

Fraud prevention curriculum

REUSABLE TEACHING MODULES. FREE TO COPY, ADAPT, AND TEACH.

MODULE 02: MEDICARE AND MEDICAID BILLING FRAUD

When your Medicare number gets used *without you*

A 45 minute session on Medicare and Medicaid billing fraud: how a number that seems harmless becomes a bill you never generated, the specific signals that appear before and after it happens, and the one thing to do about it. Written to be taught by a volunteer with no technical background.

MEDICARE SUMMARY NOTICE, DETAIL LINE

SPECIMEN, TEACHING MATERIAL ONLY

Durable medical equipment, back brace, custom fitted

Service date 03 / 14 · Provider: ORTHO SUPPLY PARTNERS LLC · Claim
#.....4471

\$1,842.00

The participant never ordered a back brace. Six weeks earlier she gave her Medicare number to a caller offering a free one, "covered by Medicare, no cost to you." Everything between those two events happened without her. This line is the first and only place she could have seen it, and it arrived three months after the fact.

AUDIENCE Medicare and Medicaid beneficiaries Plus family caregivers and adult children	RUN TIME 45 minutes 30 minute cut sheet included	GROUP SIZE 6 to 40 In person or virtual
FACILITATOR Any trained volunteer No clinical or technical background needed	MATERIALS Handout and specimen notice Both included below, printable	VERSION [VERSION] Published [DATE]
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Where this came from

This module is the back of a detection model, turned around

Nothing here is general advice about being careful. Every cue in this module is a measurement from a working fraud detection system, restated in the words of the person the fraud is aimed at.

Building a system that finds fraudulent billing in Medicare and Medicaid claims data requires describing a scheme in operational terms: what the person running it has to obtain, in what order, and what traces that leaves behind in the data. That description is what the model consumes.

Read it in the other direction and the same description says what the scheme looks like from the inside: what gets asked for, what pressure is applied, what a legitimate counterpart would never do. A detection feature and a recognition cue are two renderings of one analysis. The model uses it to score a billing entity. This module uses it to teach a person.

The practical consequence is specificity. General fraud awareness material tends toward advice that is true but not actionable, such as *be suspicious of unexpected calls*, because its authors are not working from an operational characterization of any particular scheme. It also ages badly. Material derived from active detection work is specific, and stays current, because new patterns identified in the detection work feed back into the module instead of the module aging into inaccuracy.

Every module in this series uses the same four parts, in the same order, so that a volunteer who has taught one can teach any of them: **how the scheme works, the specific signals, the single action to take, and where to report.** Everything after those four parts is delivery support.

**Before
you teach**

What a participant can do at
the end

Written as things a person does, not things a person knows. If a participant cannot do these five things after 45 minutes, the session did not work.

- ☐ State the one item a billing scheme actually needs from them, and name three situations where they should not give it.
- ☐ Find the claims list for their own coverage, on the quarterly notice in the mail or in their online account.
- ☐ Read a single claim line and say whether they received that service.
- ☐ Describe the one action to take when a caller asks for their Medicare number, without needing to decide whether the caller is legitimate.
- ☐ Name the number they would call and what they would have in front of them when they called.

THE POINT OF THE SESSION

Participants do not need to become fraud investigators. They need to become the one person in the chain who can see the whole thing, because on a claim billed under their number, they are.

01

How the scheme works

Teach the shape first, then the variants. The variants change constantly. The shape has not changed in years, and a participant who has the shape can recognize a variant nobody has told them about.

Step 1

Get the number

Through a free offer, a screening booth, a health fair, a friendly call, a mailed form, or a compromised office. The number is obtained, not stolen from a wallet.

Step 2

Attach a billable service

A test, a brace, a supply order, a visit. Often something real is shipped or performed, cheaply, so the claim has something behind it.

Step 3

Bill the program

The claim goes to Medicare or Medicaid, not to the beneficiary. It is paid first and examined later, if at all. No one asks the patient.

Step 4

The beneficiary finds out last

Weeks or months later, on a notice most people file unopened. This step is the only one they can affect, and this session is about that step.

