NOTIFICATION OF COMMENCEMENT OF MEDICAL TREATMENT FORM

(TWENTY ONE DAY NOTICE)

(N.J.A.C. 11:3-25, et seq)

TREATING HEALTH CARE PROVIDER:

NAME: EASTPOINTE CHIROPRACTIC
Johnathan Mendez, D.C. Travis Impellizzeri, DC
Laura Anastasia, DPT., Andrew Grogan, DPT., Nicholas Mancini, DPT.

ADDRESS: 2397 HWY 36
ATLANTIC HIGHLANDS, NJ 07716

PHONE: 732-872-6595 FAX: 732-872-1508

PATIENT INFORMATION:

NAME:
ADDRESS:

INSURED INFORMATION (IF DIFFERENT FROM PATIENT):

NAME:
ADDRESS:

INSURER INFORMATION:

NAME:
ADDRESS:

POLICY NUMBER:
CLAIM NUMBER:
DATE OF ACCIDENT:
FIRST TREATMENT DATE:

ASSIGNMENT OF PIP MEDICAL BENEFITS FORM

PATIENT AUTHORIZATION:

I am the PATIENT described above and I authorize and direct the INSURER described above to pay the TREATING HEALTH CARE PROVIDER described above, the amount due under the terms of the policy described above for any PIP medical benefits rendered by the TREATING HEALTH CARE PROVIDER described above and/or all staff associated with that office.

I further authorize the TREATMENT HEALTH CARE PROVIDER described above to file a DEMAND FOR ARBITRATION (PIP) against the INSURER described above for any PAYMENT DISPUTE for PIP medical benefits rendered by the TREATING HEALTH CARE PROVIDER described above and/or all staff associated with that office.

PAYMENT DISPUTE shall include a denial and/or non-payment by the INSURER described above for PIP medical benefits rendered by the TREATING HEALTH CARE PROVIDER described above and/or all staff associated with that office. PAYMENT DISPUTE shall also include a denial and/or refusal to authorize by the INSURER named above any recommended medical benefits as part of the TREATMENT PLAN of the TREATING HEALTH CARE PROVIDER described above and/or all staff associated with that office.

Patient Signature _____

TREATING HEALTH CARE PROVIDER REPRESENTATION:

I am the TREATING HEALTH CARE PROVIDER described above and provide the following representations to the INSURER named above in order for the ASSIGNMENT OF BENEFITS executed by the PATIENT named above to be honored. Specifically:

- All requirements of the DECISION POINT REVIEW PLAN and/or PRECERIFICATION PLAN of the INSURER named above that are in accordance with the regulations promulgated by the DEPARTMENT OF BANKING AND INSURANCE (DOBI) shall be complied with; and
- In the event of a failure to comply with the aforementioned requirements, the PATIENT described above will not be held financially liable for any imposed penalty.

It is understood the and INSURER may apply to DOBI pursuant to N.J.A.C. 11:3-4.9(a)
For "approval policy forms that include reasonable procedures for restriction on the assignment of personal injury protection benefits, consistent with the efficient administration of the coverage." As such, please provide me within ten days of receipt of FORM with any documentation required to effectuate the intent of the PATIENT described above. Failure to provide any documentation will be construed as a constructive acceptance of this FORM and the intent of the PATIENT described above.

_____ _____

Dr. Laura Anastasia, PT. DPT. Dr. Johnathan Mendez D.C.

_____ _____

Dr. Andrew Grogan, PT. DPT. Dr. Travis Impellizzeri D.C.

_____

Dr. Nicholas Mancini, PT. DPT.

AASIGNMENT OF BENEFITS & LTD. POWER OF ATTORNEY

Patient's Name: _____

Accident date: _____

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me as a result of this automobile accident and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. | irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize you to act on my behalf. I consent to your acting on my behalf in this regard an in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" set forth in the NJ Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is deemed invalid, I execute this limited power of attorney and appoint your collection attorney as my agent to collect payment for your medical services directly against the carrier in this case including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name of in your name as medical provider rendering services to me.

1 authorize you and your assigned to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

Patient Signature:_____Date:_____

New Jersey Application for Benefits
Personal Injury Protection

Claim Number: _____

<Name>
<Address 1>
<Address 2>
<Address 3>

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 authorizations, Affidavit and Notice attached.
3. Return promptly with any medical bills you have received to date.

Please be advised that knowingly filing a statement of claim containing any false, inaccurate or misleading information, or intentionally omitting information material to the claim will result in the denial of benefits. Any person who knowingly files a statement of claim containing any false or misleading information is subject to subject to criminal and civil penalties.

Your Name (First, Middle, Last)	Gender: Male ☐ / Female ☐		
List any aliases, maiden names or other names you use or have used in the past	Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
Your Address (No. & Street, City/Municipality, State, County & Zip Code	Date of Birth	Social Security No. (if none, enter "none")	
Your Previous Address (If you lived at the above address for less than 2 years from the accident date)	Email:		

Date of Accident	Time of Accident AM ☐ PM ☐	Place of Accident (Street, City/Town & State)

Brief Description of Accident

Do you own a vehicle? Yes ☐ No ☐
Name of Insurance Company _____
Does anyone living in your residence own a vehicle? Yes ☐ No ☐
Name of Insurance Company _____
Do you have health insurance? Yes ☐ No ☐
Name of Insurance Company _____

	Yes	No
Were you the driver of the vehicle?	☐	☐
Were you a passenger in the vehicle?	☐	☐
Were you a pedestrian?	☐	☐
Were you a member of vehicle owner's household?	☐	☐

As a result of this accident were you injured? Yes ☐ No ☐ If your answer is "Yes", complete the remainder 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 expenses? Yes ☐ No ☐	At the time of your accident, 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 loss to date: $_____	What is your average weekly wage or salary? $

Your 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 Workers' Compensation Law?	☐	☐
(2) Employees' Temporary Disability Benefit Statute?	☐	☐
(3) Medicare?	☐	☐

If yes, amount: $_____ Per week ☐ Per month ☐

If you are a Medicare beneficiary, enter your Health Insurance Claim Number (HICN) _____

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 & Address	Occupation	Dates: From - To

As a result of your injury, have you had any other expenses? Yes ☐ No ☐ If your answer is "Yes", explain on reverse side.

Signature: _____ Date: _____

Do Not Detach - HIPAA Authorization for Medical Information - Do Not Detach

I hereby authorize all medical providers to release my Protected Health Information to the bearer of this PIP application regarding medical treatment rendered to me for this accident as well as any prior or subsequent treatment pursuant to the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164 or any other statutory or regulatory authority. I understand my eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that if I wish to revoke this authorization I must revoke it in writing to the health information management department of the medical providers. I understand that the revocation will not apply to information that has already been released in response to this authorization and that once the above information is disclosed it may be re-disclosed by the recipient and may no longer be protected by state or federal privacy laws or regulations.

Signature: _____ Date: _____

Do Not Detach - Authorization for Wage Information - Do Not Detach

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wage or salary while employed by you. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____ Date: _____