Checklist of Documents required by Medical Office For No Fault

- ☐ Patient's demographics including correct spelling of name, address, telephone number DOB and social security number.
- ☐ No Fault insurance information, including: Name of insurance company, Date of Accident, Policy number and Claim number.
- ☐ Name and Telephone number of Adjustor (Not Required however recommended)
- ☐ Assignment of Benefit (AO8)
- ☐ Medical Lien Form Signed by Patient
- ☐ No Social Security Number form (If patient does not have a social security number)
- ☐ Original prescription signed by MD. Rx must include legible name, date, compound and number of refills. Referral Form may also be used however **ORIGINAL PRESCRIPTION IS REQUIRED!**
- ☐ Letter of Medical Necessity or Initial report (Recommended however not required)
- ☐ Financial Hardship letter (If patient cannot pay for the co-payment)
- ☐ Pickup medications at the pharmacy or Delivery? (Home delivery or Doctors office delivery?)
- ☐ Do not send us prescription if it was sent to another pharmacy. Only one pharmacy will get paid.
- ☐ Claim must be active and policy must not be exhausted.

Please keep original paperwork and prescription(s) in a Express Health Mart Pharmacy folder for our driver to pick up. If you have any questions please feel free to call Express Health Mart Pharmacy at **347-221-1100**

PRACTICE NAME: _____

Insurance Information Form

Patient Referred by: Dr's NPI _____

Other: Name / ID Number _____

Patient Info:

Full Name _____ Date of Accident _____

Address _____

Sex _____ DOB _____ SS# _____ Type of Case _____

Home Tele# _____ Work# _____ Cell# _____

No Fault Insurance Information

Policy Holder's Full Name _____

Insurance Company's Name _____

Insurance Company's Address _____

Policy # _____

Claim# _____

Adjuster's Name _____ **Adjuster's Tele #& EXT** _____

Date NF-2 Filed _____ **Filed By** _____

Worker's Comp Insurance Information

Employer Name _____

Employer Address _____

Insurance Company Name _____

Insurance Company Address _____

WCB # _____ **Carrier Cash #** _____

Claim Handler Name _____ **Claim Handler Tele # &: EXT** _____

Attorney Information

Attorney Name _____

Address _____ **Tele #** _____

Fax # _____

DR. NAME _____

Company _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone _____ **Fax** _____ **NPI#** _____ **DEA#** _____

Patient _____ **DOB** _____

Driver's License # _____ **Driver's License Expiration** _____

Address _____ **Telephone** _____

City _____ **State** _____ **Zip** _____ **Allergies** _____

ATTENTION PHYSICIANS

Please provide the appropriate Diagnose Code

Please fax Patient Insurance Information

Diagnosis Code _____

ICD 9/10 Code _____

PAIN CREAM

Flurbiprofen	20%
Baclofen	2%
Clonidine	0.2%
Gabapentin	10%
Lidocaine	5%

MUSCULOSKETAL PAIN CREAM

ketamin	15%
Gabapetin	6%
Baclofen	2%
Cyclobenzaprine	2%
Flurbiprofen	10%

WOUND CREAM

Mopirocin	5%
Fluticasone Propionage	1%
Itraconazole	5%
Urea	40%
Spira-Wash	

ECZEMA CREAM

Tacrolimus	0.5%
Mometasone	0.5%
Vitamin E Acetate	0.5%
Glycerine to levigate	

SCAR CREAM

Mometasone	.05%
Levecetirize	2.0%
Tranillast	1.0%

PAIN CREAM

Mometasone	0.05%
Doxepin	0.05%
Lidicaine(120ml 2% Lidocine Viscous)	0.26%
Diphenhydramine	0.225%

Inactive: Glycerine, Sterile water, Flavoring, Products for Preservation & Stability 900 ccs's/ month supply

GOUT PAIN CREAM

Indomethacin	6%
Bupivacaine	2%
Mometasone	.20%
Flurbiprofen	10%

ANTI FUNGAL CREAM

Urea	40%
Fluconazole	0.20%
Mometasone	0.20%

ABNOMINAL HERNIA

Ketamine	10%
Flurbiprofen	5%
Gabapentin	6%
Bupivacaine	1%
Discylomine	1%
Ondansetron	0.5%

SINUS ALLERGY SPRAY

Fluticasone	3mg
Itiaconazole	50mg
Tobramycin	120mg

NelMed Sinus Rinse Bonle

ALLERGY

Fluticasone	3mg
Itiaconazole	50mg
Levofloxacin	125mg

NelMed Sinus Rinse Bonle

NASAL SPRAY

Fluticasone	1mg
Itiaconazole	3mg
Levofloxacin	5mg per 60ml

PLANTAR FIBROMATIONSIS

Verapamil	10%
Diclofenac	5%
Baclofen	2%
Mometasone	0.10%
Bupivacaine	1%

MIGRAIN TRANDERMAIL GIL

Sumatripan	3.33mg
Ketamine	2.50mg
Flurbiprofen	2.50mg
Gabapentin	3%
Amitriptyline	1.5%
Ondansetron	0.25%

