Fax

To:	Pharmacy	From:	AutoRX
Fax:		Pages:	4 (including cover)
Phone:		Date:	
Re:	NY AOB	CC:	

X Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Please have patient complete the attached New York state AOB form and the AutoRx Patient Form and please fax back to

877-730-3338

P.O. Box 271589 • Salt Lake City, UT 84127 • Phone 866-428-8679 • Fax 888-460-6906

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

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

I, _____ (Print patient's name), ("Assignor") hereby assign to VascuScript Pharmacy (Print hospital or health care provider name), ("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 _____ (Print accident date), 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 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)

_____ (Address of Patient)

VascuScript Pharmacy (Print name of Provider)

_____ (Signature of Provider)

2470 Walden Ave. Suite 2400

_____ (Date of signature)

Cheektowaga, NY 14225 (Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

Dear Auto Insurance claimant:

In most cases, in order for you to receive a prescription medication related to an automobile accident you would have to pay for the prescription out-of-pocket, keep the receipts, turn the receipts in with appropriate paperwork to your auto insurance carrier and wait for the reimbursement.

By filling out a few short forms you may be eligible to take advantage of AutoRX services which allow you to receive automobile accident related prescription medications with little or no out-of-pocket expense.

Let AutoRX worry about the paperwork and hassle of dealing with the insurance companies while you worry about taking care of you and your family.
Please ask your pharmacist for the appropriate forms to complete to take advantage of this service.

Patient Acknowledgment Form

***Patient Name: _____**

***Patient Address: _____**

***City: _____, New York _____**

***Phone#_____ Date of Birth: _____**

*** Email: _____**

***Date of Accident: _____**

Attorney Name: _____

Attorney Phone: _____

***Insurance Carrier: _____**

***Agent's Name: _____**

***Agent's Phone #:____ _____**

***Claim #:_____**

Policy #:_____

Adjusters Name: _____

Adjusters Phone #:_____

Dispensing Pharmacy: VascuScript Pharmacy

**indicates a required field*

You have a right to choose where and how to get your prescriptions filled. Thank you for choosing the dispensing pharmacy for your pharmacy needs. In order for the dispensing pharmacy to receive payment directly from your insurance carrier for the medication(s) you received relating to your motor vehicle accident, you must sign a No-Fault Assignment of Benefits Form (NYS Form NF-AOB).

In addition, by signing below you acknowledge that you have sufficient insurance benefits available to cover the cost of the medication(s) you received from the dispensing pharmacy that are directly related to your motor vehicle accident. Furthermore, you acknowledge that the total amount you or your insurance company will be charged for the aforementioned medication(s) will reduce your available insurance benefits by the billed amount. An invoice listing the medication(s) dispensed, amount to be paid by the insurance carrier, and payment(s) paid by you (if any) will be provided to the insurance carrier by the dispensing pharmacy.

In the event your available insurance benefits are exhausted or the pharmacy claim is denied for whatever reason, you agree to remain financially responsible for payment and will promptly pay the dispensing pharmacy (or its agent) the remaining unpaid balance (minus any co-payment obligations) for those medication(s) that said pharmacy was unable to collect from your insurance carrier or applicable third party.

By signing below, I affirm that I have carefully read and fully understand the statements set forth above and hereby authorize the dispensing pharmacy to bill the applicable insurance carrier for the medications I received relating to my motor vehicle accident.

I further affirm that I did in fact receive the medications from the dispensing pharmacy and paid any applicable co-payment.

If required, I hereby authorize the applicable insurance carrier and my treating healthcare provider to release any and all medical records and other information relating to my motor vehicle accident to the dispensing pharmacy or its authorized agent.

In addition, I hereby affirm that I have provided the dispensing pharmacy with a signed No-Fault Assignment of Benefits Form (NYS Form NF-AOB).

*By: _____ *Signed: _____ *Date/Time: _____

Print Patient's Full Legal Name or Legal Guardian — Sign Patient's Full Legal Name or Legal Guardian

Fax Completed Form to (877) 730-3338