Associated Plastic Surgeons & Consultants, P.C.
Cosmetic & Reconstructive Plastic Surgery
Diplomates, American Board of Plastic Surgery
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Tel: 631-423-1000
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No-Fault Information Request

The following information is required to submit a claim for No-Fault benefits on your behalf.

Patient's Name _____

Address _____

City, State, Zip _____

Telephone _____

Insurance Company

Address _____

City, State, Zip _____

_____

Policy Holder Name

Address _____

City, State Zip _____

_____

File/Claim or Policy #

_____

Date of Accident

_____

NOTE: In order for the insurance company to pay benefits on your claim, you must file an "Application for Medical Benefits" immediately with the insurance carrier.

I certify the information contained above is correct to the best of my knowledge. In the event the policy above stated is not in effect, canceled or otherwise not valid, I note that I personally will be held responsible for payment. In addition, in the event this account becomes delinquent, I am aware that I will be held fully responsible for full payment as well as legal fees incurred in the collection of a delinquent account.

Patient's Signature _____