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Indian National Pleads Guilty to $227M Medicare Fraud

An Indian national pleaded guilty today to a $227 million Medicare fraud scheme in which hundreds of thousands of Medicare beneficiaries' personally identifiable information was purchased from a company based in Pakistan and used to bill Medicare for COVID-19 test kits that were never provided.

According to court documents and statements made in court, Syed Murtuza Kablazada, 36, an Indian national residing in Des Plaines, Illinois, engaged in a scheme to defraud the Medicare program by submitting false and fraudulent claims for over-the-counter COVID-19 test kits that were not requested by beneficiaries or provided to them. Over the course of six months, starting in January 2023, Kablazada and his co-schemers acquired three Chicago-area laboratories, Chicago Care, V Care, and Al-Ameer. Kablazada then paid approximately $11 million to a purported telemarketing company based in Pakistan to obtain personally identifiable information for hundreds of thousands of Medicare beneficiaries. Using those Medicare beneficiaries' information, Kablazada caused the laboratories to submit $227 million in false and fraudulent claims to Medicare for test kits that he knew were never requested by or shipped to the Medicare beneficiaries, for which Medicare paid approximately $136 million. To conceal their involvement in this scheme, Kablazada and his co-schemers paid themselves through overseas money transfers and unlicensed money transmitters, and they used the proceeds in part to purchase luxury vehicles.

As part of his plea agreement in this case, Kablazada agreed to forfeit over $46 million in fraud proceeds that law enforcement seized from ten bank accounts.

Kablazada pleaded guilty to two counts of health care fraud. He is scheduled to be sentenced on a later date and faces a maximum penalty of 20 years in prison. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Assistant Attorney General Colin M. McDonald of the Justice Department's National Fraud Enforcement Division; Special Agent in Charge Ryan Whalen of the FBI Chicago Field Office; and Special Agent in Charge Thomas Ethridge of the Department of Health and Human Services Office of Inspector General (HHS-OIG) made the announcement.

The FBI Chicago Field Office and HHS-OIG investigated the case.

Deputy Chief Patrick Mott and Trial Attorney Claire Sobczak Pacelli of the Fraud Division's Health Care Fraud Section are prosecuting the case. Assistant U.S. Attorney Andres Almendarez for the Northern District of Illinois assisted in investigating and prosecuting this case.

On April 7, the Department of Justice announced the creation of the Fraud Division. The Fraud Division is laser-focused on investigating and prosecuting those who commit fraud against the American people. The Department's work to combat fraud supports President Trump's Task Force to Eliminate Fraud, a whole-of-government effort chaired by Vice President J.D. Vance to eliminate fraud, waste, and abuse within Federal benefit programs.

The Department of Justice's Health Care Fraud Strike Force Program, currently comprised of nine strike forces operating in federal districts across the country, has charged more than 6,200 defendants who collectively billed federal health care programs and private insurers more than $45 billion since 2007. In addition, the Centers for Medicare & Medicaid Services, working in conjunction with the Office of the Inspector General for the Department of Health and Human Services, are taking steps to hold providers accountable for their involvement in health care fraud schemes. More information can be found at www.justice.gov/criminal-fraud/health-care-fraud-unit .