of all deposits into the H Services Account, as shown below:

EFT Check Date	EFT Amount	Deposited Account No.
2/24/2025	$389,424.77	898118513086
2/25/2025	$161,331.09	898118513086
2/26/2025	$157,356.71	898118513086
2/27/2025	$181,161.83	898118513086
2/28/2025	$150,010.33	898118513086
3/3/2025	$74,478.65	898118513086
TOTAL	**$1,113,763.38**	

20. Based on bank records, on or about April 3, 2025, Bank of America closed the H Services Account and transferred its entire balance of $1,113,748.23 into a hold harmless account.

21. An analysis conducted in accordance with generally accepted accounting principles demonstrated that, as of April 3, 2025, H Services Account's entire balance of $1,113,748.23 was 100% traceable to Medicare reimbursements.

22. On or about December 12, 2025, law enforcement agents served a federal seizure warrant on Bank of America for the balance of the H Services Account. *See* Case No. 25-MJ-04345-TORRES (S.D. Fla.).

23. Pursuant to the seizure warrant, Bank of America remitted to Homeland Security Investigations ("HSI") approximately $1,113,748.23 in U.S. currency from the H Services Account (the "Defendant Asset").

IV. BASIS FOR FORFEITURE

24. Pursuant to 18 U.S.C. § 981(a)(1)(C), any property, real or personal, which constitutes or is derived from proceeds traceable to a specified unlawful activity or a conspiracy to commit such offense is subject to civil forfeiture.

25. Pursuant to 18 U.S.C. § 1956(c)(7)(F), any act or activity constituting an offense involving a "Federal health care offense" constitutes a specified unlawful activity.

26. Health care fraud, in violation of 18 U.S.C. § 1347, is a "Federal health care offense." *See* 18 U.S.C. § 24(a).

FIRST CLAIM
Proceeds of Health Care Fraud
18 U.S.C. § 981(a)(1)(C)

27. The factual allegations in paragraphs 1 through 26 are re-alleged and incorporated by reference as if fully set forth herein.

28. As set forth above, the Defendant Asset is property that constitutes or is derived from proceeds traceable to health care fraud in violation of 18 U.S.C. § 1347, which is a specified unlawful activity pursuant to 18 U.S.C. § 1956(c)(7)(F).

29. Accordingly, the Defendant Asset is subject to forfeiture pursuant to 18 U.S.C. § 981(a)(1)(C).

WHEREFORE, Plaintiff, the United States of America, requests that the Clerk of the Court issue a warrant for the arrest *in rem* of the Defendant Asset; that notice of this action be provided to persons known or thought to have an interest in or right against the Defendant Asset; that the Defendant Asset be forfeited and

condemned to the United States of America; and for such other and further relief as may be deemed just, necessary and proper.

Respectfully submitted,

JASON A. READING QUIÑONES
UNITED STATES ATTORNEY

By: */s/ Sandra Demirci*

Sandra Demirci (Court ID A5503244)
Assistant United States Attorney
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Counsel for United States of America

VERIFICATION

Pursuant to 28 U.S.C. § 1746, I, Manuel Hernandez, hereby verify and declare, under penalty of perjury, that I am a Special Agent with the Homeland Security Investigations and that I have read the foregoing Verified Complaint for Forfeiture *In Rem* and that the foregoing factual allegations are true and correct to the best of my knowledge and belief. The sources of my knowledge and information and the grounds of my belief are the official files and records of the United States, information supplied to me by other law enforcement agents, as well as my investigation of this case, together with others, as a Special Agent of the Homeland Security Investigations.

Executed on this 18th of June 2026.

Manuel Hernandez, Special Agent,
Homeland Security Investigations

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO.

UNITED STATES OF AMERICA,

Plaintiff,

v.

APPROXIMATELY $2,652,928.19 (US) FORMERLY DEPOSITED IN ACCOUNT NUMBER 657036698 HELD AT JP MORGAN CHASE BANK, N.A., IN THE NAME OF ALWAYS MEDICAL CENTER CORP, SEIZED ON OR ABOUT APRIL 25, 2025, PURSUANT TO JUDICIAL WARRANT,

and

APPROXIMATELY $569,955 (US) FORMERLY DEPOSITED IN ACCOUNT NUMBER 693886569 HELD AT JP MORGAN CHASE BANK, N.A., IN THE NAME OF ALWAYS MEDICAL CENTER CORP, SEIZED ON OR ABOUT APRIL 25, 2025, PURSUANT TO JUDICIAL WARRANT,

Defendants *in Rem*.

VERIFIED COMPLAINT FOR FORFEITURE *IN REM*

Plaintiff, the United States of America, by and through its undersigned counsel, alleges as follows:

I. NATURE OF THE ACTION

1. This is a civil action *in rem* brought pursuant to 18 U.S.C. § 981(a)(1)(C) and the procedures set forth in Rule G of the Supplemental Rules for Admiralty or Maritime Claims and Asset

Forfeiture Actions, the Federal Rules of Civil Procedure, to judicially forfeit the Defendants *in Rem*, more fully described as follows (collectively, "Defendant Assets"):

(a) Approximately $2,652,928.19 (US) formerly deposited in account number 657036698 held at JP Morgan Chase Bank, N.A., in the name of Always Medical Center Corp ("Subject Account 1"), which was seized on or about April 25, 2025, pursuant to judicial warrant, to include accrued interest ("Defendant Asset 1"), and

(b) Approximately $569,955 (US) formerly deposited in account number 693886569 held at JP Morgan Chase Bank, N.A., in the name of Always Medical Center Corp ("Subject Account 2"), which was seized on or about April 25, 2025, pursuant to judicial warrant, to include accrued interest ("Defendant Asset 2").[1]

II. JURISDICTION AND VENUE

2. This Court has jurisdiction over this subject matter. *See* 28 U.S.C. §§ 1345, 1355(a); 18 U.S.C. § 981(a)(1).

3. This Court has *in rem* jurisdiction over the Defendant Assets. *See* 28 U.S.C. §§ 1345, 1355(b).

4. Venue for this action is proper in this District because acts or omissions giving rise to the forfeiture occurred in the Southern District of Florida, and because this is the same District where the Defendant Assets were brought upon seizure. *See* 28 U.S.C. §§ 1355(b)(1), 1395; 18 U.S.C. § 981(h).

III. FACTUAL ALLEGATIONS

At all times material to this civil action *in rem*:

A. The Medicare Program

5. The Medicare Program ("Medicare") was a federal health care program that provided

[1] All dates and amounts referenced in this Verified Complaint are approximate.

free or below-cost health care benefits to individuals who are 65 years of age or older or disabled. The benefits available under Medicare were governed by federal statutes and regulations.

6. The United States Department of Health and Human Services ("HHS"), through its agency the Center for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare.

7. Individuals who received benefits under Medicare were commonly referred to as "Medicare beneficiaries."

8. Medicare was a "health care benefit program," as defined by 18 U.S.C. § 24(b).

9. Medicare was subdivided into four program "parts," which were: hospital insurance (Part A), medical insurance (Part B), Medicare Advantage (Part C), and prescription drug benefits (Part D).

10. Medicare Part B covered, among other things, Cellular and/or Tissue-Based Products (CTPs), which were often referred to as skin substitutes or skin substitute grafts.

11. Medicare claims for Part B services were processed and paid by Medicare Administrative Contractors ("MAC(s)"), which contracted with CMS to administer parts of Medicare in specific geographic jurisdictions.

12. Physicians, clinicians, health care facilities, and suppliers that enrolled in Medicare and delivered services to Medicare beneficiaries were referred to as Medicare "providers."

13. To enroll as a Medicare provider, physicians, clinicians, health care facilities, and suppliers were required to complete a Medicare Provider Enrollment Application (CMS-855 form).

14. Applicants were required to have a valid National Provider Identifier (NPI), which was a 10-digit, universal, lifetime identifier for healthcare providers, to enroll as a Medicare provider.

15. Applicants were required to provide identifying information, practice locations, correspondence addresses, billing agency details, and a signed certification statement.

16. Applicants were required to certify that they would comply with all Medicare laws, regulations, and policies regarding reimbursement.

17. Applicants were required to submit their Medicare enrollment application using the online Internet-based CMS Provider Enrollment, Chain, and Ownership System (PECOS) or by mailing the appropriate CMS-855 form to the MAC for their geographic region.

18. The PECOS was the online Medicare enrollment management system maintained by CMS. The platform allowed physicians, clinicians, health care facilities, and suppliers to electronically enroll as Medicare providers or suppliers. Users could also utilize PECOS to renew enrollment, withdraw from the program, report record changes, and sign documentation. While MAC(s) processed the initial applications, PECOS served as the final repository for all Medicare provider enrollment data.

16. Upon approval of a Medicare Enrollment Application, Medicare assigned an enrolled Medicare provider a Provider Transaction Access Number (PTAN), which was referred to as a Medicare "provider number."

17. A Medicare provider was authorized to submit claims to Medicare for reimbursement of medically necessary covered services rendered to Medicare beneficiaries.

19. To receive Medicare reimbursement for medically necessary covered services, Medicare providers were required to file a claim electronically or submit a CMS-1500 or UB-92 form to their MAC.

20. To be valid, a Medicare claim was required to include, among other things, the beneficiary's name and Medicare Beneficiary Identifier (MBI), the services provided, the dates and costs of the services provided, the diagnostic and procedural codes validating medical necessity, and the name and NPI of the ordering or prescribing physician.

21. Providers could use their respective MAC internet-based portals to submit Medicare claims electronically.

22. Medicare providers were legally required to submit claims only for services that were rendered and that meet Medicare's criteria for being reasonable and medically necessary.

23. Medicare providers were required to submit a CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement and a voided check or letter from their financial institution with their enrollment application to receive Medicare claims reimbursement payments electronically.

24. All Medicare reimbursement payments were transmitted directly to a Medicare provider's financial institution, whether the underlying claims were submitted electronically or on paper.

B. Always Medical Center Corp

25. Always Medical Center Corp ("Always Medical") was a Florida corporation with its principal office address listed as 10300 SW 72nd Street, Suite 272-2, Miami, Florida, 33173, which is within the Southern District of Florida.

26. According to Florida Department of State Division of Corporations records, Always Medical was incorporated on or about September 5, 2023 (Document number P23000064087; FEI/EIN 93-4943093).

27. Always Medical's Medicare enrollment became effective on November 1, 2024. Individual One was listed as Always Medical's owner, director, managing employee, and authorizing official.

28. As part of its Medicare provider enrollment application, Always Medical submitted a voided check and an EFT Authorization Agreement for Subject Account 1. The EFT agreement bore a signature purporting to be that of Individual One as Always Medical's authorized official.

C. Subject Account 1

29. On August 5, 2024, Individual One opened Subject Account 1 in Always Medical's name at a JP Morgan Chase Bank, N.A. branch on West Bird Road in Miami, Florida.

30. Individual 1 was listed as President of Always Medical on Subject Account 1's opening documents.

31. Individual 1 was listed as Subject Account 1's sole signature authority.

D. Subject Account 2

32. On January 23, 2025, Individual One opened Subject Account 2 in Always Medical's name at a JP Morgan Chase Bank, N.A. at a branch in Miramar, Florida.

