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

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____**, ("Assignor") hereby assign to** Mid-Hudson Regional**, ("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 the 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**
(Print accident date)
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 INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERICAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERICAL 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)

_____ _____
(Address of Patient) (Date of signature)

_____

Mid-Hudson Regional Hospital _____
(Print name of Provider) (Signature of Provider)

241 North Rd. _____
(Address of Provider) (Date of signature)

Poughkeepsie, NY 12601

NYS FORM NF-AOB(1/2004)

Westchester Medical Center
PO Box 350
Plainview, NY 11803-0350
Ph# (516) 454-0700
Fax# (516) 454-6274

Date_____

Re: Patient Name: _____
Patient Address: _____
Date of Service: _____

Dear Patient:

Please contact your No-Fault insurance carrier to report this accident as soon as possible. Your carrier will assign a claim number and an adjuster to handle your file. Please complete the bottom of this form with the requested information and return it in the envelope provided.

As per an update to the NY State No-Fault regulation, accidents must be reported within 30 days to your automobile insurance carrier. In addition, the regulation further requires that the Hospital must bill your No-Fault insurance within 45 days of treatment. Therefore, it is imperative that you take care of this immediately!

Please provide the insurance information for the automobile YOU WERE IN, regardless of who is at fault not the insurance of the other vehicle. In addition, please sign the second page of this letter.

You can also provide this information online at the following address @ http://www.tritechhcm.com/insurance-information.html

Thank you in advance for your prompt response regarding your claims,

No-fault Billing Unit
Please return this information to our office within **14 days**.

Patient Name: _____ Policyholder:_____

Phone #:_____ Social Security#_____

Account No.: _____ Date of Accident:_____

Claim Number: _____ Policy Number: _____

Insurance Co. Name and Address: _____

_____

Claims Adjuster's Name and Number: _____

Attorney's Name and Number:_____

Westchester Medical Center
PO Box 350
Plainview, NY 11803-0350
PH# 516-454-0700
FAX# 516-454-6274

Fecha_____

Nombre Del Paciente: _____
Direccion Del Paciente: _____
Fecha Del Servicio: _____

Estimado Paciente.

Por favor contactar a su seguro automovilistico y reportar su accidente lo mas pronto posible.
Su aseguranza le dara un numero de reclamo y el nombre de su ajustador, que se encargara de su caso.
Por favor complete este formulario con toda la informacion necesaria y enviela en su sobre
Correspondiente.

Por la regulacion de la aseguranza automovilistica del Estado de Nueva York, accidentes tendran Que ser reportados antes de los 30 dias a su aseguranza automovilistica. En adicion por regulaciones Automovilisticas require que el hospital cobre a su aseguranza antes de los 45 dias de su accidente. Por lo tanto, es inperativo encargarse de este caso inmediatamente.

Provea la informacion del seguro del auto en el cual usted estuvo accidentado, No el seguro del otro automobil.
Usted puede proveer esta informacion en linea, visitando el siguiente sitio web.
http://www.tritechhcm.com/insurance-information.html

Cordialmente.
Departamento De Facturacion Automobilistica.

Nombre Del Paciente: _____ Nombre Del Asegurado: _____

Numero De Telefono: _____ Seguro Social: _____

Numero De Cuenta: _____ Fecha Del Accidente: _____

Numero De Reclamacion: _____ Numero De Aseguranza: _____

Compañia De Seguro. Nombre y Direcion: _____
_____

Nombre Del Ajustador y Numero de Reclamo: _____

Nombre y Telefono de su Abogado: _____