NAIC UNIFORM CASE UPDATE FORM

Reporting Person:	Insurance Company:	NAIC#	For State Use Only

Mailing address:	Phone number: ( ) Fax number: ( ) E-mail address:

Referral Information

State of Insurance Fraud Division Case No.: Date of referral: Subject Name: Case Completed: ☐ Yes ☐ No Date:	State of Insurance Fraud Division Case No.: Date of referral: Subject Name: Case Completed: ☐ Yes ☐ No Date:

Additional Case Details

☐ Statements (Witness / Insured / Subject) ☐ Sworn ☐ Recorded	☐ EUO / Deposition	☐ Law Enforcement / Other Agency Reports
	☐ Copies of Receipts	☐ Claim History Extracts
☐ Proof of Loss	☐ Expert Reports	☐ IME Reports
☐ Continuance of Disability Forms	☐ Videos / Photos	☐ Investigative Reports
☐ Medical Records	☐ Claim Information	☐ External Database results
☐ Other	☐ Other	☐ Other

Case Details Comments

Attachments? Yes ☐ No ☐

Additional Information - Persons

AKA/Alias? ☐ Yes ☐ No If yes, legal name:	Additional subject of this investigation? Yes ☐ No ☐

Type:	Name (Last):	(First):	(Middle):	Date of birth:	Age:	SSN:

Street Address (include P.O. Box and apartment #'s):	Address Type: ☐ Res. ☐ Bus. ☐ Maildrop ☐ Other	Fed. TIN ☐ EIN ☐ Number:	Sex: M ☐ F ☐

City:	State:	Zip:	County:	Telephone No.: ( )	Phone Type: ☐ home ☐ cell ☐ bus.

Driver's License #:	State:	VIN:	Telephone No.: ( )	Phone Type: ☐ home ☐ cell ☐ bus.

Vehicle Year:	Make:	Model:	License Plate #:	Reported Injuries:

Employer:	Address & Phone #:	Occupation:

Involvement in referral:

Comments

Financial Information

Loss Amount $	Amount Paid $	Date Paid	Reserve Amount $
Settlement Amount $	Amount Paid $	Date Paid	Civil Litigation Pending: ☐ Yes ☐ No

Additional Investigative Agencies

Agency Type: ☐ Other State Fraud Bureau ☐ Law Enforcement ☐ Other Insurance Company ☐ Regulatory Agency ☐ Other

Agency: ____________________ Contact Person: ____________________
(Address) ____________________ (City) ____________ (State) ______ (Zip) ____________
Telephone ( ) ____________________ Fax ( ) ____________________ Case/Claim No. ____________

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Subject / Additional Party Types					
CL	Claimant	DO	Doctor of Osteopathic Medicine	MR	Laboratory
IN	Insured	DEN	Dentist	MH	Medical Clinic/Hospital
WT	Witness	PH	Pharmacist	MZ	Office Administrator
LC	Lawyer for Claimant	CHI	Chiropractor	BS	Billing Services
LI	Lawyer for Insured	NP	Nurse Practitioner	TPA	Third Party Administrator
INS	Insurer	LPN	Licensed Practical Nurse	FP	False Provider
SI	Self-Insured	PT	Physical Therapist	UP	Unlicensed Provider
IY	Insurance Company Employee	PA	Physician's Assistant	MN	Other Medical Personnel
IB	Agent/Broker	OP	Optometrist	MS	Medical Specialist
IS	Adjuster	PO	Podiatrist		_____
IR	Appraiser	RD	Radiologist	DS	Dental Specialist
BS	Body Shop	MT	Massage Therapist		_____
SY	Salvage Yard Owner / Employee	AMB	Ambulance Service Employee	NS	Nurse Specialist
TY	Tow Yard Owner / Employee	DME	DME Supplier		_____
MD	Medical Doctor	HHA	Home Health Agency	OT	Other _____

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