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Regarding Applicant or Claimant or Insured
- Advises that they were referred to doctor or attorney by an individual at the scene.
- Applicant is unsolicited, new “walk-in” business, not referred by existing policyholder.
- Applicant refuses or cannot produce current identification and/or driver’s license, or has a temporary, recently issued, or out-of-state driver’s license/state identification card.
- Does not provide a telephone number or states they do not have a home telephone or cellular phone and/or they will contact the adjuster.
- Individual is difficult to contact.
- Individual is overly pushy, aggressive or demanding for a quick, and sometimes reduced settlement (possibly to avoid providing additional documentation).
- Individual is reluctant to use mail or telephone; provides all documents and handles all business transactions in person.
- Individual is willing to accept an inordinately small settlement rather than document all claim losses.
- Individual requires that they pick up the check from the insurance company.
- Is unusually familiar with insurance terms or procedures such as medical terminology, workers compensation claim handling procedures and laws, vehicle repair terminology, coverage and special limits.
- Neither works nor resides near the agency (if an in person application).
- One or more claimants or insured list a post office box (mail drop) or hotel as address.
- One or more parties in collision may be employed in professional law office, clinic, billing service organization or check cashing agency.
- Parties have a history of prior claims (often of similar type losses).

Regarding Attorney Involvement
- All claimants represented by the same attorney or law firm.
- Attorney becomes involved early in the claim process.
- Attorney lien or representation letter is dated the day of or soon after the reported incident.
- Attorney refuses to allow insured/claimant to appear for statements or IME.
- Attorney reports claim to insurance company.
- Attorney solicits new clients at the clinic (and the insured/claimant is not provided a choice of attorneys).
Individual initially wants to settle with insurer, but after retaining an attorney, complains of increased subjective injuries.
Legal representation is contacted/obtained immediately after the accident/incident is reported.
Medical bills and narrative reports are sent from the attorney’s office.
Numerous prior questionable claims from the same attorney.

Regarding Automobile Accident Schemes
Accident occurs shortly after one or more of the vehicles were rented, purchased or registered.

Regarding Claim
All occupants provide the same facts regarding the accident, in many cases using the same exact wording - they may have been coached.
Claimant denies or has excuses for waving insured to proceed.
Description of the loss is inconsistent with the claimed injuries (e.g. the injured person claims the vehicle was moving at an excessive rate of speed yet only soft tissue injuries claimed).
During the insurance company interview, individuals can’t recall where they were seated in the vehicle at the time of the accident.
Individual cannot identify other vehicle in “hit and run” injury loss.
Individuals cannot remember why or where they were going, where they were coming from and why other passengers’ stories are different.
Injuries are inconsistent with the collision (e.g. extensive injuries with very low speed impact).
Insured advises that while waiting for police, the unknown mystery vehicle was seen driving past the accident scene.
Involved parties claim no previous connection, but are associated in prior claims.
Number of occupants on police report differs from insurance company report.
Parties involved in the accident know each other, work together, live together, are neighbors, or in the same geographical area or are from the same country or ethnic background.
Police report was taken over the telephone or via walk-in no on scene investigation.
Statements given on police report do not match statements given to insurance company.
The same witness appears in prior claims (often with other insurance companies and with similar circumstances).

Regarding Damage
Damage to vehicles is inconsistent with accident facts.
Signs of pre-existing damage to claimant vehicle.

Regarding Diagnosis
Claimant/Insured(s) have the same or similar soft tissue injury.
Commonly refer patients for a “second opinion”.
Injuries are subjective (e.g. pain, headaches, nausea, inability to sleep, depression, dizziness and soft tissue).
Medical records do not explain excessive, expensive medical testing/treatment.

Regarding Facility/Operation
Alleges they were contacted by telephone by an unknown person who advised them to seek treatment at a specific clinic/provider.
Can’t provide a description of the clinic or medical provider.
Ownership of clinic is questionable.
Regarding Incident
- Accident occurs late at night in a secluded area.
- Insured advised that claimant waved them on to proceed and then struck them.
- Insured describes swoop and squat scenario.
- Insured indicates that claimant's brake lights never came on.
- Insured indicates that the driver of claimant's vehicle and mystery vehicle appear to have been talking on the phone just prior to the collision.
- Insured indicates two occupants in claimant's vehicle and one was looking back at insured just prior to the collision.
- Private property collision, no accident report taken.
- Unknown mystery vehicle cuts off claimant's vehicle causing the accident.
- Vehicle has numerous passengers claiming the same type of injuries.
- Witness or driver is over eager and is too willing to be involved and/or accept blame for an accident.

Regarding Medical Bills
- Billing for daily treatment for an extended period of time.
- Continuous billing for comfort modalities for an extended period of time.
- Duplicate bills for same type of treatment with a different procedural name (e.g. electrical stimulation and TENS unit).
- MRI bills appear early on in the treatment and repeated again in later treatment.
- Medical bills are not on a standard HCFA form or CMS 1500 form.
- Medical provider bills for new patient visit, but insured/claimant advised that the doctor only spent a few minutes with them or they didn't see the doctor.
- Physical Therapist is affiliated with the clinic.
- Repeated billing by the medical provider for extensive established patient visits (e.g. repeated bills for X-rays on a soft tissue injury).
- The treatment requires a licensed medical professional, but the provider is not licensed.

Regarding Medical Fraud/Claim Inflation
- Accident occurs in a different state than the policy where there are higher limits and therefore higher coverage will apply to the claim.
- All of the injured individuals submit medical bills from the same doctor or medical facility and/or use same attorney.
- Clinic/Medical facility does not have patient sign-in sheets or patient signatures appear to be signed all at one time.
- Medical bills indicate routine treatment being provided on Sundays, holidays, or other days that facilities would not normally be open.
- Narrative reports submitted appear to be templates.
- Same treatment prescribed for all patients in spite of different accident facts.
- The patient's signature appears several times on the same sign in sheet.

Regarding Medical Treatment
- Clinic treats injured family members on different days.
- Does not use their regular family physician.
- Individuals travel across town to receive medical treatment.
- No injuries reported at the scene, but within a short period of time after the accident medical bills are submitted for treatment of injuries.
- On-the-scene treatment is refused.
Patients in one claim all receive the same treatment (same treatment dates, same examination/progress reports, etc.).

Provider only treats patients that are represented by an attorney.

Same type of treatment is given to children and adults.

Treatment continues with no changes in plan.

Treatment plan exceed 90 days with no evaluations during the 90-day period.

Unable to describe medical treatment received.

Regarding Payment

Insurance premium was paid in cash or a combination of credit card and cash.

Regarding Policy/Coverage

Losses occur just before/after coverage takes effect, just before it ceases, just after it has been increased, or after a cancellation notice has been sent.

Policy obtained from an agent not located in the close proximity to insured’s residence or work.

Policy purchased online, by mail or phone without face-to-face contact.

Regarding Professional Issues

Attorney, body shop and clinic frequently appear linked together in other claims with various insurance carriers, producers/agents.

Attorney/Medical provider is not located near the claimant/insured’s residence.

Body shop employees or owners have been known to provide referrals and/or transportation to the attorney’s office or a medical clinic.

Body shop employees or owners have personal claims with attorney or clinic.

Producer/Agent linked in other claims with body shops, clinic or attorney’s office.

Provider/Clinic doesn’t allow a clinic inspection to be conducted or makes scheduling an inspection appointment very difficult.

Vehicle owner referred to repair shop, attorney and/or doctor by tow truck driver.

Regarding Specific CPT Codes

Unbundling of CPT Codes.

Regarding Vehicle and/or Vessel

All vehicles in a reported accident are taken to the same body shop or shops that may be owned by the same person(s).

Claimant’s vehicle is not insured.

Claimant’s vehicle is older model and insured’s vehicle is a high value, newer model.

Discrepancies with true ownership of the vehicle.

Insured’s vehicle is owned by a large commercial business (e.g. UPS, trucking firm, etc.).

Vehicle has recent state registration.

Vehicle has theft, claims and/or salvage history.

Vehicle is rental.

Vehicle purchased/rented out-of-state or area (often for cash).

Vehicle registered to someone other than the insured or claimant.

Vehicle was very recently purchased.
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Regarding Applicant or Claimant or Insured

- Business telephone number is connected to an answering machine or answering service during normal business hours.
- Claimant started employment shortly before accident occurred.
- Efforts to verify lost wage statement with employer raise doubts about employer’s legitimacy, or about the actual employment of the individual.
- Employment information is for an unknown business, an answering machine “message” that doesn’t sound legitimate, often with a post office box for its address, or a street address in a residential area.
- Individual is going to be out of town soon due to death or sickness in family, on vacation, or is a transient/moving.
- Individual is reluctant to use mail or telephone; provides all documents and handles all business transactions in person.
- Is unusually familiar with insurance terms or procedures such as—medical terminology, workers compensation claim handling procedures and laws, vehicle repair terminology, coverage and special limits.
- Lost earnings statement is handwritten or typed on blank paper, not business letterhead.
- One or more claimants or insured list a post office box (mail drop) or hotel as address.
- Provided an incorrect address.
- Threatens to obtain an attorney or go to a physician for further medical treatment if the claim is not quickly settled (but may delay doing so).

Regarding Attorney Involvement

- Attorney lien or representation letter is dated the day of or soon after the reported incident.
- Claimant has previously been represented by the same attorney or law firm on prior slip and fall claims.
- Legal representation is contacted/obtained immediately after the accident/incident is reported.
Regarding Automobile Accident Schemes
- Accident occurs shortly after one or more of the vehicles were rented, purchased or registered.
- Despite expensive damage claims, the vehicle remains drivable. Often there are no towing charges for removing the vehicle from the scene of the accident.
- Has no record of prior insurance coverage although damaged vehicle was purchased much earlier than inception of policy and date of loss.
- ISO ClaimSearch has a history of accidents within a short period of time (especially on one policy).
- No police report in situations where police would normally investigate or an over-the-counter report for an accident resulting in multiple injuries and/or extensive physical damage.
- Serious accident with expensive physical damage claim, but only minor, subjectively diagnosed injuries, with little or no medical treatment.
- The kind of accident or type of vehicles involved is not typical of those seen on a regular basis.

