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| COURT\_VENUE  COURT\_NAME | **Index No.: IndexOrAAA\_Number** |
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| |  |  |  | | --- | --- | --- | | PROVIDER\_NAME  A/A/O INJUREDPARTY\_NAME | | | |  | | PLAINTIFF (S), | |  | -AGAINST- |  | | INSURANCECOMPANY\_NAME | | | |  | | DEFENDANT(S), | | RESPONSE TO DEMAND FOR INTERROGATORIES |
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| Plaintiff, in response to defendants Demand for Interrogatories, upon information and belief, sets forth as follows:   1. Set forth the full name and address of the plaintiff responding to these interrogatories.   ANSWER:   1. Set forth the name and address of any other person who aided in responding to these interrogatories.   ANSWER:   1. Set forth the educational background of the plaintiff, stating what degrees were obtained, when they were obtained, in which state or states the plaintiff was licensed, whether the plaintiff is board certified as a specialist, and in what specialties and when the plaintiff became so certified, and whether the plaintiff’s license to practice medicine was ever suspended or revoked, and when such suspension and/ or revocation took place and in what states.   3a. If the plaintiff is a corporation, provide the names of the treating health care providers. Set forth the educational background of the plaintiff, stating what degrees were obtained, when they were obtained, in which state or states the plaintiff was licensed, whether the plaintiff is board certified as a specialist, and in what specialties and when the plaintiff became so certified, and whether the plaintiff’s license to practice medicine was ever suspended or revoked, and when such suspension and/ or revocation took place and in what states.  ANSWER:   1. Set forth the dates of treatment and / or examination provided by the plaintiff assignee.   ANSWER:   1. For each date of treatment and / or examination set forth what complaints the patient assignor made.   ANSWER:   1. Attach a copy or printout of the office calendar or diary for the time period that the plaintiff’s assignee was treating or being seen by the plaintiff’s office.   ANSWER:   1. For each date of treatment and / or examination set forth what diagnostic tests were performed and the result of each test, appending a copy of any test reports herein.   ANSWER:   1. For each date of treatment and/ or examination set forth whether any notes or reports were taken or transcribed concerning said treatment and/ or examination, appending copies thereof.   ANSWER:   1. Set forth what treatment was rendered on each date that the plaintiff’s assignor was seen.   ANSWER:   1. Set forth provisions of the contact allegedly violated by the defendant, METROPOLITAN CASUALTY INSURANCE COMPANY.   ANSWER:   1. Set forth the date, times and places of the alleged breach.   ANSWER:   1. Set forth when, to whom, and how demand for payment was made, appending copies of any written demands.   ANSWER:   1. Set forth when and how refusal for payment was made.   ANSWER:   1. Set forth any and all communications between the plaintiff and / or the Plaintiff’s assignor METROPOLITAN CASUALTY INSURANCE COMPANY regarding the claim/ claims which are the subject matter of this lawsuit.   ANSWER:   1. Set forth whether the plaintiff is a corporation, partnership, limited liability company, private corporation or sole proprietorship and annex a copy of the certificate of incorporation, if applicable hereto.   ANSWER:   1. Set forth the names of the providers listed on the bills that are in dispute. State whether each provider is a director, officer, employee, independent contractor, or otherwise, of the plaintiff.   ANSWER:   1. Set forth the precise amount of unpaid bills in dispute. 2. Set forth whether each item was partially paid. Or denied in full annex copies hereto. 3. If any portion of the bill in dispute was paid, set forth by whom and in what amount.   ANSWER:   1. Set forth a list of names of all parties that have appeared in this action, together with the names and addresses of their respective attorneys pursuant to Section 2013 (e) of the C.P.L.R.   ANSWER:   1. A statement pursuant to C.P.L.R. 4545 (c), in writing under oath, setting forth the amount of: (a) medical, (b) dental, (c) custodial, (d) rehabilitative costs, € loss of earnings or (f) other economic loss that was or will be replaced or indemnified by (a) insurance, (b) Social Security, (c) worker’s compensation, (d) employee benefit programs or (e) other service including No-Fault basic economic loss in automobile cases.   ANSWER:   1. The name and address of each expert witness which you expect to call at the trial of this action.   ANSWER:   1. The subject matter in reasonable detail upon which each such expert is expected to testify   ANSWER:   1. The substance of the facts and opinions upon which each such expert is expected to testify   ANSWER:   1. The qualifications of each such expert witness.   ANSWER:   1. A summary of the grounds for each such expert(s) opinion.   ANSWER:   1. Provide a copy of each such expert’s report furnished to you or your client(s).   ANSWER:   1. Provide the Index number for the instant case.   ANSWER: |

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| Dated: | Franklin Square, New York. NOWDT |

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|  | Your, etc.  THE BEYNENSON LAW FIRM, PC.  Attorneys for Plaintiff(s)  475 Franklin Avenue  Franklin Square, NY11010  Tel: 516-858-4411  Fax: 516-216-5405  **Our Case Id: Case\_Id,** |

