Pakistani Scammers Used AI to Fake Patient Voices in $703 Million Medicare Fraud

Federal prosecutors say criminals created artificial recordings of Medicare patients consenting to medical services they never wanted

A Pakistani-led criminal network used artificial intelligence to create fake recordings of Medicare patients. The recordings appeared to show the patients agreeing to receive medical equipment and COVID-19 test kits they never requested.

What's even worse is they used stolen identities that they hacked off of US Databases which means that identity theft victims were also victims of deepfakes too.

The Department of Justice charged five defendants in what prosecutors called one of the largest Medicare fraud cases ever prosecuted. The indictment filed in Chicago federal court shows how criminals are now using AI technology to commit healthcare fraud on an unprecedented scale.

A Scheme That Was Created In Pakistan

Ruknuddin "Rick" Charolia and Aamir Ali Arif, both Pakistani citizens, led the operation from Pakistan and the United Arab Emirates.

They worked with three accomplices to submit over $703 million in fraudulent Medicare claims between January 2023 and April 2025.

They Used Deepfake AI Voices To Show Patient Consent

The Pakistani fraudsters used AI to manufacture fake recordings that made it sound like Medicare patients were asking for medical equipment and COVID-19 test kits.

These bogus deepfake audio clips were then submitted to Medicare and insurance companies as proof that patients had requested the items.

"Defendants created and distributed Medicare BINs and fabricated records and fake recordings, including through the use of artificial intelligence, that purportedly demonstrated beneficiaries consenting to the receipt of over-the-counter COVID-19 test kits," the indictment states.

The fake recordings were so convincing that Medicare paid out hundreds of millions in claims.

They Targeted Three Types Of Medical Services

The scheme targeted three types of medical services.

First, the group submitted fraudulent claims for over-the-counter COVID-19 test kits using the AI-generated consent recordings. Medicare had authorized up to eight free test kits per month for each beneficiary during the pandemic.

Second, they billed Medicare for durable medical equipment like knee braces, ankle braces, and back braces. Patients never received these items, but the fake AI recordings made it appear they had requested them.

Third, the network submitted claims for genetic testing services that were never performed. These tests supposedly checked for diseases like Parkinson's, Alzheimer's, and diabetes.

How They Stole Patient Information

To get Medicare patient data, the criminals hacked into legitimate healthcare websites and scraped patient information from publicly available sites. They also created fake websites that tricked patients into giving up their personal information by promising free healthcare products.

"Defendants obtained Medicare BINs without lawful authority by hacking into websites which collected the information from beneficiaries lawfully, scraping patient data from publicly accessible websites, and creating websites that

convinced beneficiaries to provide their information by falsely advertising free health care products," prosecutors wrote.

Once they had patient Medicare identification numbers, they used AI to create fake consent recordings in the patients' supposed voices.

They Created Shell Companies To Hide Their Scheme

The fraudsters set up fake companies in Wyoming, Missouri, and California to hide their involvement.

One of the suspects, Fizza Farid, who lived in Texas, served as a nominee owner for one of the medical equipment companies while the Pakistani masterminds actually controlled it.

The group moved money through companies called Mavens LLC, Khoka LLC, and VirtuVista Financial LLC. These shell companies had fake business addresses and conducted no real business operations.

"Defendant Aamir caused the organization of Mavens, with a registered business address in Sheridan, Wyoming, knowing that Mavens was a pass-through entity that conducted no business activities in Wyoming," the indictment says.

Modern Technology Meets Old-Fashioned Fraud

The case shows how criminals are adapting traditional Medicare fraud schemes with cutting-edge technology. While healthcare fraud has existed for decades, the use of AI to create fake patient consent represents a new frontier in medical crime.

The AI-generated recordings were detailed enough to fool Medicare's fraud detection systems initially. The criminals submitted the fake audio files along with other fabricated documentation to support their fraudulent claims.

They Arrested Suspects As They Tried To Flee The US

Law enforcement arrested four defendants as they tried to flee the United States at airports. Fizza Farid escaped to Pakistan in April 2025, traveling through Mexico and Turkey with accomplice Shearyar Arif.

Medicare paid out $418.6 million on the fake claims before investigators caught the scheme. The defendants transferred at least $45.1 million to their Pakistani bank accounts for personal use.

