ALLIANCE-MIDMED MEDICAL SCHEME

Understanding **Healthcare Fraud** and How You Can Help **Prevent It**

What is Fraud?

Fraud is when someone intentionally deceives others for personal gain or to cause harm. In the healthcare context, it means making false claims or misrepresenting facts to get benefits that aren't rightfully deserved. Healthcare fraud is a crime that not only damages individuals but also increases costs for everyone.

How Does Healthcare Fraud Happen?

Healthcare fraud occurs when a person or entity misrepresents facts in a way that allows them to gain unauthorized benefits. This could be anything from making false claims to omitting important information.

Fraud is usually committed by:

Healthcare providers

Members

Brokers

The most common perpetrators of fraud are healthcare providers and members. When fraud happens, money that should be used for healthcare is wasted.

It's estimated that healthcare fraud costs the medical aid industry around R22 billion per year.

Examples of Healthcare Fraud:

Fraud by Members:

- Not disclosing previous medical conditions
- Submitting false or altered invoices
- Working with a healthcare provider to submit false claims
- Letting others use their medical aid card when they aren't registered dependents
- Belonging to two medical aids at the same time

Fraud by Service Providers:

- **Code manipulation:** Charging for a more expensive service than the one given
- Charging fees upfront from patients without noting them on the invoice
- Submitting claims for services not rendered, sometimes for cash
- Substituting products (e.g., giving a nebuliser but billing for an oxygen tank)
- Dispensing generic medication but charging for the original brand
- Providing unnecessary services
- Claiming for non-covered benefits under covered codes

The Impact of Healthcare Fraud

Fraud harms everyone by:

- Costing the medical aid money that could otherwise be used for actual healthcare services
- Increasing healthcare costs for all members, which can lead to higher contributions
- Requiring investigation and legal costs
- Damaging the reputation of the scheme

Consequences of Committing Fraud

For Members:

- Your membership may be terminated
- All fraudulent claims will be reversed, and you'll be responsible for paying them
- You will be reported to your employer if your contributions are subsidized
- A criminal case may be opened against you

For Healthcare Providers:

- All fraudulent claims will be reversed
- Direct payments to the provider will be stopped
- The provider will be reported to the relevant authorities
- A criminal case will be opened against the provider

How You Can Help Prevent Fraud:

- **Check your claims statements carefully** to ensure you've received the services billed by the healthcare provider.
- **Don't accept money** in exchange for submitting claims.
- **Report any suspicious behaviour** to the scheme.
- **Keep your membership number and card safe** to prevent unauthorized use.
- **Report providers** who offer to change codes or submit false claims for you.

If you know a healthcare provider or member abusing benefits, please report, anonymously if you choose, to our fraudline.

WhatsApp: 063 033 1313 **OR** Send an email to speakout@beheard.co.za

By staying alert and following these simple steps, we can all help protect our healthcare system from fraud.

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