

**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:	FBI:

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:			Dates of Service:                      to		
Address of Loss / Injury:			Description of Service:		
(City)                      (State)                      (Zip)					
Claim #			Policy #		
Reserve Amount \$	Amount Paid \$	Date Paid	Procedure Code #'s: <input type="checkbox"/> CPT <input type="checkbox"/> CDT		Insurance Type
Loss Amount \$	Settlement Amt. \$	Date Paid	Civil Litigation Pending: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> PC <input type="checkbox"/> WC <input type="checkbox"/> HC <input type="checkbox"/> Auto <input type="checkbox"/> Life <input type="checkbox"/> 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: <input type="checkbox"/> Res. <input type="checkbox"/> Bus. <input type="checkbox"/> Maildrop <input type="checkbox"/> Other		Fed. TIN <input type="checkbox"/> EIN <input type="checkbox"/>	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
City:	State:	Zip:	County:	Telephone No.: (    )	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.
Driver's License #:	State:	VIN:		Telephone No.: (    )	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.
Vehicle Year:	Make:	Model:	License Plate #:	Reported Injuries:	
Employer:		Address & Phone #:		Occupation:	
Additional Party Involved <input type="checkbox"/> See Additional Party Involved/AKA Information <input type="checkbox"/>		Comments:			
Case Details (check all that apply)					
SIU Investigation Completed <input type="checkbox"/> Yes <input type="checkbox"/> No			Date Completed:		
Is there any reason to believe that this incident is related to other suspected fraudulent activity? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> Statements (Witness / Insured / Subject) <input type="checkbox"/> Sworn <input type="checkbox"/> Recorded	<input type="checkbox"/> EUO / Deposition	<input type="checkbox"/> Law Enforcement / Other Agency Reports			
<input type="checkbox"/> Proof of Loss	<input type="checkbox"/> Copies of Receipts	<input type="checkbox"/> Claim History Extracts			
<input type="checkbox"/> Continuance of Disability Forms	<input type="checkbox"/> Expert Reports	<input type="checkbox"/> IME Reports			
<input type="checkbox"/> Medical Records	<input type="checkbox"/> Videos / Photos	<input type="checkbox"/> Investigative Reports			
<input type="checkbox"/> Other	<input type="checkbox"/> Claim Information	<input type="checkbox"/> External Database results			
	<input type="checkbox"/> Other	<input type="checkbox"/> Other			
Identify Other Agency You Have Contacted Regarding This Referral					
Agency Type: <input type="checkbox"/> Other State Fraud Bureau <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Other Insurance Company <input type="checkbox"/> Regulatory Agency <input type="checkbox"/> Other					
Agency: _____			Contact Person: _____		
(Address) _____		(City) _____	(State) _____		(Zip) _____
Telephone (    ) _____		Fax (    ) _____		Case/Claim No. _____	

**Suspected Fraud Types (check all that apply)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Arson<br><input type="checkbox"/> home <input type="checkbox"/> vehicle <input type="checkbox"/> business<br><input type="checkbox"/> Fictitious loss <input type="checkbox"/> damages <input type="checkbox"/><br><input type="checkbox"/> Fictitious theft<br><input type="checkbox"/> vehicle <input type="checkbox"/> property<br><input type="checkbox"/> Inflated inventory<br><input type="checkbox"/> Inflated loss <input type="checkbox"/> damages <input type="checkbox"/><br><input type="checkbox"/> Inflated theft<br><input type="checkbox"/> vehicle <input type="checkbox"/> property<br><input type="checkbox"/> Double-dipping<br><input type="checkbox"/> Exaggerated injuries<br><input type="checkbox"/> Injuries not related to work<br><input type="checkbox"/> Malingerers<br><input type="checkbox"/> Misappropriated vehicle salvage<br><input type="checkbox"/> Premium avoidance<br><input type="checkbox"/> Prior injuries<br><input type="checkbox"/> Slip and fall<br><input type="checkbox"/> Staged injury / accident at work<br><input type="checkbox"/> Staged collisions<br><input type="checkbox"/> Paper accidents<br><input type="checkbox"/> Other _____ | <input type="checkbox"/> Agent fraud<br><input type="checkbox"/> Application fraud<br><input type="checkbox"/> Billing for services/products not provided<br><input type="checkbox"/> Failure to disclose multiple insurance companies<br><input type="checkbox"/> False claims<br><input type="checkbox"/> Illegal solicitation (cappers)<br><input type="checkbox"/> Issued fraudulent insurance policies, certificates, binders, ID cards<br><input type="checkbox"/> Misrepresentation of services / products provided<br><input type="checkbox"/> Kickbacks/bribery<br><input type="checkbox"/> Money laundering<br><input type="checkbox"/> Multiple claims<br><input type="checkbox"/> Possession/sold fraudulent insurance policies, certificates, binders, ID cards<br><input type="checkbox"/> Questioned documents<br><input type="checkbox"/> altered <input type="checkbox"/> forged <input type="checkbox"/> falsified<br><input type="checkbox"/> duplicated<br><input type="checkbox"/> Received compensation for referral to health care provider or attorney<br><input type="checkbox"/> Ring / organized activity type | <input type="checkbox"/> Duplicate billing for same service<br><input type="checkbox"/> Forged prescriptions<br><input type="checkbox"/> Fraudulent death claims<br><input type="checkbox"/> Over-utilization of services<br><input type="checkbox"/> Prescription abuse / doctor shopping<br><input type="checkbox"/> Prescriptions issued for non-medical purposes<br><input type="checkbox"/> Unbundling<br><input type="checkbox"/> Upcoding<br><input type="checkbox"/> Misrepresented non-covered services as covered<br><input type="checkbox"/> Changing dates of service, CPT/CDT/diagnostic codes<br><input type="checkbox"/> Charges inconsistent with services provided<br><input type="checkbox"/> Products billed are inconsistent with the products<br><input type="checkbox"/> Using unqualified/unlicensed persons to perform billable services<br><input type="checkbox"/> Other |
|--|---|--|

