What is fraud?
It’s any act or attempt by someone to collect money from an insurance company through deception, whether it’s outright lying, or a slight “bending of the truth”. Fraud can be perpetrated by anyone, including the insured, the uninsured, dishonest employees, lawyers, doctors, unscrupulous insurance agents, and of course, common criminals.

Insurance fraud costs Americans at least $80 billion a year, nearly $950 for each family, according to the Coalition Against Insurance Fraud. Healthcare fraud alone costs Americans $54 billion a year from acts that include everything from fudging on legitimate insurance claims to lying about how, where, and to what degree injuries occurred, to actually staging phony accidents.

What we’re doing about it.
At the Physician Network, we’ve been fighting medical insurance fraud for over fifteen years. Our experienced staff of medical practitioners is skilled in identifying and documenting fraud and providing the following services:

- Medical record reviews
- Independent medical evaluations
- Pattern and practice analysis
- Expert witnesses
- Anti-fraud training
- Investigative services (strategic partner)
- Litigation support services (strategic partner)

It’s enough to make you sick.
Unfortunately, the current system indirectly encourages fraudulent behavior. In fact a recent consumer survey revealed the shocking fact that 70% of those surveyed thought it was OK to cheat on insurance claims and 40% thought cheating shouldn’t be punished because insurers deserve to lose money. The reality is that there are too many healthcare providers enabling claimants to defraud insurance companies. Sadly, there are also healthcare providers engaged in schemes designed to defraud the insurance industry.

Medical insurance fraud is by far the biggest threat facing the insurance industry today. With total annual losses well over one trillion dollars, insurance fraud is a problem that affects everyone -- insurers, doctors, governments, and taxpayers.