Read Indictment

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

UNITED STATES OF AMERICA v. RUKNUDDIN "RICK" CHAROLIA, AAMIR ALI ARIF, SHEARYAR ARIF, FIZZA FARID, and FAIZAN SALEEM, Defendants.	**UNDER SEAL** No. Violations: Title 18, United States Code, Sections 371, 1347, and 1956(h)

COUNTS ONE THROUGH FOUR

The SPECIAL JUNE 2024 GRAND JURY charges:

1. At times material to this Indictment:

The Medicare Program

a. The Medicare program ("Medicare") was a federally funded program that provided free and below-cost health care benefits to people aged 65 years or older, the blind, and the disabled. The Centers for Medicare & Medicaid Services ("CMS"), an agency of the Department of Health and Human Services ("HHS"), was responsible for the administration of Medicare. Medicare was a "health care benefit program," as defined by 18 U.S.C. § 24(b).

b. Individuals who received benefits under Medicare were referred to as Medicare "beneficiaries." Beneficiaries were eligible to receive a variety of services, including hospital services ("Part A"), physician services ("Part B"), and

prescription drug coverage ("Part D"). Part B covered outpatient physician services, such as office visits, minor surgical procedures, durable medical equipment ("DME"), and laboratory services, such as drug testing and genetic testing, when certain criteria were met.

c. "Part C" of Medicare, commonly referred to as "Medicare Advantage," provided enrolled beneficiaries with services typically covered under Parts A and B, in addition to optional supplemental benefits, and was administered by private insurance companies.

d. A beneficiary eligible for Medicare could choose to be covered under "original" Medicare, where qualifying items and services were covered under Parts A and B, or under Part C (Medicare Advantage). A beneficiary who selected coverage under Medicare Advantage enrolled in a Medicare Advantage plan managed by a private insurance company ("Medicare Advantage Plan"). A Medicare Advantage Plan was a "health care benefit program," as defined by 18 U.S.C. § 24(b).

e. "Providers" included clinical laboratories, physicians, DME providers, and other health care providers who provided items and services to beneficiaries. In order to have the capability to bill "original" Medicare (i.e., Part A and B), a provider had to submit an enrollment application to Medicare. The enrollment application contained certification statements to which the provider had to agree before enrolling with Medicare. Specifically, the certification statement set forth, in part, that the provider agreed to abide by Medicare laws, regulations, and program instructions, including the Federal Anti-Kickback Statute, 42 U.S.C.

§ 1320a-7b(b), and would not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare. Medicare would not pay claims procured through unlawful purchases and sales of Medicare BINs.

f. A National Provider Identifier ("NPI") was a unique ten-digit identification number issued to providers by CMS. All providers that transmitted health information in electronic form, including claims for payment to Medicare and Medicare Advantage Plans, were required to obtain an NPI. Providers could apply for an NPI by completing an online application. The online application process consisted of registering for an Identity & Access User ID and completing the NPI application, which included identifying the organization, its Employer Identification Number, providing the business mailing and practice addresses, and designating a contact person, including identifying that individual's title, email address, and telephone number.

g. Under Part C, CMS paid a Medicare Advantage Plan a monthly fixed, capitated (per beneficiary) amount, adjusted by the expected risk of each beneficiary.

h. Medicare Advantage Plans were required to provide at least the same benefits as traditional Medicare. Medicare Advantage Plans were required to "provide coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Medicare Part A and Part B," which generally included coverage for DME and laboratory testing. *See* 42 U.S.C. § 1395w-22(a)(1); 42 C.F.R. § 422.101.

i. Medicare Advantage Plans were required to comply with CMS's general coverage guidelines included in Medicare manuals and instructions unless superseded by CMS's Part C regulations or related instructions. No Medicare payment could be made under Part A or Part B for any expenses incurred for items or services that were not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. *See* 42 U.S.C. § 1395y(a)(1)(A). Accordingly, Medicare Advantage Plans could not pay for DME or laboratory testing that was not medically necessary.

j. Medicare Advantage Plans received, adjudicated, and paid claims from providers seeking reimbursement for the cost of health care benefits, items, or services provided to Medicare beneficiaries. Each Medicare Advantage Plan operated an internal investigation unit responsible for conducting investigations of potential fraud, waste, and abuse.

k. The Investigations Medicare Integrity Contractor (the "I-MEDIC") was a CMS contractor that conducted investigations into fraud, waste, and abuse in Medicare Parts C and D. The I-MEDIC received and investigated complaints from many sources including Medicare beneficiaries and Medicare Advantage Plans. When appropriate, the I-MEDIC referred cases to law enforcement.

l. Each Medicare beneficiary was identified with a unique beneficiary identifier number ("BIN"). Medicare BINs were used, among other ways, to determine a beneficiary's eligibility for Medicare and Medicare Advantage Plans' benefits, and to submit claims to Medicare seeking reimbursement for covered

benefits, items, and services. Health Insurance Claim Numbers ("HICNs") and Medicare Beneficiary Identifiers ("MBIs") were two types of Medicare BINs. HICNs were typically comprised of the beneficiary's Social Security number and often included one or more additional letters. In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act ("MACRA"), which mandated that CMS phase out of the use of Social Security numbers in the assignment of Medicare BINs. One purpose of this change was to improve patient identity protection and prevent identity theft. These MBIs and BINs were considered "means of identification" pursuant to 18 U.S.C. § 1028(d)(7). CMS implemented the new MBIs in an effort to combat identity theft and safeguard taxpayer dollars.