**Subject / Additional Party Types**

- |                                   |                                |                               |
|-----------------------------------|--------------------------------|-------------------------------|
| CL Claimant                       | PH Pharmacist                  | TPA Third Party Administrator |
| IN Insured                        | CHI Chiropractor               | FP False Provider             |
| WT Witness                        | NP Nurse Practitioner          | UP Unlicensed Provider        |
| LC Lawyer for Claimant            | LPN Licensed Practical Nurse   | MN Other Medical Personnel    |
| LI Lawyer for Insured             | PT Physical Therapist          | MS Medical Specialist         |
| INS Insurer                       | PA Physician's Assistant       | DS Dental Specialist          |
| SI Self-Insured                   | OP Optometrist                 | NS Nurse Specialists          |
| IY Insurance Company Employee     | PO Podiatrist                  | OT Other                      |
| IB Agent/Broker                   | RD Radiologist                 |                               |
| IS Adjuster                       | MT Massage Therapist           |                               |
| IR Appraiser                      | AMB Ambulance Service Employee |                               |
| HS Body Shop                      | DME DME Supplier               |                               |
| SY Salvage Yard Owner / Employee  | HHA Home Health Agency         |                               |
| TY Tow Yard Owner / Employee      | MR Laboratory                  |                               |
| MD Medical Doctor                 | MH Medical Clinic/Hospital     |                               |
| DO Doctor of Osteopathic Medicine | MZ Office Administrator        |                               |
| DEN Dentist                       | BS Billing Services            |                               |

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: <input type="checkbox"/> Res. <input type="checkbox"/> Bus. <input type="checkbox"/> Maildrop <input type="checkbox"/> Other		Fed. TIN <input type="checkbox"/> Number:	EIN <input type="checkbox"/> Sex: M <input type="checkbox"/> F <input type="checkbox"/>
City:	State:	Zip:	County:	Telephone No.: ( )	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.	
Driver's License #:	State:	VIN:		Telephone No.: ( )	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> 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:
Street Address (include P.O. Box and apartment #'s):			Address Type: <input type="checkbox"/> Res. <input type="checkbox"/> Bus. <input type="checkbox"/> Maildrop <input type="checkbox"/> Other		Fed. TIN <input type="checkbox"/> Number:	EIN <input type="checkbox"/> Sex: M <input type="checkbox"/> F <input type="checkbox"/>
City:	State:	Zip:	County:	Telephone No.: ( )	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.	
Driver's License #:	State:	VIN:		Telephone No.: ( )	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> 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:
Street Address (include P.O. Box and apartment #'s):			Address Type: <input type="checkbox"/> Res. <input type="checkbox"/> Bus. <input type="checkbox"/> Maildrop <input type="checkbox"/> Other		Fed. TIN <input type="checkbox"/> Number:	EIN <input type="checkbox"/> Sex: M <input type="checkbox"/> F <input type="checkbox"/>
City:	State:	Zip:	County:	Telephone No.: ( )	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.	
Driver's License #:	State:	VIN:		Telephone No.: ( )	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.	
Vehicle Year:	Make:	Model:		License Plate #:	Reported Injuries:	
Employer:		Address & Phone #:			Occupation:	
Involvement in referral:						

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Type:	Name (Last):	(First):	(Middle):	Date of birth:	Age:	SSN:
Street Address (include P.O. Box and apartment #'s):			Address Type: <input type="checkbox"/> Res. <input type="checkbox"/> Bus. <input type="checkbox"/> Maildrop <input type="checkbox"/> Other		Fed. TIN <input type="checkbox"/> Number:	EIN <input type="checkbox"/> Sex: M <input type="checkbox"/> F <input type="checkbox"/>
City:	State:	Zip:	County:	Telephone No.: ( )	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.	
Driver's License #:	State:	VIN:		Telephone No.: ( )	Phone Type: <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> bus.	
Vehicle Year:	Make:	Model:		License Plate #:	Reported Injuries:	
Employer:		Address & Phone #:			Occupation:	
Involvement in referral:						