33. Individual 1 was listed as President of Always Medical on Subject Account 2's opening documents.

34. Individual 1 was listed as Subject Account 2's sole signature authority.

E. Medicare Fraud Scheme

35. From on or about December 2, 2024, through on or about February 14, 2025 ("relevant period"), Individual 1, with co-conspirators, submitted and/or caused Always Medical to submit false and fraudulent claims totaling $13,662,471 (US) to Medicare for skin substitute grafts that were not medically necessary and were not provided to Medicare beneficiaries.

36. All Medicare claims submitted by Always Medical during the relevant period designated the identical set of skin substitute graft diagnosis codes for claimed Medicare beneficiaries.

37. None of the Medicare beneficiaries listed on Always Medical's claims submitted during the relevant period had a medical need for skin substitute grafts, nor did they request or receive any skin substitute graft treatment.

38. All Medicare claims submitted by Always Medical during the relevant period listed Doctor 1 as the referring provider.

39. Doctor 1 never examined or treated any Medicare beneficiary listed on Always Medical's claims submitted during the relevant period.

40. Doctor 1 practiced general medicine and had never heard of Always Medical. Furthermore, Doctor 1 never examined or treated any of Always Medical's claimed beneficiaries, nor did he/she see any patients after October 5, 2023. Finally, Doctor 1 has never prescribed skin substitute grafts and never authorized Always Medical to use his/her NPI for Medicare billing

F. Defendant Assets

Defendant Asset 1

41. Between February 18 and March 12, 2025, Subject Account 1 received $6,547,345 (US) in Medicare reimbursement payments for claims submitted by Always Medical during the relevant period. This accounted for 99.84% of Subject Account 1's total deposits during this period.

42. An analysis conducted in accordance with generally accepted accounting principles demonstrated that, as of April 25, 2025, Subject Account 1's entire balance of $2,652,928.19 (US) was fully traceable to fraudulently procured Medicare reimbursement payments.

43. On April 28, 2025, federal law enforcement agents served a judicial warrant on JP Morgan Chase Bank, N.A. for all principal, deposits, interest, dividends, and other amounts credited to, and/or formerly on deposit in, the Subject Account 1.

44. Pursuant to the judicial warrant, JP Morgan Chase Bank, N.A. remitted $2,652,928.19 (US) to federal law enforcement agents accordingly.

45. Pursuant to the judicial warrant, the Federal Bureau of Investigation seized $2,652,928.19 (US), which constitutes the Defendant Asset 1.

Defendant Asset 2

46. Between February 18 and March 12, 2025, Subject Account 2 received $1,350,000 (US) from Account 1. This accounted for 99.95% of Subject Account 2's total deposits during this period.

47. An analysis conducted in accordance with generally accepted accounting principles demonstrated that, as of April 25, 2025, Subject Account 2's entire balance of $569,955 (US) was fully traceable to fraudulently procured Medicare reimbursement payments.

48. On April 28, 2025, federal law enforcement agents served a judicial warrant on JP Morgan Chase Bank, N.A. for all principal, deposits, interest, dividends, and other amounts credited to, and/or formerly on deposit in, Subject Account 2.

49. Pursuant to the judicial warrant, JP Morgan Chase Bank, N.A. remitted $569,955 (US) to federal law enforcement agents accordingly.

50. Pursuant to the judicial warrant, the Federal Bureau of Investigation seized $569,955 (US), which constitutes Defendant Asset 2.

IV. BASIS FOR FORFEITURE

51. Pursuant to 18 U.S.C. § 981(a)(1)(C), any property, real or personal, which constitutes or is derived from proceeds traceable to a specified unlawful activity or a conspiracy to commit such offense is subject to civil forfeiture.

52. Pursuant to 18 U.S.C. § 1956(c)(7)(F), any act or activity constituting an offense involving a "Federal health care offense" constitutes a specified unlawful activity.

53. Pursuant to 18 U.S.C. § 24(a)(1), a violation of, or a conspiracy to violate, 18 U.S.C. § 1347 (Health Care Fraud) is a "Federal health care offense."

54. Pursuant to 18 U.S.C. § 1347 it is a crime for anyone, in connection with the delivery of any health care benefits, items, or services, to knowingly and willingly execute, or attempt to execute, a scheme or artifice: (1) to defraud any health care benefit program; or (2) to obtain, by means of

materially false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

FIRST CLAIM
Proceeds of Conspiracy to Commit Health Care Fraud
18 U.S.C. § 981(a)(1)(C)

55. The factual allegations in paragraphs 1 through 54 are re-alleged and incorporated by reference as if fully set forth herein.

56. As set forth above, the Defendant Assets are property that constitutes or is derived from proceeds traceable to a conspiracy to commit health care fraud in violation of 18 U.S.C. § 1349, which is a specified unlawful activity pursuant to 18 U.S.C. § 1956(c)(7)(F).

57. Accordingly, the Defendant Assets are subject to forfeiture pursuant to 18 U.S.C. § 981(a)(1)(C).

SECOND CLAIM
Proceeds of Health Care Fraud
18 U.S.C. § 981(a)(1)(C)

58. The factual allegations in paragraphs 1 through 54 are re-alleged and incorporated by reference as if fully set forth herein.

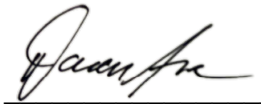
59. As set forth above, the Defendant Assets are property that constitutes or is derived from proceeds traceable to health care fraud in violation of 18 U.S.C. § 1347, which is a specified unlawful activity pursuant to 18 U.S.C. § 1956(c)(7)(F).

60. Accordingly, the Defendant Assets are subject to forfeiture pursuant to 18 U.S.C. § 981(a)(1)(C).

WHEREFORE, the United States of America prays that notice issue on the Defendant Assets; that due notice be given to all parties to appear and show cause why the forfeiture should not be decreed; that a warrant of arrest *in rem* issue according to law; that judgment be entered declaring that the Defendant Assets be forfeited for disposition according to law; and that the United States of America be granted such other relief as this Court may deem just and proper, together with the costs and disbursements of this action.

Respectfully submitted,

JASON A. REDING QUIÑONES
UNITED STATES ATTORNEY

By: 

Daren Grove (Court No. A5501243)
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VERIFICATION

I, Steffi Rodriguez, hereby verify and declare, under penalty of perjury, that I am a Special Agent with the Federal Bureau of Investigation (FBI) and that the foregoing factual allegations are true and correct to the best of my knowledge and belief.

The sources of my knowledge and information and the grounds of my belief are the official files and records of the United States, information supplied to me by other law enforcement agents, as well as my investigation of this case, together with others, as a Special Agent of the FBI.

Executed on this 18th day of June 2026.

Steffi Rodriguez
Special Agent, Federal Bureau of Investigation

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO.

UNITED STATES OF AMERICA,

Plaintiff,

v.

APPROXIMATELY $877,036.72 (US) FORMERLY ON DEPOSIT IN ACCOUNT NUMBER 229057932478 HELD AT BANK OF AMERICA, N.A., IN THE NAME OF PRONTO MEDICAL CENTER CORP SEIZED ON OR ABOUT FEBRUARY 23, 2026, PURSUANT TO JUDICIAL WARRANT,

Defendant *in Rem*.

VERIFIED COMPLAINT FOR FORFEITURE *IN REM*

Plaintiff, the United States of America, by and through its undersigned counsel, alleges as follows:

I. NATURE OF THE ACTION

1. This is a civil action *in rem* brought pursuant to 18 U.S.C. § 981(a)(1)(C) and the procedures set forth in Rule G of the Supplemental Rules for Admiralty or Maritime Claims and Asset Forfeiture Actions, the Federal Rules of Civil Procedure, to judicially forfeit the Defendant *in Rem*, more fully described as follows (collectively, the "Defendant Asset"):

(a) Approximately $877,036.72 (US) formerly on deposit in account number 229057932478 held at Bank of America, N.A., in the name of Pronto Medical Center Corp ("Subject Account"), which was seized on or about February 23, 2026, pursuant to judicial warrant, to include accrued interest.

II. JURISDICTION AND VENUE

2. This Court has jurisdiction over this subject matter. *See* 28 U.S.C. §§ 1345, 1355(a); 18 U.S.C. § 981(a)(1).

3. This Court has *in rem* jurisdiction over the Defendant Asset. *See* 28 U.S.C. §§ 1345, 1355(b).

4. Venue for this action is proper in this District because acts or omissions giving rise to the forfeiture occurred in the Southern District of Florida, and because this is the same District where the Defendant Asset was brought upon seizure. *See* 28 U.S.C. §§ 1355(b)(1), 1395; 18 U.S.C. § 981(h).

III. FACTUAL ALLEGATIONS

At all times material to this civil action *in rem*:

A. The Medicare Program

5. The Medicare Program ("Medicare") was a federal health care program that provided free or below-cost health care benefits to individuals who are 65 years of age or older or disabled. The benefits available under Medicare were governed by federal statutes and regulations.

6. The United States Department of Health and Human Services ("HHS"), through its agency the Center for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare.

7. Individuals who received benefits under Medicare were commonly referred to as "Medicare beneficiaries."

8. Medicare was a "health care benefit program," as defined by 18 U.S.C. § 24(b).

[1] All dates and amounts referenced in this Verified Complaint are approximate.

9. Medicare was subdivided into four program "parts," which were: hospital insurance (Part A), medical insurance (Part B), Medicare Advantage (Part C), and prescription drug benefits (Part D).

10. Medicare Part B covered human cell, tissue, or cellular or tissue-based products (HCT/P), frequently referred to as skin substitutes or skin substitute grafts.

11. As a biologic skin substitute graft, SimpliMax was classified as an HCT/P. It was categorized as a cellular and tissue-based product for the treatment of diabetic foot ulcers and venous leg ulcers.

12. Medicare claims for Part B services were processed and paid by Medicare Administrative Contractors ("MAC(s)"), which contracted with CMS to administer parts of Medicare in specific geographic jurisdictions.

13. Physicians, clinicians, health care facilities, and suppliers that enrolled in Medicare and delivered services to Medicare beneficiaries were referred to as Medicare "providers."

14. To enroll as a Medicare provider, physicians, clinicians, health care facilities, and suppliers were required to complete a Medicare Provider Enrollment Application (CMS-855 form).

15. Applicants were required to have a valid National Provider Identifier (NPI), which was a 10-digit, universal, lifetime identifier for healthcare providers, to enroll as a Medicare provider.

16. Applicants were required to provide identifying information, practice locations, correspondence addresses, billing agency details, and a signed certification statement.

17. Applicants were required to certify that they would comply with all Medicare laws, regulations, and policies regarding reimbursement.

18. Applicants were required to submit their Medicare enrollment application using the online Internet-based CMS Provider Enrollment, Chain, and Ownership System (PECOS) or by mailing the appropriate CMS-855 form to the MAC for their geographic region.

19. The PECOS was the online Medicare enrollment management system maintained by CMS. The platform allowed physicians, clinicians, health care facilities, and suppliers to electronically enroll as Medicare providers or suppliers. Users could also utilize PECOS to renew enrollment, withdraw from the program, report record changes, and sign documentation. While MAC(s) processed the initial applications, PECOS served as the final repository for all Medicare provider enrollment data.

20. Upon approval of a Medicare Enrollment Application, Medicare assigned an enrolled Medicare provider a Provider Transaction Access Number (PTAN), which was referred to as a Medicare "provider number."

21. A Medicare provider was authorized to submit claims to Medicare for reimbursement of medically necessary covered services rendered to Medicare beneficiaries.

22. To receive Medicare reimbursement for medically necessary covered services, Medicare providers were required to file a claim electronically or submit a CMS-1500 or UB-92 form to their MAC.

