1553 State Hwy 27, Suite 3100
Somerset, NJ 08873
Ph: 732-249-9400   Fax: 732-249-9500
www.njsportspinemed.com

PIP/Auto Injury Information

Name of Patient: ______________________________ Today's Date:_____________________

Name of Insured if different from Patient: ____

Relation to patient: _______________________

Name of Auto Insurance Company: ____

Insurance Phone Number: ______________________ Date of Accident: __________________

Claim Number: __________________________

Policy Number: _________________________

Adjuster's Name: __________________________

Adjuster's phone #:________________________ Adjuster's fax#:________________________

As a result of this accident, were you injured? ☐ YES ☐ NO

Describe your injury: (Include all areas of your body that were injured):

____

____

____

Any previous accidents? ☐ YES ☐ NO   Date of previous accident(s): ____________________

Signature: _____________________________________   Date:_______________________

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PIP ASSIGNMENT OF BENEFITS

I ____, undersigned, as patient of Andrew K. Ankamah, M.D. hereby assign to Andrew K. Ankamah, M.D. certain rights to make claim and/or sue any insurance company, included but not limited to make a claim of my PIP carrier for payment of outstanding medical bills I have incurred with Andrew K. Ankamah, M.D. as a result of my accident on ____/____/______.

It is hereby understood and agreed that Andrew K. Ankamah, M.D. has the option, but is not required to retain services of an attorney of his choice to institute a lawsuit or file a PIP Arbitration in my name and on my behalf for the collection of my medical bills against ____ insurance company. It is understood that Andrew K. Ankamah, M.D. is not obligated to institute any proceedings on my behalf and that **I remain personally responsible for any outstanding charges if he elects not to do so.**

I further agree to provide Andrew K. Ankamah, M.D. and/or designated attorney with any help or assistance they may require to collect my outstanding medical bills.

Signature:______________________________________ Date: _______________________________

ATTENDING PROVIDER TREATMENT PLAN

☐ INITIAL SUBMISSION ☐ FOLLOW-UP SUBMISSION

TYPE OR PRINT LEGIBLY	CLAIM #: - - 07 -	DATE SUBMITTED	Month	Day	Year

PATIENT INFORMATION

Field	Value
1. PATIENT'S NAME — Last / First / Initial	
2. PATIENT'S ADDRESS (No., Street)	
3. CITY	
4. STATE	
5. ZIP CODE	
6. TELEPHONE # (Include Area Code)	
7. PATIENT BIRTHDATE	
8. SEX	☐ M ☐ F
9. S.S. NUMBER	
10. INSURANCE COMPANY	
11. POLICY NUMBER	
12. DATE OF ACCIDENT	
13. IS PATIENT'S CONDITION RELATED TO:	
A. EMPLOYMENT	☐ YES ☒ NO
B. AUTO ACCIDENT?	☒ YES ☐ NO
C. OTHER ACCIDENT?	☐ YES ☐ NO
14. IS PATIENT UNABLE TO WORK?	☐ NO ☐ YES

POLICYHOLDER INFORMATION (if different)

Field	Value
15. POLICYHOLDER'S NAME — Last / First / Initial	
16. POLICYHOLDER'S ADDRESS (No.; Street)	
17. CITY	
18. STATE	
19. TELEPHONE # (Include Area Code)	
20. ZIP CODE	
21. RELATIONSHIP TO PATIENT	

PROVIDER INFORMATION

Field	Value
22. NAME OF TREATING PROVIDER — Last	Ankamah
First	Andrew
Initial	K
23. TAX I.D. NUMBER	261832216
24. SPECIALTY	Physical Medicine&Rehabilitation
25. FACILITY OR OFFICE NAME	NJSS
26. FACILITY/OFFICE ADDRESS (No.; Street)	1553 State Hwy 27, Suite 3100
27. CITY	Somerset
28. STATE	NJ
29. ZIP CODE	08873
30. TELEPHONE # (Include Area Code)	732-249-9400
31. EMAIL ADDRESS	ankamahpmr@gmail.com
32. FAX # (Include Area Code)	732-249-9500
33. INITIAL DATE OF TX	
34. DATE OF LAST VISIT	

35. PATIENT MEDICAL HISTORY. HAS PATIENT EVER HAD ANY OF THE FOLLOWING SERVICES? CHECKMARK THOSE APPLICABLE BELOW.
(*NOTE-ALL BOXES CHECKED REQUIRE A BRIEF DESCRIPTION OF SERVICE AND DATE PROVIDED ON SEPARATE ATTACHMENT)

☐ ALL MEDICATION ☐ MRI ☐ SURGERY ☐ X-RAY ☐ DIAGNOSTICS TESTING ☐ OTHER

36. PRIMARY DIAGNOSIS (ICD-9)	37. SECONDARY DIAGNOSIS (ICD-9)	38. ADDITIONAL DIAGNOSIS (ICD-9)	39. ADDITIONAL DIAGNOSIS (ICD-9)

PROPOSED COURSE OF TREATMENT AS IT RELATES TO THIS MVA

40. DATE(S) OF TREATMENT REQUESTED

FROM	TO

41. CHECK APPROPRIATE CARE PATH (if applicable)

☐ CP1 ☐ CP2 ☐ CP3 ☐ CP4 ☐ CP5 ☐ CP6

42. REQUEST FOR SERVICES : CPT / HCPS / NDC CODES

(Use left box for single codes or left and right box for a range of codes)		FREQUENCY (Times per visit)	FREQUENCY (Visits per week)	DURATION (Number of weeks)	TOTAL UNITS

42. CHECKMARK ATTACHMENTS BELOW. (*NOTE-ALL SUPPORTING DOCUMENTS CHECKED **MUST** BE PROVIDED ON SEPARATE ATTACHMENT)

☐ SOAP NOTES ☐ PROGRESS NOTES ☐ TEST RESULTS ☐ MEDICAL HISTORY ☐ PRESCRIPTIONS ☐ OTHER

FRAUD PREVENTION-NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED AND REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

43. ______________________________

SIGNATURE OF PROVIDER DATE

ATPT Form Version 1.1 (9/2004)

PCD 4017 HP Ed. 10/04

NO FAULT AUTO ENROLLMENT FAX FORM

FAX THIS FORM AND PRESCRIPTIONS(S) TO OUR TOLL FREE PRESCRIPTION FAX HOTLINE

PHARMACY FAX: 800-497-4276

Toll Free: 866-926-8497

PERSONAL INFORMATION

*Name: ____
Last First Middle Gender

*Address: ____
Street Apt # City State Zip

*Primary Phone Number: (____) ____________________ *Alternate Phone Number: (____) ____________

*Social Security #: ________-______-__________ *Primary Language: ____________________

*Date of Birth: ____/____/____ Patient Email Address: ____________________
MM DD YR

CLAIM INFORMATION

*Auto Insurance Carrier: ____
Carrier Name City State Zip

*Phone Number: (____) ____________________ *Policy #: ____________________
Carrier Phone

*Claim Number: ____________________ Policy Dollar Limit (If known) ____________________

*Date of Accident: ____/____/____ *Injury: ____________________
MM DD YR Body Part(s)

*Law Firm: ____ (____)
Name Attorney Name Phone

*Treating Physician: ____ (____)
Name Address Phone

*Is this claim against a Third Party? (circle one) Yes No

If Yes, Carrier Name: ____ (____)
Carrier Name City State Zip Phone

☐ MSA – Self Administrator

☐ MSA Administrator: ____

* INDICATES REQUIRED INFORMATION