

No Fault Injuries

Assignment of Benefits

Patient name: _____

Date of birth: _____

No fault carrier information

Name of carrier		
Street	Claim Number	Policy Number
City	State	Zip
Carrier phone number	Carrier fax number	Case number
Adjuster's name	Adjuster's phone number	Adjuster's fax number

Injury information

Date of injury	Place of injury
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Upper East Orthopaedics Contract

I authorize release of all medical information necessary to process my insurance claims or that is pertinent to my medical and/or surgical benefits, including major medical benefits to which I am entitled, by Upper East Orthopaedics. This agreement will remain in effect until revoked by me in writing. A photocopy of this release and assignment is to be considered as valid as the original.

I hereby authorize payment of benefits under the Accident plan to be paid directly to Upper East Orthopaedics for services rendered to me as the result of an accident which occurred on: If for any reason my Insurance Carrier rejects this claim, I am responsible for the charges incurred. I therefore agree to pay Upper East Orthopaedics their usual and customary fees for services rendered by Upper East Orthopaedics to me.

X

Signature of patient