23. To be valid, a Medicare claim was required to include, among other things, the beneficiary's name and Medicare Beneficiary Identifier (MBI), the services provided, the dates and costs of the services provided, the diagnostic and procedural codes validating medical necessity, and the name and NPI of the ordering or prescribing physician.

24. Providers could use their respective MAC internet-based portals to submit Medicare claims electronically.

25. Medicare providers were legally required to submit claims only for services that were rendered and that meet Medicare's criteria for being reasonable and medically necessary.

26. Medicare providers were required to submit a CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement and a voided check or letter from their financial institution with their enrollment application to receive Medicare claims reimbursement payments electronically.

27. All Medicare reimbursement payments were transmitted directly to a Medicare provider's financial institution, whether the underlying claims were submitted electronically or on paper.

B. Pronto Medical Center Corp

28. Pronto Medical Center Corp ("Pronto") was a Florida corporation with its principal office address listed as 900 West 49 Street, Unit 408 Hialeah, Florida 33012, which is within the Southern District of Florida.

29. According to Florida Department of State Division of Corporations records, Pronto was incorporated on or about September 21, 2018 (Document number P18000079936; FEI/EIN Number: 83-1975597.

30. Pronto's corporate filings detailed a series of presidential changes as follows:

(a) September 21, 2018 (Articles of Incorporation): Lists Individual One as President.

(b) March 1, 2025 (2025 Annual Report): Lists Individual Two as President, removing Individual One.

(c) March 20, 2025 (2025 Amended Annual Report): Lists Individual Three as President, removing Individual Two.

(d) March 25, 2025 (Articles of Amendment): Reaffirms Individual Three as President.

(e) September 9, 2025 (Articles of Amendment): Lists Individual Four as President, removing Individual Three.

31. Pronto's Medicare enrollment became effective on April 3, 2024. Individual One was listed as Pronto's owner, director, managing employee, and authorizing official.

32. As part of its Medicare provider enrollment application, Pronto submitted a voided check and an EFT Authorization Agreement for the Subject Account. The EFT agreement bore a signature purporting to be that of Individual One as Pronto's authorized official.

33. PECOS records indicate Pronto submitted a Change of Information (COI) application on March 20, 2025, with the following details:

(a) Individual Three was designated as Pronto's sole owner, authorizing official, director, and managing employee.

(b) The COI was approved on April 10, 2025, with a retroactive effective date of March 20, 2025.

(c) The EFT Authorization Agreement directing payments to the Subject Account remained unchanged.

C. Subject Account

34. On September 27, 2018, Individual One opened the Subject Account at Bank of America in Miami, Florida, under Pronto's name. The Subject Account's opening documents listed Individual One as Pronto's President and sole authorized signer.

35. On March 1, 2025, Individual Three replaced Individual One on the Subject Account's documents, assuming the roles of Pronto's President and its sole authorized signer.

D. Medicare Fraud Scheme

36. Between May and June 2025 ("Subject Period"), co-conspirators caused Pronto to submit $13,605,400 (US) in false and fraudulent Medicare claims for SimpliMax and skin substitute grafts allegedly provided to sixteen (16) beneficiaries. These treatments were neither medically necessary nor ever provided.

37. Every claim used the exact same three diagnosis codes, which purported to reflect a residence visit and the application of SimpliMax skin grafts to wounds on the trunk, arms, or legs.

38. The purported beneficiaries had no medical need for wound care dressings and never requested or received these SimpliMax grafts.

39. All claims submitted by Pronto during this period identified Doctor 1 as the referring provider.

40. Throughout the Subject Period, Doctor 1, a pediatrician, had no knowledge of Pronto. Doctor 1 never treated any of the claimed beneficiaries, never prescribed wound care dressings or SimpliMax grafts, and never authorized Pronto to use his/her NPI for Medicare billing.

E. Defendant Asset

41. On June 5, 2025, the Subject Account had an end-of-day closing balance of $84.47 (US).

42. Between June 6 and June 27, 2025, the Subject Account received $2,491,632.24 (US) in eight Medicare reimbursement payments for claims Pronto submitted during the Subject Period. This comprised all deposits into the Subject Account during June 2025.

43. At the end of June 2025, Bank of America, N.A. closed the Subject Account and transferred its remaining balance of $877,036.72 (US) into a "hold harmless" account.

44. A tracing analysis conducted under generally accepted accounting principles (GAAP) demonstrated that the Subject Account's entire closing balance of $877,036.72 (US) derived exclusively from fraudulently procured Medicare reimbursements.

45. On February 23, 2026, federal law enforcement agents served a judicial warrant on Bank of America, N.A. for all funds, principal, interest, and dividends credited to or formerly on deposit in the Subject Account.

46. Pursuant to the warrant, Bank of America, N.A., remitted $877,036.72 (US) to federal law enforcement.

47. Accordingly, Homeland Security Investigations (HSI) seized the $877,036.72 (US), which constitutes the Defendant Asset.

IV. BASIS FOR FORFEITURE

48. Pursuant to 18 U.S.C. § 981(a)(1)(C), any property, real or personal, which constitutes or is derived from proceeds traceable to a specified unlawful activity or a conspiracy to commit such offense is subject to civil forfeiture.

49. Pursuant to 18 U.S.C. § 1956(c)(7)(F), any act or activity constituting an offense involving a "Federal health care offense" constitutes a specified unlawful activity.

50. Pursuant to 18 U.S.C. § 24(a)(1), a violation of, or a conspiracy to violate, 18 U.S.C. § 1347 (Health Care Fraud) is a "Federal health care offense."

51. Pursuant to 18 U.S.C. § 1347 it is a crime for anyone, in connection with the delivery of any health care benefits, items, or services, to knowingly and willingly execute, or attempt to execute, a scheme or artifice: (1) to defraud any health care benefit program; or (2) to obtain, by means of materially false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

FIRST CLAIM
Proceeds of Conspiracy to Commit Health Care Fraud
18 U.S.C. § 981(a)(1)(C)

52. The factual allegations in paragraphs 1 through 51 are re-alleged and incorporated by reference as if fully set forth herein.

53. As set forth above, the Defendant Asset is property that constitutes or is derived from proceeds traceable to a conspiracy to commit health care fraud in violation of 18 U.S.C. § 1349, which is a specified unlawful activity pursuant to 18 U.S.C. § 1956(c)(7)(F).

54. Accordingly, the Defendant Asset is subject to forfeiture pursuant to 18 U.S.C. § 981(a)(1)(C).

SECOND CLAIM
Proceeds of Health Care Fraud
18 U.S.C. § 981(a)(1)(C)

55. The factual allegations in paragraphs 1 through 51 are re-alleged and incorporated by reference as if fully set forth herein.

56. As set forth above, the Defendant Asset is property that constitutes or is derived from proceeds traceable to health care fraud in violation of 18 U.S.C. § 1347, which is a specified unlawful activity pursuant to 18 U.S.C. § 1956(c)(7)(F).

57. Accordingly, the Defendant Asset is subject to forfeiture pursuant to 18 U.S.C. § 981(a)(1)(C).

WHEREFORE, the United States of America prays that notice issue on the Defendant Asset; that due notice be given to all parties to appear and show cause why the forfeiture should not be decreed; that a warrant of arrest *in rem* issue according to law; that judgment be entered declaring that the Defendant Asset be forfeited for disposition according to law; and that the United States of America be granted such other relief as this Court may deem just and proper, together with the costs and disbursements of this action.

Respectfully submitted,

JASON A. READING QUIÑONES
UNITED STATES ATTORNEY

By: _____

Daren Grove (Court No. A5501243)
Assistant United States Attorney
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500 E. Broward Boulevard, Office 822
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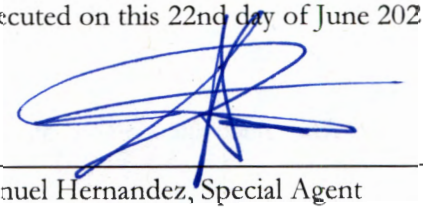
VERIFICATION

I, Manuel Hernandez, hereby verify and declare, under penalty of perjury, that I am a Special Agent with the Homeland Security Investigations (HSI) and that the foregoing factual allegations are true and correct to the best of my knowledge and belief.

The sources of my knowledge and information and the grounds of my belief are the official files and records of the United States, information supplied to me by other law enforcement agents, as well as my investigation of this case, together with others, as a Special Agent of the FBI.

Executed on this 22nd day of June 2026.



Manuel Hernandez, Special Agent
Homeland Security Investigations

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO.

UNITED STATES OF AMERICA,

Plaintiff,

v.

APPROXIMATELY $4,224,384.96 IN U.S. CURRENCY SEIZED FROM ACCOUNT NO. 898156223325 AT BANK OF AMERICA N.A. IN THE NAME OF THERON MEDICAL CENTER LLC.

Defendant *In Rem*.

VERIFIED COMPLAINT FOR FORFEITURE *IN REM*

Plaintiff, the United States of America, by and through its undersigned counsel, alleges as follows:

I. NATURE OF THE ACTION

1. This is a civil action *in rem*, pursuant to 18 U.S.C. § 981(a)(1)(C) and the procedures set forth in Rule G of the Supplemental Rules for Admiralty or Maritime Claims and Asset Forfeiture Actions, and the Federal Rules of Civil Procedure, to forfeit seized funds[1], more fully described as approximately $4,224,384.96 in U.S. currency formerly on deposit in account number 8981 5622 3325 held at Bank of America, N.A. in the name of Theron Medical Center LLC (the "Theron Account"),

[1] All dates and amounts referenced in this Verified Complaint are approximate.

which was seized on or about May 22, 2026, to include accrued interest.

II. JURISDICTION AND VENUE

2. This Court has jurisdiction over this subject matter. *See* 28 U.S.C. §§ 1345, 1355(a); 18 U.S.C. § 981(a)(1).

3. This Court has *in rem* jurisdiction over the Defendant Asset. *See* 28 U.S.C. §§ 1345, 1355(b).

4. Venue for this action is proper in this District because acts or omissions giving rise to the forfeiture occurred in the Southern District of Florida, and because this is the same District where the Defendant Asset were brought upon seizure. *See* 28 U.S.C. §§ 1355(b)(1).

III. FACTUAL ALLEGATIONS

At all times material to this Action:

A. The Medicare Program and Skin Substitutes

5. The Medicare Program ("Medicare") was a federal health care program that provided free or below-cost health care benefits to individuals who are 65 years of age or older or disabled. The benefits available under Medicare were governed by federal statutes and regulations.

6. The United States Department of Health and Human Services ("HHS"), through its agency the Center for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare.

7. Individuals who received benefits under Medicare were commonly referred to as "Medicare beneficiaries."

8. Medicare was a "health care benefit program," affecting interstate

commerce as defined by 18 U.S.C. § 24(b).

9. Medicare was subdivided into multiple program "parts." Medicare Part B covered, among other things, physician services and outpatient care, including medically necessary skin substitute and skin graft products applied to beneficiaries in non-facility settings, such as a beneficiary's home.

10. Skin substitutes, also referred to as cellular and/or tissue-based products or skin grafts, were products that included amniotic-tissue-based allografts such as Simplimax used to aid in the closure of certain chronic, non-healing wounds, such as diabetic ulcers and pressure ulcers. Medicare reimbursed skin substitute products under product-specific Healthcare Common Procedure Coding System ("HCPCS") codes on a per-square-centimeter basis, together with associated application procedure codes.

