



AUTOMOBILE INSURANCE ASSIGNMENT OF BENEFITS

Name of Insurance: _____
Claim/Policy No.: _____
Date of Accident: _____
Adjuster: _____

To my auto insurance carrier:

I, _____, request that payment of authorized medical benefits for
NAME OF INSURED
_____, who is covered under my automobile policy, be made
NAME OF PATIENT

on my behalf and assigned to University Orthopaedic Associates, LLC, TIN# 26-1257314, for
any auto related injuries. In the event my covering insurance carrier pays benefits directly
to me, I will be financially responsible to return any and all monies to University Orthopaedic
Associates, LLC.

Date

Insured's Signature

Witness

Michael P. Coyle, Jr., MD
Stephen S. Cook, MD
Timothy M. Hosea, MD

Mark S. Butler, MD
David A. Harwood, MD
Jeffrey R. Bechler, MD

Charles J. Gatt, Jr., MD
Timothy P. Leddy, MD
David R. Polonci, MD

Carlos A. Sagebien, MD
Gino Chiappetta, MD
Christopher Doumas, MD

215 Easton Avenue
New Brunswick, NJ 08901
732-545-0400
(fax) 732-545-4011
Middlesex County

211 North Harrison Street
Princeton, NJ 08540
609-685-7800
(fax) 609-685-7875
Mercer County

562 Easton Avenue
Somerset, NJ 08873
732-565-5450
(fax) 732-220-1505
Somerset County

4810 Belmar Blvd., Suite 102
Wall, NJ 07753
732-958-6090
(fax) 732-938-5680
Monmouth County