

Professional Evaluation Medical Group

No-fault

Was an automobile involved? _____ Date of injury: _____

Are you still working? _____ If no, last date worked: _____

No fault carrier: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____

Policyholder's name: _____

Claim #: _____

Policy #: _____

I, _____ hereby authorize payment of No-fault benefits directly to **Professional Evaluation Medical Group**. In the event that I fail to file a claim for No-fault benefits for this illness or condition, or it is determined by the No-fault carrier that the illness or condition is not a result of a compensable No-fault case, I hereby agree to pay **Professional Evaluation Medical Group** his usual and customary fees for all services rendered.

I HEREBY AUTHORIZE **Professional Evaluation Medical Group**. TO RELEASE INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO BE RELEASED TO MY NO-FAULT CARRIER AND/OR MY ATTORNEY.

Signature: _____

Date: _____