Regarding the Claim
- Identified in previous NICB Questionable Claims.
- Involved parties claim no previous connection, but are associated in prior claims.

Regarding Diagnosis
- All injuries are subjectively diagnosed, such as headaches, muscle spasms, strains, sprains, traumas and others.

Regarding Incident
- Insured, even though legally liable for accident, is adamant that claimants were responsible for accident, indicating that the insured may have been “targeted” by the claimants for a caused accident.
- Reported accident occurred on private property near residence of those involved.
- Vehicle has numerous passengers claiming the same type of injuries.
- Vehicle was struck by a rental vehicle soon after the rental had occurred.
- Witness or driver is over eager and is too willing to be involved and/or accept blame for an accident.

Regarding Medical Bills
- Medical bills submitted are photocopies of originals.
- Summary medical bills are submitted without dates and descriptions of office visits and treatments, or treatment extends for a lengthy period without any interim bills.

Regarding Medical Fraud/Claim Inflation
- All of the injured individuals submit medical bills from the same doctor or medical facility and/or use same attorney.
- Medical bills indicate routine treatment being provided on Sundays, holidays, or other days that facilities would not normally be open.
- Minor accident produces major medical costs and often lost wages, household help, transportation and unusually expensive demands for pain and suffering.
- Past experience demonstrates that the physician’s bill and report, regardless of the varying accident circumstances, is always the same in terms of duration and type of therapy.
- Same treatment prescribed for all patients in spite of different accident facts.
- The patient’s signature appears several times on the sign in sheet.
- Treatment extends for a lengthy period without interim bills.
Regarding Medical Treatment

- Individuals travel across town to receive medical treatment.

Regarding Policy/Coverage

- Accident occurred after the addition of comprehensive and collision coverage to the policy and/or a decrease in deductible.

Regarding Slip & Falls or Food Products Liability

- No supporting evidence of foreign or contaminated substance; individual threw food out and has only the can, box or wrapper.
- Use of prop (broken glass, broken dental plate, etc.) to support or inflate the claim.

Regarding Vehicle and/or Vessel

- All vehicles in a reported accident are taken to the same body shop or shops that may be owned by the same person(s).
- Individual has a history of vehicle/vessel theft claims.
- No lien holder is reported (especially if new and/or high value vehicle purchased with cash).
- Vehicle driven by the insured person is an old “clunker” with minimal coverage.
- Vehicle hidden or enclosed by other vehicles so adjuster cannot take full pictures or conduct a complete inspection of vehicle.
- Vehicle is not to be repaired locally (in some instances driven or shipped out-of-state for repair).
- Vehicle is repaired and/or damaged parts removed before damage can be inspected.
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Regarding Applicant or Claimant or Insured

► Individual cannot recall place and/or date of purchase for newer items of significant value.
► Individual indicates distress over prospect of an examination under oath.
► Individual is overly pushy, aggressive or demanding for a quick, and sometimes reduced settlement (possibly to avoid providing additional documentation).
► Individual is willing to accept an inordinately small settlement rather than document all claim losses.
► Is unusually familiar with insurance terms or procedures such as- medical terminology, workers compensation claim handling procedures and laws, vehicle repair terminology, coverage and special limits.

Regarding Catastrophe Indicators Concerning Fire/Flood Losses

► Although the renter maintains a tenant policy, landlord claims tenant’s contents.
► Insured property was not located in major damaged area.
► Property was in poor condition prior to loss.
► Vacated rental property claimed as primary residence.

Regarding Claim

► Claims the identical items under different policies or with a different insurance company.
► Incorrect or no sales tax on receipt.
► Individual indicates property or auto is unavailable for inspection/viewing.
► Individual over-documents losses with a receipt for every loss and/or receipts for older items of property.
► Individual provides credit card receipts with incorrect or no approval code.
► Individual provides receipt(s) with no store logo (blank receipt).
► Individual provides receipts from same supplier with sequence numbers in reverse order of purchase date.
► Individual provides receipts/invoices from same supplier that are numbered in sequence.
► Individual provides single receipt with different handwriting or typefaces.
► Individual provides two different receipts with same handwriting or typeface.
► Insured claims unrepaired damage from a previous disaster.
► Loss inventory indicates unusually high number of recent purchases.
► Owner cannot provide original receipt, bank or credit card records and/or has lack of documentation for the loss or damaged property, recently purchased items, and high valued items.
► Provides numerous receipts for inexpensive items, but no receipts for items of significant value.
► Unable to provide proof of identity and/or home ownership.
Regarding Facility/Operation

- Arrives at loss site without being solicited.
- Contractor or public adjuster initiates contact with the building owner and solicits the claim.
- Have inadequate equipment and/or staff to perform repairs/restoration/cleaning (non-vehicle).

Regarding Insured with Catastrophe Coverage

- Extensive commercial losses occur at site where few or no security measures are in effect.
- Individual declares extensive losses without physical evidence, photographs or documented receipts.
- Investigation reveals absence of family photographs, heirlooms or items of sentimental value.
- Items claimed cannot physically fit in existing floor space.
- Items claimed do not match individual’s life-style, décor, house, occupation or income.
- Lack of carpet indentation from alleged large furniture or appliances.
- On scene investigation reveals absence of remains of items claimed and normally found in a home or business.

Regarding Insured without Catastrophe Coverage

- Affected area was not evacuated.
- Individual can’t properly describe item’s function or features.
- Individual claims items were new.
- Insured had all cash purchases.
- Insured submits a theft claim as a result of looting.
- Lack of security in the area (resulting in theft).
- Name or address on receipt does not match insured’s name and/or address.
- No or very few homes or businesses were damaged or destroyed in the affected area.

Regarding Professional Issues

- Business is not bonded or is underinsured.
- Business/Contractors/Cleaning company are not licensed or are newly licensed.
- Contractor does not maintain a local office and/or have a local telephone number.
- Contractor is not able to provide references.
- Contractor wants “cash” for payment or down payment prior to starting work.
- Offers below market prices - “too good to be true.”
- Offers cash incentives to get the job.

Regarding Work Performed and Supporting Documentation

- Estimate is very general - lump sum.
- Multiple contractors using same license.
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**Regarding Facility/Operation**

- A business with several locations rarely bills using “metropolitan” area rates.
- Adding chargers to the bill for tinting, VIN etching, molding, clean up, hazardous waste disposal and other miscellaneous charges.
- Additional claims on the same policy after the initial glass work is performed (these additional glass work claims can be submitted as soon as the next day or years later).
- Billing for “back” or “quarter panel” glass when less expensive windshield glass was actually installed.
- Billing for replacement when only repairs were done or billing for repairs when there was no actual work done at all.
- Billing for substandard, incomplete repairs.
- Billing for the most expensive glass - sometimes called Original Equipment Manufacturer (OEM) glass - or billing for “back” glass or “quarter” glass (higher priced pieces of glass) when the windshield (lesser priced glass) was actually installed.
- Bills all seem to have the same miscellaneous charges.
- Bills are submitted weeks or months after the work was done.
- Bills from the glass repair company always comes from a rural address.
- Facility nearly always bills for maximum allowable amount of repairs.
- Facility with known metropolitan address consistently bills using “rural” area rates.
- Local Better Business Bureau has record of consumer complaints.
- No record of supplies delivering parts/glass to facility in rural areas.
- Operation is “mobile” with no fixed location.
- Owner/Employees avoid appointments for interviews.
- Owner/Employees avoid appointments for site/facility inspection.
- Owner/Employees avoid producing paperwork for claim(s) in question.
- Previous instances of questionable activity concerning glass claims.
- Repairing and billing for chips/cracks not needing repair.
- Site visit or other means verifies the facility address as a mail drop or shell/sham/ghost shop (usually in a rural area).
- Some glass companies submit legitimate initial claims but then submit additional fraudulent claims after they have the policy information. This can be accomplished by impersonating the insured.
The glass repair/replacement facility always bills for the maximum number of repairs (even if there are less) knowing the insurance company will pay for this number of chips/cracks to be repaired.

The unscrupulous glass repair/replacement facility bills the insurance company for specialty glass (such as heated, Original Equipment Manufacturer Glass or Heads Up Display compatible) when the insured’s vehicle did not have this kind of glass.

Unusually high percentage of claims having “add-on” charges.

Unusually high percentage of claims having replacement versus repair.

Unusually high percentage of claims with specialty glass.

**Regarding Glass Repair Fraud Indicators Provided by the Policyholder**

- Owner states having no knowledge of any glass claims being made on their policy.
- Owner states no glass repair/replacement work was done on their vehicle.
- Owner states no knowledge of miscellaneous charges included in the bill.
- Owner states the “sales tactics” were aggressive (often targeting youthful drivers or seniors).
- Owner states the glass was repaired and not replaced.
- Owner states the work was done at one location however the bill states another location.
- Owner states their vehicle received a full service wash shortly before the bill was submitted.
- Owner states their vehicle was “serviced” shortly before the bill was submitted.
- Owner states they did not call in the claim (owners have been impersonated by repair facility).
- Owner states they did not know about the damage until the “recruiter” pointed it out.
- Owner states they did not order any “add-ons” or specialty glass.
- Owner states they did not provide their insurance information to anyone.
- Owner states they were “pressured” to have the repair/replacement done immediately.
- Owner states they were “recruited” by the facility with offers of gifts and/or waived deductibles.
- Owner states they were “recruited” while getting gas, an oil change, car wash, etc.
- Owner states they were advised continued driving with damaged glass was illegal.
- Owner states they were advised the damaged glass would shatter if they continued driving.
- Owner states they were offered free estimates for providing their insurance information.
- Owner states they were offered incentives for repairs and/or offered the repairs for “free”.

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**Regarding Applicant or Claimant or Insured**
- Individual is overly pushy, aggressive or demanding for a quick, and sometimes reduced settlement (possibly to avoid providing additional documentation).
- Individual is willing to accept an inordinately small settlement rather than document all claims losses.
- Is unusually familiar with insurance terms or procedures such as- medical terminology, workers compensation claim handling procedures and laws, vehicle repair terminology, coverage and special limits.
- Parties have a history of prior claims (often of similar type losses).

**Regarding Claim**
- An apparent random or unreported storm.
- Friend brings vehicle in for inspection, but the friend doesn’t know any details of the loss (e.g. where vehicle was located or when loss occurred).
- Vehicle/Structure was in poor condition prior to the storm (e.g. bad motor, transmission, roof, siding).

