No Fault Information

Patient Name: ____ **DOB:** ________________

Telephone: (______) _______-___________ **Social Security #:** ________ - _______ - __________

Employer's Name: ____

Address: ____

Contact Person/Manager: _________________________ **Phone #:** (_____) _______-________

Date of injury/accident: ______ / ______ / ________ **State where injury occurred:** _______

On the date of injury, describe your usual work activities: ___________________________________

On that date, what was your job title/description: _____________________________________

NO FAULT INSURANCE INFORMATION

Name of Insurance Carrier: ____

Address: ____

Address of where the injury/accident occurred: ____

Contact Person: _______________________ **Phone #:** (______) ______-_________

WCB Case #: ___________________________ **Carrier Case #:** __________________________

Describe how your injury occurred:

____

____

____

Have you lost time from work? ____ **No** ____ **Yes,** **If yes, how long?** ____________________

Are you working now? ____ **No** ____ **Yes,** **Last date worked:** ____________________

Have you seen another doctor for this injury? ____ **No** ____ **Yes**

If yes, please provide his name and phone number?

Physician's Name: ____________________________ **Phone #:** (_____) _______-______________

Please note: Should the insurance company refuse to accept this claim as a no fault/car accident case, I do understand that I am fully responsible my medical bills at the physician's standard fee.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW

ASSIGNMENT OF BENEFITS FORM

I, ____________________________ (print patient's name) hereby assign to _____________________________ (print provider's name) all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) pf the Insurance law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on __________________, notwithstanding any other agreement to the contrary.

This agreement may be revoked by the Assignee when benefits are not payable based upon the Assignor's lack of coverage and or violation of a policy condition due to the actions or conduct of the Assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANU OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH VIOLATION.

Patient's Name: _______________________________

Signature of Patient: ____________________________

Date of Signature: ______________________________

Address: ____

NY Orthopedics
130 East 77th Street, 5th Fl
New York, NY 10075
Tel: 212-737-3301

Signature of Provider: ___________________________
Date of Signature: ______________________________