Say this part out loud

The money does not come out of the participant's pocket, which is exactly why this is hard to teach. There is no missing withdrawal, no declined card, no bill in the mail demanding

payment. The loss lands on the Medicare and Medicaid programs, which is to say on the taxpayer, and the beneficiary's only stake appears to be paperwork.

It is not only paperwork, and the session should say why. A service billed under someone's number goes into their claims history. It can exhaust a benefit they will later need, put an equipment item on their record so a real one gets denied, or record a diagnosis they do not have. And a number that has been used once is a number that gets used again, and sold.

The variants, as of this version

The free screening

HEALTH FAIRS, SENIOR
CENTERS, MAILERS

A booth or a mailer offers a free genetic test, cancer screening, or cardiovascular scan, "covered by Medicare, no cost to you." A cheek swab is taken. The Medicare number is written on the form.

What is billed afterward can run to thousands of dollars for tests that were never medically ordered. Participants frequently remember the swab and not the form.

The free brace or supply

PHONE, TEXT, ONLINE AD

A caller offers a back, knee, or wrist brace, a catheter supply, or diabetic testing supplies at no cost. Something arrives in the mail. Sometimes nothing arrives at all and the claim is filed anyway.

Repeat shipments of supplies nobody ordered are a strong marker. The number has been passed on, and each recipient bills it again.

The card replacement call

PHONE, THE MOST COMMON
SINGLE PRETEXT

The caller says a new Medicare card is being issued, in plastic, or with a chip, or because of a system update, and needs the current number to send it.

There is nothing to correct here except the premise. Medicare does not call people to issue cards, and there is no chip card program.

Services never provided

BY A REAL, ENROLLED
PROVIDER

A provider the participant genuinely sees bills for visits that did not happen, a longer or more complex visit than occurred, or equipment never received.

This is the variant participants resist most, because it means suspecting someone they like. The session does not ask them to suspect anyone. It asks them to check whether a line matches what happened, and to ask about it.

Enrollment without consent

HOSPICE, HOME HEALTH, CARE
PLANS

A signature is collected at a fair or a home visit and used to enroll the person in a service they did not choose. Hospice enrollment is the most damaging case, because it changes what else the program will cover.

Teach the marker rather than the mechanism: a covered service the participant did not knowingly choose, appearing in their record.

Medicaid service hours

PERSONAL CARE,
TRANSPORTATION, THERAPY

An attendant bills for hours not worked, a ride bills for a trip not taken, a therapy session bills for a visit that did not occur. The beneficiary is often present for part of it, which makes the discrepancy hard to see.

For participants on both programs, note that Medicaid statements vary by state. The facilitator should have the local one in hand, and the guide explains how to find it.

Billing after a death

FOR CAREGIVERS AND
SURVIVORS

Claims filed under a deceased person's number, sometimes months afterward, on the assumption that nobody is still reading the notices.

This is the clearest case where the detection side and the participant side are the same fact. A claim dated after a date of death is one of the strongest signals a model can see, and it is also the one thing a family member can check for free.

KEEP THE NATIONAL FIGURES SMALL

If a participant asks how big this is: federal improper payment estimates for these programs run to tens of billions of dollars annually [VERIFY, current CMS figure and year]. Say plainly that improper payments are not all fraud, since many are documentation errors, and that no one can put a precise figure on the fraud portion. Overstating it costs credibility with the one participant in the room who knows better.

Derivation

One analysis, two renderings

Left: what the detection model measures in claims data. Right: the same fact, stated to the person it happens to. Facilitators do not teach the left column. It is here so that anyone can check that the right column was not invented.

