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 BILL S YOU HAVE RECEIVED TO DATE.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO: _____
CLAIM DEPT.

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		

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? YES ☐ NO ☐
NAME OF INSURANCE COMPANY _____

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 AUTOMOBILE OWNER'S HOUSEHOLD? YES ☐ NO ☐

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? 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 ACCIDNT 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: _____

A 3965A (1-95)

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:

9800 Fredericksburg Road
San Antonio, Texas 78288

USAA®

LIMITED ASSIGNMENT OF NJ NO-FAULT BENEFITS

(This is not a confirmation of coverage or a guarantee of payment)

USAA Insured's Name: _____

USAA Number: _____

Date of Loss: _____

Patient Name: _____ ("Assignor")

Provider of Service: _____ ("Assignee")

Date(s) of Service: _____

By my signature below, I hereby authorize and direct:

United Services
Automobile Association

("Company") to pay directly to the provider of service named above, all monies due and payable to the provider under the covered person/member's New Jersey no-fault PIP coverage. All approved payments shall be subject to the New Jersey no-fault fee schedule and any applicable co-payment and deductible for which the Patient/Assignor shall be solely liable. Provider/Assignee agrees to abide by the USAA Pre-Certification and Decision Point Review Plan requirements, and shall hold the Patient/Assignor harmless for its failure to do so. Patient and Provider understand that execution of this Limited Assignment is not a guarantee of payment or a confirmation of coverage.

Written Consent to Assignment

When this Limited Assignment form ("form") is used without any alterations, this form constitutes the Company's written consent. If this form is altered, Company has not consented to the assignment. Once accepted by Company, any attempted transfer of this assignment rescinds Company's written consent and acceptance, patient's direction to pay, and Company's obligation to abide by this assignment.

In exchange for Company's written consent to assignment, the provider of service, Assignee, agrees:

(1) To comply with all requirements of Company's Pre-certification Decision Point Review Plan ("Plan");

(2) To initiate all pre-certification review and decision point review requests as required by the Plan;

(3) To submit disputes in accordance with the Internal Appeal procedures in the Plan and to exhaust all internal appeals prior to initiating a demand for dispute resolution;

(4) To submit all other issues involving payment for services under an existing policy to dispute resolution in accordance with the process established by the Department of Banking and Insurance ("DOBI"); and

(5) To hold the patient harmless for the amount of benefits denied because the Provider failed to follow the plan.

Merger

The Limited Assignment constitutes the entire agreement between Patient and Provider as to payment for services rendered to this patient. All prior express, or implied agreement(s), including any alleged waivers of policy conditions, no longer exist when both Patient and Provider have executed this assignment below. Upon execution, this Limited Assignment may not be changed, altered, or modified in any way, except in a separate writing signed by the parties.

Severability

If any provision of this Limited Assignment is deemed to be invalid or unenforceable by a court of competent jurisdiction or a dispute resolution professional designated by the DOBI, the invalid or unenforceable provision shall be reformed to comply with New Jersey law. If reformation of this is not possible, this assignment shall be construed as if such invalid or unenforceable provision had never been included in the assignment. All other provisions will remain in full force and effect with the remaining document being construed as one instrument.

By our signature below, both Patient and Provider agree to all of the terms and conditions contained in this Limited Assignment.

Patient/Assignor

Date

Provider of Service/Assignee

Date

Acceptance:

This Limited Assignment of Benefits shall be deemed to be accepted by Company seven (7) days after the execution by the last party to sign above, if the assignment is returned without any alterations to the insuring Company at: P.O. Box 33490, San Antonio, Texas 78265; This deemed acceptance shall be irrevocable except in cases of fraud or duress.

51962 9-05

TRAVELERS
of New Jersey

FIRST TRENTON INDEMNITY COMPANY
TRAVELERS INSURANCE CO. OF NEW JERSEY
PERSONAL INJURY PROTECTION BENEFITS
CONDITIONAL ASSIGNMENT OF BENEFITS

Policy Number: **Claim Number:**
Patient's Name: **Medical Provider's Name:**

I authorize and request First Trenton Indemnity Company/Travelers Auto Insurance Co. of New Jersey(hereinafter referred to as the "Company") to pay directly to the above-named provider, the amount due me under the terms of the above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associates with the provider's office.

Date: _____ _____

Patient's Signature or
Parent/Legal Guardian

I have read the information sent by the Company concerning the Decision Point Review plan, including any pre-certification requirements (collectively referred to hereafter as the "Plan") and, as a condition precedent to the Company's acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1) I (we) have complied and will comply with all the procedures identified within the Plan;

2) I (we) will comply with all requests for additional information from the Company concerning the presentation of the claim including but not limited to the submission of medical records with clinically supported findings to support the diagnosis, casual relationship to the accident and care plan and if necessary submit to Examinations Under Oath;

3) I (we) will submit all disputes in accordance with the Internal Appeal Procedure set forth in the Plan;

4) I (we) will not institute litigation or initiate the Personal Injury Protection Dispute Resolution process outlined in the Plan until there has been a final determination of the Internal Appeal Procedure of the dispute; and

5) In the event that I (we) fail to comply with the requirements of the Plan, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services attributable to such failure to comply with the Plan.