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| COURT\_VENUE  COURT\_NAME | **Index No.: IndexOrAAA\_Number** |
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| Plaintiff, by its attorneys, The Beynenson Law Firm, P.C., in response to defendant's Notice of Discovery and Inspection and Combined Demands, alleges as follows:   1. Index number of the above mentioned action.   ANSWER:   1. Report of physician/health service provider who referred patient to plaintiff.   ANSWER:   1. Police report or accident in which plaintiff’s assignor was allegedly injured.   ANSWER:   1. License of plaintiff.   ANSWER:   1. Narrative report of plaintiff.   ANSWER:   1. Progress Notes of plaintiff.   ANSWER:   1. Letter of Medical Necessity.   ANSWER:   1. Copy of bill of plaintiff.   ANSWER:   1. Demand is made for the index number of the within action.   ANSWER:   1. Experts:   The name and address of any expert the plaintiff expecs to call at the time of trial setting forth:   1. The subject matter on which each expert is expected to testify: 2. The substance of the facts and opinions each expert is expected to testify on: 3. The qualification of each expert; and 4. The summary of ground for the opinion expressed by each expert.   ANSWER: |

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| Dated: | Franklin Square, New York. NOWDT |

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|  | Your, etc.  THE BEYNENSON LAW FIRM, PC.  Attorneys for Plaintiff(s)  475 Franklin Avenue  Franklin Square, NY11010  Tel: 516-858-4411  Fax: 516-216-5405  **Our Case Id: Case\_Id** |

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| To:  KATZ & ASSOCIATES 335 ADAMS STREET, SUITE 2701  BROOKLYN, NY 11201  **Your File No. Attorney\_FileNumber,** |  |

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| PURSUANT TO SECTION 130-1 OF THE RULES OF THE CHIEF ADMINISTRATOR (22 NYCRR) I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF, FORMED AFTER AN INQUIRY REASONABLE UNDER THE CIRCUMSTANCES, THE WITHIN RESPONSES ARE NOT FRIVOLOUS.  Notice Pursuant to CPLR 2103(5) declining service by electronic transmittal  The Beynenson Law Firm, P.C. Attorneys for Plaintiff  475 Franklin Avenue Franklin Square, NY 11010   To:  KATZ & ASSOCIATES 335 ADAMS STREET, SUITE 2701  BROOKLYN, NY 11201  **Your File No. Attorney\_FileNumber**  Attorneys for Defendant  Service of a copy of the within DISCOVERY RESPONSES is hereby admitted.   Dated: |

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attorney for Defendant |

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| STATE OF NEW YORK COUNTY OF NASSAU | ) ) ss. |

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| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, being duly sworn say:  I am over 18 years old and am not a party to this action. On \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I served upon the defendant herein a copy of the annexed responses by depositing same in a post-paid envelope in care of the United States Post Office, and affixed thereupon was the defendant's address:  KATZ & ASSOCIATES 335 ADAMS STREET, SUITE 2701  BROOKLYN, NY 11201 |
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| Sworn to before me    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Roza Pinkhasova  Notary Public, State of New York  No. 01PI6209788  Qualified In Queens County  Commission Expires August 03, 2017 |
| **Our Case Id: Case\_Id** |

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| *The Beynenson Law Firm, PC.* 475 Franklin Avenue, Franklin Square, New York, 11010 Tel: 516-858-4411  Fax: (516) 216-5405 |
| DATE: NOWDT |
| PROVIDER\_NAME Provider\_PERM\_Address Provider\_PERM\_City, Provider\_PERM\_State Provider\_PERM\_Zip   |  |  | | --- | --- | | Provider: | PROVIDER\_NAME | | Patient: | InjuredParty\_Name | | Claim No.: | Ins\_Claim\_Number | | Service: | Provider\_Type | | Amount: | Balance\_Amount | | D/S: | DateOfService\_Start – DateOfService\_End |   Dear Provider\_President::  Attached hereto please find discovery responses that we have taken the liberty of preparing on your behalf. Please review the responses, and if accurate, sign the annexed VERIFICATION and return to our office within **7 DAYS**.  If you have any questions, please call. Thank you. |

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|  | Very truly yours, The Beynenson Law Firm, PC |

**Our Case Id No.: Case\_Id**

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| |  |  |  | | --- | --- | --- | | PROVIDER\_NAME A/A/O INJUREDPARTY\_NAME | | | |  | | PLAINTIFF (S), | |  | -AGAINST- |  | | INSURANCECOMPANY\_NAME | | | |  | | DEFENDANT (S), | | **VERIFICATION** |
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| STATE OF NEW YORK ) COUNTY OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ) ss. |
| I, PROVIDER\_PRESIDENT, being duly sworn, deposes and says:  I am the owner of the plaintiff's office (PROVIDER\_NAME), and as such, am fully familiar with the facts set forth in plaintiff's discovery responses annexed hereto. I hereby verify that the plaintiff's interrogatory responses annexed hereto are true and accurate to the best of my knowledge. I make this verification based upon a review of the patient's file as maintained by this office.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PROVIDER\_PRESIDENT   Sworn to before me this \_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_.   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Notary Public    **Our Case Id No.: Case\_Id,** |

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| **Patient** | **Carrier ClaimNo** | **DOA** | **DOS** | **Claim Amt** | **Collect Amt** | **Balance** | **Provider** |
| InjuredParty\_name | Ins\_Claim\_Number | Accident\_Date | DateofService\_Start - DateofService\_End | Claim\_Amount | Paid\_Amount | Balance\_Amount | Provider\_Name |
|  |  |  |  | Claim\_Amount | 0 | Balance\_Amount |  |