

# Prevention of Medical Insurance Fraud

## What is Medical Insurance Fraud?

Fraud is committed when a dishonest health care provider or customer intentionally submits, or causes someone else to submit, **false or misleading information**. This is done in order to obtain more payments for medical expenses than were actually incurred. Health insurance fraud can affect all parties, including UN Volunteers.

Examples of fraud or plan abuse include:

- ›› **Submitting claims for services or medication that were not received.**
- ›› **Modifying medical bills, medical records and prescriptions in view of getting reimbursed for non-covered items.**
- ›› **Using someone else's coverage or sharing membership details with anyone else, including family members.**
- ›› **Obtaining prescriptions for medications or appliances that are not needed by the patient and sold/given to others afterwards.**
- ›› **Making an agreement with a provider that misrepresents a claim in view of a higher reimbursement.**

## What are the risks?

**Fraud is a serious offence** and anyone found to have engaged in any form of fraudulent activity could find himself or herself at risk **of financial penalties, disciplinary measures**, and even **criminal charges** as the cases may be referred to the national law enforcement authorities.

## How can you help prevent fraud?

By following the below guidance, you can help to prevent fraud.

- ›› **Check whether the billed amount corresponds to the treatment you received.**
  - ›› **Ask your health care provider whenever you do not understand the billed charges, did not receive the billed service, or believe the service provided was not medically necessary.**
-

- ›› **Be careful of offers of ‘free’ medical tests or supplies in exchange for sharing a copy of your membership card.**
- ›› **Beware of publicity promising that Cigna will pay for certain care, supplies or equipment.**
- ›› **Never sign a blank document.**
- ›› **Always keep a copy of any document you sign.**
- ›› **Return any medical equipment to the supplier when you no longer need it and make sure you get a return receipt.**
- ›› **Never share your membership details or insurance certificate or access code to e-system with anyone else.**

### **How is fraud detected?**

Health insurance companies have developed **effective anti-fraud policies and practices** aimed at prevention, detection and investigation. Insurers have professional investigators and experts. They perform plausibility checks, such as matching treatments with the underlying medical conditions before they reimburse a claim. Insurance companies also conduct retrospective reviews of all historically claimed expenses through sophisticated fraud detection technology in order to identify patterns or trends in previous claims. As a result of these checks, insurance companies may ask individuals or the health care provider to provide more detailed information about the costs of medical treatment sent for reimbursement.

*For any questions or queries, please contact [support@unv.org](mailto:support@unv.org).*

---