NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is <u>not</u> for verification of hospital treatment)

NAME AND ADDRESS OF INSURER OR SELF-INSURER*	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

PROVIDER'S NAME AND ADDRESS*

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE <u>BUT NO LATER THAN 45 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT</u>. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM**.

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

2. DATE OF BIRTH	3. SEX	4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR? DATE: _____	7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: _____

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?
YES [ ] NO [x] IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?
YES [x] NO [ ] IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?
YES [ ] NO [x]

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?
YES [ ] NO [ ] NOT DETERMINABLE AT THIS TIME [x]
IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK) FROM: _____ THROUGH: _____	13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON: _____ (DATE)

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