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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. State the name, title, and relationship to the Defendant of the person answering these interrogatories.   ANSWER: PROVIDER\_PRESIDENT   1. State any name used by each plaintiff other than specifically stated above.   ANSWER: Provider\_Name Provider\_PERM\_Address Provider\_PERM\_City, Provider\_PERM\_State Provider\_PERM\_. See NYS Form NF-3/ bills, medical reports and supporting documentation annexed hereto, as applicable.   1. State whether the Plaintiff’s Assignor has submitted a No-Fault Application for Benefits.    1. If so, advised the date it was submitted, and the address to where it was sent.    2. Provide a true and correct copy of the application for benefits [NF-2].    3. Provide a copy of proof of mailing.   ANSWER:   1. State whether the Plaintiff or Plaintiff’s Assignor received a copy of a Police Accident Report describing the accident in issue.    1. Provide a true and correct copy of the report.   ANSWER:   1. State whether Plaintiff submitted any bills to Defendant for payment resulting from the accident in issue.    1. If so, state the date the bill was mailed.    2. Provide a true and correct copy of the bills.    3. Attach hereto proof of mailing of said bills.   ANSWER:   1. Set forth and identify every date of treatment and/or service rendered to assignor by the plaintiff.   ANSWER:   1. State whether the Plaintiff has received any payment, including the amount of the payment(s).   ANSWER:   1. State whether the Plaintiff submitted a valid assignment of benefits for payment of health care services from Plaintiff’s Assignor.    1. If so attach a true and correct copy of the assignment.   ANSWER:   1. State whether the Plaintiff received any request for additional verification.    1. If so, state wheat additional verification was requested, and the date(s) of such request.    2. Provide a true and correct copy of all the requests.   ANSWER:   1. State whether the Plaintiff submitted any response or correspondence in reply to Defendant’s verification requests.    1. If so, indicate what information was provided, the dates such information was sent and the address where it was sent.    2. Provide a true and correct copy of all information submitted.   ANSWER:   1. State whether the Defendant forwarded a Denial of Claim Form(s) [NF-10] to the Plaintiff for the bill in issue.    1. State the dates of service(s) denied.    2. State the amount billed.    3. State the amount billed for each session, if the bill involves multiple sessions.    4. State the amount paid, if any.    5. Provide a true and correct copy of the denial.    6. State the date that said denials were received by Plaintiff.   ANSWER:   1. State whether copies of medical records in Plaintiff’s possession were forwarded to the Defendant in consideration along with Plaintiff’s bill.    1. Provide a true and correct copy of the record(s).   ANSWER:   1. State whether there was any correspondence between the Plaintiff and the Defendant.    1. Set forth a true and correct copy of the correspondence.   ANSWER:   1. State the date, time, and place for each alleged treatment, test, modality, or office visit for which payment is sought.   ANSWER:   1. What type of business entity is the plaintiff?   ANSWER:   1. State the address, principals, and date of incorporation of the plaintiff.   ANSWER:   1. State whether the plaintiff was licensed in the state of New York to provide the treatment or services provided to the assignor.    1. Set forth a true and correct copy of the license.   ANSWER:   1. Set forth and identify by name and license number each person who provided treatment to the Assignor.    1. List all corporate business names.    2. List all dates license(s) were issued.   ANSWER:   1. State the name and address of each person who administered tests, treatment, or office visit rendered by this provider.    1. If that person is a technician, attach a copy of his/her license.    2. If the person that administered the test is a technician or unlicensed individual, state how they were supervised and trained to administer each test, treatment or office visit.   ANSWER:   1. State the names and addresses of each corporation for which the physicians employed by the Plaintiff who treated the Assignor have been associated with as an employee, consultant, or owner for the past two years.   ANSWER:   1. State the name and address of the office manager and/or each individual who assisted in preparing and sending bills and/or verification of treatment forms attached to the Plaintiff’s complaint.   ANSWER:   1. State what injuries, conditions and symptoms the Plaintiff treated the Assignor for, including a description of the symptoms.   ANSWER:   1. Set forth a detailed description of the testing or health services that were rendered, including a statement setting forth the condition and medical purposes for each test or health service.    1. Set forth and explanation of the purpose for each test, including a detailed explanation on how the test results affected the diagnosis and treatment.   ANSWER:   1. Ste forth the modalities utilized in the treatment of the Assignor on each date for which payment is sought. Include a statement setting forth the condition and medical purpose for each modality.   ANSWER:   1. For each alleged health service set forth the following information:    1. The dollar and regional conversion factor(s) and unit value;    2. Fee schedule treatment code(s) and charge(s);    3. How the bill was determined in accordance with the rates authorized under Insurance Law 5108, including proof that the health service(s) was/were billed in accordance with the fees authorized by Insurance Law 5108.   ANSWER:   1. If the plaintiff is a supply company:    1. When did the plaintiff deliver the supplies to the claimant?    2. Did the claimant ever receive a prescription for the supplies rendered? If so, when?    3. Provide a true and correct copy of the prescription for supplies rendered.   ANSWER:   1. Describe the equipment, its manufacturer, make, and model used by the Plaintiff.   