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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 whether plaintiff received defendant’s additional and/or follow up verification(s).   ANSWER:   1. State whether plaintiff received defendant’s denial(s).   ANSWER:   1. State whether an itemized bill or bills were rendered to the Defendant for the medical services provided by the Plaintiff.   ANSWER:   1. Has the Plaintiff received any payment from Defendant?   ANSWER:   1. If no itemized bill for medical services was rendered, set forth an itemized statement of all charges, which make up the cause of action.   ANSWER:   1. Under what section of the medical fee schedule as promulgated by the Superintendent of Insurance is this fee reimbursable?   ANSWER:   1. Did another doctor refer the patient to Plaintiff?   ANSWER:.   1. Did Plaintiff take a medical history of the patient?   ANSWER:   1. Did referring doctor provide Plaintiff with a medical history?   ANSWER:   1. Did Plaintiff conduct a physical of patient?   ANSWER:   1. Did referring doctor provide Plaintiff with course of treatment that patient was undergoing?   ANSWER:   1. Had any x-rays, CT scans or MRI been performed prior to or subsequent to the treatment rendered by Plaintiff.   ANSWER:   1. Had patient sought medical attention form a medical doctor prior to being treated by Plaintiff?   ANSWER:   1. Was a narrative report ever submitted to the Defendant?   ANSWER:   1. State Plaintiff’s workers Compensation Board rating.   ANSWER   1. State specialty, if any, or Plaintiff.   ANSWER:   1. If Plaintiff is a Corporation, state the place and date of incorporation, setting forth a true and corrct copy of the Certificate of Incorporation including a list of shareholders.   ANSWER:   1. State whether the Provider secured photographic identification of the eligible injured person at any time prior to, during or after the treatment was rendered.   ANSWER:   1. State the manner in which the eligible injured person was referred to the provider for medical care and/or treatment.   ANSWER:   1. Identify the date when the eligible injured person was first seen/evaluated for medical care and treatment at the location where the Provider rendered the services for which reimbursement is sought.   ANSWER:   1. Identify each and every medical provider (in addition to the Plaintiff) who provided medical care and/or treatment to the eligible injured person as a result of the accident/occurrence.   ANSWER:   1. Identify each and every document that the Provider reviewed and/or consulted in connection with its initial evaluation of the eligible injured person and its development of the treatment plan for the eligible injured person.   ANSWER:   1. State each and every defense that will be claimed by Plaintiff or the Plaintiff’s assignor to the Defendant’s denial of the plaintiff’s claim.   ANSWER:   1. Indentify all documents that relate to, refer to or concern communications between the Plaintiff and the Defendant regarding:   ANSWER:   1. State whether the Provider is a (1) corporation, (2) limited liability company, (3) professional corporation and/or a (4) professional limited liability, and provide the additional information on regard thereto, provide the following information:   ANSWER:   1. With regard to the medical care/treatment provided by the Plaintiff for which reimbursement is sought, state the following information:   ANSWER:   1. For each charge submitted by the Provider to the Defendant for reimbursement, set forth the following information:   ANSWER:   1. For each doctor, therapist, chiropractor, acupuncturist or healthcare provider that rendered services to the eligible injured person on behalf of the Provider, state whether the individual is licensed by the State of New York to provide said services, and provide the following information:   ANSWER:   1. For each doctor, therapist, chiropractor, acupuncturist or healthcare provider that rendered services to the eligible injured person on behalf of the Provider, state whether the individual is employed by the provider or an independent contractor. To the extent that the individual was an employee, state the following:   ANSWER:   1. State whether the eligible injured person had to sign a log, register or other document on each date that treatment was rendered by the provider.   ANSWER:   1. State whether an itemized bill or bills were rendered to the Defendant for surgical supplies provided by the Plaintiff.   ANSWER:   1. Did plaintiff provide a copy of the wholesale invoice to the Defendant?   ANSWER:   1. Did the Plaintiff provide a copy of the letter of medical necessity for the surgical supplies to the Defendant?   ANSWER:   1. Did Defendant request any verification of the claim from the Plaintiff?   ANSWER:   1. State the name, address and specialty of the prescribing health care provider.   ANSWER:   1. State whether the provider secured photographic identification of the eligible injured person at any time prior to, during or after the treatment was rendered.   