



Comprehensive Diagnostic Imaging & Radiology

NEW YORK NO-FAULT FORM

MEDICAL RECORD # \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE OF ACCIDENT: \_\_\_\_\_

NAME OF INSURANCE COMPANY: \_\_\_\_\_

INSURANCE COMPANY ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIPCODE: \_\_\_\_\_

POLICY #: \_\_\_\_\_ FILE #: \_\_\_\_\_

INSURED (POLICY HOLDER): \_\_\_\_\_

**AUTHORIZATION TO PAY PHYSICIAN**

I, \_\_\_\_\_, HEREBY AUTHORIZE THE \_\_\_\_\_  
\_\_\_\_\_ INSURANCE COMPANY TO PAY BY CHECK MADE

OUT AND MAILED DIRECTLY TO HARTSDALE DIAGNOSTIC AND WOMENS IMAGING SERVICES  
PC 141 SOUTH CENTRAL AVE HARTSDALE NY 10530 THE MEDICAL EXPENSE BENEFITS

ALLOWABLE AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY,  
AS PAYMENT TOWARD THE TOTAL CHARGES FOR PROFESSIONAL SERVICES RENDERED.

IN THE EVENT THE PROVIDER'S CHARGES ARE OUTSTANDING AND I FAIL TO FILE AN  
APPLICATION FOR BENEFITS UNDER THE NEW YORK NO-FAULT INSURANCE LAW, I HEREBY

AUTHORIZE THE PROVIDER TO FILE SUCH CLAIM ON MY BEHALF SO THAT THE PROVIDER  
DOES NOT REALIZE PAYMENT FROM THE INSURER, I AM PERSONALLY RESPONSIBLE TO

HARTSDALE DIAGNOSTIC AND WOMENS IMAGING SERVICES PC 'S USUAL AND CUSTOMARY  
FEES FOR SERVICES RENDERED.

PATIENTS SIGNATURE: \_\_\_\_\_

PATIENTS NAME (PLEASE PRINT): \_\_\_\_\_

DATE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

(IF SIGNED BY OTHER THAN 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 \_\_\_\_\_, ("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)