WHAT THE MODEL MEASURES	WHAT THE PARTICIPANT IS TAUGHT
DOD · Alive Claim service dates compared against the beneficiary's recorded date of death. A claim dated after it cannot correspond to care delivered.	If you handle a relative's affairs after they die, keep opening their Medicare notices for at least a year. Closing the mail is what the scheme counts on. Nobody else is going to look.
NoOfMonths_PartACov · NoOfMonths_PartBCov Short coverage duration paired with high reimbursement, meaning billing front loaded into the months right after enrollment.	The months right after you enroll are when the offers arrive. That timing is not a coincidence. New enrollees are targeted deliberately, before they know what their notices normally look like.
ChronicCond_* · ChronicDiseaseIndex Services claimed cross referenced against documented conditions, exposing care billed for a condition the record does not support.	Be most careful about a test or item offered to everyone your age, rather than to you for a reason. Real care follows from something a doctor found. "Everyone over 65 qualifies" is a sales line, not a medical one.
IPAnnualReimbursementAmt · OPAnnualReimbursementAmt Reimbursement amounts that are outliers relative to the beneficiary's profile and to peer providers.	Look at the amount, not just the service name. A big number attached to a small thing is the signal. A swab that shows up as four figures is the discrepancy the model is looking for, and you can see it too.
Provider level aggregation Scoring the biller rather than the bill: one entity showing the same pattern across many beneficiaries, where each single claim looks defensible.	If a whole group signed up at once, at a fair, a center, a church hall, that is the pattern, not an endorsement. Volume is the point. Your neighbor's participation is not evidence that it was real.

Repeat and short interval claims The same item or service billed again within an implausible interval for the same beneficiary.	Supplies that keep arriving without you asking are being billed every time they arrive. Do not just throw the box away. The box is the receipt for a claim.
BeneID The beneficiary identifier is a required input on every claim. No claim exists without one.	Your Medicare number is the only thing the whole scheme actually needs from you. Not your bank details, not your Social Security number. This is the item. Treat it like an account number, because that is what it is.

Feature names above are the measurements used in the provider level claims anomaly detection work this curriculum is derived from. See [\[LINK, reference implementation\]](#) and [\[LINK, feature dictionary\]](#).

01 · HOW THE SCHEME WORKS

02 · THE SIGNALS

03 · THE ONE ACTION

04 · WHERE TO REPORT

02

The specific signals

Two sets, because there are two moments. The first set appears while the approach is happening. The second appears in the paperwork afterward, which is where most people will actually catch it.

Set A: signals in the approach

THEY CONTACTED YOU

You did not start the conversation

The single most reliable divider. A call, text, email, door knock, or booth you did not seek out, that ends up needing your Medicare number.

FREE

"Free" and "covered by Medicare" in the same sentence

These two claims contradict each other. If Medicare is billed, it is not free, it is paid for. That sentence is a sales script.

NUMBER FIRST

The number is needed before anything happens

Legitimate care starts with a doctor deciding you need something. It does not start with a stranger collecting your number and then finding a reason.

URGENCY

A deadline that has nothing to do with your health

"Today only," "the van leaves at four," "this qualification expires." Time pressure exists to prevent the one phone call that would end it.

NEW DOCTOR

A doctor you have never met is arranging your care

A name you do not recognize signing off on equipment or tests, sometimes after a two minute call you were told was a consultation.

GROUP SETTING

Everyone in the room is signing the same form

A booth processing a line of people quickly, with the same clipboard and the same offer. Volume is the business model.

Set B: signals in the paperwork

CLAIMS LIST A service you do not remember receiving Not a service you cannot pronounce, but a service you did not receive. Teach participants to check the date and ask what happened that day.	CLAIMS LIST A provider name you do not recognize Lab and equipment company names are often unfamiliar even when legitimate, so this one gets checked rather than assumed. It is a question, not a verdict.
CLAIMS LIST A date when nothing happened A visit billed for a day they were traveling, in hospital, or at home. Dates are easier to verify than service descriptions.	CLAIMS LIST The same thing billed twice One item, two lines, close together. Sometimes an error. Always worth the call.
MAIL Equipment or supplies arriving unordered Especially on a repeating schedule. Each delivery is a claim, and the shipments continue until someone stops them.	DENIAL A denial for something you actually need "You already received this." A denial that makes no sense is often the first visible consequence of a claim someone else filed.

Lines participants report hearing

Read two or three aloud. Recognition of the exact phrasing does more work than any list of principles.

"We just need to verify the number on your red, white, and blue card."

Verification is the pretext. There is nothing to verify. The caller wants the number they claim to be verifying.

"Medicare is sending out new cards with a chip. Can you read me the old number?"

There is no chip card. Medicare does not call to issue cards.

