ARTICLE 45-15
INSURANCE FRAUD

Chapter
45-15-01 Insurance Fraud

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INSURANCE FRAUD

Section
45-15-01-01 Insurance Fraud

45-15-01-01. Insurance fraud.

A person engaged in the business of insurance having knowledge or a reasonable belief that a fraudulent insurance act has been, is being, or will be committed shall provide information concerning the known or suspected fraudulent insurance act to the commissioner in writing within sixty days of having that knowledge or reasonable belief. The information may be reported on the national association of insurance commissioners uniform suspected insurance fraud reporting form, a copy of which is attached as appendix A. Thereafter, the person engaged in the business of insurance shall promptly provide to the commissioner any additional information that the commissioner may request concerning the known or suspected fraudulent insurance act. For the purposes of this rule, a reasonable belief means that the person engaged in the business of insurance has a given fact or combination of facts which in their totality result in a determination that more likely than not, a fraudulent insurance act has been, is being, or will be committed.

History: Effective March 1, 2004; amended effective April 1, 2017.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02.1, 26.1-02.1-11

Appendix A

UNIFORM SUSPECTED INSURANCE FRAUD REPORTING FORM

State of
Division of Insurance Fraud Bureau

For State Use Only
Case No: Status: FYI:

Reporting Person:	Insurance Company:	NAIC#
Mailing address:	Phone number: ( ) Fax number: ( ) E-mail address:	

Detailed synopsis. Attach additional pages, if necessary.

Date of Loss / Injury: Address of Loss / Injury: (City) (State) (Zip)	Dates of Service: to Description of Service:
Claim #	Policy #

Reserve Amount $	Amount Paid $	Date Paid	Procedure Code #'s: ☐ CPT ☐ CDT	Insurance Type ☐ PC ☐ WC
Loss Amount $	Settlement Amt. $	Date Paid	Civil Litigation Pending: ☐ Yes ☐ No	☐ HC ☐ Auto ☐ Life ☐ Disability

Subject Information

Type:	Name (Last / Business):	(First):	(Middle):	Date of birth:	Age:	SSN:

Street Address (include P.O. Box and apartment #'s):	Address Type: ☐ Res. ☐ Bus. ☐ Maildrop ☐ Other	Fed. TIN ☐ EIN ☐ Number:	Sex: M ☐ F ☐

City:	State:	Zip:	County:	Telephone No.: ( )	Phone Type: ☐ home ☐ cell ☐ bus.
Driver's License #:	State:	VIN:		Telephone No.: ( )	Phone Type: ☐ home ☐ cell ☐ bus

Vehicle Year:	Make:	Model:	License Plate #:	Reported Injuries:

Employer:	Address & Phone #:	Occupation:

Additional Party Involved ☐ AKA Information: ☐	**See Additional Party Involved/AKA Information**	Comments:

Case Details (check all that apply)

SIU Investigation Completed ☐ Yes ☐ No Date Completed:

Is there any reason to believe that this incident is related to other suspected fraudulent activity? ☐ Yes ☐ No

☐ Statements (Witness / Insured / Subject) ☐ Sworn ☐ Recorded	☐ EUO / Deposition	☐ Law Enforcement / Other Agency Reports
	☐ Copies of Receipts	☐ Claim History Extracts
☐ Proof of Loss	☐ Expert Reports	☐ IME Reports
☐ Continuance of Disability Forms	☐ Videos / Photos	☐ Investigative Reports
☐ Medical Records	☐ Claim Information	☐ External Database results
☐ Other	☐ Other	☐ Other

Identify Other Agency You Have Contacted Regarding This Referral

Agency Type: ☐ Other State Fraud Bureau ☐ Law Enforcement ☐ Other Insurance Company ☐ Regulatory Agency ☐ Other

Agency: ______________________ Contact Person: ______________________
(Address) ______________________ (City) ______________ (State) _____ (Zip) __________
Telephone ( ) ______________________ Fax ( ) ______________ Case/Claim No. ______________

Suspected Fraud Types (check all that apply)

