



**No Fault Claim Information\***

*\*ALL INFORMATION MUST BE FILLED IN FOR PROPER FILING*

**Patient Information**

**Patient Name:** \_\_\_\_\_

**Patient Address:** \_\_\_\_\_

**Patient City, State Zip:** \_\_\_\_\_

**Patient Home Phone#:** \_\_\_\_\_ **Patient Work Phone #:** \_\_\_\_\_

**Patient Social Security#:** \_\_\_\_\_ **Patient Date of Birth:** \_\_\_\_\_

**No Fault Information**

**Insurance Name:** \_\_\_\_\_

**Insurance Address:** \_\_\_\_\_

**Insurance City, State Zip:** \_\_\_\_\_

**Insurance Phone#:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Date of Accident:** \_\_\_\_\_

**Time of Accident:** \_\_\_\_\_

**Location of Accident:** \_\_\_\_\_

**Name of Police:** \_\_\_\_\_

**Until a VALID No Fault claim is established, you will be responsible for all charges. The information requested above is essential to establishing your claim. Your assistance is appreciated.**

**Signature:** \_\_\_\_\_

**Brentwood Office**  
(613) 231-4455

**Huntington Office**  
(613) 549-2020

**Port Jefferson Office**  
(613) 331-1414

**Saville Office**  
(613) 563-2206

**West Islip Office**  
(613) 661-3455