SMG Mediquip, LLC
P.O. Box 736
Bethpage, NY 11714-0736
516.586.4934 (phone)
800.717.2573 (fax)
800.211.0404 (fax)
www.smgmediquip.net

NO-FAULT ASSIGNMENT OF BENEFITS FORM

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
(For Accidents Occurring on and after 3/1/02)

Claim Number : ____________________

I,______________________________, ("Assignor") hereby assign to SMG MEDIQUIP ("Assignee") all
(Print Patient's Name)
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 ____________________, notwithstanding any other agreement to the contrary.
(Print Accident Date)

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)
____________________ (Address)	____________________ (Date of Signature)
SMG Mediquip LLC (Print Name of Provider)	____________________ (Signature of SMG Mediquip Representative)
4792 Hempstead Turnpike, Farmingdale, NY 11735 (Address)	____________________ (Date of Signature)

PLEASE INDICATE WHICH EQUIPMENT HAS BEEN RECEIVED BY PATIENT:

___ **TENS UNIT** ____ **PRONEX CERVICAL TRACTION UNIT** ___ **ASPEN 631 LUMBAR BRACE**