☐ Arson
  ☐ home ☐ vehicle ☐ business
☐ Fictitious loss ☐ damages ☐
☐ Fictitious theft
  ☐ vehicle ☐ property
☐ Inflated inventory
☐ Inflated loss ☐ damages ☐
☐ Inflated theft
  ☐ vehicle ☐ property
☐ Double-dipping
☐ Exaggerated injuries
☐ Injuries not related to work
☐ Malingerers
☐ Misappropriated vehicle salvage
☐ Premium avoidance
☐ Prior injuries
☐ Slip and fall
☐ Staged injury / accident at work
☐ Staged collisions
☐ Paper accidents
☐ Other _____

☐ Agent fraud
☐ Application fraud
☐ Billing for services/products not provided
☐ Failure to disclose multiple insurance companies
☐ False claims
☐ Illegal solicitation (cappers)
☐ Issued fraudulent insurance policies, certificates, binders, ID cards
☐ Misrepresentation of services / products provided
☐ Kickbacks/bribery
☐ Money laundering
☐ Multiple claims
☐ Possession/sold fraudulent insurance policies, certificates, binders, ID cards
☐ Questioned documents
  ☐ altered ☐ forged ☐ falsified
  ☐ duplicated
☐ Received compensation for referral to health care provider or attorney
☐ Ring / organized activity type

☐ Duplicate billing for same service
☐ Forged prescriptions
☐ Fraudulent death claims
☐ Over-utilization of services
☐ Prescription abuse / doctor shopping
☐ Prescriptions issued for non-medical purposes
☐ Unbundling
☐ Upcoding
☐ Misrepresented non-covered services as covered
☐ Changing dates of service, CPT/CDT/diagnostic codes
☐ Charges inconsistent with services provided
☐ Products billed are inconsistent with the products
☐ Using unqualified/unlicensed persons to perform billable services
☐ Other

Subject / Additional Party Types

CL Claimant
IN Insured
WT Witness
LC Lawyer for Claimant
LI Lawyer for Insured
INS Insurer
SI Self-Insured
IY Insurance Company Employee
IB Agent/Broker
IS Adjuster
IR Appraiser
BS Body Shop
SY Salvage Yard Owner / Employee
TY Tow Yard Owner / Employee
MD Medical Doctor
DO Doctor of Osteopathic Medicine
DEN Dentist

PH Pharmacist
CHI Chiropractor
NP Nurse Practitioner
LPN Licensed Practical Nurse
PT Physical Therapist
PA Physician's Assistant
OP Optometrist
PO Podiatrist
RD Radiologist
MT Massage Therapist
AMB Ambulance Service Employee
DME DME Supplier
HHA Home Health Agency
MR Laboratory
MH Medical Clinic/Hospital
MZ Office Administrator
BS Billing Services

TPA Third Party Administrator
FP False Provider
UP Unlicensed Provider
MN Other Medical Personnel
MS Medical Specialist _____
DS Dental Specialist
NS Nurse Specialist _____
OT Other _____

Communications are protected under the immunity provisions of
N.D. Cent. Code § 26.1-02.1-04.

Additional Party Involved / AKA Information

Type: | Name (Last): | (First): | (Middle): | Date of birth: | Age: | SSN:

Street Address (include P.O. Box and apartment #'s): | Address Type: ☐ Res. ☐ Bus. ☐ Maildrop ☐ Other | Fed. TIN ☐ EIN ☐ Number: | Sex: M ☐ F ☐

City: | State: | Zip: | County: | Telephone No.: ( ) | Phone Type: ☐ home ☐ cell ☐ bus.

Driver's License #: | State: | VIN: | Telephone No.: ( ) | Phone Type: ☐ home ☐ cell ☐ bus.

Vehicle Year: | Make: | Model: | License Plate #: | Reported Injuries:

Employer: | Address & Phone #: | Occupation:

Involvement in referral:

Additional Party Involved / AKA Information

Type: | Name (Last): | (First): | (Middle): | Date of birth: | Age: | SSN:

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Employer: | Address & Phone #: | Occupation:

Involvement in referral:

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