ANSWER:   1. State the manner in which the eligible injured person was referred to the Provider for medical care and/or treatment.   ANSWER:   1. Identify the date when the eligible injured person was first seen/evaluated for medical care and treatment at the location where the Provider rendered the services for which reimbursement is sought.   ANSWER:   1. Identify each and every document that the Provider reviewed and/or consulted in connection with its initial evaluation of the eligible injured person and its development of the treatment plan for the eligible injured person.   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  Ph-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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| |  |  |  | | --- | --- | --- | | **PROVIDER\_NAME**  A/A/O **INJUREDPARTY\_NAME** | | | |  | | PLAINTIFF (S), | |  | -AGAINST- |  | | **INSURANCECOMPANY\_NAME**,\ | | | |  | | DEFENDANT(S), | | RESPONSE TO COMBINED DEMANDS |
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| Plaintiff, by its attorneys, The Beynenson Law Firm, PC., in response to defendants Combined Demands, upon information and belief sets forth and alleges as follows:   1. Set forth and attach true and accurate copies of all bills, invoices and claims submitted to INSURANCECOMPANY\_NAME, for all treatment, tests and services rendered to assignor.   ANSWER:   1. Attach copies of all accounts receivable documentation kept in the ordinary course of business of Plaintiff, as it pertains to the dates of treatment, services and fees for treatment and services rendered to assignor, including an itemization of any and all payments received thereon from any source.   ANSWER   1. Attach true and accurate copies of all insurance statements submitted and/or forwarded to INSURANCECOMPANY\_NAME, regarding assignor.   ANSWER:   1. Attach copies of all accounts receivable documentation kept in the ordinary course of business of Plaintiff, as it pertains to the dates of treatment, services and fees for treatment and services rendered to assignor, including and itemization of any and all payments received thereon from any source.   ANSWER:   1. Attach copies of all correspondence, drafts, memorandums and/or documents which establish and/or indicate the amount of payment received from INSURANCECOMPANY\_NAME, for any and all treating, treatment and services rendered to assignor.   ANSWER:   1. Attach copies of any and all letters, documents and/or correspondence forwarded to any attorney, individual, organization and/or insurance company, indicating that Plaintiff has a lien and/or is due an owing any fee for any medical treatment rendered to assignor.   ANSWER:   1. Attach copies of any and all medical reports and/or opinions prepared by or on behalf of the Plaintiff pertaining to assignor.   ANSWER:   1. Attach copies of Defendant’s NF10 and Explanation of Medical Bill Payment received by Plaintiff from INSURANCECOMPANY\_NAME, in conjunction with the claim(s) that is the subject matter if the lawsuit herein.   ANSWER:   1. Attach a copy of the envelope in which Defendant’s NF10 and Explanation of Medical Bill Payment was received by Plaintiff from INSURANCECOMPANY\_NAME, in conjunction with the claims(s) that is the subject matter of the lawsuit herein.   ANSWER:.   1. Attach copies of proof of mailing from Plaintiff to Defendant of each bill it issue.   ANSWER:   1. Attach a copy of assignment.   ANSWER:   1. Attach copies of all the licenses of each technician and/or physician who provided services to Plaintiff’s assignor.   ANSWER:   1. Attach copies of all progress notes of Plaintiff.   ANSWER:   1. Attach copies of any and all reports of the physician/health service provider who referred patient to Plaintiff.   ANSWER:   1. Attach copies of incorporation papers of Plaintiff, including a list of the shareholders.   ANSWER:   1. Attach a copy of the Plaintiff’s assignor’s medical file.   ANSWER:   1. A copy of the Provider’s bank resolutions account agreements, and signature cards for all accounts that have been maintained and/or operated by the Professional Corporation for the period of January 1, 2007 to the present.   ANSWER:   1. A copy of the Provider’s federal, state and local income tax returns for the years 2007 and 2008.   ANSWER:   1. Copies of all documents that refer to, relate to or memorialize any agreement between the Provider and any consulting/Management company for the period of January 1, 2007 to the present.   ANSWER:   1. All documents that refer to, relate to or memorialize any agreements between the Provider and any billing/collection company, for the period of January 1, 2007 to the present.   ANSWER:   1. All documents the relate to, refer to or memorialize any agreements (financial or otherwise) between the Provider and any other Provider that has rendered services at the location where the Provider delivered the services for which reimbursement is sought.   ANSWER:   1. All documents to the employment status of the individuals that provided services (both health care related and non-health care related) for on behalf of the Provider for the period of January 1, 2009 to present, including but not limited to copies of all IRA W-4, IRS W-2, IRS 1099 AND INS 1-9 forms.   