PENNSYLVANIA FINANCIAL RESPONSIBILITY ASSIGNED CLAIMS PLAN

Suite 700 1835 Market Street Philadelphia, PA 19103

Telephone: (215) 665-1165 Fax #: (215) 305-8990 Email: PFRACP@PFRACP.ORG

APPLICATION FOR BENEFITS

IMPORTANT: 1. You must complete and sign the application, authorization and HIPPA form.

2. Please answer all questions with information as of the date of the accident.

3. All questions must be answered. Use N/A or unknown if appropriate.

Applicant's Name:	Phone no.	Secondary Number

Address on Date of Accident (No. Street, City or Town, State and Zip Code)	Date of Birth	Social Security No.

Did you own a motor vehicle at the time of accident? ☐ Yes ☐ No

Were you a member of a household owning a motor vehicle? ☐ Yes ☐ No

If yes, list name of Insurance Company & Policy no.

Please list all residents in your household. Provide full name, age and & relationship:

Describe all motor vehicles owned by you or by any member of your family residing with you:

Name or owner: Insurer:

Year	Make	Model	VIN #	Tag #	State	Color

Date & Time of Accident: Place of Accident (Street, City or Town & State)

At the time of accident:

Were you the driver of a motor vehicle? ☐ Yes ☐ No Were you a pedestrian ☐ Yes ☐ No

Were you a passenger in a vehicle? ☐ Yes ☐ No Were you a passenger in ☐ Yes ☐ No

Were you on a bicycle: ☐ Yes ☐ No Other:

Describe the Motor vehicle in which you were riding, or which struck you or the trolley:

Name and address of Owner:

Year	Make	Model	VIN #	Tag #	State	Color

Name of Insurer:

Name and address of the Operator of the above-described vehicle at time of the accident:

Name and address of other occupants of the above describe vehicle:

Was the accident reported to the Police? ☐ Yes ☐ No

If yes date and time reported as well as police district:

Other vehicles involved in the accident:

Vehicle 1: Owner Name and address:

Operator Name and address:

Year	Make	Model	VIN#	Tag#	State	Color	Insurance Co.	Policy #

Vehicle 2: Owner Name and address:

Operator Name and address:

Year	Make	Model	VIN#	Tag#	State	Color	Insurance Co.	Policy #

Have you made a claim against anyone as a result of this accident? ☐ Yes ☐ No

If yes, please provide the name and address of the person:

Do you have a pending lawsuit against any person or organization in connection with this accident?

☐ Yes ☐ No If yes, date of settlement:

Provide name and address of whom you made settlement with:

Have you ever applied for benefits from the PFRACP before? ☐ Yes ☐ No

If yes, date of accident: File number:

Description of accident:

Names and addresses and phone # of any witness to accident:

Describe your injury:

Were you treated by a doctor? If yes, provide the name and address of doctor and/or facility:

Were you treated in a hospital? ☐ Yes ☐ No Were you an Inpatient ☐ Outpatient ☐ Date:

Name and address of hospital:

Were you taken by ambulance? ☐ Yes ☐ No

Are you entitled to any medical benefits? ☐ Yes ☐ No If yes, check all boxes that apply

☐ HMO ☐ Medicate ☐ Part A ☐ Medicare Advantage ☐ Supplemental

☐ DHS/ Medicaid ☐ Social Security Disability

☐ Other:

If you are 26 or younger, are you entitled to benefits through your parents or guardian? ☐ Yes ☐ No

If yes to any of the above, list insurance company and policy #:

Were you employed? ☐ Yes ☐ No. If yes list employer name and address:

Did you miss any time from work? ☐ Yes ☐ No

If yes date your disability began: _____ Date you returned to work: _____

List name and address of your employer, occupation, and dates of employment:

_____

_____

Were you married? ☐ Yes ☐ No If yes, name of spouse: _____

Was your spouse employed? ☐ Yes ☐ No If yes name and address of employer:

_____

If you were age 26 or younger, did you reside with your parent or guardian? ☐ Yes ☐ No

Was your parent/guardian employed? ☐ Yes ☐ No

If yes, please list name of parent/guardian, employer, and address: _____

_____

Are you aware of any liens currently filed against you? (Does not have to be connected to this accident)

☐ Child support lien ☐ Medicaid lien ☐ Medicare lien

☐ Subrogation lien ☐ Other type of lien _____

Are you aware of any Non-Disbursement orders filed against you? ☐ Yes ☐ No

Pursuit to 18 Pa.C.S. Section 4904, I certify that all the information set forth in this application is true and correct to the best of my knowledge.

WARNING NOTICE

Any person who, knowingly and with intent to injure or defraud the PFRACP or its representative, files an application or claim containing any false, incomplete or misleading information may, upon conviction, be subject to imprisonment or payment of fine.

_____ _____

Signature of applicant Date

_____

Signature and affiliation of person filling out application if other than the inured party

AUTHORIZATION FOR EMPLOYEMENT AND BENEFITS INFORMATION

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my employment/benefits while employed by you.

_____ _____

Signature of applicant Date

If you are represented by an attorney, please provide the following information:

Name of Law Firm: _____

Name of Attorney: _____

Address: _____

Phone #: _____ Email: _____

Tax ID # _____ Fax#: _____

HIPAA Release of information
AUTHORIZATION FORM

For:

Patient Name | Date of Birth

Street Address - City, State, Zip Code

Home Phone Number | Work Phone Number

I,_____ __, hereby authorize _____, to release to Pennsylvania Financial Responsibility Assigned Claims Plan and its representative _____ _, telephone number 215-665-1260, extension _, fax number _____ e-mail_____ my personal health information *(e.g.,* information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number, insurance claim number) maintained by _____ for the purpose of applying for statutory benefits from the Pennsylvania Financial Responsibility Assigned Claims Plan. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

The dates of treatment for which this release applies are: _____ _

The information to be released is the entire medical record.

These records may be released via mail, fax or e-mail.

This authorization is valid from the date of my/my representative's signature below and shall expire upon one year thereafter. I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written, dated communication to _____ [the entity releasing the info] and/or that my consent expires under the circumstance above.

I understand that my records are protected under the Health Insurance Portability and Accountability Act, Federal Privacy Act, P.L. 93-575, the Federal Alcohol and Drug Abuse Act, P.L. 92-282, the Pennsylvania Mental Health Procedures Act, 1976 and the Pennsylvania Confidentiality of HIV Related Information Act, and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that any information disclosed in response to this request will not include information related to my treatment for AIDS/HIV, psychiatric care/treatment, treatment for drugs/alcohol, unless I specifically consent to the release of this information by checking any or all of the boxes below:

✓ AIDS/HIV Information ✓ Psychiatric Care/Treatment ✓ Drug/Alcohol Use/Abuse Treatment

Patient's Signature | Date of Authorization

Signature of parent/legal guardian/
Legal representative | Date of Authorization

Witnessed by | Date