**Regarding Claim Reporting**
- Contractor, roofer or storm chaser reports the claim.
- Initial damage report appears to have been significantly delayed.

**Regarding Damage**
- All dents are the same size and depth (real hail dents vary in size) or all have similar markings at the deepest part of the dent.
- Damage or pattern or spacing is consistent all over surface rather than random.
- Damage/Dents inconsistent with the reported size of hail.
- Damaged surfaces did not face the oncoming storm.
- Damages look like hammer marks and/or are cuts rather than dings.
- Dents are deeper than wider.
- Individual reports damage was done to a specific part of the vehicle/structure.
- No other claims or structure/vehicle damage in area where the claimed loss occurred.
- Owner cannot provide documentation confirming prior damage has been repaired.
- Paint is scratched or removed at the point of the dent.
- Paint oxidation, coloration and age in the bottom of the dents are consistent with the undamaged areas.
- Weather damage inconsistent with the claimed loss.
Regarding Policy/Coverage
- Individual contacts agent to verify coverage or extent of coverage or to increase coverage just prior to loss date.

Regarding Structure
- Damage only in center of roof.
- Damage only on edges of roof.
- Damages only on vertical surfaces and not horizontal surfaces (or vice versa).
- No air vents or gutter damage.
- No window or screen damage.
- One neighborhood with several homeowners being solicited by the same roofer.

Regarding Vehicle and/or Vessel
- Car was recently purchased in an “as is” condition.
- Comprehensive coverage on older car where the premium outweighs the value of the vehicle.
- Damage only appears on a specific part of the vehicle (e.g. hail damage to the hood but not the roof of the car).
- Damages are on low parts of the vehicle that wouldn’t normally be exposed.
- Estimation services show records of similar, previous hail damage.
- Hail damage on one vehicle is not consistent with damage seen on other vehicles damaged in the same area.
- Hail markings appear on all four sides of vehicle.
- No damage to side panels.
- The vehicle was waxed or buffed shortly after the alleged damage occurred.
- Trim pieces are not damaged.
- Vehicle not parked under available protective cover (e.g. a garage).
- Windshield and rear windows are chipped.
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Regarding Attorney Involvement
- Attorney is listed as the insurer on the medical bill.
- Legal representation is contacted/obtained immediately after the accident/incident is reported.
- Medical bills and narrative reports are sent from the attorney’s office.
- The same attorney appears in all BI/WC cases involving a particular medical provider.

Regarding Claim
- Damages/losses presented by one or more parties are inconsistent with facts of loss/accident (lack of injury/damage causing mechanism, etc.).

Regarding Diagnosis
- A test or series of diagnostic imaging tests is given to all patients at a clinic or medical office regardless of injury.
- Alleged injury relates to a pre-existing injury or health problem.
- Bills for diagnostic imaging are submitted without supporting documentation such as reports.
- Commonly refer patients for a “second opinion”.
- Comparison diagnostic tests are ordered by provider (e.g. performing a diagnostic test on an uninjured joint so the results can be “compared” to the diagnostic test results from the injured joint).
- Diagnosis in the bill is not supported by other documentation.
- Diagnostic imaging is not consistent with the nature of the injury or treatment.
- Diagnostic imaging is performed on several separate visits rather than one.
- Diagnostic testing (X-rays, EMG testing, MRIs, etc.) is performed often and early in the treatment.
- Diagnostic testing is billed repeatedly without a report of a worsening condition in objective findings or a report of a new injury.
- Discrepancies exist between the locations of diagnostic imaging testing (and other types of tests) and the person interpreting the test.
- Electrocardiograms (ECGs or EKGs) are administered to patients with no complaints or conditions.
- Evidence exists of payments/commissions from a diagnostic test provider to the ordering practitioner.
- Injuries are subjective (e.g. pain, headaches, nausea, inability to sleep, depression, dizziness and soft tissue).
Insured questions the amount of diagnostic imaging tests ordered.
Medical records do not explain excessive, expensive medical testing/treatment.
Mobile unit performs neurological or other tests, which are read at remote locations.
Multiple diagnoses are indicated.
Multiple diagnostic procedures are billed with separate CPT codes when there is a CPT code that includes all of the billed procedures.
Patient does not know the result of the diagnostic test(s).
Patient's account of diagnosis process is inconsistent with the actual test.
Range of motion (ROM) tests are conducted frequently.
Specialized equipment is required for diagnosis but the injured person cannot describe the equipment or procedure.
Surface EMGs (SEMG) are used for diagnoses.

Regarding Facility/Operation
Claims representative receives a sudden flood of medical bills from one new center/clinic.
Clinic/Center was recently incorporated.
Contact with clinic/center is difficult.
Equipment and treating facility is out-of-date, broken or inconsistent with treatment billed.
New or unknown diagnostic clinic/center.
No request, reports, or any indication the treatment was needed or conducted prior to receiving the medical bill.
Office/building has no furniture.
Ownership of clinic is questionable.
Provider utilizes established and trusted files, members, insured, patients, and doctor’s information without their knowledge.
Telephone for the clinic/center is not listed on the medical bills.
The Tax ID number provided is real, but medical identity theft is suspected.
The building is too small to operate a clinic/center.
The clinic/center address is a P.O. Box number.
The date(s) of medical service(s) is prior to the date the clinic/center was established.
The location of the clinic/center is in a deteriorating or unsafe part of town.
The physical address of the clinic has inadequate, inconvenient, or no parking for patients and staff.
The word “Diagnostic” appears in the name of the facility submitting the medical bill.

Regarding Incident
Vehicle has numerous passengers claiming the same type of injuries.

Regarding Medical Bills
1500 Bill does not show the injury as auto accident or workplace related.
A physician bills out of multiple offices on one day (treatment time is more than possible for one day).
Amounts billed for are much more than other providers (of the same specialty) charge.
Billing and coding for cervical, thoracic, and lumbar x-rays when a full spine x-ray was performed.
Billing for daily treatment for an extended period of time.
Billing for quantitative testing but performing qualitative testing.
Billing for thermography studies.
Bills are submitted by billing or medical finance companies and not the provider.
Bills are submitted in “bulk” just before the time deadline.
Bills are submitted months after treatment is rendered.
Bills are submitted without appropriate supporting documentation (e.g. PT worksheets or diagnostic imaging reports).
Bills are templates or prepared forms that do not document the actual facts of a patient’s case.
Bills for E&M provide little or no detail but the CPT code billed reflects an office visit of high complexity, comprehensive history/exam, etc.
Bills include high dollar additions for off-site system and surgical monitoring for surgical procedures (e.g. by doctors who are not even in the room at the time of the surgery).

CPT codes are billed for the treatment which is usually not associated with the particular diagnosis/ICD code.

Continuous billing for comfort modalities for an extended period of time.

Contradictions are revealed when comparing the bills to other documents or sources of information.

DME billed for multiple patients is the same.

Duplicate bills for same type of treatment with a different procedural name (e.g. electrical stimulation and TENS unit).

Durable medical equipment (DME) bill shows charges for equipment not in the doctor’s order or patient’s receipt.

Durable medical equipment (DME) bill shows markups for equipment in excess of your state’s standards for such markups.

Emergency services are billed by providers (providers say they provided services on a day when their office is routinely closed).

MRI bills appear early on in the treatment and repeated again in later treatment.

Medical bills accrued for the injury have a higher dollar value compared to the other providers treating patients for similar injuries.

Medical bills are not on a standard HCFA form or CMS 1500 form.

Medical provider bills for new patient visit, but insured/claimant advised that the doctor only spent a few minutes with them or they didn’t see the doctor.

Multiple providers in one office all treat the patient on the same day.

Multiple time-based modalities are billed for the same treatment session, resulting in the patient being in treatment for two or more hours (including acupuncture and massage).

Patient cannot describe the physical aspects of items appearing on the bill (e.g. ROM test exercises).

Patient indicates the provider listed on the bill is not the same person providing treatment.

Patient is quoted a treatment price but the bill shows a much higher amount.

Patient refutes charges.

Provider bills a referral fee for medical services that were never rendered.

Provider bills cancellation charges for office visits that were not originally scheduled.

Provider bills for an examination and treatment when in fact no treatment was provided.

Provider bills for medical supplies that were not used.

Provider bills for medical tests or evaluations that were not conducted.

Provider bills for office visits that were not made.

Provider bills for treatment that was not provided.

Provider bills global codes then later billing separately for the technical or professional.

Provider bills global diagnostic CPT code without the necessary diagnostic equipment (e.g. an x-ray machine) located at the provider’s facility.

Rehabilitation or physical therapy bills are not supported by worksheets showing the who, what, when, where, effectiveness of the treatment program, and/or modification if not successful.

Repeated billing by the medical provider for extensive established patient visits (e.g. repeated bills for X-rays on a soft tissue injury).

Summary medical bills are submitted without dates and descriptions of office visits and treatments, or treatment extends for a lengthy period without any interim bills.

TENS unit bills are very expensive (often billing for more advanced units without attempting treatment with basic, less expensive units first).

TENS unit bills include frequently billed supplies such as electrodes and batteries (charges may also be excessive).

The physician’s bill and report, regardless of the varying accident circumstances, is always the same.
The treatment requires a licensed medical professional, but the provider is not licensed.

Use of a Technical (TC) or Professional (PC) component modifier with a diagnostic procedure CPT code billed in conjunction with the applicable global diagnostic CPT code.