"This screening is completely free, it's covered by Medicare."

Both halves cannot be true at once. Ask the room which half they think is the lie.

"Your doctor's office referred you to us."

Easy to test and rarely tested. Hang up, call the office on the number you already have.

"You qualify for a free back brace. There's no cost to you at all."

The cost exists. It is billed to a program the participant pays into.

01 · HOW THE SCHEME WORKS

02 · THE SIGNALS

03 · THE ONE ACTION

04 · WHERE TO REPORT

03

The single action

One action, taught as a reflex, because deciding whether a caller is legitimate is the part people get wrong. The action is designed to work without that decision.

If someone you did not call asks for your Medicare number, the conversation is over. You do not have to be sure.

This is deliberately not "be careful" or "verify the caller." Verification is what the scheme is built to survive. The caller has an answer ready for every question, and a polite person on the phone will keep asking questions until the number comes out. Ending the conversation requires no judgment about who is calling, and costs nothing when the caller was legitimate, because a real provider can be reached again on a number the participant already has.

And once a month, the second half



Open the Medicare Summary Notice when it arrives. It comes every three months, only in periods when services were billed. On Medicare Advantage or a Part D plan, the equivalent is the Explanation of Benefits from the plan.

- 2 Read down the list and ask **did this** Not "is this correct," which one question per line: **happen?** invites guessing. Did it happen.
- 3 Circle anything that did not happen, or that you are not sure about. Uncertainty is a reason to call, not a reason to wait.
- 4 Call the provider's billing office first if the name is one you know. A real share of these lines are ordinary billing errors, and that call resolves them.
- 5 If you do not recognize the provider, if the answer does not make sense, or if you would rather not call them, go straight to reporting. You never have to confront anyone.

SAY THIS BEFORE YOU CLOSE

Nobody is going to be embarrassed for calling about a line that turns out to be legitimate. That call is the system working. The only version of this that goes badly is the one where nobody calls.

IF THE NUMBER IS ALREADY OUT

A participant who has already given their number is not out of options, and should hear this before the session ends. Medicare can issue a new number when there is evidence of identity theft, and that request goes through 1-800-MEDICARE. In the meantime, reviewing claims matters more, not less, because it is how the extent of the use gets established. Nothing about having given the number away requires them to keep quiet about it.

Where to report

Give the whole list on the handout, but say one number out loud and repeat it. Participants who leave with six numbers call none of them.

REPORTING CHANNELS. CONFIRM EVERY NUMBER IS CURRENT BEFORE EACH DELIVERY.

WHO	CONTACT	USE IT FOR
Senior Medicare Patrol	1-877-808-2468 smpresource.org	The one to say out loud. Federally funded, free, and staffed by people whose job is to sit with a beneficiary and go through a notice line by line. They will help decide whether something is a billing error or worth reporting, and they will do the reporting.
Medicare	1-800-633-4227 1-800-MEDICARE, TTY 1-877-486-2048, medicare.gov	Questions about a specific claim on a Medicare notice, and requests for a new Medicare number where identity theft is suspected. Have the notice in hand.
HHS Office of Inspector General	1-800-447-8477 1-800-HHS-TIPS, oig.hhs.gov	Direct fraud reporting to federal investigators, for both Medicare and Medicaid. Reports can be made anonymously.
State Medicaid agency or Medicaid Fraud Control Unit	[LOCAL NUMBER] Facilitator: fill in before the session	Medicaid billing that does not match services received. Every state has a unit, and the contact differs by state, so this belongs on the local version of the handout.
	877-908-3360	Talking it through with a trained volunteer, including when the

WHO	CONTACT	USE IT FOR
AARP Fraud Watch Network Helpline	Free to anyone, member or not	person is not ready to file anything yet. Useful for participants who are upset and want to think before acting.
Federal Trade Commission	ReportFraud.ftc.gov IdentityTheft.gov	When the misuse extends past medical billing into wider identity theft, which it often does.

TWO THINGS TO CORRECT IN ADVANCE

Participants believe reporting is pointless. Say that reports are how patterns get built, and that one line from one beneficiary is what connects a provider to the hundred other people they billed.

