Montefiore

NO FAULT INSURANCE FORM

PATIENT INFORMATION

NAME: _____ SS#: _____

ADDRESS: _____ BIRTHDATE: _____

_____ PHONE #: _____

WHAT PART OF THE BODY ARE YOU BEING SEEN FOR TODAY? (PLEASE STATE: RIGHT OR LEFT):

_____

PLEASE LIST ALL BODY PARTS INJURED AT TIME OF ACCIDENT (PLEASE STATE: RIGHT OR LEFT):

_____

_____

INSURANCE COMPANY INFORMATION

INSURANCE CO. NAME: _____ CONTACT: _____

ADDRESS: _____ PHONE #: _____

_____ DATE OF ACCIDENT: _____

POLICY HOLDER: _____ POLICY #: _____

ADDRESS: _____ FILE/ CLAIM #: _____

LEGAL REPRESENTATIVE: _____ ADDRESS: _____

PHONE# _____ _____

AUTHORIZATION

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

I HEREBY AUTHORIZE DR. _____TO APPLY FOR BENEFITS ON MY BEHALF FOR SERVICES RENDERED. I REQUEST THAT PAYMENT FROM THE INSURANCE COMPANY BE MADE DIRECTLY TO DR. _____.

I CERTIFY THAT THE INFORMATION THAT I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT.

EITHER MY INSURANCE COMPANY OR MYSELF MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING.

SIGNATURE: _____ DATE: _____