11. Health care providers that provided items or services to Medicare beneficiaries were referred to as Medicare "providers." To participate in Medicare, providers were required to submit an enrollment application in which the providers agreed to comply with all Medicare-related laws and regulations. If Medicare approved a provider's application, Medicare assigned the enrolled provider a Medicare provider number.

12. A provider with a Medicare provider number could file claims with Medicare to obtain reimbursement for items and services rendered to Medicare beneficiaries. Enrolled Medicare providers agreed to abide by the policies, procedures, rules, and regulations governing reimbursement, and were given access to Medicare

manuals and services bulletins describing billing procedures, rules, and regulations.

13. To receive payment from Medicare, providers submitted or caused the submission of claims to Medicare, either directly or through a billing company. A Medicare claim for a skin substitute product was required to set forth, among other things, the name and unique Medicare identification number of the beneficiary, the product provided and its size, the date of service, the place of service, the diagnosis, and the identity of the rendering provider.

14. A claim for a skin substitute product submitted to Medicare qualified for reimbursement only if the product was medically necessary for the treatment of the beneficiary's illness or injury, was ordered by a licensed physician or other qualified health care practitioner and was provided to the beneficiary as billed.

B. Theron Medical Center and the Fraudulent Billing Scheme

15. As further discussed below, between May and July of 2025, THERON electronically submitted $8,576,525 in fraudulent claims to Medicare as reimbursements for skin substitutes and skin grafts, that were medically necessary for the beneficiaries. Data provided by CMS shows that between June and July of 2025, Medicare disbursed $4,227,688.31 to the Theron Account before the account was voluntarily frozen by Bank of America. Pursuant to the seizure warrant signed by the Honorable Magistrate Elfenbein, the United States seized $4,224,384.96 in Medicare fraud proceeds from the Theron Account.

16. Theron Medical Center LLC ("THERON") was a Florida limited liability corporation, with its principal office address in Miami, FL, which is within the

Southern District of Florida.

17. Florida Department of State Division of Corporations records reflected that THERON was incorporated on October 21, 2024.

18. At all times relevant to this Complaint, the only manager of THERON was Richard Linares Suarez ("LINARES SUAREZ").

19. According to Medicare enrollment records, on March 17, 2025, THERON enrolled in Medicare as a Clinic/Practice Group, listing LINARES SUAREZ as its Authorized Official and identifying the Theron Account as the account into which Medicare was to deposit reimbursement payments.

20. As part of its Medicare provider enrollment application, on February 19, 2025, THERON submitted a voided check and an electronic funds transfer ("EFT") Authorization Agreement for the Theron Account.

C, The Medicare Fraud Scheme

21. As described below, between May and July of 2025, THERON submitted false and fraudulent claims to Medicare totaling $8,576,525 for skin grafts and skin substitutes, such as Simplimax that were medically unnecessary.

22. According to Medicare records, all claims submitted by THERON to Medicare during this period included the same diagnosis code for NON-PRESSURE CHRONIC ULCER OF UNSPECIFIED PART OF LEFT LOWER LEG.

23. Law enforcement interviewed five of the Medicare beneficiaries whose Medicare identification numbers THERON used to bill Medicare.

24. Each interviewed beneficiary stated that he or she was not familiar with

THERON, did not receive and did not need skin grafts and/or skin substitutes such as Simplimax billed to Medicare using his or her Medicare identification number, and was not familiar with Physician 1, who appeared in the Medicare claims data as the rendering provider on all of THERON's claims.

25. Physician 1 stated in an interview with law enforcement agents that he or she had never heard of THERON, and he or she had not prescribed skin grafts and/or skin substitutes to the identified beneficiaries. This provider stated that the identified Medicare beneficiaries were not his or her patients. Physician 1's prescriptions accounted for 100% THERON's total billed Medicare claims.

26. On June 11, 2025 and June 19, 2025, investigators also visited THERON's purported office in Miami during business hours, which they found was closed with the lights off on both occasions. There were no signs indicating THERON was an active business.

D. The Defendant Asset

27. The United States obtained bank records for the Theron Account, which showed that as of June 1, 2025, when Medicare disbursements into the Theron Account began, the account had a balance of $74.64.

28. Between June and July of 2025, as a result of THERON's claims for reimbursement, Medicare deposited $4,227,688.31 in U.S. currency into the Theron Account.

29. These Medicare deposits constituted approximately 83.29% of all total deposits into the Theron Account, as shown below:

EFT Check Date	EFT Amount	Deposited Account Number
4-Jun-25	$ 95,286.88	898156223325
5-Jun-25	$ 95,286.88	898156223325
6-Jun-25	$ 95,286.88	898156223325
10-Jun-25	$ 23,870.72	898156223325
11-Jun-25	$142,832.32	898156223325
12-Jun-25	$166,703.04	898156223325
13-Jun-25	$ 83,400.52	898156223325
16-Jun-25	$ 47,643.44	898156223325
17-Jun-25	$ 369,065.16	898156223325
18-Jun-25	$ 285,762.64	898156223325
20-Jun-25	$ 595,298.00	898156223325
23-Jun-25	$ 237,917.71	898156223325
25-Jun-25	$ 559,442.92	898156223325
26-Jun-25	$ 250,005.56	898156223325
30-Jun-25	$ 381,343.52	898156223325
1-Jul-25	$ 178,785.40	898156223325
2-Jul-25	$ 35,757.08	898156223325
7-Jul-25	$ 429,084.96	898156223325
9-Jul-25	$ 154,914.68	898156223325
TOTAL	**$ 4,227,688.31**	

30. The remaining deposits into the Theron Account totaling $847,788.34 were counter credits and returned checks after reversals from Medicare reimbursement payments.

31. Based on bank records, on or about July 22, 2025, Bank of America closed the Theron Account and transferred its entire balance of $4,224,384.96 into a hold harmless account.

32. An analysis conducted in accordance with generally accepted accounting principles demonstrated that, as of July 22, 2025, Theron Account's entire balance of $4,224,384.96 was 100% traceable to Medicare reimbursements.

33. On May 22, 2026, pursuant to the seizure warrant signed by the

Honorable Magistrate Elfenbein, the United States seized $4,224,384.96 in Medicare fraud proceeds from the Theron Account (the "Theron seizure warrant"). *See* Case No. 26-MJ-02947-ELFENBEIN (S.D. Fla.).

34. Pursuant to the Theron seizure warrant, Bank of America remitted to the Federal Bureau of Investigation ("FBI") $4,224,384.96 in U.S. currency from the Theron Account (the "Defendant Asset").

IV. BASIS FOR FORFEITURE

35. Pursuant to 18 U.S.C. § 981(a)(1)(C), any property, real or personal, which constitutes or is derived from proceeds traceable to a specified unlawful activity or a conspiracy to commit such offense is subject to civil forfeiture.

36. Pursuant to 18 U.S.C. § 1956(c)(7)(F), any act or activity constituting an offense involving a "Federal health care offense" constitutes a specified unlawful activity.

37. Health care fraud, in violation of 18 U.S.C. § 1347, is a "Federal health care offense." *See* 18 U.S.C. § 24(b).

FIRST CLAIM
Proceeds of Health Care Fraud
18 U.S.C. § 981(a)(1)(C)

38. The factual allegations in paragraphs 1 through 37 are re-alleged and incorporated by reference as if fully set forth herein.

39. As set forth above, the Defendant Asset is property that constitute or is derived from proceeds traceable to health care fraud in violation of 18 U.S.C. § 1347, which is a specified unlawful activity pursuant to 18 U.S.C. § 1956(c)(7)(F).

40. Accordingly, the Defendant Asset is subject to forfeiture pursuant to 18 U.S.C. § 981(a)(1)(C).

WHEREFORE, Plaintiff, the United States of America, requests that the Clerk of the Court issue a warrant for the arrest *in rem* of the Defendant Asset; that notice of this action be provided to persons known or thought to have an interest in or right against the Defendant Asset; that the Defendant Asset be forfeited and condemned to the United States of America; and for such other and further relief as may be deemed just, necessary and proper.

Respectfully submitted,

JASON A. REDING QUIÑONES
UNITED STATES ATTORNEY

By: */s/ Sandra Demirci*

Sandra Demirci (Court ID A5503244)
Assistant United States Attorney
500 East Broward Boulevard
Fort Lauderdale, FL 33394
Telephone: (954) 660-5959
Facsimile: (305) 536-7599
E-mail: sandra.demirci@usdoj.gov
Counsel for United States of America

VERIFICATION

Pursuant to 28 U.S.C. § 1746, I, Alexandria Davis, hereby verify and declare, under penalty of perjury, that I am a Special Agent with the Federal Bureau of Investigation and that I have read the foregoing Verified Complaint for Forfeiture *In Rem* and that the foregoing factual allegations are true and correct to the best of my knowledge and belief.

The sources of my knowledge and information and the grounds of my belief are the official files and records of the United States, information supplied to me by other law enforcement agents, as well as my investigation of this case, together with others, as a Special Agent of the Federal Bureau of Investigation.

Executed on this 22 of June 2026.

Alexandria Davis, Special Agent,
Federal Bureau of Investigation

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO.

UNITED STATES OF AMERICA,

Plaintiff,

v.

APPROXIMATELY $695,515.02 (US) FORMERLY ON DEPOSIT IN ACCOUNT NO. 898149708624 HELD AT BANK OF AMERICA, N.A. IN THE NAME OF CASO QUALITY EAST CORP. SEIZED ON OR ABOUT JULY 8, 2025, PURSUANT TO JUDICIAL WARRANT,

Defendant *in Rem*.

VERIFIED COMPLAINT FOR FORFEITURE *IN REM*

Plaintiff, the United States of America, by and through its undersigned counsel, alleges as follows:

I. NATURE OF THE ACTION

1. This is a civil action *in rem* brought pursuant to 18 U.S.C. § 981(a)(1)(C) and the procedures set forth in Rule G of the Supplemental Rules for Admiralty or Maritime Claims and Asset Forfeiture Actions, the Federal Rules of Civil Procedure, to judicially forfeit the Defendant *in Rem*, more fully described as follows (collectively, the "Defendant Asset"):

(a) Approximately $695,515.02 (US) formerly on deposit in account number 898149708624 held at Bank of America, N.A. in the name of Caso Quality East Corp. ("Subject Account"), which was seized on or about July 8, 2025, pursuant to judicial warrant,

to include accrued interest.[1]

II. JURISDICTION AND VENUE

2. This Court has jurisdiction over this subject matter. *See* 28 U.S.C. §§ 1345, 1355(a); 18 U.S.C. § 981(a)(1).

3. This Court has *in rem* jurisdiction over the Defendant Asset. *See* 28 U.S.C. §§ 1345, 1355(b).

4. Venue for this action is proper in this District because acts or omissions giving rise to the forfeiture occurred in the Southern District of Florida, and because this is the same District where the Defendant Asset was brought upon seizure. *See* 28 U.S.C. §§ 1355(b)(1), 1395; 18 U.S.C. § 981(h).

III. FACTUAL ALLEGATIONS

At all times material to this civil action *in rem*:

A. The Medicare Program

5. The Medicare Program ("Medicare") was a federal health care program that provided free or below-cost health care benefits to individuals who are 65 years of age or older or disabled. The benefits available under Medicare were governed by federal statutes and regulations.

6. The United States Department of Health and Human Services ("HHS"), through its agency the Center for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare.