NUEROPATHIC PAIN CREAM

Ketamine	10%
Clonidine	0.20%
Gabapentin	6%
Amitriptyline	3%
Mefenamic Acid	3%
Bupivacaine	1%

ANTI-AGING FACIAL CREAM

Melatonin	1%
Ubiquinone	0.5%

Glycine Soya Protein 5% Special

PRESCRIPTION SIG

☐ 360 Grams
(Three Hundred Sixty)

☐ 30 Day Supply

☐ Refills

Circle One

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 12

Tropical Pain Cream Direction for:
Joint - Musculosketal - Neuropathic - Gout
Apply 1-2 pumps 4x daily to the affective area

Tropical Therapy Directions:
Scar Therapy - Anti- Fungal Therapy
Planter Fibromatosis
Apply to the affected area 2x daily

Migraine Transdermal Directions
Apply I pump you wrist and I pump to the top of the back of the neck. Just below the skull

* May repeat in 12 hours
* Do not exceed 4 pumps in 24 hours
Apply to the affected area 2x daily

ORAL RINSE SIG

☐ Sig. 5ML Six times a day, Dispense 1000mL 30 Day Supply

☐ Sig. 5ML Five times a day, Dispense 750mL 30 Day Supply

☐ Sig. 5ML Four times a day, Dispense 600mL 30 Day Supply

ORAL RINSE DIRECTIONS

1. Swallow
2. Inhale with open mouth to dry oral cavity
3. Inject entire 5 Ml syringe into mouth
4. Swish in mouth undiluted for 30 seconds
5. Lean over sink and excess drain from mouth - DO NOT SPIT
6. Use twice daily up to 6 time per day
7. Preferable, use after breakfast and before bedtime after brushing teeth
8. Or, use as directed

PHYSICIAN

Physician Name _____ **Physician Signature** _____

◯ January
◯ February
◯ March
◯ April
◯ May
◯ June
◯ July
◯ August
◯ Sepember
◯ October
◯ November
◯ December

Day _____ Year _____

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

(FOR ACCIDENTS OCCURRING ON AND AFTER 3I1/02)

I, _____ ("Assignor") hereby assign **Express Health Mart Pharmacy** , ("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 Ass'ignee 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 MISLEADINO. 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

_____

Express Health Mart Pharmacy _____

(Print name of Provider) Signature of Provider

1173 Nostrand Avenue

Brooklyn, New York 11225 _____

(Address of Provider) Date of Signature

MEDICAL LIEN

To: _____

RE: _____

Patient's Name

I hereby authorize and direct'you, my attorney, to pay directly to _____ . Such sum as may be due and owing for medical service rendered me both by reason of this accident and by reason of any other bills that are due to his/her office and to withhold .such sums from settlement, judgment, or verdict as may be necessary to adequately protect his/her interest. I hereby further give a lien on my case to (Practice name) against any proceeds of any settlement , judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to (practice name) for all medical bills submitted for services rendered to me and that this agreement is made solely for this provider's additional contingent on any settlement , judgment, or verdict by which I may eventually recover said fee.

Dated: _____ Parent's Signature _____

The Undersigned, being the attorney on record for the above patient, does hereby agree to observe all of the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdicts as may be necessary to adequately protect Provider (Practice Name).

Name of Law Firm: _____

Address: _____

Dated: _____

Please date, sign and return one copy to (Practice Name) also keep one for your records.

No Social Security Number

Date: _____

To Whom It May Concern:

This letter is to certify that _____ does not possess a social security number. Please accept this letter in lieu of a social security number.

Thank you,

_____

(Patient's Signature)

_____

(Please Print Name in full)

_____

(Witness)

Financial Hardship Letter

If you are reading this letter Express Health Malt Pharmacy has been asked to compound a specific medication for you.

If you are reading this letter you have a problem. Unfortunately the problem is probably affecting you in many ways.

We hope that the' medication will control your pain, increase your mobility and make things better for you.

Express Health Mart Pharmacy would like to help in any way possible. Because of your problem you may be facing financial difficulties.

Express Health Mart Pharmacy can definitely help in this regard. If you have financial difficulties because of the costs, a co-pay or coverage please contact us at the phone number listed below.

A Express Health Mart Pharmacy representative is available to discuss your problems and hopefully find a solution so that you can receive your medication(s).

If you fall into this financial category please sign on the line below and your co-pay fee will be waived.

Signature _____

Name of Patient _____

Date of Accident _____

Date _____

I would like my medications to be:

- ◯ Delivery to my residence
- ◯ Delivered to my Doctors office
- ◯ I will pick up my medication(s) from the pharmacy. Pharmacy located at: Express Health Mart Pharmacy, **1173 Nostrand Avenue Brooklyn, New York 11225,** Phone: **347-221-1100**