NORTH DAKOTA AUTOMOBILE ASSIGNED CLAIMS BUREAU APPLICATION FOR BENEFITS

To enable us to determine your entitlement to benefits under the provisions of Section 26.1-41-18 65B.64 of the North Dakota Auto Reparations Act, please complete, sign and date this form.
In order to comply with the requirements of Section 111 of Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)(P.L.110-173) requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)(P.L.110-173), all questions within the Applicant Information section below **MUST** be answered and completed and returned via email, fax or U.S. Mail to:

North Dakota Automobile Assigned Claims Bureau
#297, 8362 Tamarack Village, Suite 119, Woodbury, MN 55125-3392
ndaacp1015@gmail.com
(Tel. 763-425-6634)
(Fax 855-976-4878)

1.

Name (Last, First, MI)	Gender M	Gender F	Date of Birth	Social Security No.	Phone: Home	Work
			/ /	/ /	( )	( )

2.

Current Address (Street, Number, City, State, Zip)	Address at time of accident (Street, Number, City, State, Zip)

3.

Date and time of accident (AM/PM)	Brief description of accident
Place of accident (Street, City, State)	

4. Names of persons residing in the same household as you at the time of the accident:

Name	Date of Birth	Relationship to You
a)	/ /	
b)	/ /	
c)	/ /	
d)	/ /	
e)	/ /	

5. Names of all other occupants of the vehicle at the time of the accident:

Name	Address	Phone Number
a)		
b)		
c)		
d)		
e)		

6.

At the time of the accident:	Yes	No
a) Did you own a motor vehicle?		
b) Did any other member of your household own a motor vehicle?		

c) Describe all motor vehicles owned by you or any person residing with you in the same household at the time of the accident:

	Vehicle Make	License Plate No.	Owner	Insurance Co.	Policy Number
1.					
2.					

7. a) If you were a passenger or operator of a motor vehicle involved in the accident: Was the vehicle insured at the time of the accident? — Yes ☐ No ☐

b) If you were a pedestrian: Was the vehicle which struck you insured? — Yes ☐ No ☐

c) Describe the vehicle you were riding in or which struck you if you were a pedestrian:

	Vehicle Make	License Plate No.	Owner	Owner's Address	Insurance Co.	Policy No.

d) Describe the other vehicle involved in this accident:

	Vehicle Make	License Plate No.	Owner	Owner's Address	Insurance Co.	Policy No.
1.						
2.						

8. Describe your injury:

a) Have you previously been treated for similar injuries? Yes ☐ No ☐

9. Please provide the name, address and phone number of each medical provider with whom you treated following this accident:

10. Medical expenses to date: $ — Will you have more medical expenses? Yes ☐ No ☐

11. At the time of your accident, were you in the course of your employment? Yes ☐ No ☐

12. What is your weekly wage or salary? $ — Date disability from work began ___/___/___ — Date you returned to work ___/___/___

13. List the name and address of each employer for which you worked at the time of this accident, indicating for each your occupation and dates of employment.

Employer and Address — Occupation — From — To

Employer and Address — Occupation — From — To

14. In submitting this application, I agree to assign to the North Dakota Automobile Assigned Claims Bureau and any Servicing Insurance Company my rights to pursue from another party reimbursement of those amounts paid on my claim, pursuant to the North Dakota Reparations Act. I agree to cooperate with the plan and its Servicing Insurance Company which may assert such rights and further agree not to take any action which might prejudice those rights.

I UNDERSTAND THAT ANY PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH THE INTENT TO DEFRAUD OR HELP COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

15. Signature of applicant or guardian — Date

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AUTHORIZATION FOR RELEASE OF MEDICAL and WAGE/SALARY INFORMATION

Claim No. _____

Patient Name: _____ DOB:_____ SSN:_____

I authorize any doctor, hospital, employer, or other person to whom a signed copy or photocopy of this authorization is delivered to furnish any information, reports, or copies of records which may be requested by:

_____

Servicing Insurance Company

This request encompasses all medical records, employment and wage verification requests covering the time period from the patient's date of birth to one year beyond the date of this signed authorization, unless specifically limited in the requesting letter. I hereby authorize and direct the release of any and all medical reports and records of any type, including any and all worker's compensation records, correspondence, nurse's notes, handwritten notes, memoranda, x-rays, opinions, and billing records which the company may request regarding the patient's medical history, condition, and treatment rendered at any time. I further authorize the company to examine and copy any such information. **This information is being requested by the company so consideration may be given to claims for benefits under personal injury protection ("PIP") or medical benefits coverages.**

All records pertaining to psychiatric/mental health, alcohol, and/or drug dependency, and/or HIC/HIV related illness will not be released unless specifically authorized below in writing. I specifically authorize the release of the following records:

Psychiatric/psychological Drug _____ (initial) HIV _____ (initial) and/or Alcohol Dependency _____ (initial)

CHECK IF APPLICABLE. Notice to whomever disclosure is made concerning chemical dependency records. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42-CFR Part 2) prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of information is not sufficient for this purpose.

1. This Authorization remains in effect until one year from the date of this Authorization unless specifically revoked by written notice to the individual or organization. I understand that this Authorization may be revoked at any time. Any information released prior to my written revocation of this Authorization shall not be a breach of confidentiality.

2. I understand that authorizing the disclosure of the health information is voluntary. I can refuse to sign this Authorization. I need not sign this Authorization in order to assure treatment. However, this Authorization is required by the company in order to consider payment of any charges for treatment received. Therefore, failure to sign this Authorization may result in the patient's claims being declined.

3. I understand that I may inspect or request copies of any information disclosed under this Authorization and that I am entitled to a copy of this Authorization once I have signed it.

4. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these federal regulations. This Authorization allows the company to release to such persons, as are deemed necessary, those records necessary to facilitate the recovery of monies paid from responsible third parties.

5. A photocopy of this Authorization is as effective as the original.

X_____
Signature of Patient, Guardian, or Legal Representative **Relationship** (If Applicable**)** **Date**

If patient is unable to sign, state reason: _____