m. In cases where Medicare rules required that services be ordered or referred by a physician or other qualified practitioner, the provider authorizing the service was known as the "referring provider."

n. By agreeing to the terms of the Medicare Electronic Data Interchange Enrollment ("EDI") form, a provider affirmed that, with respect to any claim submitted by the provider, it would "retain all original source documentation and medical records pertaining to any such particular Medicare claim for a period of at least 6 years, 3 months after the bill is paid." The EDI form further stated that every source document must reflect the beneficiary's name, beneficiary's identification number, date(s) of service, diagnosis/nature of illness, and procedure/services performed.

o. In order for a provider to receive payment on a claim, CMS required, among other things, that the service billed actually had been rendered.

Background on Laboratory Testing

p. Laboratories purported to offer genetic testing that used DNA sequencing to detect mutations in genes that could indicate an increased risk of developing diseases such as Parkinson's disease, Alzheimer's disease, dementia, diabetes, obesity, pulmonary diseases, and hearing loss (collectively, "genetic testing"). All genetic testing was a form of diagnostic testing.

q. For genetic testing, a beneficiary provided a saliva sample or cheek or nasal swab containing DNA material. The DNA sample was then submitted to a laboratory to conduct genetic testing. Tests were then run on different "panels" of genes. Genetic testing typically involved performing lab procedures that resulted in billing Medicare and Medicare Advantage Plans using certain billing codes, each with its own reimbursement rate.

r. DNA samples were submitted along with requisitions (or the physician's order) that identified the beneficiary, the beneficiary's insurance, and indicated the specific type of genetic testing to be performed. For laboratories to submit claims to Medicare or Medicare Advantage Plans for genetic testing, the requisitions had to be signed by a physician or other authorized medical professional, who attested to the medical necessity of the genetic testing.

s. If diagnostic testing was reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a

malformed body member, Medicare imposed additional requirements before covering the testing. Title 42, Code of Federal Regulations, Section 410.32(a) provided, "[A]ll . . . diagnostic laboratory tests . . . must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary[.]"

Background on Over-the-Counter COVID-19 Test Kits

t. In or around April 2022, the federal government announced that Medicare beneficiaries could receive up to eight over-the-counter COVID-19 test kits per calendar month from participating pharmacies and health care providers, for the duration of the COVID-19 public health emergency, at no cost to Medicare beneficiaries. This program was intended to ensure Medicare beneficiaries had access to over-the-counter COVID-19 test kits they needed to stay safe and healthy during the COVID-19 pandemic.

u. Medicare would not pay for more than eight over-the-counter COVID-19 test kits per calendar month, per Medicare beneficiary. CMS issued guidance instructing providers to distribute over-the-counter COVID-19 test kits only to Medicare beneficiaries who requested them. Providers also were instructed to keep documentation showing a Medicare beneficiary's request for the test kits.

v. The public health emergency for COVID-19 ended on May 11, 2023, at which point Medicare would no longer pay for eight over-the-counter COVID-

19 test kits per month at no cost to beneficiaries. However, on February 9, 2023, Medicare announced that it would allow a one-year grace period for providers to bill over-the-counter COVID-19 test kits that were provided to beneficiaries prior to May 11, 2023, but that the provider was unable to bill prior to the May 11, 2023, deadline.

w. In order to receive reimbursement from Medicare for supplying over-the-counter COVID-19 test kits, providers were directed to bill Medicare using Healthcare Common Procedure Code System ("HCPCS") code K1034.

Background on Durable Medical Equipment ("DME")

x. Medicare covered an individual's access to DME, such as ankle braces, knee braces, back braces, elbow braces, wrist braces, and hand braces. Certain DME products were available "off the shelf," required minimal self-adjustment for appropriate use, and did not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual.

y. A claim for DME submitted to Medicare qualified for reimbursement only if it was medically necessary for the treatment or diagnosis of the beneficiary's illness or injury and prescribed by a licensed physician. In claims submitted to Medicare for the reimbursement of DME, providers were required to set forth, among other information, the beneficiary's name and unique Medicare identification number, the equipment provided to the beneficiary, the date the equipment was provided, the cost of the equipment, and the name and provider number of the provider who prescribed or ordered the equipment. To be reimbursed

from Medicare for DME, the claim had to be reasonable, medically necessary, documented, and actually provided as represented to Medicare.

