Winthrop Orthopaedic Associates, PC

NO FAULT INFORMATION SHEET

IN ORDER THAT BILLING CAN BE COMPLETED, PLEASE EITHER COMPLETE THE FOLLOWING INFORMATION SHEET AND RETURN IT TO US OR HAVE YOUR INSURANCE COMPANY FORWARD NO FAULT FORMS TO US. YOUR PROMPT ATTENTION TO THIS MATTER WILL BE GREATLY APPRECIATED

PATIENT NAME: _____

PATIENT ADDRESS: _____

POLICY HOLDER'S NAME: _____

RELATIONSHIP TO POLICY HOLDER: _____

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

INSURANCE COMPANY PHONE #: _____

CLAIMS ADJUSTER: _____

DATE OF ACCIDENT: _____

POLICY NUMBER: _____

CLAIM NUMBER: _____

DISABILITY DATE: FROM: _____ TO: _____

WERE YOU THE PASSENGER / DRIVER/ PEDESTRIAN (CIRCLE ONE)

DESCRIBE HOW INJURY OCCURRED:

_____

_____

IF REPRESENTED BY AN ATTORNEY, PLEASE GIVE NAME AND ADDRESS:

_____

_____

AUTHORIZATION TO PAY BENEFIT TO PHYSICIAN

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO WUH ORTHOPAEDIC DEPT OF THE SURGICAL AND/ OR MEDICAL BENEFITS, OTHERWISE, PAYABLE TO WUH ORTHO DEPT IN ACCORDANCE WITH THE NO FAULT MEDICAL FEE SCHEDULE FOR THIS SERVICES

PATIENT SIGNATURE _____ **DATE:** _____

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 2

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:

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 NO.	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 BENEFITS 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

CONTINUE ON PAGE 3