ANSWER:   1. All documents that relate to the licensure, certification and credentials of the individuals that provided health care related services for or on behalf of the provider for the period of January 1, 2009 to the present.   ANSWER:   1. All documents that relating to, referring to or concerning the treatment and/or care rendered to the eligible injured person, including but not limited to records prepared and maintained for the purpose of referral, treatment and diagnosis of the eligible injured person.   ANSWER:   1. A copy of the patient’s entire medical chart maintained by the Provider, including all records from any prior, contemporaneous or subsequent treatment and/or care rendered to or received by the eligible injured person in any medical/health care discipline.   ANSWER:   1. All documents relating to the Provider’s intake of the eligible injured person, including (a) all photo identification presented or secured by the Provider, (b) all questionnaires presented to or prepared by or on behalf of the eligible injured party (c) all insurance forms presented to or prepared by or on behalf of the eligible injured party.   ANSWER:   1. All documents relating to, referring to or concerning instructions provided to the eligible injured person by or on behalf of the Provider in connection with medical care and/or treatment rendered.   ANSWER:   1. All documents relating to, referring to or concerning the original consultation and/or examination of the eligible injured person, including by not limited to the treatment plan established by the initial evaluating physician.   ANSWER:   1. All documents relating to, referring to or concerning the dates and times when the medical/health care services were allegedly rendered by the Provider to eligible injured person, including but not limited to sign-in sheets and treatment records.   ANSWER:   1. All documents relating to, referring to or concerning the length of time for each treatment that is rendered to the eligible injured person by the Provider, including but not limited to physical therapy, chiropractic, acupuncture and massage therapy.   ANSWER:   1. All documents relating to, referring to or concerning the order on which treatment is given that is rendered to the eligible injured person by the Provider, including but not limited to physical therapy, chiropractic, acupuncture and massage therapy.   ANSWER:   1. All documents relating to, referring to or concerning all diagnostic tests. MRI’s and/or X-rays performed upon the eligible injured person by, on behalf of or at the request of the Provider, including all films, studies and reports issued to or by the Provider.   ANSWER:   1. All documentation that relates to, refers to or concerns the equipment that was used by the Provider in connection with the performance and delivery of medical services to the eligible injured person for which reimbursement is sought.   ANSWER:   1. All documents relating to, referring to or concerning referrals that were made by treating physician to the Provider, or by the Provider (if the treating physician is the plaintiff seeking reimbursement) in connection with the treatment and/or care of the eligible injured person.   ANSWER:   1. All documents relating to, referring to or concerning the many in which the eligible injured person was referred to the Provider.   ANSWER:   1. All documents relating to, referring to or concerning prescriptions made and/or received in connection with the care and/or treatment of the eligible injured person.   ANSWER:   1. All documents that were submitted to the Insurer in connection with its claim for reimbursement, and all documents that verify the date when said documents were submitted.   ANSWER:   1. All documents that were received by the provider from the Insurer in response to its initial submission for reimbursement, including but not limited to (a) delay letters, and (b) requests for additional verification.   ANSWER:   1. All documents that were submitted by the Provider to the Insurer in response to a request for additional verification.   ANSWER:   1. All documents relating to, referring to or concerning the Provider’s position that its claim for reimbursement for services provided was submitted in accordance with the applicable fee schedule.   ANSWER:   1. Attach a copy of the license of the Plaintiff.   ANSWER:   1. Attach copies of wholesale invoices substantiating Plaintiff’s purchase of medical supplies, which are at issue.   ANSWER:   1. Attach copies of proof of payment of wholesale invoices substantiating Plaintiff’s purchase of medical supplies, which are at issue.   ANSWER:   1. To the extent that you are claiming reimbursement for durable medical equipment, you are directed to provide copied of the following documentation/information for each specific item of durable medical equipment for which reimbursement is sought:   ANSWER:   1. To the extent that you are a Provider claiming reimbursement for MRI films and/or X-ray films, you are directed to provide the following documentation/information.   ANSWER:   1. To the extent that you are a Provider claiming reimbursement for dentistry services and/or orthotic dveices relative to the practice of dentistry, you are directed to provide the following documentation/information:   ANSWER:   1. To the extent that you are a Provider claiming reimbursement for psychiatric/psychological services, you are directed to provide the following documentation/information:   ANSWER:   1. To the extent that you are a Provider claiming reimbursement for biofeedback/psychotherapy services, you are directed to provide the following documentatiom/information.   ANSWER: |