Defendants and Related Entities

z. Hello International Marketing Solutions ("HIMS") was a Pakistani entity and call center.

aa. HIMS Technology (Private) Limited ("HIMS Tech PK") was a Pakistani entity.

bb. HIMS LLC ("HIMS US") was a Wyoming company.

cc. HIMS Tech Studio Technology LLC ("HIMS Tech UAE") was a United Arab Emirates company.

dd. Ciao Marketing ("Ciao") was a Pakistani entity.

ee. Bonjour Communication ("Bonjour") was a Pakistani entity.

ff. Howdy Information Technology Co. LLC ("Howdy") was an entity that held a bank account located in the UAE.

gg. Fast Practice Innovation Private Limited ("FPI") was a Pakistani entity.

hh. Fast Practice Innovations, LLC ("FPI US") was a California company.

ii. Mavens LLC ("Mavens") was a Wyoming company.

jj. Khoka LLC ("Khoka") was a Wyoming company.

kk. VirtuVista Financial LLC ("VirtuVista") was a Missouri company.

ll. Financial Institution A held bank accounts for Mavens, Khoka, and VirtuVista.

mm. HIMS, FPI, and FPI US purported to provide marketing, credentialing, and billing services to United States-based providers, including laboratories and DME providers, and received funds for such services, through entities including Mavens, Khoka, and VirtuVista, at bank accounts held in the name of HIMS, HIMS US, HIMS Tech PK, HIMS Tech UAE, Ciao, Bonjour, Howdy, FPI, and FPI US (collectively, the "HIMS Organization").

nn. Defendant RUKNUDDIN "RICK" CHAROLIA ("CHAROLIA"), a Pakistani citizen, resided in Pakistan and the United Arab Emirates and was the owner of HIMS, an owner and officer of HIMS Tech PK, an owner and officer of HIMS Tech UAE, and worked on behalf of the HIMS Organization.

oo. Defendant AAMIR ALI ARIF ("AAMIR"), a Pakistani citizen, resided in Pakistan and was an owner of HIMS Tech PK, an owner and officer of HIMS Tech UAE, worked on behalf of the HIMS Organization, and was identified as an authorized user of the Mavens bank account at Financial Institution A ("Mavens Bank Account").

pp. Defendant SHEARYAR ARIF ("SHEARYAR"), a Pakistani citizen, resided in Pakistan, and worked on behalf of the HIMS Organization.

qq. Defendant FIZZA FARID ("FARID"), a Pakistani citizen, resided in Texas, worked on behalf of the HIMS Organization, and was the nominee owner of DME Provider A.

rr. Faizan Saleem ("Saleem"), a Pakistani citizen, resided in Pakistan, worked on behalf of the HIMS Organization, and was identified as the authorized user of the VirtuVista bank account at Financial Institution A ("VirtuVista Bank Account").

ss. Individual A resided in Pakistan and was the managing director of FPI, which provided billing services for genetic testing, over-the-counter COVID-19 test kits, and DME claims submitted to health care benefit programs, including Medicare.

tt. Individual B resided in Naperville, Illinois and was the owner of DME Provider B.

uu. Individual C resided in Addison, Illinois and was an associate of Individual B.

vv. Individual D resided in Texas and was the nominee owner of DME Provider C.

ww. Individual E resided in New York and owned and operated Company A.

xx. Individual F was the applicant and authorized user for the Khoka bank account at Financial Institution A ("Khoka Bank Account").

yy. Laboratory A, Laboratory B, Laboratory C, Laboratory D, and Laboratory E were all laboratories located in the Northern District of Illinois.

2. From in or around January 2023, and continuing through in or around April 2025, in the Northern District of Illinois, and elsewhere,

RUKNUDDIN CHAROLIA,
AAMIR ALI ARIF,
SHEARYAR ARIF, and
FIZZA FARID,

defendants herein, along with Individual A, Individual B, Individual C, and others known and unknown to the Grand Jury, participated in a scheme to defraud a health care benefit program, namely Medicare and Medicare Advantage Plans, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money owned by and under the custody and control of a health care benefit program in connection with the delivery of and payment for health care benefits, items, and services, as further described below.

3. It was part of the scheme that, for the purpose of submitting fraudulent claims to Medicare and Medicare Advantage Plans, defendants CHAROLIA and AAMIR, through the HIMS Organization, sold and caused to be sold Medicare BINs for use in billing by U.S.-based provider entities, and defendants CHAROLIA, AAMIR, and SHEARYAR recruited and caused to be recruited nominee owners for U.S.-based provider entities, including defendant FARID and others. Defendants CHAROLIA, AAMIR, SHEARYAR, and FARID, and others then caused to be submitted fraudulent claims from the U.S.-based provider entities for (a) over-the-counter COVID-19 test kits, (b) DME, and (c) laboratory testing services that were not medically necessary, not requested, and/or not provided to the beneficiaries.

4. It was further part of the scheme that, for the purpose of collecting Medicare BINs that could be used in fraudulent claims submitted to health care benefit programs, defendants CHAROLIA and AAMIR, through the HIMS

Organization, obtained Medicare BINs without lawful authority by (a) hacking into websites which collected the information from beneficiaries lawfully, (b) scraping patient data from publicly accessible websites, and (c) creating websites that convinced beneficiaries to provide their information by falsely advertising free health care products.