**Regarding Medical Fraud/Claim Inflation**

- Boilerplate and matching reports from providers are present in claim file during review CPT codes appear “inflated” or “up-coded”.
- Clinic has continued billing or treatment irregularities.
- Clinic/Medical facility does not have patient sign-in sheets or patient signatures appear to be signed all at one time.
- Doctor’s notes contain no indication of checking the patient’s treatment progress/improvement of symptoms.
- Injured party’s address is located unusually far from the clinic/center.
- Medical bills indicate routine treatment being provided on Sundays, holidays, or other days that facilities would not normally be open.
- Minor accident produces major medical costs and often lost wages, household help, transportation and unusually expensive demands for pain and suffering.
- Narrative reports submitted appear to be templates.
- No changes in treatment plan after several treatment sessions have been rendered and extensive diagnostic testing (EMG, NCV, MRI etc.) is performed.
- Office visits extend daily for more than five consecutive days or continue for more than one week.
- Patients are at or near the age of eligibility for Medicare when they are first injured and begin treating.
- Patient is unable to describe the doctor or office location.
- Patient’s residence is not near treatment facility.
- Reports for initial exams, follow-ups, consultations, etc. provide little or no detail, but the CPT code billed reflects high complexity, comprehensive history/exam, etc.
- Same treatment prescribed for all patients in spite of different accident facts.
- Significant lapse between when the alleged service was provided and when the medical bill is received.
- The date(s) the medical service(s) was provided is on a weekend or holiday or during hours the clinic is not open.
- The patient decides to go back to work on their own despite the doctor classifying them with a total disability.
- The patient’s signature appears several times on the same sign in sheet.
- Treatment extends for a lengthy period without interim bills.

**Regarding Medical Treatment**

- Chiropractic treatment extends beyond the typical number of visits (approx. 30-34) for simple soft tissue injuries.
- Claimant is receiving treatment from a “known” medical provider.
- Clinic treats injured family members on different days.
- Clinic treats several or all of the claimants on same day.
- Doctor’s initial exam reports are “fill in the blank” boilerplate reports.
- Durable medical equipment (DME) given to all injured persons is the same regardless of diagnosis.
- Durable medical equipment (DME) is dispensed without instructions for use.
- Evidence that all patients see a neurologist (or other specialty) regardless of diagnosis.
- Injury progression is atypical and seems to require extended treatment (often extending beyond estimated “discharge date”).
- Medical treatment is given by receptionists or other non-medical personnel.
- Minor injury results in a network of treatment providers, diagnostic procedures, and treatments.
- Multiple treatment procedures are billed using separate CPT codes when there is a CPT code that includes all of the billed procedures.
No referral is made to another specialist for evaluation when no progress is made after four weeks of treatment.

Pain management protocol is not modified (treatment is continued) even when not effective.

Passive treatment modalities are used exclusively without encouraging use of a home program of exercises/activity.

Patient is seen multiple days in a row.

Patient's account of the treatment process is inconsistent with bill.

Patients are seen only by a chiropractor on the initial visit, yet proceed to get treatment and multiple modalities (acupuncturist, physical therapist, neurologist, etc.) before seeing a medical doctor.

Patients in one claim all receive the same treatment (same treatment dates, same examination/progress reports, etc.).

Patients who are members of the same family are treated on different days.

Pharmaceutical bills indicate repackaging or compounding on the part of the treating provider.

Provider only treats patients that are represented by an attorney.

Provider repeatedly uses x-rays, ultrasounds, nerve conduction tests, or spinal video fluoroscopy to check treatment progress.

Same type of treatment is given to children and adults.

The employee/individual is unaware of or has no recollection of receiving the medical treatment being billed for.

The frequency or number of therapy modalities does not decrease after four weeks of treatment.

The treatment plan does not change over time (especially if additional diagnostic tests have been done).

Time dependent procedures don’t match what was billed (more treatments than possible in a 24 hour day).

Treatment begins prior to the accident date.

Treatment continues with no changes in plan.

Treatment dates on the bill indicate the start of treatment is delayed by more than four weeks from the loss date.

Treatment is ended when the policy’s monetary limits are reached.

Treatment is extended, without re-evaluation or outcome assessment.

Treatment is not consistent with usual standards of care.

Treatment plan exceeds 90 days with no evaluations during the 90-day period.

Treatment prescribed for the various injuries resulting from differing accidents is always the same in terms of duration and type of therapy.

Treatment provided is not usually associated with this type of injury.

Treatment requires specialized equipment, but the injured person cannot describe the equipment or procedure.

Treatment shows more than three therapy modalities in a single treatment session.

Regarding Professional Issues

Attorney/Medical provider is not located near the claimant/insured’s residence.

Business/Contractors/Cleaning company are not licensed or are newly licensed.

Clinician has multiple locations and bills indicate regular or frequent treatment at one location.

Evidence of a D.C./M.D. collusion to provide unnecessary pain management/prescriptions (e.g. compounded topical pain management cream).

Provider/Clinic doesn’t allow a clinic inspection to be conducted or makes scheduling an inspection appointment very difficult.

Regarding Slip & Falls or Food Products Liability

Emergency medical responders were not called to the scene of the slip and fall.

The claimant did not receive medical treatment at an emergency room after the slip and fall.
Regarding Specific CPT Codes

- Acupuncture, first 15 minutes (97810 or 97813) billed numerous times per visit.
- Acupuncture, subsequent 15 minutes (97811 or 97814) billed more than twice per visit.
- Biofeedback (90901) is performed on all of a provider’s patients.
- Chiropractic manipulation (98940-5) routinely billed in conjunction with an E&M visit without documentation of a separate office visit where treatment was required beyond normal pre and post manipulation assessment (should be billed with a -25 modifier).
- Community reintegration training (97537) billed repeatedly.
- Consultation (99241-5) billed for own patient.
- Davis series (72052) charge with fewer than seven images or reports.
- Digital analysis of electroencephalogram (97957) routine appearance on bills.
- E&M codes, complex/severe (992x4-5) billed for every visit until discharge.
- E&M codes, complex/severe (992x4-5) billed for problem of relatively low severity.
- E&M new patient (99201-5) billed every visit.
- E&M, new patient (99201-5) billed for by provider in the same medical group where the patient has previously received treatment within the past three years.
- E&M, prolonged services (99358), routine appearance on bills.
- ESI (62310 or 62311) separate charge for drug and supplies (e.g. syringes, gloves, alcohol, etc.).
- ESI (62310 or 62311) billed more than three times in one calendar year.
- Electric stim (97014) with modifier -50.
- Interpretation hours (90887), billed with little detail in report.
- MUA (22505) manipulation under anesthesia billed by a chiropractor (may also bill for assistant surgeons and standby assistant).
- MUA (22505) manipulation under anesthesia in conjunction with (23700 and 27194).
- MUA (22505) manipulation under anesthesia performed early in treatment.
- Manual therapy (97140) routine appearance of charge.
- Mechanized traction (97012), routine appearance of charge.
- Modifier -51, routine appearance on bills.
- Modifier -52, routine appearance on bills.
- Modifiers - frequent use.
- Muscle testing (95831) billed for each muscle rather than each extremity.
- Muscle testing (95831) billed in conjunction with E&M codes (e.g. 99201-5).
- Needle EMG (95860 single extremity) multiple times per visit.
- Needle EMG (95864) all four extremities (without justification documentation).
- Nerve conduction (*95907 and *95913) on the same bill for the same nerve (*95913 includes *95907).
- Nerve conduction tests (*95907 and *95913) billed multiple times for the same nerve.
- Nerve conduction tests (*95907 and *95913) show the same results across patients.
- Neuromuscular re-education (97112) billed in connection with a soft-tissue injury without nerve damage.
- PDD (62287, Percutaneous disk decompression), routine appearance on bills.
- Psychological test interpretation time (90887) is billed along with administration time (96101) without supporting documentation.
- Psychological testing (96101) report is without detail.
- Range of motion testing (95832) frequent.
- Range of motion testing (95832) is billed for each muscle tested.
- Range of motion testing (95832) is billed in conjunction with 95831.
- Range of motion testing (95832) is billed in conjunction with E&M (e.g. 99201-5).
- Self-care/home management training (97535) billed repeatedly.
- Subcortical/cortical mapping (95961 and 95962), routine appearance on bills.
- Therapeutic activities (97530) billed in conjunction with 97112.
- Therapeutic procedure with- 51modifier.
Unbundling of CPT Codes.
Unlisted codes (ending in 99).
Unlisted modality (97039) routine appearance on bills.
Unlisted procedure (97139) routine appearance on bills.
Unlisted rehab (97799) routine appearance on bills.

Regarding Vehicle and/or Vessel
Vehicle driven by the insured person is an old "clunker" with minimal coverage.
Most claims are legitimate, but some are fraudulent. Therefore, it is appropriate to review all claims for possible fraud. Detecting fraud is aided by familiarity with industry identified fraud indicators.

Indicators assist in the identification of claims which merit closer scrutiny. The presence of an indicator (or several indicators) do not prove fraud. Indicators of possible fraud are not actual evidence, they only “indicate” the need for further investigation.

Some claims, although questionable, may be paid due to a lack of conclusive evidence of fraud. However, they should be submitted as questionable claims to NICB for further review.

For additional information on the following indicators, please see the NICB’s Interactive Indicator Guide. This Guide is a software application providing the concern associated with each indicator as well as suggested resolution steps. For access to the Interactive Indicator Guide, please contact NICB’s Training Department.

Regarding Applicant or Claimant or Insured

- Applicant is unsolicited, new “walk-in” business, not referred by existing policyholder.
- Applicant refuses or cannot produce current identification and/or driver’s license, or has a temporary, recently issued, or out-of-state driver’s license/state identification card.
- Business telephone number is connected to an answering machine or answering service during normal business hours.
- Cannot be contacted by phone, pager, cell phone, voicemail or answering service.
- Claimant started employment shortly before accident occurred.
- Does not provide a telephone number or states they do not have a home telephone or cellular phone and/or they will contact the adjuster.
- During statements, individuals appear to have “selective memories” on some facts, and cannot remember simple issues that would be common to remember.
- Employment information is for an unknown business, an answering machine “message” that doesn’t sound legitimate, often with a post office box for its address, or a street address in a residential area.
- Enters agent’s office at noon or end of day when agent and staff may be rushed.
- Has lived at current address less than six months.
- Individual avoids/cancels scheduled appointments with claim adjusters for statements and/or examinations under oath.
- Individual cannot recall place and/or date of purchase for newer items of significant value.
- Individual denies involvement in the accident.
- Individual frequently changes address and/or phone number.
- Individual has an accumulation of parking tickets in connection with the vehicle.
- Individual has multiple insurance claims.
- Individual is difficult to contact.
- Individual is going to be out-of-town soon due to death or sickness in family, on vacation, or is a transient/moving.
- Individual is overly pushy, aggressive or demanding for a quick, and sometimes reduced settlement (possibly to avoid providing additional documentation).
Individual is reluctant to use mail or telephone; provides all documents and handles all business transactions in person.

