

**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*
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NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
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DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
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PROVIDER'S NAME AND ADDRESS*
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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)

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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 (DBA), 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 OF FUTURE 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 #21)**

**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

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**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 _____ PATIENT (Assignor)	SIGNED _____ PATIENT DATE
PRINT NAME _____ PROVIDER OF HEALTH CARE SERVICE (Assignee)	SIGNED _____ PROVIDER OF HEALTH CARE 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 FRAUD 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

# \* PT MUST FILL OUT THIS FORM & DOCTOR MUST SIGN

## 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)

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\_\_\_\_\_  
(Date of signature)





# LONG ISLAND PODIATRY GROUP, P.C.

## MEDICINE AND SURGERY OF THE FOOT

Board Certified by the American Board of Podiatric Surgery  
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### NO FAULT INITIAL SHEET

PATIENT NAME: \_\_\_\_\_ SS#: \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_ BODY PART: \_\_\_\_\_

WHERE DID THE ACCIDENT HAPPEN? \_\_\_\_\_

DESCRIBE HOW THE ACCIDENT OCCURRED: \_\_\_\_\_

\_\_\_\_\_

HAVE YOU BEEN SEEN BY ANOTHER DOCTOR/HOSPITAL? (CHECK ONE): YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, WHO?: \_\_\_\_\_

WHEN?: \_\_\_\_\_

HAVE YOU FILED AN ACCIDENT REPORT? (CHECK ONE): YES \_\_\_\_\_ NO \_\_\_\_\_

ARE YOU WORKING? (CHECK ONE): YES \_\_\_\_\_ NO \_\_\_\_\_

IF NO, WHAT DATE DID YOU STOP WORKING?: \_\_\_\_\_

WHAT DATE DID YOU RETURN?: \_\_\_\_\_

IF YES, ARE YOU ON REGULAR DUTY OR LIGHT/PARTIAL DUTY?: \_\_\_\_\_

NO FAULT INSURANCE CARRIER: \_\_\_\_\_

CARRIER ADDRESS: \_\_\_\_\_

ADJUSTOR NAME: \_\_\_\_\_ ADJUSTOR PHONE #: \_\_\_\_\_

POLICY #: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

IN THE EVENT I FAIL TO PROSECUTE THE CLAIM FOR NO FAULT FOR THIS ILLNESS OR CONDITION, OR IT IS DETERMINED THAT THE ILLNESS OR CONDITION IS NOT A RESULT OF A COMPENSABLE NO FAULT INJURY, I HEREBY AGREE TO DR. \_\_\_\_\_ THE USUAL AND CUSTOMARY FEES FOR SERVICES RENDERED TO THE ABOVE NAMED CLAIMANT. I AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION NECESSARY TO SUBSTANTIATE A CLAIM.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_