

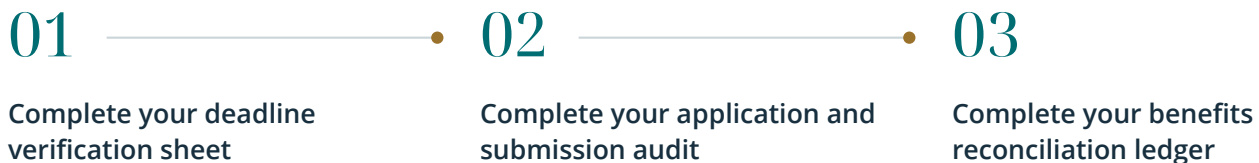


COVERAGE & CLAIM ROUTES

PIP Benefits Application and Deadline Workbook

Assemble an accurate first-party PIP application and ongoing proof-of-loss stream, keeping accident notice, care eligibility, bill submission and legal deadlines separate.

WHAT THIS WORKBOOK HELPS YOU DO



For people handling accident-related paperwork and preparing clear, evidence-backed questions.

Use it on screen or on paper. Save a personal copy before entering information. Blank response areas are fillable; printed copies work just as well. Keep completed copies private.

Scope. Educational organization tools, not legal, medical, tax or financial advice. No claim result, coverage decision or payment is promised. Verify policy language, current local rules and all deadlines with the appropriate professional or official source.



START HERE

Start with a clear working file

Work on one claim, account or issue at a time. Keep originals unchanged and label working copies with a short evidence ID. Complete the guidance in order, then use the worksheets to turn questions into an organized next step.

A practical order

- 01 Read the four guidance pages before filling the worksheets. Mark facts you can support and questions that still need an answer.

GUIDANCE / PAGES 03-06

- 02 Use the fictional examples to check your method. Their facts and dollar amounts do not describe your claim or predict an outcome.

EXAMPLES / PAGE 07

- 03 Complete the four working sheets, then use the readiness check and next-step page. Duplicate a worksheet when you need another record.

WORKSHEETS / PAGES 08-11

Protect your information

Store completed copies somewhere private. Use a claim or account suffix when a full identifier is unnecessary. Share only relevant copies through a verified recipient and appropriate channel. A saved PDF can contain personal information even when it is not open on screen.

Before a deadline. Do not wait to finish this workbook when a notice, release, court paper or policy deadline needs attention. Verify the actual requirement and seek qualified help promptly.



GUIDANCE 1

01

Understand the claim being opened

Use this workbook to organize a first-party PIP claim, not to decide medical care or the value of a lawsuit. PIP can address specified injury-related benefits under the applicable law and policy; it does not settle every fault, property or liability question arising from the crash. Record the benefit you are seeking, the injured person and the reason you believe a policy may apply. Keep medical, income and permitted service claims distinct so each can be supported accurately. Do not assume every state offers the same categories or that every accident-related expense is payable. Begin with a benefits-and-questions list rather than a single estimated claim total.

Find the applicable insurer and forms

Identify the applicable insurer before relying on a particular application. Record the accident state, occupied vehicle, owner, injured person's own or household coverage and any work-related involvement. Ask the carrier to confirm the correct claim contact and forms, using the actual facts. State priority rules and special-vehicle exceptions can change the route, so a generic no-fault state label is not enough. Obtain the current form and its instructions, and preserve their version or download date. If carriers disagree about responsibility, keep both written positions and seek timely help. An unresolved routing question does not mean you should assume every notice or filing requirement is paused.

RELATED WORKING SHEETS

- Application and submission audit
- Wage and replacement-service proof

Sources for this page: [1], [2], [3]. See the linked source guide.



GUIDANCE 2

02

Separate four kinds of clock

Make separate rows for accident notice, any initial-care eligibility condition, individual bill or wage-proof submission and legal action deadlines. Each row needs its own trigger, source, recipient and proof of completion. New York's official FAQ describes different general windows for notice, medical bills and lost-earnings submissions, including an exception for justified late notice. Florida's current statute uses an initial-care condition that is different in nature. Keep those examples clearly labeled by state. Do not turn them into a national countdown or conclude that every late submission fails. When timing is uncertain, verify promptly; the workbook must never delay needed care or encourage unnecessary treatment.