Individual is self-employed but vague about the business and actual responsibilities.

Individual is vague on the actual facts of the loss or has discrepancies in the facts of loss.

Individual is willing to accept an inordinately small settlement rather than document all claim losses.

Individual refuses to give a statement.

Individual returns completed documentation unsigned or mails in the signed documentation which was not signed in agent's view.

Individual uses cell phone that is "pay as you go".

Individual’s driver’s license has recently been suspended.

Individual’s place of contact is a hotel, tavern, or other place that is neither his/her place of employment nor place of residence.

Initial phone number (and/or address) provided is incorrect and/or often disconnected or never in service.

Insured and claimant are from the same family.

Insured and claimant have shared the same address.

Is a university student, unemployed, with current employer less than six months, self-employed (especially if self-employed in transient occupation such as roofing or asphalt).

Is never available to meet in person, resists communication over the telephone and supplies all information by mail or email only.

Is unusually familiar with insurance terms or procedures such as- medical terminology, workers compensation claim handling procedures and laws, vehicle repair terminology, coverage and special limits.

Knowledge of insurance terminology although appears to be poorly educated.

Lost earning statement is handwritten or typed on blank paper not business letterhead.

May switch between attempting to endear themselves to adjuster and using abusive and threatening language if claim is not proceeding as they expected.

Multiple identities and/or social security numbers.

Neither works nor resides near the agency (if an in person application).

Often claims to have spoken to an “attorney friend” and knows the value of each claimant’s claim.

One or more claimants or insured list a post office box (mail drop) or hotel as address.

One or more parties in collision may be employed in professional law office, clinic, billing service organization or check cashing agency.

Parties have a history of prior claims (often of similar type losses).

Provided an incorrect address.

Questions agent closely on claim handling procedures.

Threatens to obtain an attorney or go to a physician for further medical treatment if the claim is not quickly settled (but may delay doing so).

Wants to immediately dispose of or retain vehicle salvage.

**Regarding Application**

Address provided is a small business like barber shop, deli, etc.

Claims no previous insurance.

Has had a driver’s license for significant period, but no prior vehicle ownership and/or insurance.

Income is not compatible with value of vehicle/vessel to be insured.

Only one line of business, policy limits either minimal or appear to be unwarranted on the high end, especially medical payment limits.

Out-of-state driver’s license and vehicle title.

Provided address is inconsistent with employment/income.

Recently purchased/rented property or dwelling.

Suggests price is no object when applying for coverage.
Regarding Arson for Profit or Fire-Related Fraud

- Building and/or business were recently purchased.
- Business or insured is experiencing financial difficulties (e.g. bankruptcy, foreclosure).
- Fire site is claimed by multiple mortgages or chattel mortgages.
- Had a smaller loss at the same site within the preceding year.

Regarding Attorney Involvement

- All claimants represented by the same attorney or law firm.
- Attorney becomes involved early in the claim process.
- Attorney lien or representation letter is dated the day of or soon after the reported incident.
- Attorney reports claim to insurance company.
- Attorney threatens further legal action unless a quick settlement is made.
- Attorney’s office is a satellite, run by an administrator.
- High incidence of claims from attorney who recently passed the bar exam.
- Individual initially wants to settle with insurer, but after retaining an attorney, complains of increased subjective injuries.
- Individual receives all mail by and through his attorney.
- Individual’s mail is handled by his attorney.
- Legal representation is contacted/obtained immediately after the accident/incident is reported.
- The attorney on record for the injured party frequently changes or attorney constantly misses hearing/deposition appointments.

Regarding Automobile Accident Schemes

- A single car accident, late at night, in remote location, with no witnesses.
- Accident occurs shortly after one or more of the vehicles were rented, purchased or registered.
- Driver is at fault and is not injured but all other passengers are.
- Individuals do not know name, addresses, phone numbers and/or relationship between passengers or each other.
- Multiple passengers are in either vehicle.
- No police report in situations where police would normally investigate or an over-the-counter report for an accident resulting in multiple injuries and/or extensive physical damage.
- Serious accident with expensive physical damage claim, but only minor, subjectively diagnosed injuries, with little or no medical treatment.

Regarding Claim

- All occupants provide the same facts regarding the accident, in many cases using the same exact wording – they may have been coached.
- Arrive at “catastrophe” site just prior to storm.
- Avoids meetings with investigators and/or claims adjusters for interviews or viewing damage.
- Claims expensive contents in vehicle/vessel at time of theft.
- Commercial losses include old or non-saleable inventory or chemicals/materials they are not licensed to posses.
- Commercial losses that primarily involve seasonal inventory or equipment, and that occur at the end of the selling season (e.g. a ski inventory loss in the spring or a farm machinery loss in the fall).
- Damaged or stolen property still in moving boxes (e.g. clothing stacked or piled in rooms other than bedrooms at time of loss).
- Damaged property disposed of or repaired before adjuster can view damages.
- Damages/losses presented by one or more parties are inconsistent with facts of loss/accident (lack of injury/damage causing mechanism, etc.).
- Drivers of both cars live out-of-state or out of the area.
Excuses provided for delay in reporting loss immediately.
Facts of the loss can only be verified through witnesses who are relatives and no police report was made.
High-value items claimed as destroyed or stolen, with no documentation.
Individual brings in medical specials; very cooperative in documenting casualty loss.
Individual cannot be located.
Individual cannot identify other vehicle in “hit and run” injury loss.
Individual is anxious to and/or readily admits fault.
Individual or someone known by insured recovers stolen vehicle/vessel.
Individual over-documents losses with a receipt for every loss and/or receipts for older items of property.
Individuals cannot remember why or where they were going, where they were coming from and why other passengers' stories are different.
Insured produces photos of claimed property instead of receipts.
Involved parties claim no previous connection, but are associated in prior claims.
Loss inventory differs significantly from police department’s crime report.
Loss inventory indicates unusually high number of recent purchases.
Loss occurs soon after moving into area or acquiring insurance coverage.
Losses are incompatible with residence, occupation and/or income.
Losses include a large amount of cash.
Minor damage, vehicle operable, no injury at scene.
Multiple locations involved in the claim (e.g. loss in one state, policy in another, and address in a third state).
Neighbors, friends and family are not aware of loss.
New tenant files dispute with insured landlord.
No or late police report filed & police did not respond to the scene.
One spokesperson for multiple persons.
Owner cannot provide original receipt, bank or credit card records and/or has lack of documentation for the loss of damaged property, recently purchased items, and high valued items.
Parties involved in the accident know each other, work together, live together, are neighbors, or in the same geographical area or are from the same country or ethnic background.
Prior claim connections between involved parties and witnesses.
Property recently moved into state or area by insured in U-Haul or similar moving truck with no inventory of contents.
Similarities of insured and claimant vehicles (e.g. old cars, old damages, high mileage, purchased/registered out-of-state or area, recent insurance coverage, both cars are older model luxury cars, etc.).
Supporting documentation lost with items stolen or destroyed for nearly all major items.
Total thefts of travel trailers occur from truck stops, rest areas or from the side of the road following a reported disablement of the tow vehicle.
Uncooperative in documenting the loss.
Uncooperative with insurance company representatives.
Witness appears to be involved in another case (sometimes with the insured/claimant) or insured/claimant is involved in other claims.
Witness is/are relatives or friends of insured/claimant.
Witness version of loss does not coincide with facts of loss as presented.
Witness/Participant appears familiar with one or more parties to the loss and may refer to them by first name.

Regarding Claim Reporting
No report or claim is made to insurance carrier within seven days of the theft.
Regarding Damage
- Damage to vehicles is inconsistent with accident facts.
- Damages to “struck” vehicle far more substantial than those to “striking” vehicle.
- In physical damage losses, it appears there is possible enhanced damage to vehicles.
- Signs of pre-existing damage to claimant vehicle.
- Vehicle appears to have been intentionally damaged.

Regarding Diagnosis
- All injuries are subjectively diagnosed, such as – headaches, muscle spasms, strains, sprains, traumas and others.
- Injuries are subjective (e.g. pain, headaches, nausea, inability to sleep, depression, dizziness and soft tissue).
- Medical records do not explain excessive, expensive medical testing/treatment.
- Mobile unit performs neurological or other tests, which are read at remote locations.

Regarding Facility/Operation
- Arrives at loss site without being solicited.
- Equipment and treating facility is out-of-date, broken or inconsistent with treatment billed.
- Have inadequate equipment and/or staff to perform repairs/restoration/cleaning (non-vehicle).

Regarding Fire (Loss/Incident)
- Commercial fire occurs on holiday, weekend or when business is closed.
- Fire alarm and/or sprinkler system failed to work at the time of the loss.
- Fire damage is inconsistent with loss description.
- Fire occurs at night, especially after 11 p.m.

Regarding Fire Scene
- Burned building is in deteriorating condition and/or located in a deteriorating neighborhood.
- Fire scene investigation reveals absence of items of sentimental value (e.g. family bible, family photos, trophies and the remains of items usually found in a home or business).
- Fire scene investigation reveals absence of remains of expensive items used to justify an increase over normal 50% contents coverage (e.g. antiques, piano, or expensive stereo/video equipment).
- Fire scene investigation reveals absence of remains of non-combustible items of scheduled property (e.g. coin or gun collection or jewelry).
- Fire scene investigation suggests that property/contents were heavily over-insured.

Regarding Incident
- Description of accident suggests possible “set-up scenario.
- Interstate accident with excuse for no police investigation.
- Loss occurred while out-of-state or area on business or vacation.
- Parking lot losses resulting in injury to pedestrians.
- Sudden or unwarranted stop or lane change for no apparent reason could be indication of a “caused accident”.
- Vehicle has numerous passengers claiming the same type of injuries.
- Vehicle was struck by a rental vehicle soon after the rental had occurred.
- Witness or driver is over eager and is too willing to be involved and/or accept blame for an accident.