7. Individuals who received benefits under Medicare were commonly referred to as "Medicare beneficiaries."

8. Medicare was a "health care benefit program," as defined by 18 U.S.C. § 24(b).

[1] All dates and amounts referenced in this Verified Complaint are approximate.

9. Medicare was subdivided into four program "parts," which were: hospital insurance (Part A), medical insurance (Part B), Medicare Advantage (Part C), and prescription drug benefits (Part D).

10. Medicare Part B covered, among other things, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), which was the overarching Medicare benefit category that covered medically necessary equipment, devices, and supplies used to treat a medical condition, illness, or injury in the Medicare beneficiary's home.

11. Under Medicare Part B, wound care dressings, including collagen-based wound fillers, were classified as surgical dressings and were covered under the DMEPOS Supplies category.

12. Medicare claims for Part B services were processed and paid by Medicare Administrative Contractors ("MAC(s)"), which contracted with CMS to administer parts of Medicare in specific geographic jurisdictions.

13. Physicians, clinicians, health care facilities, and suppliers that enrolled in Medicare and delivered services to Medicare beneficiaries were referred to as Medicare "providers."

14. To enroll as a Medicare provider, physicians, clinicians, health care facilities, and suppliers were required to complete a Medicare Provider Enrollment Application (CMS-855 form).

15. Applicants were required to have a valid National Provider Identifier (NPI), which was a 10-digit, universal, lifetime identifier for healthcare providers, to enroll as a Medicare provider.

16. Applicants were required to provide identifying information, practice locations, correspondence addresses, billing agency details, and a signed certification statement.

17. Applicants were required to certify that they would comply with all Medicare laws, regulations, and policies regarding reimbursement.

18. Applicants were required to submit their Medicare enrollment application using the online Internet-based CMS Provider Enrollment, Chain, and Ownership System (PECOS) or by mailing the appropriate CMS-855 form to the MAC for their geographic region.

19. The PECOS was the online Medicare enrollment management system maintained by CMS. The platform allowed physicians, clinicians, health care facilities, and suppliers to electronically enroll as Medicare providers or suppliers. Users could also utilize PECOS to renew enrollment, withdraw from the program, report record changes, and sign documentation. While MAC(s) processed the initial applications, PECOS served as the final repository for all Medicare provider enrollment data.

20. Upon approval of a Medicare Enrollment Application, Medicare assigned an enrolled Medicare provider a Provider Transaction Access Number (PTAN), which was referred to as a Medicare "provider number."

21. A Medicare provider was authorized to submit claims to Medicare for reimbursement of medically necessary covered services rendered to Medicare beneficiaries.

22. To receive Medicare reimbursement for medically necessary covered services, Medicare providers were required to file a claim electronically or submit a CMS-1500 or UB-92 form to their MAC.

23. To be valid, a Medicare claim was required to include, among other things, the beneficiary's name and Medicare Beneficiary Identifier (MBI), the services provided, the dates and costs of the services provided, the diagnostic and procedural codes validating medical necessity, and the name and NPI of the ordering or prescribing physician.

24. Providers could use their respective MAC internet-based portals to submit Medicare claims electronically.

25. Medicare providers were legally required to submit claims only for services that were rendered and that meet Medicare's criteria for being reasonable and medically necessary.

26. Medicare providers were required to submit a CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement and a voided check or letter from their financial institution with their enrollment application to receive Medicare claims reimbursement payments electronically.

27. All Medicare reimbursement payments were transmitted directly to a Medicare provider's financial institution, whether the underlying claims were submitted electronically or on paper.

B. Caso Quality East Corp

28. Caso Quality East Corp ("CASO") was a Florida corporation with its principal office address listed as 4471 NW 36th Street, Suite 233, Miami Springs, Florida 33166, which is within the Southern District of Florida.

29. Florida Department of State Division of Corporations records reflected CASO was incorporated on February 12, 2024 (Document Number P24000011220/FEI 99-1332600).

30. CASO's Medicare enrollment became effective on September 23, 2024. Individual One was listed as CASO's owner, director, managing employee, and authorizing official.

31. CASO was a purported supplier of DMEPOS, which it allegedly provided to Medicare beneficiaries.

32. As part of its Medicare provider enrollment application, CASO submitted a voided check and an EFT Authorization Agreement for the Subject Account. The EFT agreement bore a signature purporting to be that of Individual One as CASO's authorized official.

C. Subject Account

33. On February 20, 2024, Individual One opened the Subject Account in CASO's name at Bank of America, N.A., in Miami, Florida.

34. The Subject Account's opening documents listed Individual One as CASO's President and the sole authorized signer.

D. Medicare Fraud Scheme

35. From on or about November 4, 2024, through on or about January 31, 2025, co-conspirators submitted and caused CASO to submit false and fraudulent claims totaling $2,637,024 (US) in billing to Medicare for collagen-based wound fillers that were not medically necessary and were not provided to Medicare beneficiaries as represented.

36. All claims submitted by CASO to Medicare during this period included the same diagnosis code for an unspecified open wound on the claimed Medicare beneficiary's right knee.

37. Throughout this period, CASO's claimed beneficiaries had no medical need for, nor did they request or receive wound care dressings, including collagen-based fillers.

38. All claims submitted by CASO to Medicare during this period listed either Doctor 1 or Doctor 2 as the referring provider.

39. Throughout this period, Doctor 1: (a) specialized in critical care, (b) never heard of CASO, (c) never treated any of CASO's claimed beneficiaries, (d) never prescribed wound care dressings, including collagen-based fillers, and (e) never authorized CASO to use his/her NPI for Medicare billing.

40. Throughout this period, Doctor 2: (a) specialized in Nephrology, (b) never heard of CASO, (c) never treated any of CASO's claimed beneficiaries, (d) never prescribed wound care dressings, including collagen-based fillers, and (e) never authorized CASO to use his/her NPI for Medicare billing.

E. Defendant Asset

41. On February 7, 2025, the Subject Account had a balance of $3,570.63 (US).

42. Between February 7 and March 24, 2025, the Subject Account received $695,580.34 (US) in Medicare reimbursements for claims submitted by CASO from November 4, 2024, through January 31, 2025. This accounted for 99.99% of the Subject Account's total deposits during this

period.

43. On or about March 24, 2025, Bank of America, N.A. closed the Subject Account and transferred its entire balance of $695,515.02 (US) into a hold harmless account.

44. An analysis conducted in accordance with generally accepted accounting principles demonstrated that, as of March 24, 2025, the Subject Account's entire balance of $695,515.02 (US) was fully traceable to Medicare reimbursements.

45. On July 8, 2025, federal law enforcement agents served a judicial warrant on Bank of America, N.A., for all principal, deposits, interest, dividends, and other amounts credited to, and/or formerly on deposit in, the Subject Account.

46. Pursuant to the judicial warrant, Bank of America, N.A., remitted $695,515.02 (US) to federal law enforcement agents accordingly.

47. Pursuant to the judicial warrant, the Federal Bureau of Investigation seized $695,515.02 (US), which constitutes the Defendant Asset.

IV. BASIS FOR FORFEITURE

48. Pursuant to 18 U.S.C. § 981(a)(1)(C), any property, real or personal, which constitutes or is derived from proceeds traceable to a specified unlawful activity or a conspiracy to commit such offense is subject to civil forfeiture.

49. Pursuant to 18 U.S.C. § 1956(c)(7)(F), any act or activity constituting an offense involving a "Federal health care offense" constitutes a specified unlawful activity.

50. Pursuant to 18 U.S.C. § 24(a)(1), a violation of, or a conspiracy to violate, 18 U.S.C. § 1347 (Health Care Fraud) is a "Federal health care offense."

51. Pursuant to 18 U.S.C. § 1347 it is a crime for anyone, in connection with the delivery of any health care benefits, items, or services, to knowingly and willingly execute, or attempt to execute, a scheme or artifice: (1) to defraud any health care benefit program; or (2) to obtain, by means of

materially false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

FIRST CLAIM
Proceeds of Conspiracy to Commit Health Care Fraud
18 U.S.C. § 981(a)(1)(C)

52. The factual allegations in paragraphs 1 through 51 are re-alleged and incorporated by reference as if fully set forth herein.

53. As set forth above, the Defendant Asset is property that constitutes or is derived from proceeds traceable to a conspiracy to commit health care fraud in violation of 18 U.S.C. § 1349, which is a specified unlawful activity pursuant to 18 U.S.C. § 1956(c)(7)(F).

54. Accordingly, the Defendant Asset is subject to forfeiture pursuant to 18 U.S.C. § 981(a)(1)(C).

SECOND CLAIM
Proceeds of Health Care Fraud
18 U.S.C. § 981(a)(1)(C)

55. The factual allegations in paragraphs 1 through 51 are re-alleged and incorporated by reference as if fully set forth herein.

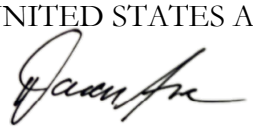
56. As set forth above, the Defendant Asset is property that constitutes or is derived from proceeds traceable to health care fraud in violation of 18 U.S.C. § 1347, which is a specified unlawful activity pursuant to 18 U.S.C. § 1956(c)(7)(F).

57. Accordingly, the Defendant Asset is subject to forfeiture pursuant to 18 U.S.C. § 981(a)(1)(C).

WHEREFORE, the United States of America prays that notice issue on the Defendant Asset; that due notice be given to all parties to appear and show cause why the forfeiture should not be decreed; that a warrant of arrest *in rem* issue according to law; that judgment be entered declaring that the Defendant Asset be forfeited for disposition according to law; and that the United States of America be granted such other relief as this Court may deem just and proper, together with the costs and disbursements of this action.

Respectfully submitted,

JASON A. REDING QUIÑONES
UNITED STATES ATTORNEY

By: 

Daren Grove (Court No. A5501243)
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Facsimile: 954.356.7180

VERIFICATION

I, Jaylin Gethers Bingham, hereby verify and declare, under penalty of perjury, that I am a Special Agent with the Federal Bureau of Investigation (FBI) and that the foregoing factual allegations are true and correct to the best of my knowledge and belief.

The sources of my knowledge and information and the grounds of my belief are the official files and records of the United States, information supplied to me by other law enforcement agents, as well as my investigation of this case, together with others, as a Special Agent of the FBI.

Executed on this 22nd day of June 2026.

Jaylin Gethers Bingham
Special Agent, Federal Bureau of Investigation

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO.

UNITED STATES OF AMERICA,

Plaintiff,

v.

APPROXIMATELY $960,356.62 IN U.S. CURRENCY SEIZED FROM JP MORGAN CHASE BANK ACCOUNT NO. 950128279 IN THE NAME OF VCG BEST SERVICES, LLC.

Defendant *In Rem*.

VERIFIED COMPLAINT FOR FORFEITURE *IN REM*

Plaintiff, the United States of America, by and through its undersigned counsel, alleges upon information and belief as follows:

I. NATURE OF THE ACTION

1. This is a civil action *in rem*, pursuant to 18 U.S.C. § 981(a)(1)(C) and the procedures set forth in Rule G of the Supplemental Rules for Admiralty or Maritime Claims and Asset Forfeiture Actions, and the Federal Rules of Civil Procedure, to forfeit seized funds, more fully described as:

(i) Approximately[1] $960,356.62 in U.S. currency seized from account number 950128279 at JP Morgan Chase Bank, N.A. in the name of VCG Best Services, LLC (the "Defendant Asset").

[1] All dates and amounts referenced in this Verified Complaint are approximate.