5. It was further part of the scheme that defendants CHAROLIA and AAMIR, without lawful authority, sold, distributed, and/or arranged for the sale and distribution of Medicare BINs and other information to U.S.-based provider entities, for use in the submission of fraudulent claims for reimbursement to Medicare and Medicare Advantage Plans.

6. It was further part of the scheme that defendants CHAROLIA, AAMIR, and SHEARYAR recruited and caused to be recruited individuals in the United States, including FARID, Individual B, and others, to assist, without lawful authority, in the sale, distribution, and/or arrangement for the sale or distribution of Medicare BINs and other information for use by U.S.-based provider entities.

Fraudulent Over-the-Counter COVID-19 Test Kit Billing

7. It was further part of the scheme that defendants CHAROLIA, AAMIR, and others, through the HIMS Organization, created and distributed to Individual B and others Medicare BINs and fabricated records and fake recordings, including through the use of artificial intelligence ("AI"), that purportedly demonstrated beneficiaries consenting to the receipt of over-the-counter COVID-19 test kits, to sell

to laboratories knowing the records and recordings would be used support fraudulent claims for reimbursement to Medicare and Medicare Advantage Plans.

Fraudulent DME Billing

8. It was further part of the scheme that defendants CHAROLIA, SHEARYAR, FARID, Individual B, and others recruited individuals to act as nominee owners of DME providers that, in fact, were owned and controlled by defendants CHAROLIA and SHEARYAR.

9. It was further part of the scheme that defendants CHAROLIA and SHEARYAR, through others, caused the submission of false incorporation and organization documents to the States in which the nominee-owned DMEs were incorporated and organized, which CHAROLIA and SHEARYAR knew concealed the true ownership and control of the nominee-owned DME providers.

10. It was further part of the scheme that defendants CHAROLIA and SHEARYAR, through others, caused the submission of false credentialing documents to CMS and Medicare Advantage Plans on behalf of the nominee-owned DME providers, which CHAROLIA and SHEARYAR knew concealed the true ownership and control of the nominee-owned DME providers.

11. It was further part of the scheme that defendants CHAROLIA, SHEARYAR, and FARID, through Individual A and others, caused the submission of fraudulent claims to Medicare Advantage Plans on behalf of the nominee-owned DME providers, for DME that defendants CHAROLIA, SHEARYAR, and FARID knew

beneficiaries did not request, consent to receive, or receive, and/or doctors did not prescribe, and which were not eligible for reimbursement by Medicare.

12. It was further part of the scheme that defendants CHAROLIA and SHEARYAR, through Individual A and others, caused the submission of additional fraudulent documentation to Medicare Advantage Plans' Special Investigation Units purportedly supporting the fraudulent claims to Medicare Advantage Plans on behalf of the nominee-owned DME providers.

13. It was further part of the scheme that defendants CHAROLIA, SHEARYAR, and FARID, and others caused checks from Medicare Advantage Plans reimbursing the nominee-owned DME providers for fraudulent claims to be deposited into bank accounts opened by the nominee owners.

Fraudulent Genetic Testing Billing

14. It was further part of the scheme that defendants CHAROLIA and AAMIR recruited individuals to act as nominee owners of laboratories that, in fact, were owned and controlled by defendants CHAROLIA and AAMIR, and who CHAROLIA and AAMIR instructed may need to leave the country in the event of an insurance audit of the laboratory.

15. It was further part of the scheme that defendants CHAROLIA and AAMIR, through others, caused the submission of false incorporation and organization documents to the States in which the nominee-owned laboratories were incorporated and organized, which CHAROLIA and AAMIR knew concealed the true ownership and control of the nominee-owned laboratories.

16. It was further part of the scheme that defendants CHAROLIA and AAMIR, through others, caused the submission of false credentialing documents to CMS and Medicare Advantage Plans on behalf of the nominee-owned laboratories, which CHAROLIA and AAMIR knew concealed the true ownership and control of the nominee-owned laboratories.

17. It was further part of the scheme that defendants CHAROLIA and AAMIR caused the submission of fraudulent claims to Medicare on behalf of the nominee-owned laboratories, for genetic testing that defendants CHAROLIA and AAMIR knew beneficiaries did not request, consent to receive, or receive, and/or doctors did not prescribe, and which were not eligible for reimbursement by Medicare.

Further Acts in Support of Scheme

18. It was further part of the scheme that defendants CHAROLIA, AAMIR, SHEARYAR, FARID, Individual A, Individual B, Individual C, and others concealed, misrepresented, and hid, and caused to be concealed, misrepresented, and hidden, the existence, purpose, and acts done in furtherance of the scheme.

