UCJ Fund Reimbursement & Reserve Form **SEE INSTRUCTIONS FOR COMPLETING ITEMS A THROUGH L ON THE REVERSE SIDE**	A. INJURED PARTY NAME	B. EMB FILE NUMBER
	C. DATE OF LOSS	D. INSURER CLAIM NUMBER
	E. NAIC NUMBER ☐ MTF ☐ NJAFIUA	F. TAX PAYER ID NUMBER

G. NAME AND ADDRESS OF INSURER SEEKING REIMBURSEMENT (DO NOT USE GROUP NAME)	H. PAYEE NAME AND ADDRESS IF DIFFERENT THAN INSURER

I. PROGNOSIS OF INJURED PARTY AND EXPECTED FUTURE TREATMENTS (CHECK ALL THAT APPLY AND PROVIDE A DETAILED DESCRIPTION OF FUTURE TREATMENTS AND THEIR EXPECTED DURATION)

☐ 1. DECEASED: _____ (MO/DAY/YEAR)

CAUSE OF DEATH: _____

☐ 2. LIKELY TO REQUIRE SURGERY IN FUTURE, WHEN: _____ (MO/YEAR)

TYPE: _____ ESTIMATED COST: _____

☐ 3. FOLLOW-UP/MAINTENANCE CARE ONLY

☐ 4. REQUIRES LONG TERM CARE

CHECK ONE: ☐ INSTITUTIONAL ☐ HOME CARE ☐ HOSPICE

CHECK ONE: ☐ PER DIEM CHARGE $ _____ ☐ NON PER DIEM CHARGE

☐ 5. REHABILITATION: (DESCRIBE THERAPIES AND EXPECTED DURATION)

☐ 6. OTHER: (DESCRIBE ANY OTHER PERTINENT INFORMATION RELATING TO PROGNOSIS OR TREATMENT)

☐ 7. NO FURTHER TREATMENT IS ANTICIPATED. MEDICAL EXPENSE FILE WAS CLOSED ON: _____ (MM/DD/YEAR)

J. OTHER REQUIRED INFORMATION PURSUANT TO N.J.A.C. 11:3-28

☐ 1. PIP PAYMENT RECORD (FORM UC-323) AND ADDITION VERIFICATION TAPE ATTACHED. YOUR REQUEST CANNOT BE PROCESSED WITHOUT THIS INFORMATION

☐ 2. AUDIT REPORTS ATTACHED AS PER N.J.A.C. 11:3-28.10 ☐ 3. COMPREHENSIVE MEDICAL REPORT ATTACHED

☐ 4. CLAIM IS IN LITIGATION/ARBITRATION. SUMMARY AND LEGAL/ARBITRATION DOCUMENTS ATTACHED

☐ 5. BENEFITS PAID FROM _____ (MM/DD/YEAR) THROUGH _____ (MM/DD/YEAR)

☐ 6. OTHER:

K. PAYMENTS AND RECOMMENDED LOSS RESERVES

1. INCURRED LOSS _____
2. THRESHOLD _____
3. AMOUNT PREVIOUSLY REIMBURSED _____
4. PAYMENT CURRENTLY BEING SOUGHT _____
5. RESERVE AFTER THIS REIMBURSEMENT _____
6. ANTICIPATED PAYMENTS DURING THE NEXT TWO YEARS _____
7. POTENTIAL RECOVERY, REIMBURSEMENT OR SUBROGATION AMOUNT FROM OTHER SOURCES, IF ANY _____

L. PAYEE DECLARATION

I CERTIFY THAT THE WITHIN PAYMENT REQUEST IS COMPLETE IN ALL ITS PARTICULARS, THAT THE DESCRIBED MEDICAL EXPENSES HAVE BEEN INCURRED AND PAID, THAT NO BONUS HAS BEEN GIVEN OR RECEIVED ON ACCOUNT OF SAID DOCUMENT AND THAT ALL THE FOREGOING STATEMENTS MADE BY ME ARE TRUE.

