

RETURN TO THIS ADDRESS WITHIN 5 DAYS:

Tri-Tech - 265 Spagnoli Road, Suite 200, Melville, NY 11747

ATTENTION ALL PATIENTS SEEKING INSURANCE COVERAGE UNDER A WORKER'S
COMPENSATION POLICY OR AUTOMOBILE (MEDICAL PAYMENT) POLICY

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Westchester Medical Center utilizes Tri-Tech to assist it in billing and securing payment from worker's compensation carriers (in case of individuals injured in the course of their employment) and automobile insurers (in the case of individuals injured through the use or operation of an automobile). In order to ensure that the insurance company is timely and correctly billed, thereby ensuring their consideration of your bill for services rendered by the hospital, it is imperative that you complete and return this form to Tri-Tech. If you have any questions or require assistance, call Tri-Tech at (516) 454-0700. This form can also be faxed to (516) 454-6274.

Patient Name: _____ Date of Birth: _____
Patient Address: 10 Woods Road, Valhalla, NY 10595 Social Security #: XXX-XX-XXXX
Home Telephone #: (914) 231-1400
Name of Employer: Westchester County Department of Correction Work Telephone #: (914) 231-1400
Address of Employer: 10 Woods Road, Valhalla, NY 10595

For Automobile No-Fault Insurance Claims:

**PER NYS LAW, ALL NO-FAULT BILLS MUST BE SUBMITTED WITHIN 45 DAYS FROM THE DATE OF SERVICE.
PLEASE RESPOND PROMPTLY, FAX TO (516) 454-6274.**

Name of Insurance Carrier: _____ Telephone #: _____
Address of Insurance Carrier: _____ Policy #: _____
Claim #: _____
Name of Insured: _____ Date of Accident: _____
Address of Insured: _____

For Worker's Compensation Claim:

Name of Compensation Carrier: _____ Telephone #: _____
Address of Insurance Carrier: _____ Policy #: _____
Claim #: _____
WCB Case #: _____ Date of Accident: _____

Do you have an attorney? ☐ Yes ☐ No If yes: _____
Name of Attorney: _____ Telephone #: _____
Address of Attorney: _____

ASSIGNMENT OF BENEFITS (NO-FAULT ONLY)

I, _____ ("Assignor") hereby assign to the above provider, ("Assignee") all rights and privileges and remedies to which I am entitled under Article 51 (the No-Fault provisions) 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 above date, notwithstanding any prior written agreement to the contrary.

This agreement shall become null and void if at any time it is determined that the benefits are not payable due to the following circumstances: lack of coverage, violation of a policy condition or determination that the treatment/services rendered are not related to said motor vehicle accident.

In consideration of the services rendered by Westchester Medical Center, I hereby authorize payment to be made directly to the hospital of any insurance benefit due.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the hospital to release any medical information to the insurance carrier to process my claim for benefits.

Signature: _____ Date: _____