UB | MD ORTHOPAEDICS & SPORTS MEDICINE

No Fault/Workers' Compensation Form

☐Please check here if not applicable

Please complete if Auto (No Fault) or Work Accident (Workers' Compensation)

*Please note: if you are unable to provide us with this information, or your claim is not yet in process, you will be responsible for the payment of your office visit until the information is presented to us. Also, we recommend that you have a back-up referral in place with your personal health insurance carrier to help you cover any costs that may be denied by the Workers' Compensation, No-fault or third party liability carrier.

Patient Name: ______________________ Social Security #: ______________________

Date/Time of Accident/Injury: ______________________ Adjuster/Case Manager Name: ______________________

No Fault/Workers' Compensation Insurance Information

Name of Insurance Carrier: ______________________ Claim #/Carrier Case #/Policy #: ______________________

Insurance Carrier Address: ______________________ City: __________ State: ______ Zip: ______

Insurance Carrier Phone #: ______________________ Insurance Fax Phone #: ______________________

If No Fault/Auto Accident: Please complete the attached **Assignment of Benefits Form** on the reverse of this page.

Please complete the following **only if Workers' Compensation**:

WCB #: ______________________ Carrier W #: ______________________

Employer: ______________________ Employer Phone #: ______________________

Employer Address: ______________________ City: __________ State: ______ Zip: ______

Location injury occurred (if different from employer address): ______________________

Job Title at time of Injury: ______________________ Body Part(s) Injured: ______________________

Date Injury reported to your employer: ______________________

Description of how injury occurred: ______________________

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____

Have you lost time from work due to this injury: ☐ No ☐ Yes If yes: what dates: ______________________

Have you had the same or similar injury prior to this accident: ☐ No ☐ Yes If yes: what dates: ______________________

Have you been treated by another doctor for this injury: ☐ No ☐ Yes If yes: by whom: ______________________

The information on this form has been completed accurately to the best of my knowledge. I understand it is my responsibility to inform the doctor's office of any change in my information.

x______________________________________ Date: ______________

Signature of Patient or Parent/Legal Guardian (if patient is under 18 years of age)

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 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)**

__________________________ __________________________
(Date of signature)

____
(Address of Provider)