Regarding Medical Bills
- Clinic billing may be done by outside service. Often this service is linked to the clinic or other participants as part of the “network”.
- Medical bills accrued for the injury have a higher dollar value compared to other providers treating patients for similar injuries.
- Workers compensation insurer and health carrier are billed simultaneously; payment is accepted from both (especially if worker is at the age of Medicare when they are injured).
Regarding Medical Fraud/Claim Inflation

- CPT codes appear “inflated” or “up-coded”.
- Clinic has continued billing or treatment irregularities.
- Clinic/Medical facility does not have patient sign-in sheets or patient signatures appear to be signed all at one time.
- Employee is immediately referred for a wide variety of psychiatric tests, when the original claim involved trauma only. These claims usually present with vague complaints of “stress”.
- Injured party is unable to give detailed description of medical facility, type and duration of treatment and description of doctor or staff.
- Medical bills indicate routine treatment being provided on Sundays, holidays, or other days that facilities would not normally be open.
- Minor accident produces major medical costs and often lost wages, household help, transportation and unusually expensive demands for pain and suffering.
- Patient is classified as having total disability from initial visit and remains that way through the life of the claim.
- Patients are at or near the age of eligibility for Medicare when they are first injured and begin treating.
- The patient decides to go back to work on their own despite the doctor classifying them with a total disability.
- The patient’s signature appears several times on the same sign in sheet.

Regarding Medical Treatment

- Clinic treats several or all of the claimants on same day.
- Extensive or unnecessary treatment for minor, subjective injuries.
- Individuals travel across town to receive medical treatment.
- Medical treatment claimed out-of-state or area.
- Participants seek treatment from a hospital far away from their home or place of employment.
- Several or all of the individuals treat with the same clinic or provider, often on the same dates.
- The employee/individual is unaware of or has no recollection of receiving the medical treatment being billed for.
- Treatment provided is not usually associated with this type of injury.

Regarding Payment

- Applicant pays the minimum dollar amount for premium down payment.
- Insurance premium was paid in cash or a combination of credit card and cash.
- Wants to or already paid premium in cash or by other non-traceable method (e.g. cashier’s check or money order).

Regarding Policy/Coverage

- Coverage is for minimum liability with full comprehensive coverage on late model and/or expensive vehicle/ vessel.
- Exceptionally high liability limits are requested or are in force for older vehicle inconsistent with applicant’s employment, income or lifestyle.
- Loss payee is not a legitimate lending institution (e.g. bank or finance company).
- Losses occur just before/after coverage takes effect, just before it ceases, just after it has been increased, or after a cancellation notice has been sent.
- Name of previous insurance carrier or proof of prior coverage cannot be provided.
- No prior insurance coverage is reported (or proof of prior coverage provided) although the individual’s age would suggest prior ownership of a vehicle and/or property.
- Policy obtained from an agent not located in the close proximity to insured’s residence or work.
- Policy purchased online, by mail or phone without face-to-face contact.
- Questions about prior claims are left unanswered.
- Significant lapse in coverage is reported under prior policy.
Regarding Professional Issues

- A non-attorney or public adjuster performs attorney functions (e.g., duties more related to legal functions, which a licensed attorney should perform).
- Attorney’s staff handles claims and attorney is rarely or never seen at the office.
- Attorney, body shop and clinic frequently appear linked together in other claims with various insurance carriers, producers/agents.
- Body shop employees or owners have been known to provide referrals and/or transportation to the attorney’s office or a medical clinic.
- Body shop employees or owners have personal claims with attorney or clinic.
- Business is not bonded or is underinsured.
- Business/Contractors/Cleaning company are not licensed or are newly licensed.
- Clinician has multiple locations and bills indicate regular or frequent treatment at one location.
- Contractor does not maintain a local office and/or have telephone number.
- Contractor is not able to provide references.
- Contractor wants “cash” for payment or down payment prior to starting work.
- Contractor/Repair provider does not advertise locally (Yellow Pages, White Pages, billboards, internet, etc.).
- Link established between attorneys, clinics, participants, car rental agencies and body shops with various claims.
- Members of the attorney’s office staff are from other offices you are familiar with.
- Offers below market prices—“too good to be true”.
- Offers cash incentives to get the job.
- Physician is known for handling suspect claims.
- Producer/Agent linked in other claims with body shops, clinic or attorney’s office.
- The attorney and doctor are known for handling a certain type of claim.

Regarding Rental Claims Process

- Alleges to have repaired damage prior to vehicle being inspected or alleged to have paid large bill in cash, but has no receipt or one that appears altered.
- Driver is a passenger in the vehicle and has authorized additional driver driving at the time of the accident.
- Makes an allegation that a defect with equipment caused the accident.
- Mileage is inconsistent with new address, if moving.
- Primary driver is not in the vehicle and there is an authorized additional driver who is driving at the time of the accident.
- Rental vehicle is driven very few miles.

Regarding Slip & Falls or Food Products Liability

- No supporting evidence of foreign or contaminated substance; individual threw food out and has only the can, box or wrapper.

Regarding Vehicle and/or Vessel

- All vehicles in a reported accident are taken to the same body shop or shops that may be owned by the same person(s).
- An individual, rather than a bank or financial institution, is named as the lien holder.
- Federal vehicle safety certification label displays different VIN than is displayed on vehicle.
- Federal vehicle safety certification label is altered or missing.
- Has an incorrect VIN (failed edit, not manufactured, inconsistent with model).
- Information concerning prior owner is unavailable and/or they cannot be located.
- License plate does not match vehicle and/or is not registered to individual.
No lien holder is reported (especially if new and/or high value vehicle purchased with cash).
Often expensive, high volume vehicles are used for losses.
One or both parties were driving a previously salvaged vehicle.
Recovered burned (especially if there aren’t any personal items in vehicle/vessel) and or vandalized.
Title history shows non-existent addresses.
Title indicates the vehicle is rebuilt, junk, salvage, out-of-state, out-of-country, photocopied or duplicated.
Travel trailer is not titled or registered.
Travel trailer or mobile home purchased directly from factory, not through a dealer.
Vehicle VIN is different than VIN appearing on title.
Vehicle VIN numbers were removed prior to fire or theft (especially if recovered burned).
Vehicle VIN provided to police is incorrect.
Vehicle coverage is only a binder.
Vehicle has a Canadian history.
Vehicle has theft, claims and/or salvage history.
Vehicle is older model with exceptionally low mileage (e.g. odometer, rollover/rollback).
Vehicle is towed to isolated yard at owner’s request.
Vehicle or vehicles are not available for inspection (photos may be submitted in lieu of inspection).
Vehicle purchased/rented out-of-state or area (often for cash).
Vehicle was not seen for an extended period of time prior to the reported theft.
Vehicle was recovered clinically or carefully stripped (particularly if insured or body shop wants to retain salvage or if repair seems impractical). Sometimes recovered burned.
Vehicle/Vessel was purchased for cash with no bill of sale or proof of ownership.

Regarding Work Performed and Supporting Documentation
Estimate is very general- lump sum.
Repair bills are consecutively numbered or dates show work accomplished on weekends or holidays.

Regarding Workers Compensation Accident
Accident occurs just prior to a strike, layoff or near the end of probationary period.
Incident shares many of the same factors of other claims reported by other employees in a relatively short period of time.

Regarding Workers’ Compensation Claimant
After injury, employee is never home or spouse/relative answering phone states the employee “just stepped out”, or may have to contact him/her by pager or cell phone.
Employee has submitted substantial material misrepresentation on the employment application.
Employee is consistently uncooperative.
Employee is disgruntled, soon-to-retire, or facing imminent firing or layoff.
Employee is involved in seasonal work that is about to end.
Employee is new on the job.
Employee protests about returning to work and never seems to improve.
Employee submits documents which contain cross-outs and/or white out.
Has several other family members also receiving worker’s compensation benefits or other “social insurance” benefits (e.g. unemployment).
Injured worker moves out-of-state or country shortly after filing claim.
Most claims are legitimate, but some are fraudulent. Therefore, it is appropriate to review all claims for possible fraud. Detecting fraud is aided by familiarity with industry identified fraud indicators. Indicators assist in the identification of claims which merit closer scrutiny. The presence of an indicator (or several indicators) do not prove fraud. Indicators of possible fraud are not actual evidence, they only “indicate” the need for further investigation.

Some claims, although questionable, may be paid due to a lack of conclusive evidence of fraud. However, they should be submitted as questionable claims to NICB for further review.

For additional information on the following indicators, please see the NICB’s Interactive Indicator Guide. This Guide is a software application providing the concern associated with each indicator as well as suggested resolution steps. For access to the Interactive Indicator Guide, please contact NICB’s Training Department.

Regarding Applicant or Claimant or Insured
- Individual cannot recall place and/or date of purchase for newer items of significant value.
- Individual had a loss at the same site within the preceding year.
- Individual indicates distress over prospect of an examination under oath.
- Individual is overly pushy, aggressive or demanding for a quick, and sometimes reduced settlement (possibly to avoid providing additional documentation).
- Individual is recently separated or divorced.
- Individual is reluctant to use mail or telephone; provides all documents and handles all business transactions in person.
- Individual is willing to accept an inordinately small settlement rather than document all claims losses.
- Is unusually familiar with insurance terms or procedures such as- medical terminology, workers compensation claim handling procedures and laws, vehicle repair terminology, coverage and special limits.
- Takes an unusual interest in the claims handling process.

Regarding Arson for Profit or Fire-Related Fraud
- Building and/or business were recently purchased.
- Building and/or contents or vehicle/vessel were up for sale at the time of the loss.
- Business or insured is experiencing financial difficulties (e.g. bankruptcy, foreclosure).
- Fire site is claimed by multiple mortgages or chattel mortgages.
- Had a smaller loss at the same site within the preceding year.
- Suspicious coincidental absence of family pet at time of fire.

Regarding Automobile Accident Schemes
- No police report in situations where police would normally investigate or an over-the-counter report for an accident resulting in multiple injuries and/or extensive physical damage.

