**OPTIMIZATION OF FRAUDULENT CLAIM DETECTION**

* DOMIAN

Insurance Domain

* DESCRIPTION

False insurance claims are hazard to all the insurance companies, which are being claimed in numbers and bringing billions of dollars of loss to the insurance economy. Every insurance provider is a victim of these bogus claims and would want to implement measures against this malpractice.

* MAJOR ROLES IN THE PROJECT
* Insurance Admin
* Hospital Admin
* Insurance Agent
* Person
* Claim Approver
* Investigator
* SCOPE OF THE PROJECT

This project enables the insurance company in its functions like,

* Early fraud Detection
* Identification of appropriate claims
* Automation of prolonged processes

In the event a claim is deemed suspicious; the claims are organized in a priority and adjusted per the application in a timely manner. This makes it possible to concentrate on the high payback opportunities and appropriate fund allocation to genuine claims.

Our project features a novel approach in surmounting this unlawful pretense and in facilitating easy processing of documentation. This saves money and time for the insurance providers, by which their services can be extended to the much-needed applicants. This approach involves verifying the bills made by the individual or group being claimed, at the generation site.

Also, this application has inter-enterprise communication, by which the total turn-around time is reduced. This is achieved by sending the documents directly from the site of generation to the site of processing, automatically. This ensures no time delay in the procedure.

* CONCLUSION
* This will help the insurance company in detecting false claims and thus save huge amount of money.
* Inter-enterprise communication will minimize the claim settlement turn around and hence benefiting the customers with genuine claim requests.