Participants believe reporting gets their own doctor in trouble. Say that a question about a billing line is a question, that most turn out to be errors, and that nobody is investigated on the strength of one phone call.

Delivery

Forty five minutes, timed

Timings are the version that survives contact with a real room. If you are running long, the cut is marked below. Cut it rather than compressing the exercise.

0:00 to 0:04	Open with the object, not the topic Hold up the specimen notice. Read the one line. Ask: "This person never ordered a back brace. How would she know?" Do not introduce the topic first. Starting with the artifact gets attention that starting with "today we're talking about Medicare fraud" does not.
0:04 to 0:12	How the scheme works, the four steps Walk the four steps. Spend the time on step four: the beneficiary finds out last, and only if they open the notice. <i>"Nobody in this chain has any reason to tell you. The only place it shows up is a piece of mail most of us file without reading. That's the whole problem, and it's also the whole solution."</i>
0:12 to 0:20	The signals, approach then paperwork Read three of the quoted lines aloud in the caller's voice. Ask who has heard something close to one of them. Hands will go up, and that is the moment the room engages. Cover Set A quickly and Set B carefully. Set B is what they will actually use.
0:20 to 0:32	Exercise, read the specimen notice Hand out the specimen. Four minutes in pairs or alone: circle anything you would ask about. Then take answers from the room before revealing. Take wrong answers seriously. The unfamiliar but legitimate lab name is in there on purpose, and someone flagging it is the teachable moment, not a mistake.
0:32 to 0:38	The one action, and the monthly habit State the action once, plainly. Then have the room say it back. Then walk the five review steps against the specimen they just marked up. <i>"If someone you didn't call asks for your Medicare number, the conversation is over. You don't have to be sure. You don't have to be polite about it."</i>

0:38 to 0:43

Where to report

Hold up the handout, point at the Senior Medicare Patrol line, say the number, and say what happens when they call it: a person, free, who goes through the notice with them.

One number said aloud beats six numbers printed.

0:43 to 0:45

Close, and stay in the room

Close on the sentence about calling being the system working. Then say you will stay for ten minutes, and stay.

Most disclosures happen after the session ends, not during it. Leaving promptly costs the session its most important conversations.

THE 30 MINUTE CUT

Drop the variant list to three (screening, brace, card replacement), cut Set A to the first three signals, and run the exercise for six minutes instead of twelve. **Do not cut the exercise or the reporting segment.** A session that explains the problem and stops is a session that leaves people worried and unequipped.

Exercise

The specimen notice

Seven lines from one quarter. Three of them should not be there. Participants mark what they would ask about, and the facilitator reveals afterward. On screen, select a line to see the answer. On paper, the answer key is on the back.

SPECIMEN, TEACHING MATERIAL, NOT A REAL NOTICE
CLAIMS PROCESSED THIS PERIOD

Medicare Summary Notice

Beneficiary: **Ruth A. Whitfield** (fictional) · Period: January to March · Notices like this arrive every three months when services were billed.

DATE	SERVICE AND PROVIDER	AMOUNT BILLED
Jan 09	Office visit, established patient. MERIDIAN FAMILY PRACTICE	\$128.00
This one is fine. Her own doctor, a visit she remembers, an ordinary amount. Include lines like this so participants practice distinguishing rather than flagging everything.		
Jan 22	Genetic testing panel, hereditary cancer. COASTAL PRECISION DIAGNOSTICS	\$6,412.00
Ask about this one. She gave a cheek swab at a health fair in January and was told it was free. No doctor ordered it and no result was ever returned to her. Two signals stack here: an amount far out of line with what she experienced, and a test offered to everyone at a booth rather than to her for a reason.		
Feb 03	Comprehensive metabolic panel. QUANTRIX CLINICAL LABS	\$47.00
Unfamiliar name, legitimate line. Her doctor drew blood on February 3rd and sent it to an outside lab. She has never heard of the lab, because patients rarely do. This is the most useful line in the exercise. An unrecognized provider is a reason to ask, not a reason to conclude. If someone in the room flags it, that is correct behavior, and the answer is "good catch, and here's how you'd check."		
Feb 17	Durable medical equipment, back brace, custom fitted. ORTHO SUPPLY PARTNERS LLC	\$1,842.00
Ask about this one. A caller offered her a free brace in December and took her Medicare number. A brace arrived, and she never wore it. It is billed as custom fitted, and nobody fitted anything. "Custom fitted" is worth pointing out. The description on the line often claims a level of service that did not occur, and the participant is the only person who knows it.		

