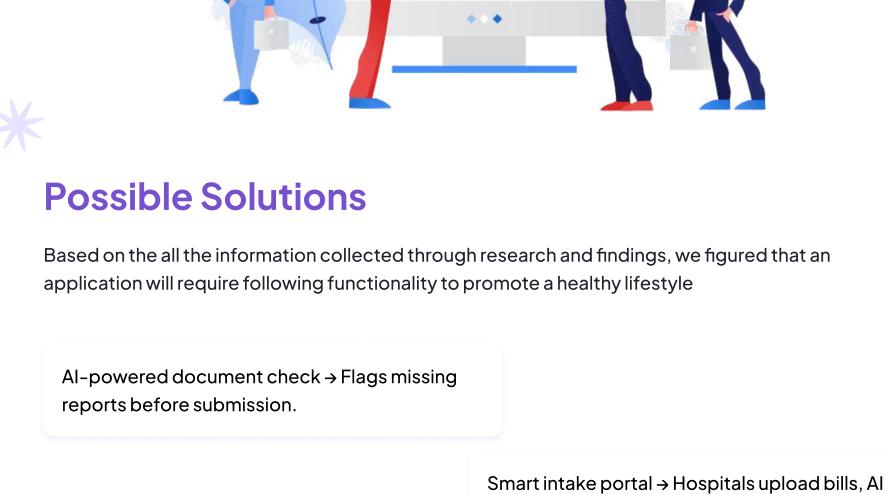


## 4. Complex policies → Staff can't easily match treatments with coverage rules. reduced.

5. Poor transparency → Patients and providers don't understand why payouts are

3. Fraud risks → Insurers struggle to catch inflated or duplicate claims.

2. Missing documents → Hospitals get repeated queries for the same files.



language to staff.

Risk-based triage → Al sorts claims into auto-

approve, review, or fraud-suspect. Fraud detection engine → Spots duplicate or

pre-validates instantly.

abnormal billing patterns.

Transparent payout calculator → Shows why

deductions happen with policy links.

Role-based dashboards → Give hospitals, insurers, and auditors clarity in one place.

**Understanding the Problem** 

Policy-matching AI → Explains coverage in plain

We studied how hospitals, insurers, and patients struggle with claims. Long approval times, missing documents, fraud risks, and unclear payouts create stress at every step. By mapping each pain point, I realized the process needs AI to simplify checks, detect fraud, and give transparent, faster approvals.

**Primary Research** We interviewed hospital staff, claims officers, and compliance managers, studied real

We found some insights;

workflow gaps.

Findings:

documents.

transparency.

fraud detection

• Policy rules are complex and unclear, causing wrong payouts. • Lack of transparent communication leads to frustration for providers and patients.

• Hospitals face 25-30% rejections due to incomplete documents.

• Fraud detection is mostly manual audits, missing subtle patterns.

• Claims approval takes 10–14 days on average, even for simple cases.

claims and rejection letters, and shadowed a claims associate to uncover key delays and

I reviewed industry reports, insurance regulations, and healthcare compliance guidelines to understand claim approval standards. I also studied competitor platforms and market case studies, which highlighted gaps in automation, fraud detection, and transparency

**Secondary Research** 

- across the industry.
- 3. Fraudulent claims cost insurers billions globally, with common cases like duplicate billing and inflated procedures. 4. Regulations like HIPAA, GDPR, and IRDAI require strict audit trails, data privacy, and

5. Existing claim platforms focus more on document storage than intelligent triage or

**User Personas** 

1. Average claim approval time in India is 10–15 days, even longer for complex cases.

2. 25-30% of hospital claims face delays or rejections due to incomplete or mismatched

Bio Handles 30-40 insurance claims daily in a mid-size hospital. Works with doctors and insurers to ensure smooth payouts.

payments.

• Confusing policy terms, hard to

match with treatments.

within SLA timelines.

• Time wasted switching between

• Hard to detect fraudulent or

• Pressure to meet targets while

duplicate claims quickly.

ensuring accuracy.

multiple systems and documents.

**Pain Points** 

## **Pain Points** • Frequent claim rejections for missing documents. • Long approval times delay hospital • Clear guidance on



Final payout

with

Medical Reviewer

Hi-Fi Designs

**ClaimAl** 

Welcome back, John

Reviewing 32 open cases needs your genius

■ ravi.sharma@insurer.com

♠ Enter your password

→ Sign In

or continue with

Continue with Microsoft

G Continue with Google

Login / Secure Onboarding

Healthcare = sensitive. Secure login is

the trust gate.