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

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

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| To:  SMITH & BRINK, P.C.  1205 FRANKLIN AVENUE SUITE 260  GARDEN CITY, NY 11530  **Your File No. Attorney\_FileNumber,** |  |

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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 NOTICE OF DISCOVERY AND INSPECTION |
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| Plaintiff, in response to defendants Notice of Discovery and Inspection, upon information and belief, sets forth as follows:  1.The NF-10(s) and Explanation(s) of Medical Bill Payment received by Plaintiff **PROVIDER\_NAME**, PCEVALUATION, Assignee of **INJUREDPARTY\_NAME** and/or counsel for Plaintiff, ALEK BEYNENSON, ESQ., for the claim(s) that is the subject matter of the suit herein;  ANSWER:  2.The envelope(s) in which the NF-10(s) and Explanation(s) of Medical Bill Payment were received by Plaintiff **PROVIDER\_NAME**, PCEVALUATION, Assignee of **INJUREDPARTY\_NAME** and/or counsel for Plaintiff, ALEK BEYNENSON, ESQ., for the claim(s) that is the subject matter of the suit herein.  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  Ph-516-858-4411  Fax-516-216-5405  **Our Case Id: Case\_Id** |
| To:  SMITH & BRINK, P.C.  1205 FRANKLIN AVENUE SUITE 260  GARDEN CITY, NY 11530  Your File No. Attorney\_FileNumber, |  |

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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 COPIES OF MEDICAL REPORTS |
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| Plaintiff, in response to defendants Demand for Copies of Medical Reports, upon information and belief, sets forth as follows:   * + 1. Serve upon and deliver to the attorney for the Defendants copies of the medical reports of those physicians who have previously treated or examined the Plaintiff and who will testify in his behalf. These shall include a detailed recital of the injuries and conditions as to which testimony will be offered at the trial, referring to and identifying those x-rays and technician’s reports which will be offered at the trial.   ANSWER:   * + 1. Serve upon and deliver to the attorney for the Defendants duly executed and acknowledged written authorization permitted all parties to obtain and make copies of all hospital records and such other records, including x-rays and technician’s reports, as to be referred to and indentified in the statement of the Plaintiff physicians.   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  Ph-516-858-4411  Fax-516-216-5405  **Our Case Id: Case\_Id** |
| To:  SMITH & BRINK, P.C.  1205 FRANKLIN AVENUE SUITE 260  GARDEN CITY, NY 11530  Your File No. Attorney\_FileNumber, |  |

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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), | | |  | | --- | |  | |
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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, PC. Attorneys for Plaintiff  475 Franklin Avenue Franklin Square, New York 11010  Ph-516-858-4411  Fax-516-216-5405  Our Case Id: Case\_Id  To:  SMITH & BRINK, P.C.  1205 FRANKLIN AVENUE SUITE 260  GARDEN CITY, NY 11530   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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| 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), | | |  | | --- | | **AFFIDAVIT OF SERVICE** | |  | |
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| STATE OF NEW YORK COUNTY OF NASSAU | ) ) 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:  SMITH & BRINK, P.C.  1205 FRANKLIN AVENUE SUITE 260  GARDEN CITY, NY 11530 |
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| Sworn to before me on this day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2011   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Roza Pinkhasova  Notary Public, State of New York  No. 01PI6209788  Qualified In Queens County  Commission Expires August 03, 2013 |
| **Our File No.: 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 File 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.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr. Provider\_President    Sworn to before me this \_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_.   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Notary Public    **Our Case Id No.: Case\_Id** | |