Montefiore

NO FAULT INSURANCE FORM

PATIENT INFORMATION

NAME: _____ SS #: _____

ADDRESS: _____ BIRTHDATE: _____

_____ PHONE #: _____

WHAT PART OF THE BODY ARE YOU BEING SEEN FOR TODAY? (PLEASE STATE: RIGHT OR LEFT):

_____

PLEASE LIST ALL BODY PARTS INJURED AT TIME OF ACCIDENT (PLEASE STATE: RIGHT OR LEFT):

_____

_____

INSURANCE COMPANY INFORMATION

INSURANCE CO. NAME: _____ CONTACT: _____

ADDRESS: _____ PHONE #: _____

_____ DATE OF ACCIDENT: _____

POLICY HOLDER: _____ POLICY #: _____

ADDRESS: _____ FILE/CLAIM #: _____

LEGAL REPRESENTATIVE: _____ ADDRESS: _____

PHONE #: _____ _____

AUTHORIZATION

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

I HEREBY AUTHORIZE DR._____ TO APPLY FOR BENEFITS ON MY BEHALF FOR SERVICES RENDERED. I REQUEST THAT PAYMENT FROM THE INSURANCE COMPANY BE MADE DIRECTLY TO DR._____.

I CERTIFY THAT THE INFORMATION THAT I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT.

EITHER MY INSURANCE COMPANY OR MYSELF MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING.

_____	_____	_____
PRINT NAME	SIGNATURE	DATE/TIME

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ **, ("Assignor") hereby assign to** _____ **, ("Assignee")**
(Print patient's name) (Print hospital or health care provider 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) of 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 _____ **, not withstanding any other agreement**
(Print accident date)
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 COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, 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 VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)	**(Signature of Patient)**
	(Date of signature)
(Address of Patient)	
(Print name of Provider)	**(Signature of Provider)**
	(Date of signature)
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)