NEW YORK STATE
INSURANCE DEPARTMENT

FIRST AMENDMENT TO REGULATION NO. 68-C
(11 NYCRR 65-3)

REGULATIONS IMPLEMENTING THE COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT

I, Gregory V. Serio, Superintendent of Insurance of the State of New York, pursuant to the authority granted by Sections 201, 301, and Article 51 of the Insurance Law, do hereby promulgate the following First Amendment to Part 65-3 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Regulation No. 68-C) and Appendix 13, to take effect upon publication in the State Register, to read as follows:

(MATTER UNDERLINED IS NEW; MATTER IN BRACKETS IS DELETED)

Subdivisions (b), (d) and (e) of Section 65-3.5 are amended to read as follows:

(b) Subsequent to the receipt of one or more of the completed verification forms, any additional verification required by the insurer to establish proof of claim shall be requested within 15 business days of receipt of the prescribed verification forms. Any requests by an insurer for additional verification need not be made on any prescribed or particular form. If a claim is received by an insurer at an address other than the proper claims processing office, the 15 business day period for requesting additional verification shall commence on the date the claim is received at the proper claims processing office. In such event, the date deemed to constitute receipt of claim at the proper claim processing office shall not exceed 10 business days after receipt at the incorrect office.

(d) If the additional verification required by the insurer is [an examination under oath or] a medical examination, the insurer shall schedule the examination to be held within 30 calendar days from the date of receipt of the prescribed verification forms.

(e) All examinations under oath and medical examinations requested by the insurer shall be held at a place and time reasonably convenient to the applicant and medical examinations shall be conducted in a facility properly equipped for the performance of the medical examination. The insurer shall inform the applicant at the time the examination is scheduled that the applicant will be reimbursed for any loss of earnings and reasonable transportation expenses incurred in complying with the request. When an insurer requires an examination under oath of an applicant [as additional verification] to establish proof of claim, such requirement must be based upon the application of objective standards so that there is specific objective justification supporting the use of such examination. Insurer standards shall be available for review by Department examiners.

Paragraph (2) of section 65-3.8(c) is amended to read as follows:

(2) Notwithstanding paragraph (1) of this subdivision, where there is a denial in part of a medical bill as a result of charges not conforming to section 5108 of the Insurance Law, an insurer may effect compliance with paragraph (1) for those overcharges of $50 or less by telephone agreement with the provider or provider's representative, with proper documentation of such agreement in the claim file. The provider must have been entitled to direct payment pursuant to section [65-3.12] 65-3.11 of this subpart.

Subdivision (a) of section 65-3.10 is amended to read as follows:

(a) An applicant or an assignee shall be entitled to recover their attorney's fees, for services necessarily performed in connection with securing payment, if a valid claim or portion thereof was denied or overdue. If such a claim was initially denied and subsequently paid by the insurer, the attorney's fee shall be $80. If such a claim was overdue but not denied, the attorney's fee shall be equal to 20 percent of the amount of the first-party benefits and any additional first-party benefits plus interest payable pursuant to section [65-3.10] 65-3.9 of this subpart, subject to a maximum fee of $60.

Subdivisions (b) and (c) of Section 65-3.11 are relettered subdivisions (d) and (e) and new subdivisions (b) and (c) are added to read as follows:

(b) In order for a health care provider/hospital to receive direct payment from the insurer, the health care provider or hospital must submit to the insurer:

(1) a properly executed Authorization to Pay Benefits as contained on NYS Forms NF-3, NF-4 or NF-5 or other claim form acceptable to the insurer. Execution of an authorization to pay benefits shall not constitute or operate as a transfer of all rights from the eligible injured person to the provider; or

(2) a properly executed assignment on:

(i) the prescribed Verification of Treatment by Attending Physician or Other Provider of Service form (NYS Form NF-3); or

(ii) the prescribed Verification of Hospital Treatment form (NYS Form NF-4), or the prescribed Hospital Facility form (NYS Form NF-5); or

(iii) the prescribed No-Fault Assignment of Benefits form (NYS Form NF-AOB) contained in Appendix 13 or an equivalent form containing non-substantive enhancements, but no changes may be made to the assignment language itself.

