AIT Fraud Indicators and System Flagging Rules – 2025

This document outlines key fraudulent indicators in AIT health insurance claims that may originate from members, healthcare providers, or general claim patterns. It is designed to support the configuration of automated fraud detection rules within the core insurance system, enabling timely identification and review of potentially fraudulent claims.

1. Member-Driven Fraud Indicators

Sn	Fraud Indicator	Description	Example System Rule / Action
1	Excessive claim frequency	Member submits unusually high number of claims within a short period	>3 OPD claims within 7 days
2	Multiple claims for same service/date	Member files several claims for the same procedure or consultation	Duplicate claim detection logic
3	Claims soon after joining or policy renewal	Claims raised shortly after new enrollment or renewal may indicate pre-existing or opportunistic fraud	Flag all claims <30 days from policy start
4	Unusual provider switching	Member visits many different hospitals in a short time	>3 unique providers in 30 days
5	Claiming for non-covered family members	Using policy to cover non-registered dependents	Cross-check ID numbers and relationship verification
6	High-cost drugs or procedures repeatedly claimed	Pattern of repeated expensive treatments	Rule: repeated same procedure within 14 days
7	Altered receipts or invoices	Scanned documents differ from originals or contain inconsistent metadata	Optical/fraud document check flag

2. Hospital/Provider-Driven Fraud Indicators

Sn	Fraud Indicator	Description	Example System Rule / Action
1	Upcoding	Provider bills for higher-cost procedures than those actually performed	Compare diagnosis-to-procedure cost ratio vs. benchmark
2	Unbundling of procedures	Billing separately for services normally billed together	Check for procedure package mismatch
3	Phantom billing	Charging for services not rendered	Validate patient visit confirmation (biometric, digital signature, or timestamp)
4	Excessive average billing per visit	Provider's claim average much higher than peer average	Outlier detection vs. provider type averages
5	Unusual procedure mix	Procedures inconsistent with hospital type or specialization	Flag e.g., 'Dental procedure in general hospital'
6	Frequent high-cost drug prescriptions	Pattern of expensive medication with low medical justification	AI-based anomaly detection by ICD-drug mapping
7	Identical diagnosis for multiple patients	Same diagnosis and cost for many different members	Cluster analysis on claims within timeframe
8	Backdated claims	Claims entered long after treatment date	Flag if >30 days from service date

3. General System-Level Fraud Indicators

Sn	Fraud Indicator	Description	Example System Rule / Action
1	Claim pattern anomalies	Sudden spikes in number or value of claims	Statistical anomaly detection (Z-score or ML model)
2	Mismatch between diagnosis and age/gender	Example: prostate exam for female member	Cross-check ICD vs demographic validation
3	Repetitive doctor-patient combinations	Same doctor repeatedly treating same patient for identical conditions	Frequency and pattern scoring
4	Duplicate submission channel	Same claim submitted via multiple routes (email, broker, hospital portal)	Unique claim ID or hash match
5	Weekend or after-hours claims	Unusual time-of-day or day-of-week claim timestamps	Time-based fraud rules
6	Claims from blacklisted or suspended providers	Provider has a prior fraud record	Auto-block and manual review
7	Inconsistent data formats	Missing codes, wrong currency, or altered PDFs	Automated data validation error flag