19. It was further part of the scheme that, for the purpose of concealing and hiding, and causing to be concealed and hidden, the existence, purpose, and acts done in furtherance of the scheme, defendant FARID fled the United States to Pakistan in late April 2025. During FARID's flight, SHEARYAR traveled with FARID from Mexico to Pakistan, through Turkey.

20. It was further part of the scheme that defendants CHAROLIA, AAMIR, SHEARYAR, and FARID, along with Individual A, Individual B, Individual C, and

others caused the laboratories and DME providers to submit at least approximately $703,834,742.77 in fraudulent claims for over-the-counter COVID-19 test kits, DME, and laboratory testing, that was medically unnecessary, which patients did not request, receive, or consent to receive, and were ineligible for reimbursement, for which the DME providers and laboratories received at least approximately $418,646,326.36 from Medicare and Medicare Advantage Plans.

21. It was further part of the scheme that defendants CHAROLIA, AAMIR, SHEARYAR, FARID, and others caused the DME providers and laboratories to transfer at least approximately $45,100,161 in payments based on the fraudulent claims to Mavens, Khoka, and VirtuVista.

22. It was further part of the scheme that CHAROLIA, AAMIR, SHEARYAR, and FARID diverted proceeds of the fraud for their personal use and benefit of themselves and others, and to continue the fraud.

23. On or about the submission dates below, in the Northern District of Illinois, Eastern Division, and elsewhere,

RUKNUDDIN CHAROLIA,
AAMIR ALI ARIF,
SHEARYAR ARIF, and
FIZZA FARID,

defendants herein, did knowingly and willfully execute, and attempt to execute, the above-described scheme by causing the submission of claims to a health care benefit program, namely Medicare and Medicare Advantage Plans, for health care benefits, items, and services that were not actually provided, requested, and/or medically necessary, each such submission constituting a separate count:

Count	Defendants	Approx. Submission Date	Approx. Date of Service	Billing Entity	Patient	Approx. Amt. Billed	Approx. Amt. Paid
1	CHAROLIA AAMIR	04/10/2023	09/12/2022	Lab. B	G.S.	$120	$94.08
2	CHAROLIA AAMIR	05/03/2023	03/09/2023	Lab. A	B.W.	$120	$94.08
3	CHAROLIA SHEARYAR FARID	6/23/2023	06/15/2023	DME Provider A	D.L.	$8,150	$2,565.66
4	CHAROLIA SHEARYAR	12/26/2023	12/20/2023	DME Provider C	E.S.	$4,200	$1,906.98

In violation of Title 18, United States Code, Section 1347.

COUNT FIVE

The SPECIAL JUNE 2024 GRAND JURY further charges:

1. At times material to Count Five of this Indictment:

a. Paragraphs 1(a) to 1(yy) of Count One of the Indictment are incorporated here.

2. From in or around October 2019, and continuing until in or around October 2023, in the Northern District of Illinois, and elsewhere,

RUKNUDDIN CHAROLIA,
AAMIR ALI ARIF, and
FAIZAN SALEEM,

defendants herein, together with others known and unknown to the Grand Jury, knowingly conspired to: (a) to defraud the United States by impairing, impeding, obstructing, and defeating through deceitful and dishonest means, the lawful government functions of the United States Department of Health and Human Services in its administration and oversight of Medicare, in violation of Title 18, United States Code, Section 371; and (b) without lawful authority, knowingly and willfully sell and distribute, and arrange for the sale and distribution, of Medicare BINs to laboratories and DME providers, in violation of Title 42, United States Code, Section 1320a-7b(b)(4).

Purpose of the Conspiracy

3. It was a purpose of the conspiracy for defendants CHAROLIA, AAMIR, and SALEEM, with Individual B and others, to unlawfully enrich themselves by, among other things: (a) selling and distributing, and arranging for the sale and

distribution, of Medicare BINs to others, including laboratories and DME providers, resulting in claims being submitted to Medicare; (b) providing false documentation, including fake recordings, purporting to establish patients' consent to receive certain items and services, to fraudulently support claims submitted to Medicare for such items and services; and (c) diverting proceeds of payments from Medicare based on claims involving the Medicare BINs for the personal use and benefit of defendants CHAROLIA, AAMIR, and SALEEM and their co-conspirators.

Manner and Means

4. It was part of the conspiracy that defendants CHAROLIA and AAMIR, through the HIMS Organization, without lawful authority, knowingly and willfully sold, distributed, and/or arranged for the sale and distribution, of Medicare BINs, including by obtaining Medicare BINs by hacking into websites which collected the information from beneficiaries lawfully, scraping patient data from publicly accessible websites, and creating websites that convinced beneficiaries to provide their information by falsely advertising free health care products.

5. It was further part of the conspiracy that defendants CHAROLIA and AAMIR, through the HIMS Organization, fabricated and falsified records purportedly demonstrating patient consent to over-the-counter COVID-19 test kits and DME, including through the use of AI, to fraudulently support claims submitted to Medicare for such items and services.

