NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, __________________________, ("Assignor") hereby assign to New Island Pharmacy Inc. **, ("Assignee")**
(Print patient's name) (Print hospital or health 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 statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not 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 other agreement
(Print accident date)
to the contrary.

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 INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, 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)
(Address of Patient)	
New Island Pharmacy Inc. **(Print name of Provider)**	 **(Signature of Provider)**
1912A Deer Park Avenue	(Date of signature)
Deer Park, New York 11729 (Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)

********************************Please fill out the information on back of this page********************************

No Fault Patient Vehicle Insurance Information

Please fill out the following form with accurate information regarding your no fault claim. This will help us process your claim efficiently. If you have any questions while completing this form, do not hesitate to ask a technician for help.

AUTO Insurance Information

Claim Number: ____

Name of Insurance Carrier: ____________________________________

If you have addtional information to add, please fill in below. (For example, name of Doctor you will be seeing for treatment for this no fault claim, name or number of adjuster with insurance company, in case we need)

Thank you for providing the necessary information. Our team will review your submission and contact you for any additional details required. Please ensure all information is correct before submitting.

Confidentiality Notice: This email/form and any attachments are intended solely for the use of the individual or entity to whom they are addressed and may contain confidential information. If you are not the intended recipient, you are hereby notified that any dissemination, distribution, copying, or use of this email or its contents is strictly prohibited. If you have received this email in error, please notify the sender immediately and delete all copies from your system.

For internal use only:

Name of RPH/Tech doing data entry for claim: ____________________________

Initial of RPH/Tech confirming completion on faxing autorx: ____________________

Autorx fax number is: (866) 785-7065 **Autorx fax number is:** (866) 428-8679