REGIONAL RADIOLOGY
REGIONAL IMAGING & THERAPEUTIC RADIOLOGY SERVICES, PC.
P.O. Box 100108 • Staten Island, New York • 10310-0108 • (718) 447-4900 • Fax (718) 447-4511

NO FAULT INFORMATION

Patient Name: ______________________ SS# ______________
Date of Accident: ____________ Account # ______________
Address: ______________ Apt # ______ Telephone: ( ) - ______
City: ______________ State: ______ Zip: ____________

Name of Owner of Vehicle: ______________________________
Address: ______________ Apt # ______ Telephone: ( ) - ______
City: ______________ State: ______ Zip: ____________

Name of Driver of Vehicle: ______________________
Were you on the job when this accident occurred? NO ______ YES ______
If YES, Please download the workmans comp form to complete.

No Fault Insurance Carrier Name: ______________________________
Claim Office Address: ______________________ Telephone ( ) - ______
City: ______________ State: ______ Zip: ____________

POLICY # ______________________ CLAIM # ______________________
FILE # ______________________ AGENT: ______________________

Attorney Name: ______________________
Address: ______________________ Telephone: ( ) - ______
City: ______________ State: ______ Zip: ____________

Have you or your attorney filed your No Fault Application with your No Fault Insurance Carrier?
NO ______ YES ______ Date Filed: ____________

Failure to file your No Fault Insurance Application within 3 months from the date of accident (required by NYS No Fault Insurance Law), can and will result in your carrier denying payment of any claims. I hereby authorize Regional Radiology to file a claim on my behalf and receive payment for any and all No Fault Automobile Insurance benefits for services rendered by the provider. In the event payment is denied or any portion of today's charges are outstanding, I understand that I am responsible for payment of today's charges.

You can provide us with your health insurance information to be used only in the event your No Fault carrier denies payment of these services. Please note that you are responsible to obtain and provide us with any necessary precertification or referrals required by your health insurance carrier for today's services. It would be advisable to obtain any necessary requirements immediately and have them on hand in the event of a No Fault denial. If your health insurance carrier also denies payment of these services for any reason, you remain ultimately responsible for payment of the full outstanding balance.

Name of Health Plan: ______________________ Policy # ______________
Address: ______________________ Telephone: ( ) - ______
City: ______________ State: ______ Zip: ____________
Policy Holder Name: ______________________ Relationship to Policy Holder: ______

Signature: ______________________