6. It was further part of the conspiracy that defendants CHAROLIA, AAMIR, and SALEEM, as well as Individual B and others, without lawful authority

sold, distributed, and/or arranged for the sale and distribution, of Medicare BINs to others, including Individual C and Individual E, so that the Medicare BINs could be used to submit claims to Medicare by DME providers and laboratories.

7. It was further part of the conspiracy that DME providers and laboratories used the Medicare BINs to submit claims to Medicare for DME, over-the-counter COVID-19 test kits, and/or laboratory testing.

8. It was further part of the conspiracy that the DME providers and laboratories which purchased Medicare BINs diverted proceeds of the reimbursement payments they received from Medicare to others, including Individual C and Individual E.

9. It was further part of the conspiracy that Individual C, Individual E, and others then further diverted proceeds of the reimbursement payments from Medicare to CHAROLIA, AAMIR, and SALEEM for their and their co-conspirators' personal use.

10. It was further part of the conspiracy that defendants CHAROLIA, AAMIR, and SALEEM, as well as Individual B and Individual C, caused the execution of contracts with laboratories on behalf of HIMS that concealed the reason why laboratories were paying Mavens and other entities—namely, without lawful authority, to purchase and arrange for the purchase of Medicare BINs.

11. It was further part of the conspiracy that CHAROLIA, AAMIR, and SALEEM, as well as Individual B and others misrepresented, concealed, hid, and

caused to be misrepresented, concealed, and hidden, the purpose of the conspiracy and the acts done in furtherance of the conspiracy.

12. Over the course of the conspiracy, defendants CHAROLIA, AAMIR, SALEEM, and others caused the DME providers and laboratories to pay at least approximately $31,233,788 in exchange for the BINs to Mavens and other entities.

Overt Acts

13. In furtherance of and to effect the objects of the conspiracy, the defendants committed and caused to be committed the following overt acts, among others, constituting payments in exchange for the sale or distribution of Medicare BINs to laboratories and DME providers in the Northern District of Illinois, and elsewhere:

a. The following payments to Mavens:

	Approx. Date	**Payor**	**Payee**	**Approximate Amount**
(i)	01/17/2023	Company A	Mavens	$27,500
(ii)	4/21/2023	Lab. C	Mavens	$558,363.30
(iii)	5/1/2023	Lab. A	Mavens	$509,644
(iv)	5/4/2023	Lab. D	Mavens	$195,000
(v)	5/18/2023	Lab. B	Mavens	$895,000
(vi)	5/24/2023	Lab. C	Mavens	$996,671

All in violation of Title 18, United States Code, Section 371.

COUNT SIX

The SPECIAL JUNE 2024 GRAND JURY further charges:

1. At times material to Count Six of this Indictment:

a. Paragraphs 1(a) to 1(yy) of Count One of the Indictment are incorporated here.

2. From in or around July 2022, and continuing through in or around February 2024, in the Northern District of Illinois, and elsewhere,

RUKNUDDIN CHAROLIA,
AAMIR ALI ARIF,
SHEARYAR ARIF,
FAIZAN SALEEM, and
FIZZA FARID,

defendants herein, did knowingly conspire with each other and with others known and unknown to the Grand Jury, to knowingly conduct a financial transaction affecting interstate and foreign commerce, involving proceeds of a specified unlawful activity—namely, health care fraud, in violation of Title 18, United States Code, Section 1347, and the unauthorized sale and distribution of BINs, in violation of Title 42, United States Code, Section 1320a-7b(b)(4)—knowing that the property involved in the transaction represented the proceeds of some form of unlawful activity, and knowing that the transaction was designed, in whole and in part, to conceal and disguise the nature, the location, the source, the ownership, and the control of the proceeds of the specified unlawful activity, in violation of Title 18, United States Code, Section 1956(a)(1)(B)(i).

Purpose of the Conspiracy

3. It was a purpose of the conspiracy for defendants CHAROLIA, AAMIR, SHEARYAR, SALEEM, and FARID to unlawfully enrich themselves and others by, among other things: (a) conducting transactions that were designed to conceal and disguise the nature, location, source, ownership, or control of the proceeds of unlawful activity; and (b) diverting proceeds of the unlawful activity for the personal use and benefit of the defendants and their co-conspirators.

Manner and Means

4. It was part of the conspiracy that defendants CHAROLIA, AAMIR, SHEARYAR, SALEEM, and FARID, with others known and unknown to the Grand Jury, agreed to unlawfully enrich themselves and others by: (a) conducting transactions involving the proceeds of health care fraud and the unauthorized sale and distribution of BINs; (b) designing such transactions, and causing them to be carried out, in such a way that the transactions concealed and disguised the nature, location, source, ownership, or control of the proceeds of unlawful activity; and (c) using the laundered proceeds for the benefit of CHAROLIA, AAMIR, SHEARYAR, and others.

