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| **Russell Friedman & Associates**400 Garden City Plaza, Suite 500Garden City, NY 11530Email: Newfiles@rfriedmanlaw.comPh: 516-355-9696 Fax:516-355-9697Hospital 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.**