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

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 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 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, ◯ A TRUCK, ◯ AN AUTOMOBILE, ◯ OR A MOTORCYCLE

| | YES | NO |
|---|---|---|
| 14. WAS PATIENT THE DRIVER OF THE MOTOR VEHICLE? | ◯ | ◯ |
| WAS PATIENT A PASSENGER 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 ◯

18. WAS TREATMENT RENDERED SOLELY AS A RESULT OF INJURIES ARISING OUT OF THE ABOVE ACCIDENT?
YES ◯ NO ◯
IF NO, PLEASE EXPLAIN.

19. OPERATIONS OR PROCEDURES PERFORMED (NATURE AND DATES):

| 20. ATTACH REPORT OF SERVICES RENDERED AND ITEMIZED BILL | HOSPITAL CHARGES MUST BE COMPUTED IN ACCORDANCE by WITH RATES PERMITTED BY SECTION 5108 OF THE NEW YORK INSURANCE LAW AND INSURANCE REGULATION NO. 83. |
|---|---|

**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.**

TAKEN BY: _____ _____
PRINT NAME TITLE & PHONE NO.

_____ _____
SIGNATURE DATE

DATE TAKEN FROM RECORDS: _____

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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.

**A.** _____ **(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.

**B.** _____ **(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 #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 NAME - Assignee) (HOSPITAL REPRESENTATIVE)

| | | |
|---|---|---|
| HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? | ◯ YES | ◯ NO |
| IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? | ◯ YES | ◯ NO |

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 OF PATIENT, PARENT OR GUARDIAN) DATE