Mavens

5. It was further part of the conspiracy that defendant AAMIR caused the organization of Mavens, with a registered business address in Sheridan, Wyoming, knowing that Mavens was a pass-through entity that conducted no business activities in Wyoming.

6. It was further part of the conspiracy that defendant AAMIR opened the Mavens Bank Account and made false representations to Financial Institution A regarding the business conducted by Mavens.

Khoka

7. It was further part of the conspiracy that defendant CHAROLIA caused the organization of Khoka with a registered business address in Sheridan, Wyoming, knowing that Khoka was a pass-through entity that conducted no business activities in Wyoming.

8. It was further part of the conspiracy that defendant CHAROLIA caused Khoka to be organized under the name of Individual F, even though Khoka was in fact owned and controlled by CHAROLIA and SHEARYAR, and Individual F played no active role in Khoka or the HIMS Organization.

9. It was further part of the conspiracy that defendant CHAROLIA caused to be opened the Khoka Bank Account and caused false representations to Financial Institution A that Khoka was controlled by Individual F, even though Khoka and the Khoka Bank Account were in fact controlled by CHAROLIA and SHEARYAR.

VirtuVista

10. It was further part of the conspiracy that defendant SALEEM caused the organization of VirtuVista, with a registered business address in Harrisonville, Missouri, knowing that VirtuVista was a pass-through entity that conducted no business activities in Missouri.

11. It was further part of the conspiracy that defendant SALEEM caused to be opened the VirtuVista Bank Account, making false representations in account opening documents, including representing that VirtuVista was in the business of "innovating IT solutions, from software to cybersecurity."

Transfers to Mavens, Khoka, and VirtuVista Bank Accounts

12. It was further part of the conspiracy that defendants CHAROLIA, AAMIR, and SHEARYAR instructed laboratories and DME providers to transfer proceeds of health care fraud and the unauthorized sale and distribution of BINs to the Mavens, Khoka, or VirtuVista Bank Accounts.

13. It was further part of the conspiracy that defendants CHAROLIA and AAMIR, including through Individual B and others, directed providers that agreed, without lawful authority, to purchase Medicare BINs and other information for the purpose of causing the submission of billing to Medicare, to make payments into the Mavens Bank Account.

Transfers From Mavens, Khoka, and VirtuVista Bank Accounts

14. It was further part of the conspiracy that defendants CHAROLIA, AAMIR, and SALEEM, including through Individual B and others, caused the transfer of proceeds of health care fraud and the unauthorized sale and distribution of BINs from the Mavens, Khoka, and VirtuVista Bank Accounts to United States and overseas bank accounts controlled by the HIMS Organization, including bank accounts in the name of HIMS Tech PK, Ciao, Bonjour, HIMS Tech UAE, HIMS US, and Howdy.

Concealment

15. It was further part of the conspiracy that defendants CHAROLIA, AAMIR, SHEARYAR, SALEEM, and FARID, as well as Individual B and others, misrepresented, concealed, hid, and caused to be misrepresented, concealed, and hidden, the purpose of the conspiracy and the acts done in furtherance of the conspiracy.

All in violation of Title 18, United States Code, Section 1956(h).

FORFEITURE ALLEGATION

The SPECIAL JUNE 2024 GRAND JURY further alleges:

1. Upon conviction of an offense in violation of Title 18, United States Code, Section 1347, as set forth in this Indictment, defendants CHAROLIA, AAMIR, SHEARYAR, and FARID shall forfeit to the United States of America any property that constitutes and is derived, directly and indirectly, from the gross proceeds traceable to the commission of the offense, as provided in Title 18, United States Code, Section 982(a)(7).

2. Upon conviction of an offense in violation of Title 18, United States Code, Section 1956(h), as set forth in this Indictment, defendants CHAROLIA, AAMIR, SHEARYAR, FARID, and SALEEM shall forfeit to the United States of America any property involved in such offense, and any property traceable to such property, as provided in Title 18, United States Code, Section 982(a)(1).

3. If any of the property described above, as a result of any act or omission by a defendant: cannot be located upon the exercise of due diligence; has been transferred or sold to, or deposited with, a third party; has been placed beyond the jurisdiction of the Court; has been substantially diminished in value; or has been commingled with other property which cannot be divided without difficulty, the United States of America shall be entitled to forfeiture of substitute property, as provided in Title 21, United States Code Section 853(p).

A TRUE BILL:

_____
FOREPERSON

_____
Signed by Michelle Petersen on behalf of the
UNITED STATES ATTORNEY

_____
LORINDA LARYEA
ACTING CHIEF, FRAUD SECTION
CRIMINAL DIVISION
U.S. DEPARTMENT OF JUSTICE