II. JURISDICTION AND VENUE

2. This Court has jurisdiction over this subject matter. *See* 28 U.S.C. §§ 1345, 1355(a); 18 U.S.C. § 981(a)(1).

3. This Court has *in rem* jurisdiction over the Defendant Asset. *See* 28 U.S.C. §§ 1345, 1355(b).

4. Venue for this action is proper in this District because acts or omissions giving rise to the forfeiture occurred in the Southern District of Florida, and because this is the same District where the Defendant Asset was brought upon seizure. *See* 28 U.S.C. §§ 1355(b)(1), 1395; 18 U.S.C. § 981(h).

III. FACTUAL ALLEGATIONS

At all times material to this Action:

A. The Medicare Program and Durable Medical Equipment

5. The Medicare Program ("Medicare") was a federal health care program that provided free or below-cost health care benefits to individuals who are 65 years of age or older or disabled. The benefits available under Medicare were governed by federal statutes and regulations.

6. The United States Department of Health and Human Services ("HHS"), through its agency the Center for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare.

7. Individuals who received benefits under Medicare were commonly referred to as "Medicare beneficiaries."

8. Medicare was a "health care benefit program," as defined by 18 U.S.C. § 24(b).

9. Medicare was subdivided into multiple program "parts."

10. Medicare Part B covered physician services and outpatient care, including an

individual's access to durable medical equipment ("DME").

11. DME was equipment designed for repeated use and for a medical purpose, such as orthotic devices, wheelchairs, prosthetic limbs, back braces, knee braces, wheelchairs, nebulizers, and oxygen concentrators.

12. DME companies, physicians, and other health care providers that provided services to Medicare beneficiaries were referred to as Medicare "providers." To participate in Medicare, providers were required to submit an application in which the providers agreed to comply with all Medicare-related laws and regulations. If Medicare approved a provider's application, Medicare assigned the enrolled provider a Medicare "provider number."

13. A provider with a Medicare provider number could file claims with Medicare to obtain reimbursement for services rendered to Medicare beneficiaries.

14. Enrolled Medicare providers agreed to abide by the policies, procedures, rules, and regulations governing reimbursement. Providers were given access to Medicare manuals and services bulletins describing billing procedures, rules, and regulations.

15. To receive payment from Medicare, providers, including DME companies, submitted or caused the submission of claims to Medicare, either directly or through a billing company.

16. A Medicare claim for DME reimbursement was required to set forth, among other things, the name and unique Medicare identification number of the beneficiary, the equipment provided to the beneficiary, the date the equipment was provided, the cost of the equipment, and the name and unique physician identification number of the physician who prescribed or ordered the equipment.

17. A claim for DME submitted to Medicare qualified for reimbursement only if the

equipment was medically necessary for the treatment of the beneficiary's illness or injury, prescribed by a licensed physician, and actually provided to the beneficiary as billed.

B. VCG Best Services, LLC

18. VCG Best Services LLC, ("VCG") was an enrolled Medicare provider that purportedly provided DME to Medicare beneficiaries.

19. VCG was a Florida limited liability company located in Miami, Florida, which is within the Southern District of Florida.

20. VCG's JP Morgan Chase Bank account number 950128279 ("account ending in 8279") was opened on April 7, 2023, using an address at VCG's purported office in Miami, Florida.

21. Co-conspirators submitted and caused VCG to submit false and fraudulent claims to Medicare totaling $6,141,011.86 in U.S. currency for DME that was medically unnecessary and not provided as represented.

22. Alleged beneficiaries of VCG's Medicare claims stated in interviews with law enforcement agents that they did not receive, request, or need any of the DME that was billed for them and had never heard of VCG.

23. The sole alleged provider and prescriber of the DME identified in VCG's Medicare claims stated in an interview with law enforcement agents he or she had never heard of VCG, and he or she had not prescribed the DME to the identified beneficiaries. The sole alleged provider stated that the identified Medicare beneficiaries were not his or her patients. This provider's prescriptions accounted for 100% of VCG's total billed Medicare claims.

24. On October 31, 2023, law enforcement agents also visited VCG's purported office in Miami, Florida, which they found was closed. There were no signs indicating VCG was an

active business.

C. Defendant Asset

25. From in or about August 30, 2023, through in or about January 4, 2024, as a result of claims for reimbursements, Medicare deposited $3,450,012.64 in U.S. currency into VCG's account ending in 8279. This $3,450,012.64 in U.S. currency constituted 100% of VCG's account ending in 8279's total deposits during that time period.

26. Inclusive of this $3,450,012.64 were three transactions totaling $80,109.16, which were transfers from another account in VCG's name, but which were actually previous transfers of healthcare fraud proceeds from VCG's account ending in 8279.

27. Analysis of VCG's account ending in 8279 revealed that $960,356.62 in U.S. currency on deposit on or about January 17, 2024, which was entire balance of the account at the time, was traceable to Medicare reimbursements.

28. On February 20, 2024, law enforcement agents served a federal seizure warrant on JP Morgan Chase Bank for the balance of VCG's account ending in 8279. *See* Case No. 24-MJ-02302-TORRES (S.D. Fla.).

29. Pursuant to that seizure warrant, JP Morgan Chase remitted $960,356.62 in U.S. currency from VCG's account ending in 8279 to the Federal Bureau of Investigation.

30. The $960,356.62 in U.S. currency, which constitutes the Defendant Asset, was seized by the Federal Bureau of Investigation.

IV. BASIS FOR FORFEITURE

31. Pursuant to 18 U.S.C. § 981(a)(1)(C), any property, real or personal, which constitutes or is derived from proceeds traceable to a specified unlawful activity or a conspiracy

to commit such offense is subject to civil forfeiture.

32. Pursuant to 18 U.S.C. § 1956(c)(7)(F), any act or activity constituting an offense involving a "Federal health care offense" constitutes a specified unlawful activity.

33. Health care fraud, in violation of 18 U.S.C. § 1347, is a "Federal health care offense." *See* 18 U.S.C. § 24.

FIRST CLAIM
Proceeds of Health Care Fraud
18 U.S.C. § 981(a)(1)(C)

34. The factual allegations in paragraphs 1 through 30 are re-alleged and incorporated by reference as if fully set forth herein.

35. As set forth above, the Defendant Asset is property that constitutes or is derived from proceeds traceable to health care fraud in violation of 18 U.S.C. § 1347, which is a specified unlawful activity pursuant to 18 U.S.C. § 1956(c)(7)(F).

36. Accordingly, the Defendant Asset is subject to forfeiture pursuant to 18 U.S.C. § 981(a)(1)(C).

[Intentional Blank Space]

WHEREFORE, Plaintiff, the United States of America, requests that the Clerk of the Court issue a warrant for the arrest *in rem* of the Defendant Asset; that notice of this action be provided to persons known or thought to have an interest in or right against the Defendant Asset; that the Defendant Asset be forfeited and condemned to the United States of America; and for such other and further relief as may be deemed just, necessary and proper.

Respectfully submitted,

JASON A. READING QUIÑONES
UNITED STATES ATTORNEY

By: /s/ Brian H. Zack
Brian H. Zack
Assistant United States Attorney
Florida Bar No. 1000416
United States Attorney's Office for
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Telephone: (305)-961-9407
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VERIFICATION

I, Jaylin G. Bingham, hereby verify and declare, under penalty of perjury, that I am a Special Agent with the Federal Bureau of Investigation and that the foregoing factual allegations are true and correct to the best of my knowledge and belief.

The sources of my knowledge and information and the grounds of my belief are the official files and records of the United States, information supplied to me by other law enforcement agents, as well as my investigation of this case, together with others, as a Special Agent of the Federal Bureau of Investigation.

Executed on this 22 of June 2026.

Jaylin G. Bingham
Special Agent, Federal Bureau of Investigation

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO.

UNITED STATES OF AMERICA,

Plaintiff,

v.

APPROXIMATELY $683,428.55 IN UNITED STATES CURRENCY SEIZED FROM ACCOUNT NUMBER 898149728028 AT BANK OF AMERICA IN THE NAME OF MEDMED 137, INC.

Defendant *In Rem*.

VERIFIED COMPLAINT FOR FORFEITURE *IN REM*

Plaintiff, the United States of America, by and through its undersigned counsel, alleges upon information and belief, as follows:

I. NATURE OF THE ACTION

1. This is a civil action for forfeiture *in rem*, pursuant to 18 U.S.C. § 981(a)(1)(C) and the procedures set forth in Rule G of the Supplemental Rules for Admiralty or Maritime Claims and Asset Forfeiture Actions, and the Federal Rules of Civil Procedure, to forfeit seized funds, more fully described as:

(i) Approximately[1] $683,428.55 in U.S. currency seized from account number 898149728028 at Bank of America in the name of MedMed 137, Inc. (the "Defendant Asset").

[1] All dates and amounts referenced in this Verified Complaint are approximate.

II. JURISDICTION AND VENUE

2. This Court has jurisdiction over this subject matter. *See* 28 U.S.C. §§ 1345, 1355(a); 18 U.S.C. § 981(a)(1).

3. This Court has *in rem* jurisdiction over the Defendant Asset. *See* 28 U.S.C. §§ 1345, 1355(b).

4. Venue for this action is proper in this District because acts or omissions giving rise to the forfeiture occurred in the Southern District of Florida, and because this is the same District where the Defendant Asset was brought upon seizure. *See* 28 U.S.C. §§ 1355(b)(1), 1395.

III. FACTUAL ALLEGATIONS

At all times material to this Action:

A. The Medicare Program and Durable Medical Equipment

5. The Medicare Program ("Medicare") was a federal health care program that provided free or below-cost health care benefits to individuals who are 65 years of age or older or disabled. The benefits available under Medicare were governed by federal statutes and regulations.

6. The United States Department of Health and Human Services ("HHS"), through its agency the Center for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare.

7. Individuals who received benefits under Medicare were commonly referred to as "Medicare beneficiaries."

8. Medicare was a "health care benefit program," as defined by 18 U.S.C. § 24(b).

9. Medicare was subdivided into multiple program "parts."

10. Medicare Part B covered physician services and outpatient care, including an individual's access to durable medical equipment ("DME").

11. DME was equipment designed for repeated use and for a medical purpose, such as orthotic devices, wheelchairs, prosthetic limbs, back braces, knee braces, wheelchairs, nebulizers, and oxygen concentrators.

12. DME companies, physicians, and other health care providers that provided services to Medicare beneficiaries were referred to as Medicare "providers." To participate in Medicare, providers were required to submit an application in which the providers agreed to comply with all Medicare-related laws and regulations. If Medicare approved a provider's application, Medicare assigned the enrolled provider a Medicare "provider number."

13. A provider with a Medicare provider number could file claims with Medicare to obtain reimbursement for services rendered to Medicare beneficiaries.

14. Enrolled Medicare providers agreed to abide by the policies, procedures, rules, and regulations governing reimbursement. Providers were given access to Medicare manuals and services bulletins describing billing procedures, rules, and regulations.

15. To receive payment from Medicare, providers, including DME companies, submitted or caused the submission of claims to Medicare, either directly or through a billing company.

16. A Medicare claim for DME reimbursement was required to set forth, among other things, the name and unique Medicare identification number of the beneficiary, the equipment provided to the beneficiary, the date the equipment was provided, the cost of the equipment, and the name and unique physician identification number of the physician who prescribed or ordered the equipment.

17. A claim for DME submitted to Medicare qualified for reimbursement only if the equipment was medically necessary for the treatment of the beneficiary's illness or injury,

prescribed by a licensed physician, and actually provided to the beneficiary as billed.