The Company does not provide coverage for any insured or pay benefits to any provider who has made fraudulent statements or engaged in fraudulent conduct or made any material misrepresentation in connection with either obtaining the policy or with any accident or loss for which coverage or benefits are sought.

I (we) understand that the Company has the right to reject this assignment of benefits.

Date: _____ _____

Provider's Signature

(09/06)

STATE FARM INDEMNITY COMPANY
PERSONAL INJURY PROTECTION BENEFITS

CONDITIONAL ASSIGNMENT OF BENEFITS

Policy Number: _____ **Claim Number:** _____
Patient's Name: _____
Medical Provider's Name: _____

I authorize and request State Farm Indemnity Company (State Farm) to pay directly to the above-named medical provider, the amount due to me under the terms of the above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associated with the provider's office.

_____ Date: _____
Patient's Signature or Parent/Legal Guardian

I have read the information contained in the State Farm Indemnity Company informational letter concerning the Decision Point Review Plan, including Medical Services Review, Decision Point Review and pre-certification requirements (collectively, "**Plan**") and, as a condition precedent to State Farm's acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1) I (We) have complied and will comply with all the requirements of the **Plan**.
2) I (We) will initiate all pre-certification review and decision point review requests as required by the **Plan**.
3) I (We) will submit disputes as defined in the **Plan** to the Internal Dispute Resolution Process set forth therein. After final determination, I (we) will submit disputes not resolved by the Internal Dispute Resolution process to the personal injury protection dispute resolution process set forth in N.J.A.C. 11:3-5.
4) I (We) will submit all disputes not subject to the Internal Dispute Resolution process to the personal injury protection dispute resolution process set forth in N.J.A.C. 11:3-5.
5) I (We) will submit medical records with clinically supported findings to support the diagnosis, causal relationship to the accident, and care plan.
6) In the event that I (we) fail to comply with paragraphs one (1) though five (5) above, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty.

I (we) agree that this assignment is the only valid assignment of benefits. I (we) agree that this assignment of benefits may require State Farm's written consent. I (we) agree that State Farm has the right to reject/terminate/or revoke this assignment of benefits.

_____ Date: _____
Provider's Signature

_____ TIN Number: _____
Provider's Name (Please Print)

Address: _____

_____

_____

MOUNT PROSPECT HEALTH CENTER
600 MT. PROSPECT AVE
NEWARK, NJ 07104
(973) 485-2332
Tax ID # 22-3198062

AFFIDAVIT

I, _____, of full age, being duly sworn, according to law, upon my oath depose and say that:

1. On or about _____ (Accident Date), I lived at _____ (Street Address)

_____ (city), _____ (state), _____ (zip code)

2. I was injured in an accident involving a private passenger automobile.
3. Neither I nor any member of my household was the owner of an automobile.
4. I am not otherwise entitled to New Jersey Automobile No-Fault Benefits for this accident.
5. I am, therefore, executing this affidavit in order to receive New Jersey Automobile No-Fault benefits under the _____Insurance Company's policy issued to _____ (Policyholder's Name)
6. My Date of Birth: _____

   Social Security #:_____

   Driver License#: _____

   Home Phone #: _____

   Business Phone#: _____

Signature:_____

SWORN AND SUBSCRIBED TO BEFORE ME THIS

_____DAY OF _____, 20_____

NOTARY PUBLIC – STATE OF NEW JERSEY

MY COMMISSION EXPIRES_____, 20_____

Medical Provider's Lien

Patient's Name:_____

Date of Accident:_____

Provider's Name: _____

I hereby authorize under-signed provider to furnish my attorney _____with a full report of my examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct my attorney _____ to pay directly to my provider such sums as may be due and owing him for professional services rendered to me by reasons of this accident and by reasons of any other bills that are due his office and to withhold such sums from my settlement, judgment or verdict as may be necessary adequately to protect bills of my provider. I hereby further give a lien on my case to my provider against any and all proceeds of any settlement, judgment or verdict which may be paid to my attorney _____ or me as the result of the injuries for which I have been treated of injuries in connection herewith.

I fully understand that I am directly and fully responsible to my provider for all professional bills submitted by him for services rendered to me and that this agreement is made solely for my provider 's additional protection and in consideration of his awaiting payment.

PATIENT hereby irrevocably directs his attorney, if any to pay the full amount owing for services rendered by PHYSICIAN, or any balance thereof immediately upon receipt of an invoice from PHYSICAN from monies received from PATIENT's attorney(s) as a result of any compromise, settlement, arbitration, mediation, litigation or any other collection activities by PATIENT or PATIENT'S attorney(s). This agreement shall constitute an irrevocable assignment and lien on any monies collected or received as a result of the condition for which PHYSICIAN treats PATIENT.

PATIENT' S SIGNATURE: _____ DATED: _____

PROVIDER'S SIGNATURE:_____ WITNESS :_____