(c) The insurer may request, in writing, the original assignment or authorization to pay benefits form to establish proof of claim in accordance with the procedures contained in subdivision (d) of this section. The insurer must maintain the original form in its claim file.

Section 65-3.18 is amended to read as follows:

65-3.18 Releases. Except as provided in [paragraph 65-3.17(b)(13)] section 65-3.16(b)(13) of this Subpart (lump-sum settlements), there shall be no settlement nor any release, express or implied, for mandatory or optional personal injury protection benefits (Mandatory PIP or Additional PIP benefits).

Paragraph (5) of section 65-3.19(e) is amended to read as follows:

(5) Failure to make timely payment, as provided for in paragraph (3) or (4) of this subdivision, shall subject the no-fault insurer to the interest, attorney's fees and arbitration provisions of sections [65-3.10 and 65-3.11] 65-3.9 and 65-3.10 of this Subpart and Subpart 65-4.

The opening paragraph of paragraph (3) of section 65-3.19(f) is amended to read as follows:

(3) For all qualified wage continuation plans, (referred to in [subparagraph 65-3.17(b)(1)(i)] section 65-3.16(b)(1)(i) of this subpart), which provides benefits equal to less than 100 percent of the employee's salary, the insurer should reduce the amount paid under the plan by the amount required to be paid in satisfaction of the New York State Disability Law. Only the excess over the New York State Disability Benefits is a qualified wage continuation plan benefit.

I, Gregory V. Serio, Superintendent of Insurance, do hereby certify that the foregoing is the First Amendment to 11 NYCRR 65-3 (Regulation No. 68-C), promulgated by me on January 9, 2003 pursuant to the authority granted by Sections 201, 301,and Article 51 of the Insurance Law, to take effect upon publication in the State Register.

Pursuant to the provisions of the State Administrative Procedure Act, prior notice of the proposed amendment was published in the State Register on July 31, 2002. No other publication or prior notice is required by statute.

Gregory V. Serio
Superintendent of Insurance

January 9, 2003

APPENDIX 13

(*cf. Part 65*)

PRESCRIBED NO-FAULT FORMS

Appendix 13 has been changed as follows: the Verification of Treatment by Attending Physician or other Provider of Health Service form (NYS Form NF-3), the Verification of Hospital Treatment form (NYS Form NF-4), the Hospital Facility form (NYS Form NF-5), Verification of Self-Employment Income form (NYS Form NF-7) and the Denial of Claim form, (NYS Form NF-10) have been revised and a new No-Fault Assignment of Benefits form, (NYS Form NF-AOB) is added. Other than NYS Form NF-AOB, no deviations may be made to the prescribed forms unless expressly acknowledged by the Department. With respect to NYS Form NF-AOB, non-substantive enhancements, such as provider and insurance information may be added, but no changes may be made to the assignment language itself.

The forms contained herein have been reduced in size for convenience of promulgation. The forms must be reprinted in a size and format using type which is clear and readable and which allows sufficient space to facilitate the completion of the information requested therein.

Insurers may continue to use currently existing stocks of prescribed No-Fault forms until May 1, 2003 at which time the revised prescribed forms must be utilized.

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 OF INSURER'S CLAIMS REPRESENTATIVE
ADDRESS OF REPRESENTATIVE
PHONE NUMBER OF REPRESENTATIVE] *

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

[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 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. AGE	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)

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:

* Bracketed language to be filled in by insurer or self-insurer

CONTINUE ON PAGE 2

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 NUMBER	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)

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 BENFITS 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_____ SIGNED_____
PATIENT PATIENT 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 # 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 PROIVIDED 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 VEHCILE 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_____ SIGNED_____
PATIENT (Assignor) PATIENT DATE

PRINT NAME_____ SIGNED_____
(PROVIDER OF HEALTH CARE SERVICE - Assignee) (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 INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, 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 STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY

*Bracketed language to be filled in by insurer or self-insurer

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF HOSPITAL TREATMENT

NAME AND ADDRESS OF INSURER OR SELF-INSURER *	NAME ADDRESS AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE *

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

NAME AND ADDRESS OF HOSPITAL *

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. PATIENT'S NAME	2. DATE OF BIRTH

3. PATIENT'S ADDRESS

4. DATE ADMITTED	5. TIME ADMITTED A.M. P.M.	6. DATE DISCHARGED	7. TIME DISCHARGED A.M. P.M.

8. a. ADMITTING DIAGNOSIS:

b. DISCHARGE DIAGNOSIS:

9. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT? __YES ___NO

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

11. WAS TREATMENT RENDERED SOLELY AS A RESULT OF THE ABOVE ACCIDENT? __ YES __ NO

IF "NO" PLEASE EXPLAIN

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

IF "YES" PLEASE EXPLAIN AND INDICATE DURATION

13. ATTACH REPORT OF SERVICES RENDERED AND ITEMIZED BILL

HOSPITAL CHARGES MUST BE COMPUTED IN ACCORDANCE WITH RATES PERMITTED BY SECTION 5108 OF THE NEW YORK INSURANCE LAW AND INSURANCE DEPARTMENT REGULATION NO. 83.

*BRACKETED LANGUAGE TO BE FILLED IN BY INSURER OR SELF INSURER

CONTINUE ON PAGE 2

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 14 of this form.

14. _____ (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 #15).

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_____ SIGNED _____
(PATIENT) (PATIENT) 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 # 15 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.

15. _____ (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 #14 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 PROIVIDED 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 INURIES SUSTAINED DUE TO THE MOTOR VEHCILE 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_____ SIGNED _____
(PATIENT – Assignor) (PATIENT - Assignor) DATE

PRINT_____ SIGNED_____
(HOSPITAL REPRESENTATIVE – ASSIGNEE) (HOSPITAL REPRESENTATIVE –ASSIGNEE) 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 INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, 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 STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

TAKEN BY: _____
(SIGNATURE) (TITLE) (PHONE NO. & EXT.) (DATE)

*BRACKETED LANGUAGE TO BE FILLED IN BY INSURER OR SELF INSURER

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

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, <u>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.</u> IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE INSURER TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.**

1. INSURANCE COMPANY		2. PATIENT'S NAME	3. BIRTH DATE
4. ADDRESS OF INSURANCE COMPANY		5. PATIENT'S ADDRESS	6. PHONE NUMBER
7. AUTOMOBILE POLICY NUMBER		8. NAME OF POLICYHOLDER	
9. ACCIDENT DATE	10. ADMISSION DATE	11. ADDRESS OF POLICYHOLDER	
12. DISCHARGE DATE	13. PLACE OF ACCIDENT		

14. DESCRIPTION OF ACCIDENT

15. IDENTITY OF VEHICLE OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT

<u>OWNER'S NAME</u> <u>MAKE</u> <u>YEAR</u>

WAS PATIENT THE DRIVER OF THE MOTOR VEHICLE? __YES __NO

WAS PATIENT A PASSENGER IN THE MOTOR VEHICLE? __YES __NO

WAS PATIENT A PEDESTRIAN? __YES __NO

WAS PATIENT A MEMBER OF THE POLICYHOLDERS HOUSEHOLD? __YES __NO

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS ☐ AN AUTOMOBILE ☐ A MOTORCYCLE ☐ A TRUCK

16. A. ADMITTING DIAGNOSIS:

B. 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 DATE):

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

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, 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 STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

TAKEN BY: _____

(SIGNATURE) (TITLE) (PHONE NO. & EXT.)

_____

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.

AUTHORIZATION TO PAY BENEFITS TO:

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).

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, 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 BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROIVIDED 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 INURIES SUSTAINED DUE TO THE MOTOR VEHCILE 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.

_____ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE
(Assignor)

_____ 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

DO NOT DETACH

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

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF SELF-EMPLOYMENT INCOME

NAME AND ADDRESS OF INSURER OR SELF-INSURER *	NAME, ADDRESS AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE *

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

NAME AND ADDRESS OF APPLICANT *

DEAR APPLICANT:

The information requested below would be used to determine the amount of loss of earnings from work, if any, to which you may be entitled as a result of this accident. Therefore, it would be in your best interest to complete the form and submit all documents requested to the best of your ability. **Kindly note, depending upon the applicable endorsement in effect at the time of the accident, this completed form must be submitted to the insurer as soon as reasonably practicable or no later than 90 days after work loss was first incurred. If you are unsure of the applicable time requirement, you can contact the claim representative to determine which timeframe is applicable to this claim.**