ANSWER:   1. Set forth the length of time, the procedures and the equipment utilized in the alleged health services for which payment is sought.   ANSWER:   1. State whether the Plaintiff submitted the following items and information to the Defendant:    1. Specific findings and/or complaints for the particular patient under treatment which necessitated the testing procedure    2. Complete set of data and results of all testing procedures    3. Correlation of the data and results with:       1. The original finding and complaints;       2. The diagnosis resulting from the tests; and       3. The specific treatment plan of the claimant.   ANSWER:   1. State what remuneration has been paid to Plaintiff by the Defendant regarding the bills in issue, including the date the remuneration was received and the amount of the remuneration.   ANSWER:   1. State whether the amount sought by the Plaintiff in the complaint includes all the services allegedly rendered by the Plaintiff to the Assignor.   ANSWER:   1. State if any other diagnostic tests were performed by other health care providers prior to the testing, treatment, or office visit rendered by the Plaintiff.    1. If so, indicate the name of each provider and list tests that were administered, if any.   ANSWER:   1. Identify the business (es), company (ies), corporation(s), which provided the transportation services, if any.    1. Please provide all corporate or business name(s).    2. Please provide corporate or business addresses and telephone numbers.    3. Please provide tax identification number(s) for any and all corporation(s) or business (es) referred to in part a.   ANSWER:   1. Identify the health care provider which prescribed and/or recommended that the Assignor or Plaintiff seek substitute transportation services, including the date that the substitute services were prescribed and/or recommended, if any.   ANSWER:   1. For each alleged transportation service claimed, if any, set forth the following:    1. The date and time that each alleged transportation service was rendered;    2. Business(es), company(ies), corporation(s) which provided the transportation services;    3. Identify where each transportation service was commenced and the destination for each transportation service; and    4. State the name and address for each health care provider that rendered medical treatment.   ANSWER:   1. State if the Plaintiff signed for each alleged transportation service, if any.    1. Provide a true and correct copy of each signed receipt.   ANSWER:   1. State whether any sharhloder of the Plaintiff is also listed as a sole shareholder for any additional corporation.    1. State the name of the shareholder.       1. State the name of the corporation for which each shareholder is the sole shareholder.       2. State the nature of this business.    2. Provide the name, tax identification number, and dates f incorporation for each such corporation.    3. Provide the dates when shares were issued to owner, if applicable.    4. Provide dates of any transferring of shares and/or dissolving of corporation by owner if applicable.   ANSWER:   1. State the name of each officer in the assignees corporation, number of shares held and position and any licenses held thereby, and, if the assignee is owned by another corporate entity, please provide the name of that entity and the name of its corporate officers.   ANSWER:   1. State in what respect it will be claimed that the services rendered to the plaintiff were medically necessary.   ANSWER:   1. Set forth the basis for determining that any attorneys fees are owed herein.   ANSWER:   1. State how the charges were fixed and if reference is made to any hospital, doctor or medical society fee schedule or related documents please include a true and accurate copy of this fee schedule with your response.   ANSWER:   1. Describe the admissions or intake procedures employed by the Plaintiff with respect to the patient herein including:    1. The manner in which the Assignor’s source of payment and financial status are determined;    2. The manner in which the patient is informed of out-of pocket expenses and responsibility for payment for his/her treatment or stay;    3. Whether any deposits are required for treatment or services; and    4. The arrangements made for payment by the patient.   ANSWER:   1. Please state whether the Assignor or Plaintiff has instituted any other lawsuits or served any other demands for arbitration in regards to the instant accident giving rise to the treatment or services claimed rendered herein.   ANSWER:   1. State whether it is the custom of the Plaintiff to interview, inquiry or provide questions as part of an intake procedure which include the subject of insurance at the time of admission or at any subsequent date of treatment and if so:    1. Provide a true and accurate copy of all intake, triage, history and questionnaire documents regarding the patient herein, and    2. Dates of any interview or questioning by any personnel in the employe of or acting as agent for the Plaintiff herein.   ANSWER:   1. If the Assignor provided information regarding insurance coverage please provide the name of the carrier(s) and the policy or group numbers provided.   ANSWER:   1. State whether the Assignor has made a claim, put anyone on notice of or was eligible for Medicaid or Medicare and/or Worker’s Compensation Insurance.   ANSWER:   1. Provide true and accurate copies of any and all documents that the Assignor signed during the course of the treatment or services by the Plaintiff at the Plaintiff’s request.   ANSWER:   1. Identify all agents, representatives, or employees of the Plaintiff who negotiated the agreement or agreements between the Plaintiff and the Assignor for medical services and payment for same.   ANSWER:   1. Set forth the grounds or basis for the claim that the patient is a qualified or covered person under Section 5208 of the Insurance Law of the State of New York.   ANSWER:   1. If any statute, law, ordinance, rule, regulation or code, including any relevant no-fault regulation, is claimed to have been violated by the answering Defendant, identify same by article, section, and paragraph numbers, as well as the manner in which same was violated.   ANSWER: |