_____ _____
REQUESTOR NAME DATE

PRINT NAME: _____

TITLE: _____

TELEPHONE NUMBER: (____) _____

E-MAIL ADDRESS: _____

FOR UCJF USE ONLY	DOCUMENT #	PAYMENT #	AMOUNT APPROVED	APPROVED BY	DATE APPROVED
INITIAL SUBMISSION					
SUPPLEMENTAL					

INSURER INSTRUCTIONS
ITEMS (A) THROUGH (L) ARE TO BE COMPLETED BY INSURER

A. INJURED PARTY NAME

Enter the name of the injured party who is receiving medical treatment.

B. EMB FILE NUMBER

Enter the file number assigned to the claim by the UCJF.

C. DATE OF LOSS

Enter the date of the accident.

D. INSURER FILE NUMBER

Enter the claim number assigned by your company.

E. NAIC NUMBER

Enter the 5 digit company number assigned to your company by the National Association of Insurance Commissioners. Your actuarial or accounting departments can provide you with this number. Check the appropriate box if the policy covering this claim is a Market Transit Facility (MTF) or a New Jersey Automobile Full Insurance Underwriting Association (NJAFIUA) policy.

F. TAX PAYER ID NUMBER

Enter the federal employer identification number assigned to the payee.

G. NAME AND ADDRESS OF INSURER SEEKING REIMBURSEMENT

Enter the name and address of the insurer providing primary PIP coverage.

H. PAYEE NAME AND ADDRESS

Enter a payee name and address if the payee name and/or address is different than the primary insurer.

I. PROGNOSIS OF INJURED PARTY AND EXPECTED FUTURE TREATMENTS

1. If the injured party has died, then indicate the date and cause of death.
2. If there is a likelihood that the injured party will need surgery in the future, then provide an estimated date as to when the surgery will be needed, the type of surgery required and the estimated cost of such surgery.
3. Indicate whether the injured party is receiving only follow-up or maintenance care.
4. If the injured party requires long term care, then indicate if such care is provided at home, in an institution, or in a hospice and whether or not the provider is charging a per diem rate. Indicate the per diem charge if applicable.
5. If the injured party is actively receiving any kind of rehabilitative therapy, then indicate the kind of therapy and the expected duration of such therapy.
6. Provide other information relevant to the injured party's future medical treatment or prognosis.
7. Indicate whether the injured party has discontinued treating and that no further reimbursement requests are anticipated.

J. OTHER REQUIRED INFORMATION PURSUANT TO N.J.A.C. 11:3-28

1. You must attach your PIP payment record (Form UC-323) and verification of your addition in the form of an adding machine tape. Your reimbursement cannot be processed without this information. This box is automatically checked off.
2. Pursuant to N.J.A.C. 11:28-10, insurers shall conduct an audit of claims submitted by health care facilities where the claim is greater than or equal to $25,000 and shall conduct an audit of claims submitted by a provider where the claim is greater than or equal to $10,000. Check this box if one or more audits are enclosed.
3. Check this box if you are enclosing medical reports.
4. Check this box if this claim is the subject of litigation or arbitration. If so, attach a summary of the litigation/arbitration status, along with the legal or arbitration documents.
5. Indicate when the medical expenses relating to this reimbursement request were paid.
6. Check this box if there is any other information relevant to y our reimbursement request, and describe that information.

K. PAYMENTS AND RECOMMENDED LOSS RESERVES

1. Enter the incurred medical expense losses prior to the payment of the expenses included in this reimbursement. This value should equal your current reserve plus any medical expenses paid to date except those for which you are currently seeking reimbursement.
2. Enter the $75,000 threshold. In cases where contribution is available the threshold will exceed $75,000.
3. Enter the amount of reimbursement received from the UCJF to date.
4. Enter the amount of reimbursement currently being requested.
5. This amount is derived by subtracting the amounts in items 2, 3 and 4 from the amount in item 1.
6. Enter the amount of medical expenses you anticipate paying in the next two years. If no payments are expected, then enter zero with an explanation in the Prognosis Section (16).
7. Enter the amount of any potential recovery reimbursement or subrogation from other sources, if any.

L. PAYEE DECLARATION

The insurer representative submitting this request must complete the payee declaration, date the request form and indicate his or her name, title and telephone number.