

MANHATTAN ORTHOPEDIC & SPORTS MEDICINE GROUP, PC

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NO FAULT INFORMATION SHEET

Patient's Name: _____

Injured Body Part: _____

Date of Accident: _____

No Fault Policy/Claim#: _____

Insurance Carriers Name: _____

Insurance Address: _____

Insurance Phone#: _____

Adjusters Name: _____

Policy Holders Name, Address, & Phone number if different than patient:

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
 VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
 (This form is not for verification of hospital treatment)**

NAME AND ADDRESS OF INSURER OR SELF-INSURER*

NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
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PROVIDER'S NAME AND ADDRESS*

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

2. DATE OF BIRTH 3. SEX 4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR?
 DATE: _____

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS
 CONDITION? DATE: _____

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES NO

IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES NO

IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES NO

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES NO

NOT DETERMINABLE AT THIS TIME

IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)

FROM: _____ THROUGH: _____

13. IF STILL DISABLED THE PATIENT SHOULD BE
 ABLE TO RETURN TO WORK ON:

_____ (DATE)

**VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
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14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?
 YES NO IF YES, describe your recommendation below:

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
TOTAL CHARGES TO DATE\$				

16 IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (OBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES NO

19. ESTIMATED DURATION OFFUTURE TREATMENT

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #211)

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME: _____ SIGNED: _____
 PATIENT PATIENT DATE

CONTINUE ON PAGE 3

**VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 3**

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in# 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE 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, 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

PRINT NAME: _____ SIGNED: _____
PATIENT (Assignor) PATIENT DATE

PRINTNAME: _____ SIGNED: _____
PROVIDER OF HEALTH CARE SERVICE (Assignee) PROVIDER OF HEALTHCARE SERVICE DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED?

YES NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE?

YES NO

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.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY
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*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

NYS FORM NF-3 (Rev 1/2004)

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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 to the contrary.
(Print accident date)

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
THERE TO, 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,
COMMITTS 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)