B. MedMed 137, Inc.

18. MedMed 137, Inc. ("MedMed") was an enrolled Medicare provider that purportedly provided DME to Medicare beneficiaries.

19. MedMed was a Florida corporation located in Miami, Florida, which is within the Southern District of Florida.

20. MedMed's Bank of America account number 898149728028 ("account ending in 8028) was opened on or about February 20, 2024, using an address at MedMed's purported office in Miami, Florida.

21. MedMed submitted false and fraudulent claims to Medicare totaling approximately $1,128,452.20 for DME that was medically unnecessary and not provided as represented.

22. Alleged beneficiaries of MedMed's Medicare claims stated in interviews with law enforcement agents that they did not receive, request, or need any of the DME that was billed for them and had never heard of MedMed.

23. There were a total of six alleged providers and prescribers who accounted for 100% of the total number of claims MedMed submitted.

24. Three of the alleged providers and prescribers, who in total accounted for approximately 62% of the Medicare claims that MedMed filed, stated in interviews with law enforcement agents that they had never heard of MedMed, and they had not prescribed the DME to the identified beneficiaries.

25. Law enforcement attempted to interview an additional provider who accounted for 19% of the claims, but were unable to speak to him or her as he or she was incapacitated and lacking the capacity to communicate prior to MedMed's incorporation, which was inclusive of the

time when MedMed billed his or her NPI number for DME provided to the beneficiaries.

26. Medicare records show that an additional provider who allegedly prescribed DME and accounted for 19% of MedMed's Medicare claims had previously withdrawn from the Medicare program, had his or her NPI deactivated over a decade before MedMed claimed to have supplied beneficiaries with DME prescribed/referred by him or her, and a beneficiary stated that he or she was not familiar with this provider.

27. On or about December 31, 2024, agents from the National Council of Compensation Insurance ("NCCI") and law enforcement agents visited MedMed's purported office in Miami, Florida, observed it did not have a permanent visible sign with the supplier's business name posted on the facility, but agents spoke with the front desk receptionist, an individual with the initials N.D.

28. Law enforcement agents later determined that N.D. was previously convicted of conspiracy to commit health care fraud and sentenced to 24 months imprisonment and ordered to pay $1,355,000.00 in restitution. *See United States v. Niurka Donate*, et. al., No. 14-CR-20717-RNS (S.D. Fla.); Judgment, 14-CR-20717-RNS, Dkt. No. 90.

29. On or about April 15, 2025, April 23, 2025, and May 1, 2025, law enforcement agents visited MedMed's purported office in Miami, Florida, during operating hours and found it closed during each visit. There were no signs indicating MedMed was an active business.

C. <u>Defendant Asset</u>

30. From on or about March 10, 2025, through on or about April 9, 2025, as a result of claims for reimbursements, Medicare deposited approximately $733,419.00 in U.S. currency into MedMed's account ending in 8028. This $733,419.00 in U.S. currency constituted 100% of the MedMed's account ending in 8028's total deposits during that time period.

31. Analysis of MedMed's account ending in 8028 revealed that $683,428.55 in U.S. currency on deposit on or about April 17, 2025, which was entire balance of the account at the time, was traceable to Medicare reimbursements.

32. On or about October 9, 2025, law enforcement agents served a federal seizure warrant on Bank of America for the balance of the MedMed's account ending in 8028. *See* Case No. 25-MJ-03950-D'ANGELO (S.D. Fla.).

33. Pursuant to that seizure warrant, Bank of America remitted $683,428.55 in U.S. currency from MedMed's account ending in 8028 to the Federal Bureau of Investigation.

34. The $683,428.55 in U.S. currency, which constitutes the Defendant Asset, was seized by the Federal Bureau of Investigation.

IV. BASIS FOR FORFEITURE

35. Pursuant to 18 U.S.C. § 981(a)(1)(C), any property, real or personal, which constitutes or is derived from proceeds traceable to a specified unlawful activity or a conspiracy to commit such offense is subject to civil forfeiture.

36. Pursuant to 18 U.S.C. § 1956(c)(7)(F), any act or activity constituting an offense involving a "Federal health care offense" constitutes a specified unlawful activity.

37. Health care fraud, in violation of 18 U.S.C. § 1347, is a "Federal health care offense." *See* 18 U.S.C. § 24.

FIRST CLAIM
Proceeds of Health Care Fraud
18 U.S.C. § 981(a)(1)(C)

38. The factual allegations in paragraphs 1 through 34 are re-alleged and incorporated by reference as if fully set forth herein.

39. As set forth above, the Defendant Asset is property that constitutes or is derived

from proceeds traceable to health care fraud in violation of 18 U.S.C. § 1347, which is a specified unlawful activity pursuant to 18 U.S.C. § 1956(c)(7)(F).

40. Accordingly, the Defendant Asset is subject to forfeiture pursuant to 18 U.S.C. § 981(a)(1)(C).

WHEREFORE, Plaintiff, the United States of America, requests that the Clerk of the Court issue a warrant for the arrest *in rem* of the Defendant Asset; that notice of this action be provided to persons known or thought to have an interest in or right against the Defendant Asset; that the Defendant Asset be forfeited and condemned to the United States of America; and for such other and further relief as may be deemed just, necessary and proper.

Respectfully submitted,

JASON A. READING QUIÑONES
UNITED STATES ATTORNEY

By: /s/ Brian H. Zack

Brian H. Zack
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VERIFICATION

Pursuant to 28 U.S.C. § 1746, I, Alexandria Davis, hereby verify and declare, under penalty of perjury, that I am a Special Agent with the Federal Bureau of Investigation and that I have read the foregoing Verified Complaint for Forfeiture In Rem and that the foregoing factual allegations are true and correct to the best of my knowledge and belief.

The sources of my knowledge and information and the grounds of my belief are the official files and records of the United States, information supplied to me by other law enforcement agents, as well as my investigation of this case, together with others, as a Special Agent of the Federal Bureau of Investigation.

Executed on this 18th of June 2026.

Alexandria Davis, Special Agent,
Federal Bureau of Investigation

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO.

UNITED STATES OF AMERICA,

Plaintiff,

v.

APPROXIMATELY $793,369.68 IN U.S. CURRENCY SEIZED FROM ACCOUNT NO. 000000772419597 AT JP MORGAN CHASE BANK, N.A. IN THE NAME OF MIAMI SPECIAL CARE, INC.;

APPROXIMATELY $878,958.17 IN U.S. CURRENCY SEIZED FROM ACCOUNT NO. 000000668636635 AT JP MORGAN CHASE BANK, N.A. IN THE NAME OF ALVAR HOLDINGS CORP.; AND

APPROXIMATELY $912,915.20 IN U.S. CURRENCY SEIZED FROM ACCOUNT NO. 000000668623997 AT JP MORGAN CHASE BANK, N.A. IN THE NAME OF RARR MANAGEMENT CORP.

Defendants *In Rem*.

VERIFIED COMPLAINT FOR FORFEITURE *IN REM*

Plaintiff, the United States of America, by and through its undersigned counsel, alleges upon information and belief, as follows:

I. NATURE OF THE ACTION

1. This is a civil forfeiture action *in rem*, pursuant to 18 U.S.C. § 981(a)(1)(C), the procedures set forth in Rule G of the Supplemental Rules for Admiralty or Maritime Claims and Asset Forfeiture Actions, and the Federal Rules of Civil Procedure, to forfeit seized funds, more

fully described as the following (collectively, the "Defendant Assets"):[1]

(i) Approximately $793,369.68 in U.S. currency seized from account number 000000772419597 held at JP Morgan Chase Bank, N.A. in the name of Miami Special Care, Inc.;

(ii) Approximately $878,958.14 in U.S. currency seized from account number 000000668636635 held at JP Morgan Chase Bank, N.A. in the name of Alvar Holdings Corp.; and

(iii) Approximately $912,915.20 in U.S. currency seized from account number 000000668623997 held at JP Morgan Chase Bank, N.A. in the name of Rarr Management Corp.

II. JURISDICTION AND VENUE

2. This Court has jurisdiction over this subject matter. *See* 28 U.S.C. §§ 1345, 1355(a); 18 U.S.C. § 981(a)(1).

3. This Court has *in rem* jurisdiction over the Defendant Assets. *See* 28 U.S.C. §§ 1345, 1355(b).

4. Venue for this action is proper in this District because acts or omissions giving rise to the forfeiture occurred in the Southern District of Florida, and because this is the same District where the Defendant Assets were brought upon seizure. *See* 28 U.S.C. §§ 1355(b)(1), 1395.

III. FACTUAL ALLEGATIONS

At all times material to this Action:

A. The Medicare Program

5. The Medicare Program ("Medicare") was a federal health care program that provided free or below-cost health care benefits to individuals who are 65 years of age or older or disabled.

6. The United States Department of Health and Human Services, through its agency, the Center for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare.

[1] All dates and amounts referenced in this Verified Complaint are approximate.

7. Individuals who received benefits under Medicare were commonly referred to as "Medicare beneficiaries."

8. Medicare was a "health care benefit program," as defined by 18 U.S.C. § 24(b).

9. Medicare was subdivided into four parts: hospital insurance (Part A); medical insurance (Part B); Medicare Advantage (Part C); and prescription drug benefits (Part D).

10. Medicare Part B covered, among other things, skin substitutes, skin grafts, and surgical dressings. According to the CMS website, CMS.gov, Simplimax and Woundplus fall under "Skin Substitutes."

11. Medicare claims for Part B items and services were processed and paid by Medicare Administrative Contractors ("MAC[s]"), which contracted with CMS to administer parts of Medicare in specific jurisdictions.

12. First Coast Service Options, Inc. was the MAC that covered Florida.

13. Providers, among others, may have applied to become a "provider" with Medicare by submitting an application in which the provider agreed to abide by Medicare's policies, procedures, rules, and regulations governing reimbursement. If Medicare approved a provider's application, Medicare assigned the enrolled provider a Medicare "provider number."

14. Providers with a Medicare provider number could file claims with Medicare to obtain reimbursement for services provided on behalf of Medicare beneficiaries.

15. Providers were given access to Medicare manuals and services bulletins describing billing procedures, rules, and regulations.

16. To receive payment for a covered service from Medicare, providers had to submit a claim, either electronically or using a form, to the MAC. The claim had to contain the required information, including the provider's identifying information such as a Medicare-assigned

Provider Transaction Access Number, the patient's information, the services rendered, the name of the provider who rendered or provided the billed-for item or service, the name of the beneficiary, a medical diagnosis, the date the billed-for service was rendered or the items was provided, and the type of service rendered and/or item provided.

17. Providers could only submit reimbursement claims to Medicare for items provided and/or services rendered that were reasonable and medically necessary.

18. Reimbursement payments under Mediare were often made directly to a provider for the goods or services, rather than to a Medicare beneficiary.

19. Medicare sent reimbursement payments directly to a provider's financial institution whether claims were filed electronically or on paper. Medicare required all providers to submit an electronic funds transfer agreement and a voided check or letter from their financial institution with their enrollment application to receive payments electronically.

B. Health Care Fraud Scheme Involving Miami Special Care Inc.

20. Miami Special Care, Inc. ("Miami Special") was an enrolled Medicare provider that purportedly provided skin graft substitutes to Medicare beneficiaries.

