MASSAPEQUA NEUROLOGIC PC

DR. TERESA FARRUGIA, DO

KATHERINE A. CARROLL, PA-C

DR. TEJ-PREET SINGH, MD

95 GRAND AVENUE, MASSAPEQUA, NEW YORK 11758

(O) (516) 799-7500 (F) (516) 799-2075

NO FAULT CLAIM INFORMATION

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ SS#: _____

_____ PHONE: _____

INSURANCE CARRIER: _____

ADDRESS: _____

ADJUSTER NAME: _____

PHONE: _____ FAX: _____

POLICY #: _____ CLAIM: _____

INSURED: _____ RELATIONSHIP: _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____

LOCATION OF ACCIDENT: _____

ARE YOU WORKING? _____YES _____NO IF NOT, LAST DAY WORKED: _____

THE INFORMATION REQUESTED ABOVE IS ESSENTIAL TO ESTABLISHING YOUR CLAIM. FAILURE TO SUBMIT ALL PERTINENT INFORMATION MAY RESULT IN FULL RESPONSIBILITY OF BILL FROM THE PATIENT.

I CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT. I AUTHORIZE THE PHYSICIAN TO SUBMIT ALL MEDICAL CLAIMS TO THE INSURANCE COMPANY NOTED ABOVE. I ALSO CERTIFY THAT ALL INFORMATION HAS BEEN SUBMITTED WITHIN 45 DAYS FROM THE ACCIDENT DATE.

X _____ _____

PATIENT SIGNATURE **DATE**

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

(FOR ACCIDENTS OCCURRING ON OR AFTER 3/01/02)

I, _____, ("Assignor") hereby assign to _____, ("Assignee")

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.

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 THE 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.

_____ X _____
(Print Name of Patient) (Signature of Patient)

_____ _____
(Date of Signature)

_____
(Address of Patient)

MASSAPEQUA NEUROLOGIC, PC _____
(Print Name of Provider) (Signature of Provider)

95 GRAND AVENUE _____
(Date of Signature)

MASSAPEQUA, NY 11758
(Address of Provider)

NEW YORK MOTOR VEHICLE NO-FAUL T INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

ADJUSTER NAME: ***TELEPHONE:***

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATIONS.
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

YOUR NAME: ***YOUR ADDRESS:***

1. YOUR NAME	1. PHONE NOS. HOME	BUSINESS
3. YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE, AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET) CITY OR TOWN, AND STATE	

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ OR A MOTORCYCLE ☐ A TRUCK, ☐ AN AUTOMOBILE,

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?
YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSONS:

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH BILLS TO DATE:	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK:	AMOUNT OF TIME LOST FROM WORK:
_____	_____

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?
YES ☐ NO ☐

20. LIST NAMES AND ADDRESSES OF YOUR EMPLOYER ANDOTHER EMPLOYERS FOR ONEYEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?
YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY.

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.

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION, OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY, OR OTHER LOSS WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION, OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS, AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____

SIGNATURE* _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).