Pt: MRN: CSN: 0 Return Address Patient Financial Services 100 Kings Highway Rochester, NY 14617 Phone (585) 922-1900 Fax (585) 922-1002	NEW YORK MOTOR VEHICAL NO-FAULT INSURANCE LAW HOSPITAL FACILITY FORM KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. PLEASE NOTE, THIS COMPLETED FORM MUST BE SUMITTED TO THE INSURER AS SOONA S REASONABLE 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 CLAIM REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.			
1.INSURANCE COMPANY 2. ADDRESS OF INSURANCE COMPANY				
3. PATIENT'S NAME AND ADDRESS		4. DATE	DATE OF BIRTH 5. PHONE NUMBER	
6. AUTOMOBILE POLICY NUMBER	7. NAME AND ADDRESS OF POLICYHOLDER			
8. ACCIDENT DATE	9. ADMISSION DATE		10. DISCHARGE DATE	
11. PLACE OF ACCIDENT				
12 DESCRIPTION OF ACCIDENT				
13. IDENTITY OF VEHICLE OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT: OWNER'S NAME MAKE YEAR THIS VEHICLE WAS: A BUS OR SCHOOL BUS, OR A MOTORCYLE AN AUTOMOBILE,				
14. WAS PATIENT THE DRIVER OF THE MOTOR VEHICLE? WAS PATIENT A PASSENETER IN THE MOTOR VEHICLE? WAS PATIENT A PEDESTRIAN? WAS PATIENT A MEMBER OF THE POLICYHOLDERS HOUSEHOLD? 15. ADMITTING DIAGNOSIS:				
16. DISCHARGE DIAGNOSIS:				
17. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT? YES NO NO				
18. WAS TREATMENT RENDERED SOLE YES IF NO, PLEASE EXPLAIN. 19. OPERATIONS OR PROCEDURES PERI	NO		E ABOVE AC	CIDENT?
20. ATTACH REPORT OF SERVICES RENDERED AND ITEMIZED BILL		HOSPITAL CHARGES MUST BE COMPUTED IN ACCORANCE WITH RATES PERMITTED BY SECTION 5108 OF THE NEW YORK INSURANCE LAW AND INSURANCE DEPARTMENT REGULATION NO.83.		
ANY PERSON WHO KNOWINGLY AND APPLICATION FOR COMMERCIAL INSU CONTAINING ANY MATERIALLY FALS ANY FACT MATERIAL THERETO, AND SUCH APPLICATION OR CLAIM, KNOW MAKE A FALSE REPORT OF THE THEF AGENCY, THE DEPARTMENT OF MOTO A CRIME, AND SHALL ALSO BE SUBJE FIVE THOUSAND DOLLARS AND THE V	URANCE OR A STATEMED E INFORMATION, OR CO ANY PERSON WHO, IN C UNGLY MAKES OR KNOV F, DESTRUCTION, DAMA OR VEHICLES OR AN INST CT TO A CIVIL PENALTY	NT OF CLAIM FOR ANY CO ONCEALS FOR THE PURPOS CONNECTION WITH WINGLY ASSISTS, ABETS, GE OR CONVERSION OF A URANCE COMPANY, COME NOT TO EXCEED	OMMERCIAL OSE OF MISLEAR SOLICITS OR NY MOTOR V MITS A FRAU	OR PERSONAL INSURANCE BENEFITS ADING, INFORMATION CONCERNING CONSPIRES WITH ANOTHER TO VEHICLE TO A LAW ENFORCEMENT IDULENT INSURANCE ACT, WHICH IS
TAKE BY:PRINT NA	AME		TITLE & 1	PHONE NO.
SIGNATU	RE		D.A.	ATE

Downtime version - please follow downtime procedure.

Required identifiers (Name & DOB) must be on every page (both sides if two-sided form).

Use demographic labels or legibly hand-write the demographic information.



DATE TAKEN FROM RECORDS:

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW HOSPITAL FACILITY FORM - PAGE 2

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THIS ACT. THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE PATIENT AS TRUE UNDER THE PENALTIES OF PERJURY. (SIGNATURE OF PATIENT, PARENT OR GUARDIAN) DATE 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 A of this form. (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 ITEM B). **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. SIGNED _ SIGNED ___ (SIGNATURE OF PATIENT, PARENT OR GUARDIAN) (SIGNATURE OF HOSPITAL REPRESENTATIVE) DATE 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 item B 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. (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, <u>YOU MAY NOT</u> ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #A ABOVE). ASSIGNMENT OF NO-FAULT BENEFITS: I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED ABOVE 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. SIGNED (SIGNATURE OF PATIENT, PARENT OR GUARDIAN (Assignor) DATE SIGNED HOSPITAL REPRESENTATIVE HOSPITAL NAME - Assignee HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? NO YES YES NO IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE NYS FORM NF-5 (Rev 6/2013 AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW). SIGNATURE (PATIENT, PARENT OR GUARDIAN) DATE