EXCEL
REHABILITATION & SPORTS THERAPY
41 John Street, Babylon, NY 11702
631-321-1100 FAX 631-321-1761

New York Motor Vehicle No-Fault Insurance Law
Assignment of Benefits Form

I, _____("Assignor") hereby assign to _____, ("Assignee")
(print patient's name) (print hospital or heath care provider name)

All rights, privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statue) of the Insurance Law.

The Assignee hereby certifies that they have not receive any payment from or on behalf of the Assignor and shall pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any prior written agreement to the contrary. (print accident date)

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.

ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD ANY INSURANCE COMPANYY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION OR ANY PERSON WHO, IN CONNECTION WITH SYCH APPLICATON OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____
(Print Name of Patient)

_____
(Signature of Patient)

_____
(Date of Signature)

_____
(Patient Address)

_____
(Print Name of Provider)

_____
(Signature of Provider)

_____
(Date of Signature)

_____
(Provider Address)