NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
DENIAL OF CLAIM FORM

TO INSURER: Complete this form, including item 33. Send two copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on behalf of the injured person.

NAME, ADDRESS AND NAIC NUMBER OF INSURER OR NAME AND ADDRESS OF SELF-INSURER	For American Arbitration Association use

POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	INJURED PERSON
John Doe	**123456789**	**2025-06-15**	**Jane Smith**
CLAIM NUMBER	APPLICANT FOR BENEFITS (Name and address)		AS ASSIGNEE
CLM-987654	**Jane Smith, 123 Main St, NY 10001**		**NO**

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

☐ 1. Your entire claim is denied as follows:

☐ 2. A portion of your claim is denied as follows:

☐ A. Loss of Earnings $_____
☐ B. Health Service Benefits $_____
☐ C. Other Necessary Expenses $_____
☐ D. Interest $_____
☐ E. Attorney's Fee $_____
☐ F. Death Benefit $_____

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

POLICY ISSUES

☐ 3. Policy not in force on date of accident
☐ 4. Injured person excluded under policy conditions or exclusion
☐ 5. Policy conditions violated:
☐ a. No reasonable justification given for late Economic Loss coverage notice of claim
☐ b. Reasonable justification not established--**You may qualify for special expedited arbitration--** See page 2 of this form for instructions.
☐ 6. Injured person not an "Eligible Injured Person"
☐ 7. Injuries did not arise out of use or operation of a motor vehicle
☐ 8. Claim not within the scope of your election under Optional Basic

LOSS OF EARNINGS BENEFITS DENIED

☐ 9. Period of disability contested: period in dispute From_____Through_____
☐ 10. Exaggerated earnings claim $_____per month denied
☐ 11. Claimed loss not proven
☐ 12. Statutory offset taken
☐ 13. Other, explained below

OTHER REASONABLE AND NECESSARY EXPENSES DENIED

☐ 14. Amount of claim exceeds daily limit of coverage
☐ 15. Unreasonable or unnecessary expenses
☐ 16. Incurred after one year from date of accident
☐ 17. Other, explained below **HEALTH SERVICE BENEFITS DENIED**
☐ 18. Fees not in accordance with fee schedules
☐ 19. Excessive treatment, service or hospitalization From_____Through_____
☐ 20. Treatment not related to accident
☐ 21. Unnecessary treatment, service or hospitalization From_____Through_____
☐ 22. Other, explained below COMPLETE FOR HEALTH SERVICE BENEFITS IS ITEMS 23 THROUGH 32 IF CLAIM DENIED

23. Provider of Health Service (Name, Address and Zip Code)	25. Period of bill - treatment dates	29. Date final verification received
Dr. John Clinic, 456 Health Rd, NY 10002	2025-06-16 to 2025-06-22	2025-07-01
	26. Date of bill: 2025-05-25	30. Amount of bill: $500
24. Type of service rendered: **Physiotherapy**	27. Date bill received by insurer: 2025-05-27	31. Amount paid by insurer: $0
	28. Date final verification requested: 2025-06-28	32. Amount in dispute: $500

33. State reason for denial, fully and explicitly (attach extra sheets if needed): Treatment was not related to the accident.

DATE | Name and Title of Representative of Insurer | Telephone No. & Ext.

Name and address of Insurer claim processor (Third Party Administrator), if applicable Telephone No. & Ext. NYS FORM NF-10 (**Rev 5/2021**)

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IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

1. Should you wish to take this matter up with the New York State Department of Financial Services, you may file with the Department either on its website at http://www.dfs.ny.gov/consumer/fileacomplaint.htm or you may write to the Consumer Assistance Unit, New York State Department of Financial Services, at: One State Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 1399 Franklin Avenue, Garden City, NY 11530; or 535 Washington Street, Suite 305, Buffalo, NY 14203.

Although the Department of Financial Services will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a written complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Department of Financial Services at one of the above addresses.

If you choose this option, you may at a later date still submit this dispute to arbitration or bring a lawsuit; or

2. **You may submit this dispute to arbitration.** If you wish to submit this claim to arbitration, then mail or e-mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a $40 filing fee, payable by check, money order, or credit card to the American Arbitration Association (AAA) to:

AMERICAN ARBITRATION ASSOCIATION (AAA)
NEW YORK INSURANCE CASE MANAGEMENT CENTER
120 BROADWAY
NEW YORK, NEW YORK 10271 nyicmc.filingsubmissions@adr.org

Please contact the American Arbitration Association's customer service department at (917) 438-1660 with any questions about case filing.

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the AAA and the insurer at the time of filing for arbitration. The filing must be complete with all necessary documentation, as any late submission may not be admissible at arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and regulations promulgated thereunder.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of earnings: Date claim made: 2025-06-20

Gross earnings per month $$3,500

Amount claimed:
$3,500

Period of dispute: From 2025-06-1 Through 2025-07-15

Health Services: (Attach bills in dispute and list each one separately)

Name of Provider(s)	Date of Service	Amount of Bill	Amount in Dispute	Date Claim Mailed
Dr. John Clinic	2025-06-16	$500	$500	2025-06-20

Other Necessary Expenses: (Attach bills in dispute and list each one separately)

Type of Expenses Claimed	Amount Claimed	Date Incurred	Date Claim Mailed	Amount in Dispute
Medical Equipment	$300	2025-06-18	2025-06-21	$300

Other: (attach additional sheet if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.

- You qualify for **special expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". Your specific request for special expedited arbitration must be filed within 30 days of the date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

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3. <u>You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.</u>

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF AND REASONABLE INQUIRY THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDULENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION, THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR AND THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION

ARBITRATION REQUESTED BY: **Smith** **Jane** LAST NAME FIRST NAME	**Smith & Co**. NAME OF LAW FIRM, IF ANY	
TELEPHONE NUMBER: **(212) 555-1234**	**789 Law Ave,** **NY 10003** ADDRESS	
FAX NUMBER:		
EMAIL ADDRESS: **jane@smithlaw.com**		
SIGNATURE PN	ARE YOU AN ATTORNEY? YES	DATE **2025-07-04**

IMPORTANT NOTICE TO APPLICANT

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.) (646-205-7800) located at 100 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit, even if you intend to contest this denial.