1. OCCUPATION _____
2. BUSINESS ADDRESS _____
3. BUSINESS PHONE _____
4. NATURE OF BUSINESS OR PROFESSION _____
5. DATES YOU WERE UNABLE TO ATTEND TO YOUR BUSINESS OR PROFESSION DUE TO THIS ACCIDENT:
   FROM: _____ THROUGH: _____
6. DID YOU HIRE ANY ONE TO SUBSTITUTE FOR YOU WHILE YOU WERE ABSENT DUE TO YOUR INJURIES ☐ YES ☐ No
   If "YES", PLEASE COMPLETE THE FOLLOWING:

   A. WAGE OR SALARY PAID: $ _____ DAILY $ _____ WEEKLY $ _____ MONTHLY

   B. PERIOD SUBSTITUTE EMPLOYED: FROM _____ THROUGH _____

   C. GROSS AMOUNT PAID TO SUBSTITUTE: $ _____

   D. NAME, ADDRESS AND PHONE NUMBER OF SUBSTITUTE: _____

   _____

7. IF ANSWER TO QUESTION 6, WAS "YES", DID YOU SUFFER A NET LOSS OF EARNINGS FROM WORK IN ADDITION TO THE COST OF SUBSTITUTE SERVICES?

   ☐ YES ☐ NO IF "YES", THE AMOUNT OF NET LOSS CLAIMED:$ _____ FOR THE PERIOD CLAIMED IN QUESTION 5.

8. IF ANSWER TO QUESTION 6. WAS "NO", DID YOU SUFFER A NET LOSS OF EARNINGS FROM WORK DURING YOUR CLAIMED DISABILITY?
   ☐ YES ☐ NO IF "YES", AMOUNT OF NET LOSS CLAIMED:$_____ FOR THE PERIOD CLAIMED IN QUESTION 5.

9. IN ORDER FOR US TO EVALUATE YOUR CLAIM, IT IS ESSENTIAL THAT YOU SUBMIT COPIES OF YOUR FEDERAL INCOME TAX RETURNS FOR THE LAST TWO YEARS. IN ADDITION, SUBMIT WHATEVER DOCUMENTS ARE AVAILABLE TO PROVE YOUR INCOME FOR THE CURRENT YEAR. IF YOU HAVE NOT FILED EITHER OF THE TAX RETURNS, SUBMIT WHATEVER PROOF OF EARNINGS YOU HAVE FOR THOSE YEARS THAT YOU FEEL WILL ASSIST US IN EVALUATING YOUR CLAIM.

   IF WE ARE UNABLE TO VERIFY YOUR LOSS OF EARNINGS FROM THE DOCUMENTS SUBMITTED, THE FOLLOWING ADDITIONAL DOCUMENTATION MAY BE REQUESTED.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, 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 STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE
APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

SIGNATURE OF APPLICANT _____ DATE _____

*Bracketed language to be filled in by insurer or self-insurer.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW

DENIAL OF CLAIM FORM

TO INSURER: Complete this form, including item 33. Send 2 copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

Name, address and NAIC number of insurer or Name and address of self-insurer	For American Arbitration Association use

A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT	D. INJURED PERSON (Name and address)
E. CLAIM NUMBER	F. APPLICANT FOR BENEFITS (Name and Address)		G. AS ASSIGNEE 1. Yes ☐ 2. No ☐

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

☐ 1. Your entire claim is denied as follows:

☐ 2. A portion of your claim is denied as follows:

- ☐ A. Loss of Earnings: $ _____
- ☐ B. Health Service Benefits: $ _____
- ☐ C. Other Necessary Expenses: $ _____
- ☐ D. Interest: $ _____
- ☐ E. Attorney's Fees: $ _____
- ☐ F. Death Benefit: $ _____

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

POLICY ISSUES

☐ 3. Policy not in force on date of accident:

☐ 4. Injured person excluded under policy conditions or exclusion:

☐ 5. Policy conditions violated

- ☐ a. No reasonable justification given for late notice of claim.
- ☐ b. Reasonable justification not established. **You may qualify for expedited arbitration.** See page two of this form for instructions.