DATE	SERVICE AND PROVIDER	AMOUNT BILLED
Feb 28	Durable medical equipment, knee brace, bilateral. ORTHO SUPPLY PARTNERS LLC	\$1,190.00
Ask about this one, and notice the pattern. Same supplier, eleven days later, a second brace she did not order. Nothing arrived this time. The repeat is the teaching point. One item can be an error. The same supplier billing again on a short interval is the pattern the detection model scores, and it is visible here to anyone reading two lines together.		
Mar 06	Physical therapy, 30 minutes. MERIDIAN REHABILITATION SERVICES	\$96.00
This one is fine. She attends therapy weekly. The date and duration match what she remembers.		
Mar 20	Physical therapy, 30 minutes. MERIDIAN REHABILITATION SERVICES	\$96.00
Fine, and worth a sentence. An identical line two weeks later is not a duplicate. It is the next appointment. Repeat lines for ongoing care are normal. What matters is whether the dates line up with a real schedule.		
Three lines should not be there. Two lines are unfamiliar but legitimate.		

RUNNING IT WELL

Take answers from the room before revealing anything, and write every flagged line on the board including the wrong ones. Then reveal. The session lands when a participant sees that their instinct on the lab line was reasonable and that the answer was a phone call rather than a judgment.

**Facilitator
notes**

Someone in the room has
already been through this

In a group of thirty older adults, assume it. The session is being delivered to people for whom this is not hypothetical, and the difference between a good delivery and a harmful one is mostly in how that is handled.

Someone will say, out loud or afterward, that this happened to them. What happens next matters more than the rest of the session.

- ☐ **Believe it and say so first.** "That sounds like exactly what we've been describing" does more than any advice that follows.
- ☐ **Do not ask for details in front of the group.** "Can you stay after and we'll go through it?" moves it somewhere private without dismissing it.
- ☐ **Never let anyone read their Medicare number aloud.** Say it plainly if it starts to happen. There is no version of this session where a number is spoken in a room.
- ☐ **Do not write down or photograph anyone's number or notice.** You are not an intake worker. Handling a beneficiary's identifiers creates a risk you cannot manage and a liability you do not want.
- ☐ **Do not tell them what will happen.** You do not know whether a claim will be reversed, whether anyone will be prosecuted, or how long it will take. Say you do not know.
- ☐ **Hand them the Senior Medicare Patrol number and describe what happens when they call.** A free counselor who will go through the notice with them. That is the referral, and making it concrete is what turns it into a call.
- ☐ **Offer to sit with them while they make the call** if your organization permits it and you are willing. For many people this is the difference between intending to call and calling.

- ☐ **Watch for shame and address it directly.** "These are professionally run operations. Being taken in by one is not a failure of intelligence." Say it to the room, not only to the person.
- ☐ **Follow your organization's escalation guidance** where there are signs of coercion, cognitive decline, or possible elder abuse. Know what it says before you deliver the session, not after.

×

Not true, and participants know it, because they give it at every appointment. An instruction that contradicts daily experience gets discarded whole. The rule is about who started the conversation.

×

This implies the victims in the room lacked it. It also teaches nothing. Replace it with the specific cue.

×

Use the specimen names. You do not know the outcome of any real case, and the organization hosting you does not need the exposure.

×

Improper payment estimates are not fraud estimates. Overstating it is the fastest way to lose the most attentive person in the room.

×

"I don't know, and here's who does" is a complete and respectable answer. The referral is the deliverable, not your opinion.

×

Including in gentler forms, such as "didn't that seem strange?" A person who feels judged stops talking, and stops reporting.

Print the handout at 14 point or larger. Say every phone number twice, slowly, and write it where it can be seen. Never rely on the red marks alone to carry meaning, and say which lines are the problem. Face the room when you speak, because a facilitator reading from a

screen with their back turned is inaudible to a significant part of any older audience. Have the handout available before the session, not only after, so people can follow along.

