

Health Insurance Claims Analysis Report

1. Introduction

This report presents a comprehensive analysis of 100 health insurance claims with the objective of identifying key trends, approval patterns, potential fraud indicators, and deriving actionable insights. The primary aim is to improve claim processing mechanisms by minimizing financial losses and enhancing customer satisfaction through transparent and fair claims management.

2. Demographic Overview

The claimants in the dataset range from 19 to 79 years of age, with an average age of approximately 50 years. A majority of the claims were submitted by male patients, constituting 58% of the total, whereas female patients accounted for 42%. It was observed that high-value claims were more common among older patients (above 60 years), indicating an increased need for medical attention with advancing age.

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3. Claim Type Distribution

The claims in the dataset are categorized into three primary types:

- Hospitalization: 38%
- Pharmacy: 34%
- Outpatient: 28%

Hospitalization claims constituted the highest in terms of monetary value, while pharmacy and outpatient claims were more frequent but comparatively lower in cost. This categorization helps in identifying the segments that contribute most significantly to financial risk.

4. Claim Amount Analysis

The claim amounts varied from Rs.697 to Rs.49,580, with an average claim amount of Rs.26,015. Approximately 25% of claims were below Rs.15,520, whereas the top 25% exceeded Rs.39,305. A clear pattern emerged showing that higher-value claims are generally associated with hospitalization and older claimants. This analysis is crucial for defining risk management strategies and setting realistic approval thresholds.

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5. Pre-Existing Conditions & Diagnosis Match

A total of 54% of claimants had pre-existing conditions; however, only 46% had matching diagnoses with the submitted documentation. Claims that included accurate diagnosis matches had significantly higher approval rates. This emphasizes the importance of precise and complete medical documentation in the approval process.

6. Document Completeness and Its Role

Out of the 100 claims analyzed, 52 claims were found to have incomplete documentation. These incomplete submissions were associated with substantially lower approval rates. This highlights the critical role of thorough document verification in enhancing the efficiency and fairness of the claim approval process.

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7. Claim Approval Analysis

The analysis showed the following approval outcomes:

- Approved Claims: 66%
- Rejected Claims: 34%

The primary factors influencing claim approvals were the completeness of documents and the presence of diagnosis matches. In contrast, rejections often stemmed from incomplete documentation or high fraud risk scores. These insights indicate that improvements in documentation practices and fraud detection mechanisms can significantly increase approval efficiency.

8. Conclusions and Recommendations

The key findings from this analysis indicate that the claim approval process is heavily dependent on:

- Document completeness
- Fraud detection scores
- Accuracy of medical documentation

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