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Fake medical bills and death certificates: How policyholders file fraud claims

Several hospitals and patients have raised fake and inflated bills during the Covid pandemic to defraud insurance companies

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Insurance frauds cost a whopping Rs 45,000 crore every year to insurance companies, industry data shows. (Representative Image)

Insurance distributor Avdesh Mishra receives a call from his friend who worked at a hospital in Meerut. The friend wanted Mishra to convince his health insurance clients to file fake claims with the insurer before their policies expire. “His idea was to generate fake hospital bills in the name of my clients, who would have produced these bills to the insurer to claim insurance against hospitalisation. The claims amount would have been divided among us and my client. Not only did I refuse his offer but also blocked his number,” says Mishra.

The situation is dire in remote villages. Some gram panchayats which hold sway in villages convince insurance agents to issue policies in the name of people who have died recently. They tamper with the death certificates and manage to file life insurance claim with the insurer. “When insurance executives visit to verify the claim, they threaten them. Insurers have identified such pin codes. They do not issue policies in those areas,” says an industry player who didn’t want to be named.

There were cases — during first and second wave of Covid-19 — when hospitals colluded with the policyholders to inflate medical bills so that the insurer pays the higher amount.

“Some people have made lot of money during both waves of Covid-19. Even I was approached by some to help them in filing fraud insurance claims. Such cases are more prominent in smaller cities,” says Dr Frahim Khan, head – third party insurance department at Holi Family Hospital in New Delhi.

Insurers are aware

“Our data analysis shows there has been an increase in fraud related to reimbursement claims which indicated higher inflated bills. In addition, we observed that some hospitals have been providing fake medical payment receipt vouchers, staged hospitalisation for financial benefits, and where Covid-19 cases were also submitted as a personal accident claim for financial benefits,” says Tapan Singhel, MD and CEO, Bajaj Allianz General Insurance.

Singhel further says 65% of reported fraud cases were of collusion between the hospital and beneficiary where components that were not covered by the policy were adjusted in the final bill which subsequently inflated the medical bills.

“Higher fraudulent cases were also observed in home isolation and teleconsultation cases,” he says.

Frauds happen in other insurance types too. “Someone intentionally invests a loss or plans one, such as setting a fire, causing injury, or stealing a vehicle covered by an insurance policy to obtain money from the insurer are few examples. These are hard frauds. Soft frauds or commonly known as opportunistic frauds, include exaggeration of legitimate claims made by the insured. One such example is a case of a digital device loss, wherein the insured adds an additional accessory during the claim process to cover the deductible,” says Rakesh Goyal, director, Probus Insurance.

Whopping amount

Insurance frauds cost a whopping Rs 45,000 crore every year to insurance companies, industry data shows. They lose close to 10% of their overall premium collection to frauds, suggest industry estimates.

Insurers are digitising fraud investigations to get a better crack at it. “We extensively utilise analytics, machine learning techniques, advanced investigation tools like clinical and accident reconstruction, robotic investigation tools to identify abnormal trends and accordingly investigate such claims,” says Singhel.

However, preventive measures are equally important. There is no specific provision in the Indian Penal Code for insurance frauds. If caught, in most cases, the police register a case under Section 420-cheating. A severe prosecution may only instil fear against insurance frauds.

So far as policyholders who collude with fraudsters are concerned, they must understand that such acts impact the underwriting norms of an insurance company that may result in loading of premium. Such customers get blacklisted by all insurers.