Crystal Run Healthcare
155 Crystal Run Road
Middletown, NY 10941
845-703-6999

No Fault Information Form

Crystal Run Healthcare must submit the bill to your No Fault carrier within 45 days of your visit today. Failure to do so within this time frame will result in your No Fault carrier denying the claim.

Please return the completed forms by mail, email, or fax. You can also return forms in office at any location. Completed forms can be emailed to NewInsurance@CrystalRunHealthCare.com or by fax at 845-796-5868. If mailing the information please put to the **Attention of Ymonica S., Business Office.** If you have any questions please contact the Billing Department at 844-259-5944.

Please be advised, if the information requested is not received within five (5) days the patient will be responsible for the charges incurred.

Complete the following fields. All fields below are mandatory/required.

Today's Date:	
Patient Name:	**Patient Date of Birth:**
Date of Injury:	**State Accident Occurred:**
No Fault Policy #:	**No Fault Claim #:**
No Fault Carrier Name:	
No Fault Carrier Telephone #:	**No Fault Carrier Contact Name:**
No Fault Carrier Address:	
Policy Holder Name:	
Policy Holder Address:	

INTERNAL USE ONLY:

Encounter #: _____ Date of Service: _____

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No Fault Permission Form

Crystal Run Healthcare must submit the bill to your No Fault carrier within 45 days of your visit today. Failure to do so within this time frame will result in your No Fault carrier denying the claim.

Please return the completed forms by mail, email, or fax. You can also return forms in office at any location. Completed forms can be emailed to NewInsurance@CrystalRunHealthCare.com or by fax at 845-796-5868. If mailing the information please put to the **Attention of Ymonica S., Business Office.**

Please be advised, if the information requested is not received within five (5) days the patient will be responsible for the charges incurred.

Today's Date:	
Patient Name:	**Patient Date of Birth:**
Encounter #:	

Crystal Run Healthcare will seek payment from your No Fault carrier for the services provided.

By signing below, I authorize Crystal Run Healthcare to charge my private pay insurance for any outstanding balance after my No Fault carrier has either paid or denied my claim.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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** Crystal Run Healthcare **, ("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)

Crystal Run Healthcare

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

155 Crystal Run Road

_____ _____
(Date of signature)

Middletown, NY 10941

_____
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)