Build the application packet

Use the actual insurer or official form as the controlling list of requested information. Check names, policy and claim identifiers, incident date and place, benefit categories, attachments and signature requirements. Write 'unknown' where appropriate rather than guessing. Keep a complete copy of what was submitted, including the cover message and supporting documents, and retain evidence of transmission and receipt. A received application is not necessarily a complete claim for every benefit. Mark which portions are complete and which need more proof. Do not sign for someone else without authority or treat a broad medical authorization as routine merely because it arrived with the application.

Use separate rows and sources for each timing question; state examples are not a national countdown.



Sources for this page: [1], [2], [3]. See the linked source guide.



GUIDANCE 3

03

Coordinate provider proof

Confirm that each provider's billing office has the correct insurer, claim number and relevant contact information. Track dates of service, itemized bills, records requested and the status of each submission. Ask for clarification when an insurer requests a missing document, but do not change diagnoses, billing codes or treatment descriptions yourself. The provider and appropriate professionals should address medical necessity and coding questions. Keep billing instructions separate from clinical decisions. Where a state has provider submission rules, obtain the actual current instructions rather than importing a deadline from this example. Good coordination means identifying who will send what and verifying receipt, not assuming a bill was filed because treatment occurred.

Document wage and permitted service claims

For a wage claim, connect each missed or reduced work period to scheduled work, actual earnings records and relevant work-restriction evidence. Distinguish gross earnings, employer-paid leave, actual lost pay and any other payments, rather than treating them as interchangeable. If the policy permits replacement-service benefits, record the real task, the person who performed it, dates and actual payment or receipt. Do not fabricate receipts or turn unpaid help into an expense. Eligibility and reimbursement rules vary, so flag the coverage question before presenting a category as payable. This section supplies a proof chain; it does not establish medical inability to work or a legal entitlement.

RELATED WORKING SHEETS

- Application and submission audit
- Benefits reconciliation ledger

Sources for this page: [1], [2], [3]. See the linked source guide.



GUIDANCE 4

04

Reconcile benefit use

Reconcile submitted, paid, adjusted and pending items separately. Attach the explanation supporting each entry and distinguish an insurer payment from a provider's outstanding balance. Do not subtract every submitted charge from a benefit limit or assume a remaining balance is covered. Ask the insurer to clarify the applicable benefit category, deductible or other adjustment and the amount of benefits used. Keep unresolved calculations visibly unresolved. If another insurer or program has paid, record that fact accurately so the relevant advisers can address coordination. This ledger is a control tool for the application process, not a promise of reimbursement or a substitute for a medical-billing review.

Audit completeness and escalate

Finish with a submission audit showing the correct carrier, each form and attachment, evidence of receipt, outstanding requests and next action owner. Summarize unresolved eligibility, timing or benefit-limit questions on one page. A missing employer record calls for a different response from a formal coverage denial, so label the problem accurately. Obtain qualified help for disputed priority, a potentially missed deadline, serious injury, benefit exhaustion or a denial requiring formal action. Keep medical care decisions with clinicians and legal deadlines with appropriate advice. The practical goal is a verifiable benefits file that can be updated as losses accrue, not a declaration that the claim is approved.

RELATED WORKING SHEETS

- Application and submission audit
- Benefits reconciliation ledger

Sources for this page: [1], [2], [3]. See the linked source guide.



FICTIONAL EXAMPLES

Work through the examples

These invented cases demonstrate the method. They are not case results, estimates of what you will receive or statements of universal rights.

01 Example 1

Fictional NY accident on October 1: the notice row is separate from an October 9 medical service row. The workbook labels NY's general 30-day notice and 45-day bill rules as examples with exceptions, not a single 30-day claim deadline.

02 Example 2

An application is delivered but employer proof is outstanding. The file marks 'application received; wage proof pending' rather than marking all benefits complete.

03 Example 3

A \$900 bill is submitted and \$600 is paid, with \$300 pending review. The example records three separate statuses and does not label the unpaid balance a covered debt.

04 Example 4

A fictional employee missed two scheduled shifts; payroll records and the relevant work note are attached. A neighbor's unpaid favor is recorded honestly and not converted into a fabricated receipt.



WORKSHEET 1

01

Deadline verification sheet

Use separate rows for notice, care, each bill or wage period, and legal deadlines. Leave uncertain dates flagged; confirm promptly with the insurer and qualified professional where needed.