Regarding Burglary/Theft
- Losses are questionable (e.g. home stereo stolen out of car, fur coat stolen on trip to Hawaii).
- Losses include numerous appraised items and/or items of scheduled property.
- Losses include numerous family heirlooms.
- Theft losses include total contents of business/home including items of little or no value.
Regarding Claim

- Commercial losses include old or non-saleable inventory or chemicals/materials they are not licensed to possess.
- Commercial losses that primarily involve seasonal inventory or equipment, and that occur at the end of the selling season (e.g. a ski inventory loss in the spring or a farm machinery loss in the fall).
- Incorrect or no sales tax on receipt.
- Individual over-documents losses with a receipt for every loss and/or receipts for older items of property.
- Individual provides altered documents.
- Individual provides credit card receipts with incorrect or no approval code.
- Individual provides receipt(s) with no store logo (blank receipt).
- Individual provides receipts/invoices from same supplier that are numbered in sequence.
- Individual provides single receipt with different handwriting or typefaces.
- Individual provides two different receipts with same handwriting or typeface.
- Loss inventory differs significantly from police department’s crime report.
- Loss inventory indicates unusually high number of recent purchases.
- Losses are incompatible with residence, occupation and/or income.
- Losses include a large amount of cash.
- Owner cannot provide original receipt, bank or credit card records and/or has lack of documentation for the loss or damaged property, recently purchased items, and high valued items.
- Provides numerous receipts for inexpensive items, but no receipts for items of significant value.
- Suspiciously coincidental absence of individual or family at time of the incident.

Regarding Fire (Loss/Incident)

- Commercial fire occurs on holiday, weekend or when business is closed.
- Fire alarm and/or sprinkler system failed to work at the time of the loss.
- Fire department reports fire cause is incendiary, suspicious or unknown.
- Fire occurs at night, especially after 11 p.m.

Regarding Fire Scene

- Burned building is in deteriorating condition and/or located in a deteriorating neighborhood.
- Fire scene investigation reveals absence of items of sentimental value (e.g. family bible, family photos, trophies and the remains of items usually found in a home or business).
- Fire scene investigation reveals absence of remains of expensive items used to justify an increase over normal 50% contents coverage (e.g. antiques, piano, or expensive stereo/video equipment).
- Fire scene investigation reveals absence of remains of non-combustible items of scheduled property (e.g. coin or gun collection or jewelry).
- Fire scene investigation suggests that property/contents were heavily over-insured.

Regarding Policy/Coverage

- Individual contacts agent to verify coverage or extent of coverage or to increase coverage just prior to loss date.
- Losses occur just before/after coverage takes effect, just before it ceases, just after it has been increased, or after a cancellation notice has been sent.
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Regarding Applicant or Claimant or Insured
- Takes an unusual interest in the claims handling process.
- Takes an unusual interest in the salvage.

Regarding Claim
- Incorrect or no sales tax on receipt.
- Uncooperative with insurance company representatives.
- Vehicle or facility owner is difficult to contact (e.g. voice mail picks up) but calls back immediately.

Regarding Damage
- Damage to vehicles is inconsistent with accident facts.

Regarding Facility/Operation
- Contractor/Public Adjuster does not have proper identification.
- Does not have a business license.
- Does not have adequate equipment to complete repairs.
- Provides free transportation to owner.
- Reluctant to provide written contract for job.
- Repair facility charges for items not customary in the market/geographical area (e.g. shop materials, markup on OEM parts, labor tax when not collected in that area).
- Repair facility frequently states vehicle is not ready for inspection or requires an appointment to inspect vehicles at the shop.
- Repair facility is identified in NICB questionable claims.
- Repair facility owner or employee was prior owner of vehicle under repair.
- Repair facility requests only a certain adjuster/estimator to inspect vehicles.
- Salvage yard or repair garage take unusual interest in the claim/vehicle.
- Shop name changes frequently or high turn around in shop owners.
- Waives deductible.

Regarding Professional Issues
- Vehicle owner referred to repair ship, attorney and/or doctor by tow truck driver.
Regarding Vehicle and/or Vessel

- Vehicle hidden or enclosed by other vehicles so adjuster cannot take full pictures or conduct a complete inspection of vehicle.

Regarding Work Performed and Supporting Documentation

- Billing or charging for replacement parts that were not replaced, but repaired.
- Both vehicles from the same accident are repaired at the same facility.
- Charging excessively for “attachments” or “kits”.
- Charging for repairs on the final invoice that were not authorized.
- Damage in photos appears simulated (chalk, dropped bumpers, removed taillights, etc.).
- Delays sending the estimate and photos to the insurer.
- Does not keep original invoices on parts which were ordered for repairs.
- Estimate inconsistent with incurred damages.
- Excessive manual overrides when using electronic estimating systems.
- Final repair costs are much higher than original repair estimate.
- Following a multiple car collision, severe damages notes on one vehicle while the other vehicle has little or no damages.
- Glass damage is repaired rather than replaced as billed.
- Hand delivery of claim/repair payments by insurance personnel.
- Incomplete vehicle information on estimate.
- Insured chose the glass repair vendor based on a telephone solicitation.
- Invoices for parts, materials, sublet repairs cannot be produced or verified.
- Invoices/Receipts for parts supplied may have indication that the parts were returned and not used in the repair.
- No photos of damage before tear down.
- Owner not informed about repairs with parts that deviate from those listed on original estimate (e.g. OEM parts, new aftermarket parts or parts from a salvage vehicle).
- Patterns involving tow companies.
- Photographs taken either at the scene or shortly after do not match the photographs submitted by the repair facility, may indicate enhanced damages by the repair facility.
- Poor quality or no photos of damaged area.
- Receipts do not have repair facility name or logo.
- Reluctant to provide written contract for job.
- Repair facility charges for luxury or unique windshield (e.g. HUD, high grade or heated glass) when a standard, less expensive windshield is sufficient (e.g. some shops will use “seconds” or “used glass” and bill for new).
- Repair facility continuously submits supplemental repair estimates not noted by the original adjuster.
- Repair facility picks up claim repair/payments.
- Repair performed in location that was inconvenient for the owner.
- Repair shop is not in owner’s vicinity.
- Repairer forgoes use of software and writes out damage manually.
- Supplemental estimate actively is higher/lower than average for similar volume facilities in area.
- Supplemental orders for smaller dollar amounts not submitted to insurer for payment (perhaps in an effort to avoid drawing attention to previous larger fraudulent billing).
- The vehicle is initially disassembled prior to inspection by insurance personnel.
- Towing fee added to the invoice is higher than the average fee charged by similar repair facilities in the area.
- Vendor’s electronic record of “Preliminary Estimate” not finalized or closed in database.
- Work has not been done according to specifications in the final invoice.
Most claims are legitimate, but some are fraudulent. Therefore, it is appropriate to review all claims for possible fraud. Detecting fraud is aided by familiarity with industry identified fraud indicators.

Indicators assist in the identification of claims which merit closer scrutiny. The presence of an indicator (or several indicators) do not prove fraud. Indicators of possible fraud are not actual evidence, they only “indicate” the need for further investigation.

Some claims, although questionable, may be paid due to a lack of conclusive evidence of fraud. However, they should be submitted as questionable claims to NICB for further review.

Regarding Applicant or Claimant or Insured
- An out-of-state phone number is provided by the applicant (e.g. an out-of-state prefix).
- Applicant is unsolicited, new “walk-in” business, not referred by existing policyholder.
- Applicant refuses or cannot produce current identification and/or driver’s license, or has a temporary, recently issued, or out-of-state driver’s license/state identification card.
- Does not provide a telephone number or states they do not have a home telephone or cellular phone and/or they will contact the adjuster.
- Has lived at current address less than six months.
- Individual avoids/cancels scheduled appointments with claim adjusters for statements and/or examination under oath.
- Individual frequently changes address and/or phone number.
- Individual has an accumulation of parking tickets in connection with the vehicle.
- Individual has been with current employer less than six months.
- Individual has recent or current marital and/or financial problems.
- Individual is difficult to contact.
- Individual is employed with another insurance company.
- Individual is overly pushy, aggressive or demanding for a quick, and sometimes reduced settlement (possibly to avoid providing additional documentation).
- Individual is reluctant to use mail or telephone; provides all documents and handles all business transactions in person.
- Individual is self-employed but vague about the business and actual responsibilities.
- Individual is vague on the actual facts of the loss or has discrepancies in the facts of loss.
- Individual wants a friend or relative to pick up settlement check.
- Individual wants to retain title and salvage on total loss where repairs appear unfeasible.
- Individual’s driver’s license has recently been suspended.
- Individual’s place of contact is a hotel, tavern, or other place that is neither his/her place of employment nor place of residence.
- Insured claims no change in vehicle performance prior to the theft/fire.
- Insured did not see any warning/indicator lights prior to the theft/fire.
- Insured offers inducement for quick settlement.
- Is a university student, unemployed, with current employer less than six months, self-employed (especially if self-employed in transient occupation such as roofing or asphalt).
- Is behind in loan/lease payments on vehicle/vessel or other financial obligations.
- Is unusually familiar with insurance terms or procedures such as- medical terminology, workers compensation claim handling procedures and laws, vehicle repair terminology, coverage and special limits.
One or more claimants or insured list a post office box (mail drop) or hotel as address.

Parties have a history or prior claims (often of similar type losses).

Questions agent closely on claim handling procedures.

Takes an unusual interest in the claims handling process.

Takes an unusual interest in the salvage.

**Regarding Application**

- Income is not compatible with value of vehicle/vessel to be insured.
- Property does not appear to be appropriate for claimed address or income (e.g. a luxury vehicle in a low income neighborhood).

**Regarding Attorney Involvement**

- Legal representation is contacted/obtained immediately after the accident/incident is reported.

**Regarding Claim**

- Avoids meetings with investigators and/or claims adjusters for interviews or viewing damage.
- Claims expensive contents in vehicle/vessel at time of theft.
- Individual or someone known by insured recovers stolen vehicle/vessel.
- Neighbors, friends and family are not aware of loss.
- No or late police report filed & police did not respond to the scene.

**Regarding Claim Reporting**

- No report or claim is made to insurance carrier within seven days of the theft.

**Regarding Facility/Operation**

- Salvage yard or repair garage takes an unusual interest in the claim/vehicle.

**Regarding Fire (Loss/Incident)**

- Fire damage is inconsistent with loss description.
- Fire department reports fire cause is incendiary, suspicious or unknown.
- Fire occurs at night, especially after 11 p.m.
- Insured advises no unusual odors, sounds or visible smoke prior to seeing flames.
- Insured cannot provide a specific location where fire was first observed.
- Insured claims a cigarette caused the fire.

