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)

NYS FORM NF-AOB (Rev 1/2004)

ALDEN MEDICAL GROUP, PLLC
12845 BROADWAY
ALDEN, NY 14004
716-937-3255

Sanjeev Ahuja, MD
Venkata Jupudy, MD
Yellamraju Kumar, MD

NO FAULT FORM

Patient Name: _____ Date of Birth: _____
Address: _____ Phone #: _____
_____ Social Security #: _____
_____

No-Fault Insurance Carrier: _____
Address: _____ Phone #: _____
_____
_____

Date of Accident: _____
Dates off of Work (If applicable): _____

Claim #: _____ Policy #: _____

YOU MUST NOTIFY YOUR INSURANCE CARRIER OR YOU WILL BE RESPONSIBLE FOR ANY BILLS INCURRED

I authorize Alden Medical Group to furnish all information regarding my condition while under observation or treatment, including obtained history, x-rays and physical findings, diagnosis and prognosis to the no-fault insurance carrier. Alden Medical Group is authorized to provide this information in accordance with the New York Comprehensive Motor Vehicle Insurance Reparations Act (No-Fault Law).

I authorize benefits to be paid directly to the provider of medical service, Alden Medical Group

_____ Date: _____
Patient Signature

If the patient is a minor: parent or guardian shall sign and indicate capacity and relationship.

Complete the Assignment of Benefit Form - Attached