21. Miami Special was a Florida corporation located in Miami, Florida, which is within the Southern District of Florida.

22. Miami Special previously operated under the corporate name American Community Mental Health Center, Inc. ("American Community"), which was originally incorporated on or about July 6, 2018.

23. According to American Community's Articles of Incorporation filed with the Florida Department of State, Individual 1 was American Community's initial president and registered agent.

24. On or about July 11, 2018, American Community opened a JP Morgan Chase

account ending in 1213 with Individual 1 as a co-signatory with another individual, Individual 2. As explained below, JP Morgan Chase converted this account into JP Morgan Chase account number 000000772419597.

25. According to Medicare records, American Community became an eligible Medicare provider on or about January 3, 2020.

26. On or about September 28, 2021, American Community amended its Articles of Incorporation to change its name to Miami Special and replaced Individual 1 with Individual 3 as president and registered agent.

27. According to bank records, on or about February 28, 2022, Individual 3 amended the signature card on the account ending in 1213, changing the account holder name from American Community to Miami Special and listing Individual 3 as the account's sole signatory.

i. Individual 4's Takeover of Miami Special Care

28. On or about August 29, 2024, Miami Special amended its Articles of Incorporation to replace Individual 3 with Individual 4 as president and registered agent.

29. Days later, on or about September 5, 2024, Medicare records show that Miami Special's enrollment application was amended, adding Individual 4 as the owner and authorized official of Miami Special.

30. According to bank records, on or about September 6, 2024, Individual 4 filed a new signature card for account ending in 1213, removing Individual 3 from the account and making Individual 4 the sole signatory.

31. JP Morgan Chase later conducted a balance transfer of Miami Special's account ending in 1213 to Miami Special's account ending in 000000772419597 ("account ending in 9597").

32. Beginning in or around January 2025, the bank statements for Miami Special's

account ending in 9597 reflected a change to the address line for Miami Special and reflected Miami Special's purported office address in Miami, Florida as of August 29, 2024.

33. A review of Medicare claims data for Miami Special shows that between in or around December 2024 through April 2025, after Individual 4's takeover, Miami Special submitted reimbursement claims to Medicare totaling approximately $13,444,822.46 for Simplimax and Woundplus skin substitute grafts purportedly provided to approximately nineteen (19) Medicare beneficiaries, but were medically unnecessary, not provided as represented, and not prescribed by a licensed medical professional.

34. All of the reimbursement claims submitted to Medicare by Miami Special during that period identified a single medical provider ("Physician 1") as the treating and/or prescribing provider for each claim.

35. Law enforcement interviewed one of the nineteen Medicare beneficiaries. That beneficiary told law enforcement that he or she was not familiar with Miami Special, did not receive or need the skin grafts that were billed to Medicare under his or her Medicare beneficiary information, and was not familiar with Physician 1.

36. Additionally, law enforcement interviewed Physician 1. Physician 1 stated that he or she had never heard of Miami Special, had never been employed by the company, and had never administered a skin graft in his or her nearly forty years of medical practice. Physician 1 further stated that he or she had never billed Medicare for performing any skin-graft procedure and had no knowledge of the products Simplimax or Woundplus.

37. Accordingly, 100% of Miami Special's reimbursement claims submissions were fraudulent.

38. Based on Miami Special's fraudulent claims submissions, Medicare approved a

portion of those claims, ultimately depositing Miami Special approximately $6,712,928.60 into Miami Special's account number ending in 9597.

C. Defendant Assets

i. Miami Special's Account Ending in 9597

39. Bank records for Miami Special's account ending in 9597 confirm Medicare's deposits, showing that between on or about February 21, 2025, and on or about April 30, 2025, Medicare deposited a total of approximately $6,712,928.60 in fraudulently obtained Medicare proceeds into the account.

40. Bank records show that prior to the first Medicare deposit on or about February 21, 2025, Miami Special's account ending in 9597 had a balance of approximately $2,700.90.

41. During the relevant period, bank records show that, with the except of a few nominal deposits, Miami Special's account ending in 9597 was funded almost entirely with those health care fraud proceeds.

42. Bank records for Miami Special's account ending in 9597 further shows that a substantial portion of the Medicare fraud proceeds were typically transferred out to other accounts shortly after being deposited by Medicare.

43. For example, bank records show that between in or around February 2025 and April 2025, Miami Special's account ending in 9597 transferred a total of approximately $2,943,376.09 in healthcare fraud proceeds to JP Morgan Chase account number 000000668636635. As explained in more detail below, this account was opened by Individual 4 and held in the name of Alvar Holdings Corp., a company owned by Individual 4.

44. Similarly, bank records also show that during the same time period, Miami Special's account ending in 9597 transferred approximately $2,967,487.08 in healthcare fraud proceeds to JPMC account number 000000668623997. As explained in more detail below, this

account was also opened by Individual 4 and held in the name of Rarr Management, Corp., another company owned by Individual 4.

45. As a result of transfers and/or other withdrawals, Miami Special's account ending in 9597 account balance was drawn down, leaving it with a balance of approximately $793,369.68.

46. On or about May 7, 2025, JP Morgan Chase froze the account with that balance.

47. That entire balance consisted of proceeds of Miami Special's health care fraud scheme.

48. Between on or about May 7, 2025, and December 19, 2025, when law enforcement seized the $793,369.68 pursuant to a federal seizure warrant, no further deposits were made into the account.

ii. Alvar's Account Ending in 6635

49. According to bank records obtained for JP Morgan Chase account number 000000668636635 ("account ending in 6635"), the account was opened on or about September 18, 2024, in the name of Alvar Holdings Corp. with Individual 4 as the sole signer on the account.

50. According to documents obtained from the State of Florida, Individual 4 incorporated Alvar Holdings Corp. ("Alvar") in or around September of 2024, and was listed as the company's president and registered agent.

51. Alvar's Articles of Incorporation list its purported principal place of business as the same address as Miami Special's purported place of business, both of which are within the Southern District of Florida.

52. A review of banking records for Alvar's account ending in 6635, confirms numerous deposits between February 24, 2025, and April 25, 2025, from Miami Special's account ending in 9597, totaling approximately $2,943,376.09—all of which constitute, or are traceable to

health care fraud proceeds.

53. According to bank records, the account balance prior to the first deposit from Miami Special's account ending in 9597 was approximately $319.62.

54. During the relevant period, bank records show that Alvar's account ending in 6635 was funded entirely with health care fraud proceeds traceable to Miami Special's health care fraud scheme.

55. Bank records further show that a substantial portion of the approximately $2,943,376.09 in Medicare fraud proceeds received from Miami Special's account ending in 9597 were typically spent or withdrawn from the account shortly after being deposited into the account, which left an account balance of approximately $878,958.14.

56. On or about May 7, 2025, JP Morgan Chase froze the account with that balance.

57. That entire balance consisted of proceeds of Miami Special's health care fraud scheme.

58. Between on or about May 7, 2025, and December 19, 2025, when law enforcement seized the $878,958.14 pursuant to a federal seizure warrant, no further deposits were made into the account.

iii. Rarr's Account Ending in 3997

59. According to bank records obtained for JP Morgan Chase account number 000000668623997 ("account ending in 3997"), the account was opened on or about September 18, 2024, the same day that Alvar's account ending in 6635 was opened.

60. Bank records show that the account was held in the name of Rarr Management, Corp., with Individual 4 as the sole signer on the account.

61. According to documents obtained from the State of Florida, Individual 4

incorporated Rarr Management, Corp. ("Rarr") in or around September of 2024, and was listed as the company's president and registered agent.

62. Rarr's Articles of Incorporation list its purported principal place of business as the same address as Miami Special's and Alvar's purported place of business.

63. A review of banking records for Rarr's account ending in 3997, confirms numerous deposits between February 24, 2025, and April 25, 2025, from Miami Special's account ending in 9597, totaling approximately $2,967,487.08—all of which constitute, or are traceable to health care fraud proceeds.

64. According to bank records, the account balance prior to the first deposit from Miami Special's account ending in 9597 was approximately $364.62.

65. During the relevant period, bank records show that, with the except of a few nominal deposits, Rarr's account ending in 3997 was funded almost entirely with health care fraud proceeds traceable to Miami Special's health care fraud scheme.

66. Bank records further show that a substantial portion of the approximately $2,967,487.08 in Medicare fraud proceeds received from Miami Special's account ending in 9597 were typically spent and/or withdrawn from the account shortly after being deposited into the account, which left an account balance of approximately $912,915.20.

67. On or about May 7, 2025, JP Morgan Chase froze the account with that balance.

68. That entire balance consisted of proceeds of Miami Special's health care fraud scheme.

69. Between on or about May 7, 2025, and December 19, 2025, when law enforcement seized the $912,915.20 pursuant to a federal seizure warrant, no further deposits were made into the account.

iv. Seizure Warrant

70. On or about December 19, 2025, law enforcement agents served a federal seizure warrant on JP Morgan Chase for all funds on deposit in the following accounts: Miami Special's account ending in 9597, Alvar's account ending in 6635, and Rarr's account ending in 3997. *See* Case No. 25-MJ-04448-Louis (S.D. Fla.).

71. Pursuant to that seizure warrant, JP Morgan Chase remitted a total of $2,585,243.02 in U.S. currency, compromised of $793,369.68 from Miami Special's account ending in 9597, $878,958.14 from Alvar's account ending in 6635, and $912,915.20 from Rarr's account ending in 3997—the Defendant Assets.

IV. BASIS FOR FORFEITURE

72. Pursuant to 18 U.S.C. § 981(a)(1)(C), any property, real or personal, which constitutes or is derived from proceeds traceable to a specified unlawful activity is subject to civil forfeiture.

73. Pursuant to 18 U.S.C. § 1956(c)(7)(F), any act or activity constituting an offense involving a "Federal health care offense" constitutes a specified unlawful activity.

74. Health care fraud, in violation of 18 U.S.C. § 1347, is a "Federal health care offense." *See* 18 U.S.C. § 24.

FIRST CLAIM
Proceeds of Health Care Fraud
18 U.S.C. § 981(a)(1)(C)

75. The factual allegations in paragraphs 1 through 74 are re-alleged and incorporated by reference as if fully set forth herein.

76. As set forth above, the Defendant Assets are property that constitutes or are derived from proceeds traceable to health care fraud in violation of 18 U.S.C. § 1347, which is a specified unlawful activity pursuant to 18 U.S.C. § 1956(c)(7)(F).

77. Accordingly, the Defendant Assets are subject to forfeiture pursuant to 18 U.S.C. § 981(a)(1)(C).

WHEREFORE, Plaintiff, the United States of America, requests that the Clerk of the Court issue a warrant for the arrest *in rem* of the Defendant Assets; that notice of this action be provided to persons known or thought to have an interest in or right against the Defendant Assets; that the Defendant Assets be forfeited and condemned to the United States of America; and for such other and further relief as may be deemed just, necessary and proper.

Respectfully submitted,

JASON A. READING QUIÑONES
UNITED STATES ATTORNEY

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VERIFICATION

I, Garrett Young Bowman, hereby verify and declare, under penalty of perjury, that I am a Special Agent with the Federal Bureau of Investigation and that the foregoing factual allegations are true and correct to the best of my knowledge and belief.

The sources of my knowledge and information and the grounds of my belief are the official files and records of the United States, information supplied to me by other law enforcement agents, as well as my investigation of this case, together with others, as a Special Agent of the Federal Bureau of Investigation.

Executed on this 22 of JUNE 2026

Garrett Young Bowman
Special Agent, Federal Bureau of Investigation