

Auto Accident Form

Name _____ Today's Date ____/____/____ Date of Accident ____/____/____

History of Occurrence

- Pedestrian Driver Passenger- Middle Front Passenger- Right Front
 Passenger- Left Rear Passenger- Center Rear Passenger -Right Rear

Patient Vehicle Type

- Compact Mid-size Full-Size SUV Pick-up Motorcycle Other _____

Second Vehicle Type

- Compact Mid-size Full-Size SUV Pick-up Motorcycle Other _____

Third Vehicle Type

- Compact Mid-size Full-Size SUV Pick-up Motorcycle Other _____

Road Conditions

- Dry Icy Wet Clear Foggy Dark Other _____

Road Type

- Concrete Asphalt Gravel Dirt Other _____

- Were you aware the accident was going to occur? Yes No. Were you wearing a seatbelt? Yes No
 Did your airbag deploy? Yes No. Does your car have a head rest? Yes No.
 What position was the head rest in? Up Middle Down
 Head Position: Looking Straight Ahead Left Level Left Up Left Down
 Right Level Right Up Right Down Looking Up Looking Down

- Was your car braking? Yes No. Was your car moving? Yes No
 If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

- Was the second vehicle braking? Yes No. Was the second vehicle moving? Yes No
 If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

- Was the third vehicle braking? Yes No. Was the third vehicle moving? Yes No
 If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Collision Details

- First Impact: Hit By Another Vehicle Hit Another Vehicle Hit By An Object Hit An Object
 (on the) Front Front-Right Front-Left Left Right Right-Rear Left-Rear Rear Top

- Second Impact: Hit By Another Vehicle Hit Another Vehicle Hit By An Object Hit An Object
 (on the) Front Front-Right Front-Left Left Right Right-Rear Left-Rear Rear Top

Collision Results

- Body was thrown: Backward Forward Left Right Can't Remember
 Head Hit: Airbag Another Person's Body Back Of Front Seat Dashboard
 Front Windshield Rear-View Mirror Side Window/Door Steering Wheel
 Windshield

- Chest Hit:** Another Person's Body Back Of Front Seat Dashboard Side Window/Door
 Steering Wheel
- Shoulders Hit:** Another Person's Body Back Of Front Seat Shoulder Harness Side Window/Door
- Knees Hit:** Another Person's Body Back Of Front Seat Center Console Dashboard
 Door Panel Steering Wheel
- Hips Hit:** Another Person's Body Back Of Front Seat Center Console Dashboard
 Door Panel Steering Wheel

Vehicle Damage

- First Vehicle:** Totaled Significant Damage Light Damage No damage
Second Vehicle: Totaled Significant Damage Light Damage No damage
Third Vehicle: Totaled Significant Damage Light Damage No damage

Were you hospitalized? Yes No. If yes, please answer the questions in the paragraph below.

- When were you hospitalized? Date _____ Immediately Later The Same Day The Next Day.
How were you transported to the hospital? Ambulance Life Flight Private Transportation
What did the hospital recommend? No Instructions See This Clinic See DC See Own Doctor
 See Neurologist See Orthopedist Over The Counter Medication Prescription Medication
 Other _____

Did you have any xrays taken? Yes No. If yes, what areas? _____

What are your current symptoms? Pain Numbness Stiffness Weakness

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
 VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
 (This form is not for verification of hospital treatment)**

NAME AND ADDRESS OF INSURER OR SELF-INSURER*	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
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DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
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PROVIDER'S NAME AND ADDRESS*

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS _____

2. DATE OF BIRTH _____ 3. SEX _____ 4. OCCUPATION (IF KNOWN) _____

5. DIAGNOSIS AND CONCURRENT CONDITIONS _____

6. WHEN DID SYMPTOMS FIRST APPEAR? DATE: _____ 7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: _____

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?
 YES NO IF YES, state when and describe: _____

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?
 YES NO IF "NO", explain: _____

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?
 YES NO

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?
 YES NO NOT DETERMINABLE AT THIS TIME
 IF "YES", describe: _____

12. PATIENT WAS DISABLED (UNABLE TO WORK) FROM: _____ THROUGH: _____	13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON: _____ (DATE)
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**VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 2**

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

YES NO

IF YES, describe your recommendation below:

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
TOTAL CHARGES TO DATE\$				

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE <input type="checkbox"/>	INDEPENDENT CONTRACTOR <input type="checkbox"/>	OTHER (SPECIFY) <input type="checkbox"/>

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES NO

19. ESTIMATED DURATION OF FUTURE TREATMENT _____

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (Authorization to Pay Benefits) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME _____ PATIENT SIGNED _____ PATIENT DATE _____

CONTINUE ON PAGE 3

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 3

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (Assignment of Benefits). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE 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, NOTWITHSTANDING 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

PRINT NAME _____ PATIENT (Assignor)	SIGNED _____ PATIENT	DATE _____
PRINT NAME _____ PROVIDER OF HEALTH CARE SERVICE (Assignee)	SIGNED _____ PROVIDER OF HEALTH CARE SERVICE	DATE _____

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? YES NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? YES NO

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.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY
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*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.
 NYS FORM NF-3 (Rev 1/2004)
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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 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 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)