|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Russell Friedman & Associates**  400 Garden City Plaza, Suite 500  Garden City, NY 11530  Email: Newfiles@rfriedmanlaw.com  Ph: 516-355-9696 Fax:516-355-9697  Hospital Ambulance NO-FAULT FILING CHECKLIST\* | | | | | | | | | | | | | |
| **PATIENT NAME** *(Last, First, M.I.):* | |  | | | | 🞎 M 🞎 F | **D/O/L:** |  | | | | | |
|  | | | | | | | | | | | | | |
| **All Bolded Items are necessary to file in aN expeditious manner- If Not Available, so indicate** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **INSURANCE COMPANY:** | |  | | | | | | | | | | | |
| **CLAIM #:** | | | POLICY # | | | | | | | | | |
| **NAME AND ADDRESS OF POLICYHOLDER** (if different from above)**:** | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **INFORMATION/DOCUMENTATION NEEDED** | | | | | | | | | | | | | | |
| **Accident Info** | 🞎 Financial Records which may include: | | |  | | | | | | | | | | |
| **🞎 Assignment of Benefits** | | | 🞎 Auto Insurance Card 🞎 Police Report 🞎 Account Notes | | | | | | | | | | |
| 🞎 OTHER (Please Describe): | | | | | | | | | | | | | |
| **Treatment Records Attached** | **🞎** **Itemized Bills -HCFA 1500, NF-3, or NF-4** | | | | **🞎 ER Records/Narrative Reports** | | | | | | | | | | |
| **🞎 Call Sheet** | | | |  | | | | | | | | | | |
| **🞎 Diagnostic Tests and Results** | | | |  | | | | | | | | | | |
| **Carrier**  **Correspondence** | **Denial (s) Available** | | | | | | | | 🞎 | Yes | 🞎 | No | | |
| 🞎 **Verifications Received** | | | | **🞎 Responses to Verification, with record of or proof of mailing / Fax Confirmation** | | | | | | | | | |
| 🞎 **45 Day Denial** | | | | 🞎**45 Day Denial**- **Proof of Mailing or Reconsideration Letter** | | | | | | | | | |

**\* This Checklist is Provided for Guidance Purposes Only. This Form Need Not Be Completed When Referring a File to the Firm for Arbitration.**