**Regarding Fire Scene**

- Fire in passenger compartment self-extinguished with minimal damage.
- Fire occurred at unusual location, away from other vehicles or structures.
- Fire originated in the passenger compartment and/or cargo area.
- Fire service and/or police not called to the scene.
- Flammable liquid containers were recovered from the vehicle or at the scene.
- Floor coverings significantly burned.
- Insured was observed leaving the scene moments before the fire started and/or the insured smelled of gasoline while at the scene.
- One or more windows and/or doors, was/were partially or completely open.
- Scent of flammable liquid was detected in the passenger compartment.
- There is evidence of more than one point of origin.
- Vehicle has evidence of being towed to the fire scene.
- Vehicle is a “total burn” and/or burned beyond recognition.
- Vehicle’s filler cap was off and/or missing before the fire occurred.
Regarding Payment

- Insurance premium was paid in cash or a combination of credit card and cash.

Regarding Policy/Coverage

- Coverage is for minimum liability with full comprehensive coverage on late model and/or expensive vehicle/vessel.
- Individual contacts agent to verify coverage or extent of coverage or to increase coverage just prior to loss date.
- Losses occur just before/after coverage takes effect, just before it ceases, just after it has been increased, or after a cancellation notice has been sent.
- Policy obtained from an agent not located in the close proximity to insured’s residence or work.

Regarding Vehicle and/or Vessel

- An individual, rather than a bank or financial institution, is named as the lien holder.
- Equipped with anti-theft device and/or electronic recovery equipment (especially VATS and Transponder systems and/or recovered burned).
- Federal vehicle safety certification label displays different VIN than is displayed on vehicle.
- Federal vehicle safety certification label is altered or missing.
- Has an incorrect VIN (failed edit, not manufactured, inconsistent with model).
- Information concerning prior owner is unavailable and/or they cannot be located.
- Leased vehicle (or Smart Buy) with excessive mileage for which the individual would have been liable under the mileage limitation agreement (especially if the lease expires within 60 days of the theft and/or recovered burned).
- License plate does not match vehicle and/or is not registered to individual.
- Motorcycle/Vehicle shows signs of import racing or being a “show” vehicle such as: racing pedals, tachometer, decals, custom accessories (especially if recovered burned).
- No lien holder is reported (especially if new and/or high value vehicle purchased with cash).
- No signs of ignition/locking/security system damage when reported stolen while locked and/or without keys (especially if recovered burned).
- Recovered burned (especially if there aren’t any personal items in vehicle/vessel) and/or vandalized.
- Recovered near owner’s work address.
- There are no service bulletins or recalls for vehicle from the manufacturer prior to the fire.
- Title history shows non-existent addresses.
- Title indicates the vehicle is rebuilt, junk, salvage, out-of-state, out-of-country, photocopied or duplicated.
- Vehicle VIN is different than VIN appearing on title.
- Vehicle VIN numbers were removed prior to fire or theft (especially if recovered burned).
- Vehicle VIN provided to police is incorrect.
- Vehicle compartments are empty with valuable/personal items removed.
- Vehicle coverage is only a binder.
- Vehicle has a Canadian history.
- Vehicle has a history of mechanical problems and/or is a “gas guzzler” (especially if recovered burned and/or there is no warranty coverage).
- Vehicle has engine damage which shows signs of racing.
- Vehicle has missing engine components.
- Vehicle has poor paint condition, with severe rust and/or body damage that required expensive cosmetic repairs.
- Vehicle has severely worn or mismatched tires and/or the spare tire was removed prior to the fire and/or if lug nuts are loose.
- Vehicle has theft, claims and/or salvage history.
- Vehicle has unusual amount of aftermarket equipment (e.g. wheels, high priced stereo, CB radio, etc.).
Vehicle identified as a possible clone.
Vehicle is customized, classic and/or antique (especially if recovered burned).
Vehicle is late model with extremely high mileage with the exceptions of: taxis, police and utility vehicles (especially if recovered burned).
Vehicle is older model with exceptionally low mileage (e.g. odometer rollover/rollback).
Vehicle is older or inexpensive model and individual indicates it was equipped with expensive accessories which cannot be substantiated with receipts.
Vehicle is recovered abandoned (often with collision damage) prior to or shortly after the theft being discovered and reported (especially if recovered burned).
Vehicle is recovered with seized engine or blown transmission (especially if recovered burned).
Vehicle is towed to isolated yard at owner’s request.
Vehicle not parked under available protective cover (e.g. a garage).
Vehicle purchase price was exceptionally high or low.
Vehicle purchased/rented out-of-state or area (often for cash).
Vehicle registration renewal time is close to the reported date of theft.
Vehicle shows signs that stolen parts are “neatly” removed (e.g. stereo missing, no damage to the dash and wires unplugged).
Vehicle to be insured is an older, high end model and repair parts may be scarce.
Vehicle was not seen for an extended period of time prior to the reported theft.
Vehicle was parked for a significant period of time prior to the theft/fire.
Vehicle was previously involved in a major collision.
Vehicle was recovered clinically or carefully stripped (particularly if insured or body shop wants to retain salvage or if repair seems impractical).
Vehicle was recovered with damage (mechanical and/or body) and coverage was high deductible or no collision coverage (especially if recovered burned).
Vehicle was very recently purchased.
Vehicle/Vessel “for sale” prior to theft (especially if recovered burned).
Vessel/Vehicle was purchased for cash with no bill of sale or proof of ownership.
Vehicle’s battery is missing or was disconnected prior to the fire.
Was reported stolen prior to the issuance of a registration or title or within the waiver period of any mandatory photo inspections.

Regarding Work Performed and Supporting Documentation
Repair bills are consecutively numbered or dates show work accomplished on weekends or holidays.
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**Regarding Applicant or Claimant or Insured**
- Individual is vague on the actual facts of the loss or has discrepancies in the facts of loss.
- Insured is delinquent in payments.
- Insured states the signature on the letter of representation is not theirs.
- Insured states they were told the claim would be submitted to FEMA (not their insurer).

**Regarding Attorney Involvement**
- A non-attorney, non-public adjuster performs attorney or adjuster functions.
- Attorney/Public Adjuster does not advise the insured of the settlement dollar amount or that the claim was denied.
- Attorney/Public Adjuster is known for handling questionable claims.
- Attorney/Public Adjuster pays clients for additional referrals.
- Attorney/Public Adjuster reports the claim to the insurance company.
- Attorney/Public Adjuster uncooperative with the insurance company representative.
- Attorney/Public Adjuster will not let the insured cooperate. The insured is not allowed to sign a financial release or complete a proof of loss.
- Cleaning estimate is on the attorney’s letterhead.
- High incidence of claims from a specific firm. There maybe be hundreds of insurance companies and thousands of smoke damage claims, but very few public adjusters or attorneys processing them.

**Regarding Catastrophe Indicators Concerning Fire/Flood Losses**
- Insured property was not located in major damaged area.

**Regarding Catastrophe Indicators Concerning Landlords**
- Multiple properties of a landlord are claimed to have been damaged by smoke. This includes their residence, regardless of the home’s distance from the fire or blown ash.
- Tenants are unaware of any damage or an insurance claim.

**Regarding Claim**
- Identified in previous NICB Questionable Claims.
- Insured is contacted by an attorney, public adjuster or cleaning company via flyer, door hanger, cold call or advertisement advising of cash payouts.
- Insured is represented by a public adjuster and attorney.
Insured submits Additional Living Expenses (ALE) receipts claiming they are paying rent when in fact they just moved into their second residence.

Laboratory testing of residence and/or possessions shows no or little presence of ash or soot.

Neighbors, friends and family are not aware of loss.

Public Adjuster or cleaning company does not communicate with the insured after the insured agrees to the cleaning or restoration.

Public Adjuster uses non-licensed persons to perform public adjuster activities requiring a license.

The insured is unaware a claim has been made on their policy.

The insured property is in default or foreclosure.

There is an established relationship between a specific public adjuster and contractor or cleaning company and/or law firm on numerous questionable claims.

**Regarding Claim Reporting**

- Claim submitted near end of permissible time frame (e.g. five years after the date of the causation catastrophe or one year after the fire).
- Initial damage report appears to have been significantly delayed.
- Insured does not personally report the claim to the insurance company.

**Regarding Damage**

- Actual damage is questionable.
- Damage is difficult to prove or disprove.
- Damage is rarely visible/is subjective in nature.
- Findings of ash are not a natural distribution pattern of falling/windblown ash.
- Findings of ash are inconsistent: 40% in one area, but 0% in the area immediately adjacent.
- Owner cannot provide documentation confirming prior damage has been repaired.

**Regarding Facility/Operation**

- Arrives at loss site without being solicited.
- Contractor or public adjuster initiated contact with the building owner and solicits claim.
- Contractor/Cleaning company does not conduct any testing or tests incorrectly.
- Have inadequate equipment and/or staff to perform repairs/restoration/cleaning (non-vehicle).
- No work is ever performed.

**Regarding Insured without Catastrophe Coverage**

- Affected area was not evacuated.
- No or very few homes or businesses were damaged or destroyed in the affected area.

**Regarding Professional Issues**

- Business is not bonded or is underinsured.
- Business/Contractors/cleaning company are not licensed or are newly licensed.
- Cleaning company rarely does any of the work, only writes cleaning estimates.
- Cleaning estimates include charges for profit and overhead.
- Contractor has no workers comp insurance yet insured indicates more than one contractor employee was at the residence.
- Contractor/Cleaning company does not ask for any down payment.
- Contractor/Cleaning company does not have a fixed office location.
- Contractor/Cleaning company pays clients for additional referrals.
- Contractor/Cleaning company utilize door to door solicitation of claims.
 Estimates are high dollar and usually above $10,000.00 and up to $100,000.00 for cleaning.

 Estimates are macro in nature. The cleaning estimate is based on the total square footage of the structure.

 Estimates for cleaning include repair or replacement of roofs, pools, etc.

 Firm works exclusively smoke and ash insurance claims.

 Public Adjuster, cleaning company, etc. often associated with the same law office.

 Public Adjuster, cleaning company, law office, etc. only works on Smoke and Ash claims.

 **Regarding Work Performed and Supporting Documentation**

 Insured cannot provide documentation the cleaning was done.

 The cleaning estimators/contractors do not isolate an area of damage. They always write estimates for the entire dwelling.

 The insured submits dry cleaning invoices from a dry cleaner who is not in the same geographical area as the insured’s residence.