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		Cas	e number
Adjuster's name	Adjuster's phone number		Adj	uster's fax number

Injury information

Date of injury	Place of injury

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.



Signature of patient

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 Upper East Orthopaedics, ("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 intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial 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	
(Address of Patient)			
(Print name of Provider)	(Signature of Provider)	Date	
NYS FORM NF-AOB (Rev 1/2004)			

NYS FORM NF-AOB (Rev 1/200 P.T. (10/06)