Obligation category

Applicable jurisdiction/policy

Primary source/clause

Trigger event

Trigger date

Deadline verified by/date

Required recipient/method

Delivery evidence

Exception question

Related guidance: [Separate four kinds of clock](#)



WORKSHEET 2

02

Application and submission audit

Review every requested item against the actual form. Save exactly what was submitted and ask for confirmation of receipt; submitting paperwork does not establish eligibility.

Insurer and claim number

Form name/version

Claimant and accident identifiers

Eligibility evidence

Signature status

Bills/records attached

Employer proof

Recipient

Sent/received dates

Missing item and owner

Related guidance: [Coordinate provider proof](#)



WORKSHEET 3

03

Benefits reconciliation ledger

Do not subtract every billed charge from a benefit limit. Reconcile using payment and coverage explanations and label unresolved calculations.

Service or loss period

Benefit category

Amount submitted

Date submitted

Paid amount/date

Adjusted or pending amount

Explanation reference

Confirmed applicable limit

Insurer-confirmed remaining benefits

Related guidance: [Coordinate provider proof](#)



WORKSHEET 4

04

Wage and replacement-service proof

Record actual facts and source documents. Never invent a medical restriction or treat all household help as a payable benefit.

Missed work/service dates

Employer or substitute contact

Normal earnings/source records

Work-restriction evidence

Task unavailable

Actual service performed

Amount paid and receipt

Coverage verification

Related guidance: [Understand the claim being opened](#)



READINESS REVIEW

Check the file before using it

REVIEW EACH ITEM BEFORE MOVING ON

- ☐ Each working figure or statement is linked to an identifiable document.
- ☐ Missing information is marked as unverified rather than estimated as fact.
- ☐ The exact question and the person or organization able to answer it are identified.
- ☐ The current document version and any conflicting version are preserved.
- ☐ Independent deadlines and the source of each deadline have been checked.
- ☐ The final written response has been compared with the original question.

What still needs attention

Open fact or decision, who can resolve it, and the source needed

Completion standard. The working file is complete when the important facts are supported, the next action is assigned and any unresolved issues remain clearly visible. A completed checklist does not establish coverage, entitlement or legal compliance.



ACTION PLAN

Write down the next step

Choose the smallest useful next step. Make the request specific enough that the recipient can locate the record and explain or address the exact issue. Keep proof of what you sent and what came back.

The exact issue or request

Evidence IDs and document versions that support the request

Verified recipient and channel

Date sent and follow-up date

What response will resolve the issue, and what still needs professional review

Separate decisions. A courtesy follow-up date is not a legal deadline. A document request does not automatically pause another requirement. Do not sign, settle, move property or disclose sensitive records merely because a box on this page is complete.



REFERENCE GUIDE

Sources and scope

The linked official sources support the educational background. The forms and examples are original organization tools. Sources were checked on October 1, 2026; policies, procedures and law may change. Recheck the current source before relying on a rule.

[1] New York DFS no-fault FAQ

NY generally requires written notice as soon as reasonably practicable and no later than 30 days, with a written clear-and-reasonable-justification exception. The FAQ identifies 45-day medical-bill and 90-day lost-earnings submission windows. Scope: NY-specific, subject to full regulation, endorsement and exceptions. A late claim is not automatically lost.

https://www.dfs.ny.gov/consumers/auto_insurance/nofault_faqs

[2] Florida Statutes 627.736, 2026 edition

Florida uses initial services/care within 14 days for PIP medical benefits. The statute has distinct emergency-medical-condition provisions and medical/disability benefit rules. Scope: Verify current law, the applicable date and your policy before relying on this example. Seek care based on clinical needs; this workbook does not interpret diagnoses or recommend unnecessary care.

<https://www.flsenate.gov/Laws/Statutes/2026/627.736>

[3] Florida DFS personal automobile overview

The regulator describes 80% qualifying medical expenses, 60% work loss and the initial-care timing requirement. Scope: Consumer summary, not the complete eligibility, exclusions or billing rule set.

<https://www.myfloridacfo.com/division/consumers/understanding-insurance/personal-automobile-insurance-overview>

Keep the scope clear

Never delay needed care for paperwork

Never encourage unnecessary treatment to qualify

New York and Florida deadlines do not apply nationwide

Provider billing and eligible-person rules vary