JERSEY REHAB
PAIN MANAGEMENT
SPORTS MEDICINE

Edwin M. Gangemi, M.D. Shailendra Hajela, M.D.
Robert A. Marini, M.D.
www.jerseyrehab.com
15 Newark Avenue Belleville, NJ 07109 Tel. (973) 844-9220 Fax. (973) 844-1217

ACCIDENT INSURANCE INFORMATION

TYPE OF ACCIDENT: MOTOR VEHICLE _____ WORKMEN'S COMPENSATION _____ LIABILITY _____
DATE OF ACCIDENT: _____ DO YOU HAVE AUTO INSURANCE? YES / NO
NAME OF INSURANCE COMPANY: _____
INSURANCE COMPANY ADDRESS: _____
POLICY #: _____ CLAIM #: _____
CLAIM REPRESENTATIVE: _____
WERE YOU THE DRIVER? _____ PASSENGER? _____ PEDESTRIAN? _____ OTHER _____
BRIEF DESCRIPTION OF ACCIDENT _____
_____
HAS THIS ACCIDENT BEEN REPORTED TO YOUR INSURANCE COMPANY? YES / NO
IF NOT, YOU MUST REPORT THE ACCIDENT TO YOUR INSURANCE COMPANY TO PROTECT YOUR BENEFITS, EVEN IF YOU WERE NOT AT FAULT.

IF YOU WERE A PASSENGER IN A VEHICLE NOT OWNED BY YOU, WE WILL NEED THE FOLLOWING INFORMATION:
VEHICLE OWNER: _____ INSURANCE COMPANY: _____
POLICY #: _____ CLAIM #: _____
DOES ANYONE ELSE IN YOUR HOUSEHOLD HAVE AUTO INSURANCE OF THEIR OWN? YES / NO
NAME: _____ RELATIONSHIP: _____
INSURANCE CO: _____ POLICY #: _____

****

WORKMEN'S COMPENSATION INFORMATION: DATE OF ACCIDENT: _____
AUTHORIZED FOR TREATMENT: _____ UNAUTHORIZED FOR TREATMENT: _____
EMPLOYER'S NAME: _____
WORKMEN'S COMPENSATION CARRIER: _____
WORKMEN'S COMPENSATION CARRIER ADDRESS: _____
CITY _____ STATE _____ ZIP CODE _____ TEL # ( ) _____
CLAIM REPRESENTATIVE _____ OR CONTACT PERSON _____

****

ARE YOU REPRESENTED BY AN ATTORNEY FOR THIS INJURY? ( ) YES ( ) NO
ATTORNEY NAME: _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
TELEPHONE #: ( ) _____ PARALEGAL OR SECRETARY NAME _____

APPLICATION FOR BENEFITS—PERSONAL INJURY PROTECTION

IMPORTANT:
1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW, YOU MUST COMPLETE AND SIGN THIS FORM.
2. YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO: CURE
CLAIM DEPT.
214 CARNEGIE CENTER, SUITE 101
PRINCETON, NJ 08540

YOUR NAME	PHONE NO. HOME	BUSINESS
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH / /	SOCIAL SECURITY NO.

DATE AND TIME OF ACCIDENT / / A.M. P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)
BRIEF DESCRIPTION OF ACCIDENT	

WERE YOU THE DRIVER OF THE AUTOMOBILE? YES ☐ NO ☐
WERE YOU A PASSENGER IN THE AUTOMOBILE? YES ☐ NO ☐
WERE YOU A PEDESTRIAN? YES ☐ NO ☐
WERE YOU A MEMBER OF THE AUTOMOBILE OWNER'S HOUSEHOLD? YES ☐ NO ☐

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? YES ☐ NO ☐

DESCRIBE ALL AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY THAT RESIDED IN YOUR HOUSEHOLD AS OF THE DATE OF THE LOSS.

