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

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

Claim Number [ ]

I, [ ] ,("Assignor") hereby assign to Express Health Mart Pharmacy , ("Assignee") 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 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 ASSITS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCION, 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.

Name of Patient [ ] Date [ ]

Address of Patient [ ]

Name of Provider [ ] Date [ ]

Address of Provider [ ]

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 (AOB)
- ◯ 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 Hardships 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		SSS #		Type of Case	
Home Telephone #		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 Company Insurance Information

Employer Name			
Employer Address			
Insurance Company Name			
Insurance Company Address			
WCB #		Carrier Case #	
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 Diagnosis 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%

MUSCULOSKELETAL PAIN CREAM	
Ketamine	15%
Gabapentin	6%
Baclofen	2%
Cyclobenzaprine	2%
Flurbiprofen	10%

WOUND CREAM	
Mupirocin	5%
Fluticasone Propionate	1%
Itraconazole	5%
Urea	40%
Spira-Wash	

ECZEMA CREAM	
Tacrolimus	0.5%
Mometasone	0.5%
Vitamine E Acetate	0.5%
Glycerine to levigate	

SCAR CREAM	
Mometasone	0.5%
Levocetirizine	2.0%
Tranilast	1.0%

ORAL RINSE	
Mometasone	0.05%
Doxepin	0.05%
Lidicaine	0.26%
(120 ml 2% Lidocaine Viscous)	
Fluconazole	

GOUT PAIN CREAM	
Indomethacin	6%
Bupivacaine	2%
Mometasone	.20%
Flurbipiofen	10%

ANTI FUNGAL THERAPY	
Urea	40%
Fluconazole	.20%
Mometasone	.20%

ABDOMINAL HERNIA	
Ketamine	10%
Flurbiprofen	5%
Gabapentin	6%
Bupivacaine	1%
Dicyclomine	1%
Ondansetron	0.5%

SINUS/ALLERGY SPRAY	
Fluticasone	3mg
Itiaconazole	50mg
Tobramycin	120mg
NeilMed Sinus Rinse Bottle	

ALLERGY	
Fluticasone	3mg
Itiaconazole	50mg
Levofloxacin	125mg
NeilMed Sinus Rinse Bottle	

NASAL SPRAY	
Fluticasone	1mg
Itiaconazole	3mg
Levofloxacin	5mg per 60ML

PLANTAR FIBROMATOSIS	
Verapamil	10%
Diclofenae	5%
Baclofen	2%
Mometasone	0.10%
Bupivacaine	1%

MIGRAINE TRANSDERMAL GEL	
Sumatriptan	3.33%
Ketamine	2.50%
Flurbiprofen	2.5%
Gabapentin	3%
Amitriptyline	1.5%
Ondansetron	0.25%

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

ANTI-AGEING FACIAL CREAM	
Melatonin	1%
Ubiquinone	0.5%
Glycine Soya Protien 5% Facial	

PRESCRIPTION SIG

- ◯ 1. 360 Grams
  Three Hundred Sixty
- ◯ 30 Day Supply
- ◯ Refills
- ◯ 0 ◯ 1 ◯ 2 ◯ 3
- ◯ 4 ◯ 5 ◯ 6 ◯ 12

Topical Pain Cream Directions for:
Joint-Musculoskeletal - Neuropathic -Gout
Apply 1-2 pumps 4x daily to the affected area

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

Migraine Transdermal Directions
Apply 1 pump to wrist and 1 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

ORAL RINSE SIG

- ◯ Sig: 5 mL Six times a day, Dispense 1000 ml 30 Day Supply
- ◯ Sig: 5 mL Five times a day, Dispense 750 mL 30 Day Supply
- ◯ Sig: 5 mL Four times a day, Dispense 600 mL 30 Day Supply

ORAL RINSE DIRECTIONS

1. Swallow
2. Inhale with open mouth to help 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 times per day
7. Preferably, use after breakfast and before bedtime after brushing teeth
8. Or, use as directed

PHYSICIAN

Physician Name ______ Date ______

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 ______ 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 ______ for all the 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 ______ Patient's Name ______

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 ______ .

Name of Law Firm ______

Address ______

Dated ______

Please date, sign and return on e 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 Full Name ______ Witness ______

Financial Hardship Letter

If you are reading this letter Express Health Mart 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 c-pay fee will be waived.

Name of Patient ______________________ Date ______________________

Date of Accident ______________________

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 : 1173 Nostrand Avenue, Brooklyn, New York 11225 Phone : **347-221-1100**