Q

No. Claims are available in a Medicare account online, and 1-800-MEDICARE can go through them by phone. Notices can also be reprinted. Nothing is lost by having discarded the paper.

Q

Everything in this session works on paper and by telephone. That is deliberate. The notice arrives in the mail, the reporting numbers are voice lines, and the Senior Medicare Patrol counselor will work through it with them on the phone or in person.

Q

A beneficiary who did not receive a service is not the one who was paid for it. Do not promise an outcome. Say that this is a specific question for 1-800-MEDICARE or a Senior Medicare Patrol counselor, and that it is a reason to call sooner rather than later.

Q

Most discrepancies at a familiar office are billing errors, and one call to their billing department resolves them. Encourage that call first.

If the answer does not make sense, or they would rather not ask, the reporting channels take it from there. Nobody is obliged to confront their own doctor.

Q

It applies. The document is different, an Explanation of Benefits from the plan rather than a Medicare Summary Notice, but it lists claims the same way and gets read the same way. Plan member services is the first call, and 1-800-MEDICARE and the Senior Medicare Patrol still take reports.

Q

Say you do not know, write it down in front of them, and give the Senior Medicare Patrol number. Guessing in a session like this produces confident misinformation that travels further than the session does.

Take home

Participant handout

One page, plain language, printable at large type. This is the part that leaves the room, so it carries the action and the numbers and nothing else.

Your Medicare number is an account number

Protecting it, and checking what gets billed to it, in a few minutes a month.

If someone contacts you

- **You did not call them.**
That is the whole test. If a call, text, email, or booth ends up needing your Medicare number, the conversation is over.
- You do not have to be sure they are a scam. You do not have to be polite about it.
- "Free" and "covered by Medicare" cannot both be true.
- Medicare does not call you to issue a new card. There is no chip card.
- If they say your doctor referred you, hang up and call your doctor on the number you already have.

Once every few months

- Open your Medicare Summary Notice when it arrives. On a Medicare Advantage or Part D plan, it is called an Explanation of Benefits.
- Read down the list of services and ask one question about each line: **did this happen?**
- Circle anything that did not happen, or that you are not sure about.
- Look at the amounts. A large amount next to a small service is worth a question.
- If supplies keep arriving that you did not order, keep the box and mention it.

If something is wrong

- If it is a provider you know, call their billing office first. Many of these are simple errors.
- If you do not recognize the provider, or you would rather not call them, go straight to the numbers below.
- You never have to confront anyone.
- Nobody minds a call about a line that turns out to be legitimate. That call is the system working.
- If you have already given your number out, say so when you call. Medicare can issue a new number where identity theft is involved.

START WITH THIS ONE

1-877-808-2468

Senior Medicare Patrol. Free, and they will go through your notice with you, line by line.

Also	If it goes wider than billing	Where your claims are
• Medicare: 1-800-633-4227 (1-800-MEDICARE), TTY 1-877-486-2048 • Report fraud to HHS: 1-800-447-8477 (1-800-HHS-TIPS) • AARP Fraud Watch Helpline: 877-908-3360	• ReportFraud.ftc.gov • IdentityTheft.gov, for a recovery plan if your information is being used elsewhere • Your state Medicaid office: [LOCAL NUMBER]	• Your Medicare Summary Notice, mailed every three months when services were billed • Your account at medicare.gov, where claims appear sooner • By phone at 1-800- MEDICARE, if you would rather not use a computer

Reuse, adapt, and teach this

This module is published so that it can be delivered by people the author will never meet. Adapt the local numbers, translate it, change the specimen names, cut it to thirty minutes. The only request is that the attribution stays on it, so that a participant who wants to check where the material came from can.

DERIVED FROM

Provider level claims anomaly detection for federal healthcare programs. Reference implementation and feature dictionary: [LINK] · [DOI]

REVISION

Version [VERSION], published [DATE]. Revised when the detection work identifies new scheme patterns. Changelog: [LINK]

CORRECTIONS

Report an error, an out of date phone number, or a scheme variant this module does not cover: [CONTACT]

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