**MOTOR VEHICLE / NO-FAULT**

# SUFFOLK PLASTIC SURGEONS, P.C

**Date:**______________________

**Patient's Name** ______________________________________________

FIRST NAME MIDDLE NAME LAST NAME

TO PROCESS YOUR **MOTOR VEHICLE/ NO-FAULT RELATED** CLAIM,
WE MUST HAVE THE FOLLOWING INFORMATION.
PLEASE COMPLETE THESE FORMS IN FULL

**No-Fault Insurance Co:** ______________________________________________

Address for **Claim** Submission: ______________________________________________

Policy#: ____________________ Claim#: ____________________ Date of Accident: __ /___/___

Adjuster's Name: ____________________ Phone # : ___ ______ X-_____ FAX #: ________

Policy Holder's Name: ______________________________________________

Policy Holder's Address (If Known):______________________________________________

All Insurance Companies require that you file an **Application for Benefits**.
In New York, this is called an **NF-2.**
If you have not yet filed this form with your insurance carrier, we strongly suggest you do so immediately.
Failure to file will result in the denial of your claim(s) and any benefit(s) you may be entitled to.
Please remember, YOU are responsible for any outstanding claim(s) the insurance carrier does not cover.
This may include a deductible (if applicable)

Have you filed the Application for Benefits (NF-2) with the insurance carrier ? Yes ☐ / No ☐

HAVE YOU RETAINED AN ATTORNEY FOR THIS MOTOR VEHICLE INJURY ? Yes ☐ / No ☐

If **YES,** Please provide the following information:

Attorney's Name: ____________________ Phone: ____________ FAX:____________

Attorney's Address: ______________________________________________

Signature:______________________________ Date:____________________

Relationship:______________________________

# NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
## (ASSIGNMENT OF BENEFITS FORM)
(For Accidents Occurring on and After 3/1/02)

Claim Number: ________________

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 statue) 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 _______________, notwithstanding 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 MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSONWHO, .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) | |
| (Print Name of Provider) | (Signature of Provider) |
| | (Date of Signature) |
| (Address) | |