AUTOMOBILE	OWNER	INSURANCE CO.	POLICY NUMBER

DID YOU HAVE HEALTH INSURANCE ON THE DATE OF LOSS? YES ☐ NO ☐
IF YES, PROVIDE THE INFORMATION REQUESTED BELOW REGARDING YOUR HEALTH INSURER(S):

1. NAME: _____
ADDRESS: _____
PHONE: _____
FAX#: _____
E-MAIL: _____
POLICY/GROUP #/CERTIFICATE #: _____

2. NAME: _____
ADDRESS: _____
PHONE: _____
FAX#: _____
E-MAIL: _____
POLICY/GROUP#/CERTIFICATE #: _____

WERE YOU INJURED AS A RESULT OF THIS ACCIDENT? YES ☐ NO ☐ IF YOUR ANSWER IS **YES**, COMPLETE THE REST OF THIS FORM. IF **NO**, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: _____ DATE: _____

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐	DOCTOR'S NAME AND ADDRESS	
IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN-PATIENT? ☐ OUT-PATIENT? ☐	HOSPITAL'S NAME AND ADDRESS	
AMOUNT OF MEDICAL BILLS TO DATE: $	WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐	AT TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐
DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐	IF YES, AMOUNT LOST TO DATE $	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $

IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN _____ DATE YOU RETURNED TO WORK _____

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER

	YES	NO
(1) ANY WORKMEN'S COMPENSATION LAW?	☐	☐
(2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE?	☐	☐
(3) MEDICARE?	☐	☐

IF YES, AMOUNT $ _____ ☐ PER WEEK ☐ PER MONTH

LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN ON REVERSE SIDE.

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

SIGNATURE: _____ DATE: _____

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AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, 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 PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: _____ DATE: _____

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: _____ DATE: _____

AUTHORIZATION TO EXTEND TIME TO SCHEDULE A PHYSICAL EXAMINATION FOR DECISION POINT REVIEW

(OPTIONAL)

TO ASSURE MY ABILITY TO ATTEND THE REQUIRED PHYSICAL EXAMINATION, I HEREBY AUTHORIZE CURE TO TAKE UP TO 14 DAYS AFTER RECEIPT OF NOTICE FROM MY HEALTH CARE PROVIDER (RATHER THAN THE 7 DAYS NORMALLY REQUIRED) FOR SCHEDULING A PHYSICAL EXAMINATION IF ONE IS NEEDED IN ORDER TO MAKE A DETERMINATION REGARDING THE MEDICAL NECESSITY OF TESTS OR TREATMENTS UNDER THE CURE DECISION POINT REVIEW PLAN.

SIGNATURE: _____ DATE: _____

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ASSIGNMENT OF BENEFITS

PATIENT NAME: _____

I irrevocably assign to Jersey Rehab, P.A. all my rights and benefits under any insurance contracts for payment of services rendered to me by Jersey Rehab, P.A. I irrevocably authorize Jersey Rehab, P.A. to file insurance claims on my behalf for services rendered to me.

Jersey Rehab, P.A. has made me aware that all claims will be submitted to my insurance carrier if provided. Any co-pay, co-insurance and deductible will be my responsibility. All payments are to be directed to Jersey Rehab, P.A. There will be three attempts by Jersey Rehab, P.A. to collect any debt. If Jersey Rehab, P.A. is unsuccessful in collecting your debt, it will be handed over to a representative for suit. I understand that it is my responsibility to inform Jersey Rehab, P.A. of any insurance change to my current policy or change in insurance company and if I do not do so, I will be fully responsible for all bills incurred within that period.

This Assignment of Benefits has been explained to my full satisfaction and I understand its nature and effect. I hereby authorize photocopies of this form to be valid as the original.

Patient's signature: _____ Date: _____

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ATTORNEY RELEASE FORM

ATTORNEY NAME: _____

ATTORNEY ADDRESS: _____

_____

_____

RE: _____

D/A: _____

I authorize Jersey Rehab, P.A. to release my medical records and any other necessary information to the above-mentioned attorney.

Date: _____ **Patient signature:** _____