OCLI
OPHTHALMIC CONSULTANTS OF LONG ISLAND
Setting the Standard in Eye Care

NO FAULT CLAIM INFORMATION

Patient Name:_____

Patient Address: _____

Patient Phone # _____

Patient SS# _____ Patient Date of Birth _____

NO FAULT INFORMATION

Insurance Name: _____

Insurance Address: _____

Insurance City, State and Zip: _____

Insurance Phone #: _____

Policy Number: _____

Date of Accident: _____ Time of Accident _____

Location of Accident: _____

Name on Policy: _____

Until a VALID NO Fault claim is established, you will be responsible for all charges. The information requested above is essential to establishing your claim. Your assistance is appreciated.

ASSISGNMEMT OF BENEFITS

I, _____("Assignor") hereby assign to Ophthalmic Consultants ("Assignee")
All rights, privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (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 _____(date of accident), not withstanding any other agreement to the 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.

Print Patient's Name: _____ Signature of Patient: _____
Date Signed: _____
Print Dr's Name: _____ Signature of Dr.: _____