Case #CL-2024-8934

Apollo Delhi

Rajesh Patel, M, 45

Claims Ops Lead

Remember this

Email or Username

notified with

settlement

responds

docs

(Optional)

reply

suggestions

checker, and

appeal with

edit & send

Name: Brad

**Bio** 

Works at a large insurance company, reviews 40+ claims per

day. Responsible for approving, rejecting, or escalating cases

Goals

• Streamlined workspace

with all claim details in

• Al support to flag fraud

• Faster decisions without

and reduce manual

compromising

compliance.

against policy

one place.

errors.

**Goals** 

• Faster claim approvals

with fewer rejections.

required documents.

• Transparent payout

process to reduce

disputes.

**User Flow** 

Al checks

differences

SLA timer

ensures

turnaround

triggered

automatically

ClaimAl

Upload and pre-check patient

Patient Information

**Upload Documents** 

Drop patient documents to start pre-check

Drag & drop files here or click to

Supports PDF, JPG, PNG up to 10MB each

**Smart Intake** 

Al Doc Completeness Meter instantly

highlights missing files before submission.

□ ClaimTriage

Kavita Patel

Under Review

Avg 2.3 days

Hospital Portal

PAT-2024-5678

Rajesh Kumar

Dec 15, 2024

HDFC ERGO - 789456123

**Smart Intake** 

Name:

Admission Date:

payout or

rejection

officer exports audit

ClaimAl **Global Operations** Operations Manager - Anita **←**12% WoW Al Queue Intake Today Auto-Approve 1,284 312 A High Risk Fraud Watch **Human Review** 146 23 **Turnaround Time** On Target Current TAT 2.1 days 3.0 days Al Micro-Insight Global Ops Dashboard Clear KPIs + Al insights replace messy

Excel reports, saving hours daily.

