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## **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:						
POLICY #	CLAIM #:					
CLAIM REPRESENTATIVE:						
WERE YOU THE DRIVER? PAS	SSENGER? PEDESTRIAN? OTHER					
BRIEF DESCRIPTION OF ACCIDENT						
HAS THIS ACCIDENT BEEN REPORTED TO	YOUR INSURANCE COMPANY? YES / NO					
IF NOT, YOU MUST REPORT THE ACCIDE	NT TO YOUR INSURANCE COMPANY TO PROTECT YOUR BENEFITS,					
EVEN IF YOU WERE NOT AT FAULT.						
	OT OWNED BY YOU, WE WILL NEED THE FOLLOWING INFORMATION:					
	INSURANCE COMPANY:					
	CLAIM #:					
	HAVE AUTO INSURANCE OF THEIR OWN? YES / NO					
NAME:	RELATIONSHIP:					
INSURANCE CO:	POLICY #:					
**************	****************					
	ON: DATE OF ACCIDENT:					
	UNAUTHORIZED FOR TREATMENT:					
	OTATO ITIONALIDI TON TRANSPIRATI					
	DDRESS:					
	ZIP CODE TEL # ( )					
CLAIM REPRESENTATIVE	OR CONTACT PERSON					
	********************					
ARE YOU REPRESENTED BY AN ATTORNE	Y FOR THIS INJURY? ( ) YES ( ) NO					
	, , , , , , , , , , , , , , , , , , , ,					
ADDRESS						
CITY STATE						
	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.

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SIGNATURE:



NJ Top Doc nine of the last ten years

Edwin M. Gangemi, M.D. Shailendra Hajela, M.D.

Robert A. Marini, M.D.

15 Newark Avenue

PATIENT NAME:

<u>www.jerseyrehab.com</u> Belleville, NJ 07109

Tel. (973) 844-9220

Fax. (973) 844-1217

## **ASSIGNMENT OF BENEFITS**

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 <u>Jersey Rehab, P.A.</u> I irrevocably authorize <u>Jersey Rehab, P.A.</u> to file
nsurance 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 <u>Jersey Rehab, P.A.</u> to collect any debt. If <u>Jersey Rehab,</u>
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:		
The second secon		14
RE:		
D/A:		
I authorize Jersey Rehab, P.A. to releas above-mentioned attorney.	e my medical records and any other necessary information to th	e
Date:	Patient signature:	