

MOTOR VEHICLE (NO-FAULT)

SUFFOLK PLASTIC SURGEONS, P.C.

DATE:

Patient's Name

FIRST NAME

MIDDLE NAME

LAST NAME

TO PROCESS YOUR **MOTOR VEHICLE (NO-FAULT) RELATED** CLAIM,
WE MUST HAVE THE FOLLOWING INFORMATION.
PLEASE COMPLETE THESE FORMS IN FULL

No-Fault Insurance Co

Address for
Claim
Submission

Policy# _____ Claim# _____ Date of Accident _____

Adjuster's Name: _____ Phone # _____ X- _____ FAX # _____

Policy Holder's Name: _____

Address (If Known): _____

All Insurance Companies require that you file an **Application for Benefits**.
This is also called an **NF-2**.

If you do not submit this to the Insurance carrier in a timely fashion, they can deny your claim
You are ultimately responsible for any claims they do not cover.

If you have not filed, we strongly suggest you contact the insurance company and do so immediately

Have you filed the Application for Benefits (NF-2) with the insurance carrier ? Yes / No

HAVE YOU RETAINED AN ATTORNEY FOR THIS MOTOR VEHICLE INJURY ? Yes / No

If YES, Please provide the following information:

Attorney's Name: _____ Phone: _____ FAX: _____

Address: _____

Signature: _____

Date: _____

Relationship: _____