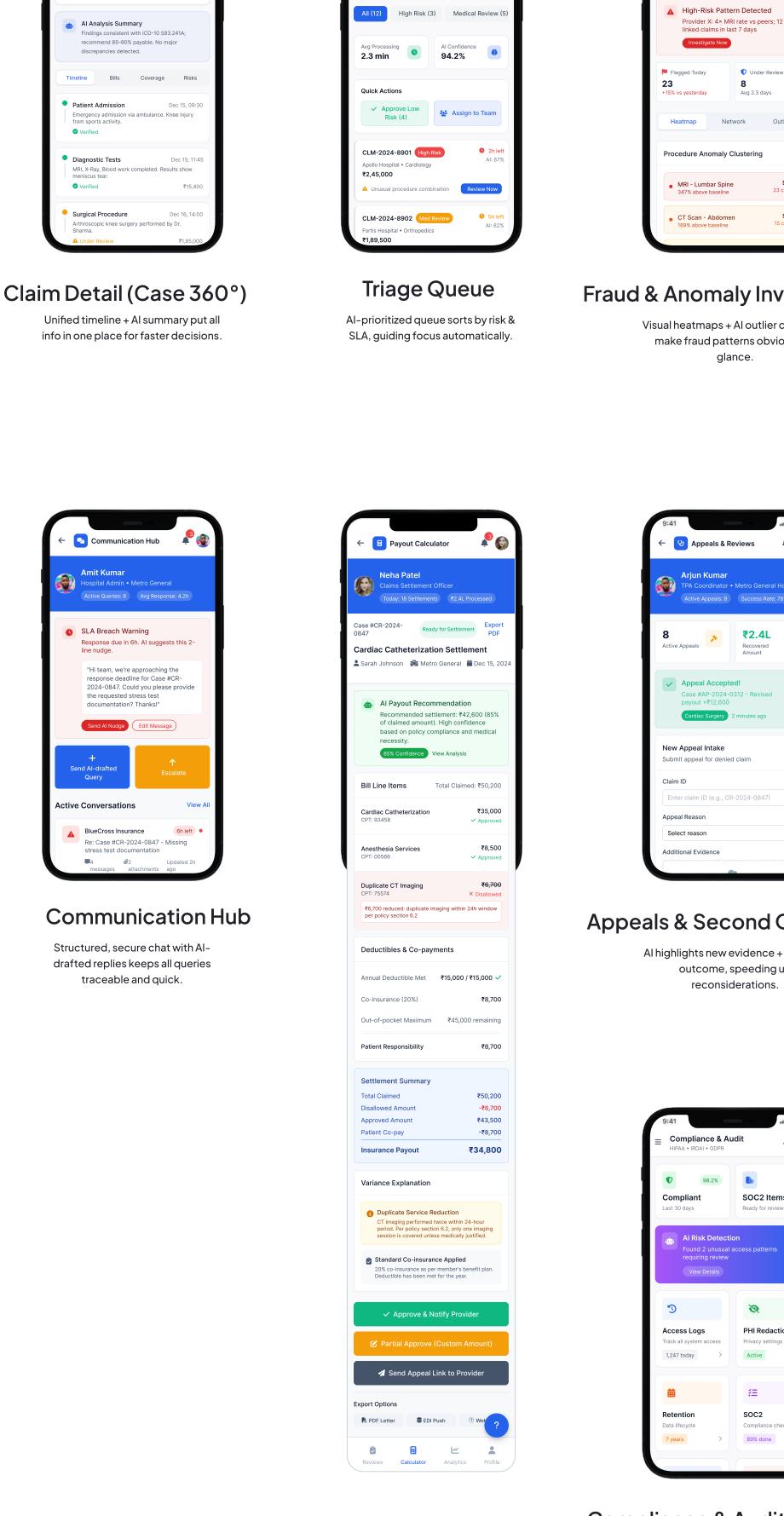
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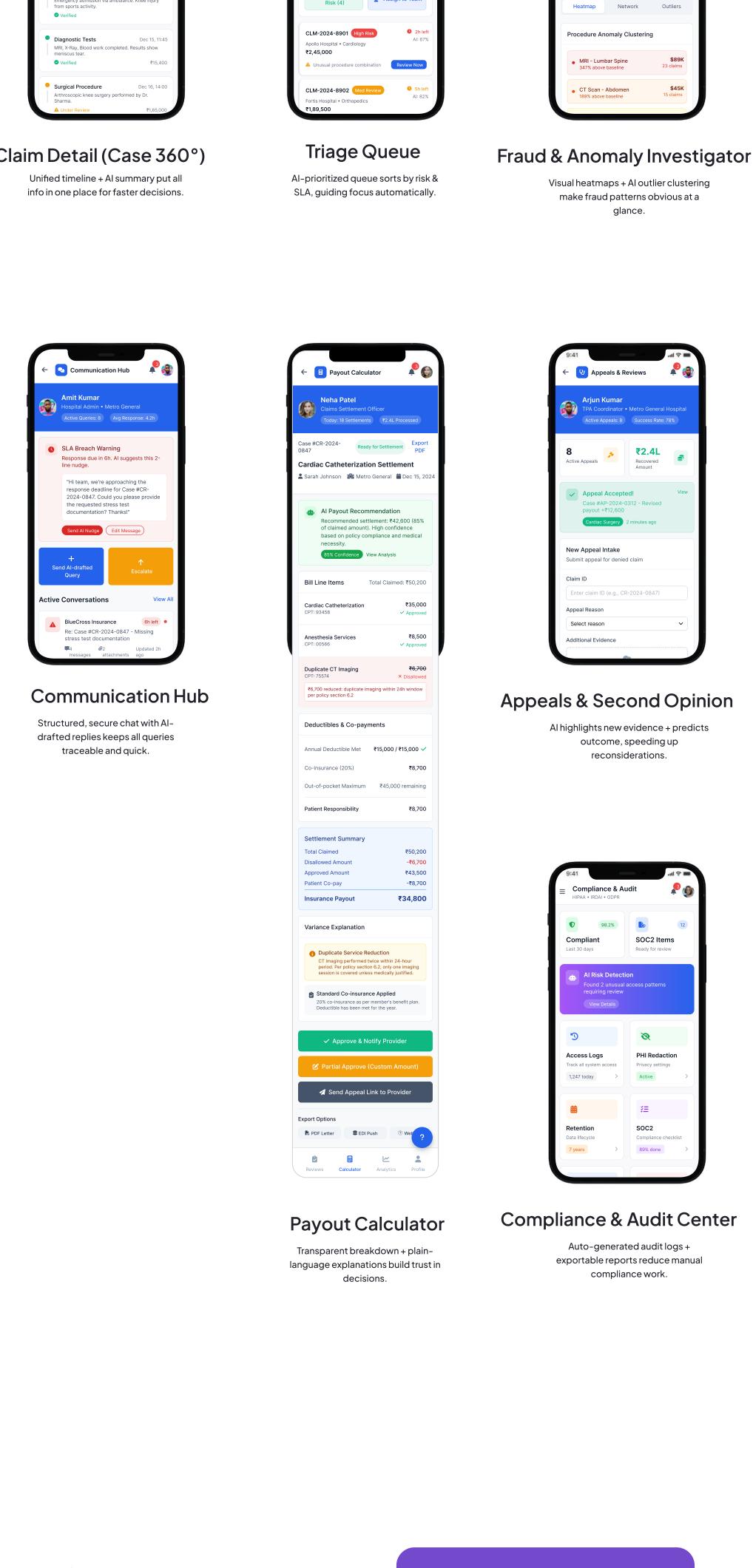
Hi Pooja

**Triage Queue** 

Al Processing Active

Auto-triaged 247 claims today. 12 need your





Thank You For Watching

Designed by -

Varun Design Hub