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

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|  | Yours, etc.  THE BEYNENSON LAW FIRM, P.C.  Attorneys for Plaintiff(s)  475 FRANKLIN AVENUE  FRANKLIN SQUARE, NY 11010  Tel: 516-858-4411: Fax: 516-216-5405  Our Case Id: Case\_Id |

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| Plaintiff, by its attorneys, The Beynenson Law Firm, P.C., in response to defendants Demand For Combined Discovery & Inspection and Inspection, alleges as follows:   1. Set forth, identify and attach copies of any and all bills, invoices and/or receipts pertaining to any and all treatment or services rendered.   ANSWER:   1. Set forth and attach any and all bill, invoices, correspondence, notices, demands or claims submitted to the defendant for all treatment, tests and services rendered to the assignor by the plaintiff.   ANSWER:   1. Attach copies of all accounts receivable documentation as it pertains to the dates of treatment, services and fees for treatment and services claimed to have been rendered to the assignor, including an itemization of any all payments received thereon from any source.   ANSWER:   1. Provide true and accurate copies of all correspondence, drafts, memorandums and/or documents which establish and/or indicate the amount of payment received for all tests or services rendered.   ANSWER:   1. Provide a complete and true copy of the patient(s) medical records pertaining to treatment or services rendered.   ANSWER:   1. Attach all medical reports or opinions prepared by or on behalf of the plaintiff pertaining to the assignor.   ANSWER:   1. Provide a true and accurate copy of any assignment of benefits or assignments executed by or on behalf of the patient herein.   ANSWER:   1. Provide a true and accurate copy of all intake, triage, history and questionnaire documents regarding the patient herein.   ANSWER:   1. Provide any photographs taken of the patient.   Answer:   1. Provide all notes and memoranda pertaining to the treatment of the patient.   ANSWER:   1. Provide proof of mailing of all bills or demands for payment to the carrier for each amount claimed.   ANSWER:   1. HIPAA complaint authorizations to obtain all records from hospitals, medical facilities, diagnostic facilities, including diagnostic films from the plaintiff assignor’s accident including date of loss occurring April 15, 2012   ANSWER: |

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

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|  | Yours, etc.  THE BEYNENSON LAW FIRM, P.C.  Attorneys for Plaintiff(s)  475 FRANKLIN AVENUE  FRANKLIN SQUARE, NY 11010  Tel: 516-858-4411: Fax: 516-216-5405  Our Case Id: Case\_Id |

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| To:  PEKNIC, PEKNIC & SCHAEFER, LLC  1005 West Beech Street  Long Beach, NY 11561  **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(s)  475 FRANKLIN AVENUE  FRANKLIN SQUARE, NY 11010  Tel: 516-858-4411: Fax: 516-216-5405  Our Case Id: Case\_Id  To:  PEKNIC, PEKNIC & SCHAEFER, LLC  1005 West Beech Street  Long Beach, NY 11561  **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 | ) ) ss. |

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| I, Alla Levy, 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:  PEKNIC, PEKNIC & SCHAEFER, LLC  1005 West Beech Street  Long Beach, NY 11561 |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Alla Levy |

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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, P.C.* 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 | | DOS: | DateOfService\_Start – DateOfService\_End |   Dear :Sir or Madame:  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 P.C. |

**Our Case Id: Case\_Id,**

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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: Case\_Id** |

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