APPLICATION FOR INSURER'S CONSENT OF ASSIGNMENT OF PERSONAL INJURY PROTECTION MEDICAL EXPENSE BENEFIT PAYMENTS

We, the undersigned Personal Injury Protection Medical Benefits claimant ("Claimant") and physician/medical provider ("Provider"), hereby request the Insurer's prior consent for the assignment of the Claimant's Personal Injury Protection Medical Benefits reimbursement payments ("PIP Benefits") from the Claimant to the Provider.

Acknowledgments. We acknowledge that any assignment requires the prior consent of the Insurer pursuant to the terms of the private passenger automobile insurance policy under which PIP Benefits are claimed.

We acknowledge that this application in no way exercises or attempts to exercise any direction or control of the treatment of the Claimant by the Provider and solely governs the assignment of PIP Benefits under the policy. The Provider and the Claimant retain all rights and authority they have prior to assignment with respect to determining the treatment the Provider should render the Claimant.

We acknowledge that the assignment of PIP Benefits does not constitute a waiver of the Insurer's right to contest the medical necessity of any treatment provided.

Conditions. We agree to follow either Decision Point Review, pre-certification plan or voluntary treatment plan or any combination of these that may apply. We agree to inform the Insurer of any proposed amendment to any voluntary treatment plan prior to rendering any further treatment pursuant to the amended treatment plan. We agree to resolve any disputes relating to any of these pursuant to the dispute resolution provisions of the Insurer's pre-certification plan.

Claimant agrees to provide, upon request by the Insurer, proof of payment of co-payments and deductibles provided in the policy. Provider agrees to provide, upon request by the Insurer, adequate proof that no co-payments or deductibles have been waived or discharged.

Provider agrees to assume along with the rights of the Claimant under the assignment of PIP Benefits, the Claimant's obligation of good faith and fair dealing toward the Insurer.

Provider Signature:	_____	Claimant Signature:	_____
Provider Address:	_____	Claimant Address:	_____
	_____		_____
Date:	_____	Date:	_____
		Claim No.	_____

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.