No Fault Insurance Form

Inspired Health Group

3671 Southwestern Blvd. Suite 101, 110 & 213

Orchard Park, NY 14127

Name: ____

Address:____

Date of Injury:____

Name of Insured: ____

Insurance Carrier: ____

Address:____

Phone: ____

No Fault Case #:____

Inspired
Health Group

In order to bill No Fault, all information above must completed in full by the injured party. Failure to do so may result in delay in claims processing and/or patient responsibility of payment.

I request that payment of authorized No Fault benefits be made to Inspired Health Group. I also authorize Inspired Health Group to release any medical information to the insurance carrier for the sole purpose of processing claims and/or determining benefits.

Print Name:____ Date:___________________

Signature of patient or Responsible Party:___________________________________ Date: __________

8/23/2011

Inspired Health Group