☐ 6. Injured person not an "Eligible Injured Person":

☐ 7. Injuries did not arise out of use or operation of a motor vehicle

☐ 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage

LOSS OF EARNINGS BENEFITS DENIED

☐ 9. Period of disability contested: period in dispute From _____ Through _____

☐ 10. Claimed loss not proven:

☐ 11. Exaggerated earnings claim of $ _____ per month denied

☐ 12. Statutory offset taken

☐ 13. Other, explained below:

OTHER REASONABLE AND NECESSARY EXPENSES DENIED

☐ 14. Amount of claim exceeds daily limit of coverage

☐ 15. Unreasonable or unnecessary expenses

☐ 16. Incurred after one year from date of accident

☐ 17. Other, explained below

HEALTH SERVICE BENEFITS DENIED

☐ 18. Fees not in accordance with fee schedules

☐ 19. Excessive treatment, service or hospitalization From _____ Through _____

☐ 20. Treatment not related to accident

☐ 21. Unnecessary treatment, service or hospitalization From _____ Through _____

☐ 22. Other, explained below:

COMPLETE ITEMS 23 THROUGH 32 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED

23. Provider of Health Service (Name, Address and Zip Code)	25. Period of bill –treatment dates	28. Date final verification requested	31.Amount paid by insurer $
	26. Date of bill	29. Date final verification received	32. Amount in dispute
24. Type of service rendered	27. Date bill received by insurer	30. Amount of bill $	$

33. State reason for denial, fully and explicitly (attach extra sheets if needed):

DATED: _____

_____
Name, and Title of Representative of Insurer

_____
Name and address of Insurer claim processor (Third Party Administrator), if applicable

TELEPHONE NUMBER: _____ EXT._____

IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

1. You may file a written complaint with:

NEW YORK STATE INSURANCE DEPARTMENT
CONSUMER SERVICE BUREAU
25 BEAVER STREET
NEW YORK, NEW YORK 10004

Although the Insurance Department will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Insurance Department at the above address. Or you can file your complaint online by visiting the Department website at www.ins.state.ny.us/complhow.htm and following the instructions that you find there. If you choose this option, you may at a later date still submit this dispute to arbitration or bring a lawsuit; or

2. You may submit this dispute to arbitration. If you wish to submit this claim to arbitration, mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a $40 filing fee, payable to the AMERICAN ARBITRATION ASSOCIATION (AAA) to:

NEW YORK NO-FAULT CONCILIATION CENTER
AMERICAN ARBITRATION ASSOCIATION (AAA)
65 BROADWAY
NEW YORK, NEW YORK 10006

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the insurer at the time of filing for arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and Insurance Department Regulations.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of Earnings: Date claim made: _____ Gross Earnings per month $_____

Period of dispute: From _____ Through _____ Amount Claimed: $_____

Health Services: (Attach bills in dispute and list each one separately.

Name of Provider	Date of Service	Amount of Bill	Amount in Dispute	Date Claim Mailed

Other Necessary Expenses: (Attach bills in dispute and list each one separately.

Type of Expense Claimed	Amount Claimed	Date Incurred	Date Claim Mailed	Amount in Dispute

Other: (Attach additional sheets, if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.
- You qualify for **expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". A request for expedited arbitration must be filed within 30 days of date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

3. You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF AND REASONABLE INQUIRY THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDLENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION, THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR, THAT THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, 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 STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

<table>
<tr><td>ARBITRATION REQUESTED BY:

LAST NAME FIRST NAME</td><td colspan="2">NAME OF LAW FIRM, IF ANY</td></tr>
<tr><td>TELEPHONE NUMBER:</td><td colspan="2" rowspan="3">ADDRESS</td></tr>
<tr><td>FAX NUMBER:</td></tr>
<tr><td>E-MAIL ADDRESS:</td></tr>
<tr><td>SIGNATURE</td><td>ARE YOU AN ATTORNEY?
☐ YES ☐ NO</td><td>DATE</td></tr>
</table>

IMPORTANT NOTICE TO APPLICANT

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.)(212-791-1280) located at 110 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit, even if you intend to contest this denial.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURING 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 INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, 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 STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

_____ _____
(Print name of Patient) **(Signature of Patient)**

_____
(Date of signature)

_____
_____
(Address)

_____
_____
(Print name of Provider) **(Signature of Provider)**

_____
(Date of signature)

_____
_____
(Address)

NYS FORM NF-AOB (5/2003)