GEICO
geico.com

GEICO Indemnity Company

Buffalo/New Jersey Claims, PO BOX 9515
Fredericksburg, VA 22403-9515

05/26/2025

Romanow Law Group

4930 MCKNIGHT RD
Pittsburgh, PA 15237-3408

Company Name:	GEICO Indemnity Company
Claim Number:	883394902 0000 001
Loss Date:	Monday, May 19, 2025
Policyholder:	Mussa Farzaliyev
Your Client:	Mussa Farzaliyev

Dear Romanow Law Group,

Your client indicated that they were injured in this accident. If they intend to file a claim, please complete and sign the enclosed "Statement of Claim under Medical Payments Coverage" form and the "HIPAA Compliant Authorization" and return all forms as soon as possible in the envelope provided.

To expedite the handling of their claim, please respond promptly. If you do not have all the information requested, you may supply it at a later date.

____ Check here if they do not intend to present a medical claim, and return this letter to us.

If you have any questions concerning the forms or the benefits available, contact me at the number below. Please refer to our claim number when writing or calling about this claim.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Sincerely,

Emily Osta-Martinez

EP0015 (09/2019)

B-9115422 002049 01 06 1
1267930806 00002049 00000001/00000006 00007227/00007285
401001883394902000001072228

716-276-4758
Claims Department
GEICO Toll-Free Number: 1-800-841-3000

Encl: C34ME, C257ME, C256ME, C36, Return Envelope

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4010018833949020000001072 29

Medical Payments Coverage Subrogation Approval Form

I agree that any payments made to me or on my behalf by GEICO Indemnity Company under the medical payments coverage of my policy may be recovered by GEICO Indemnity Company in accordance with Maine Statute M.R.S. § 2910-A and my policy with GEICO Indemnity Company. Pursuant to the terms of my policy, if I recover from a third party for my injuries, I will assist GEICO Indemnity Company in recovery of any sums paid including holding funds in a trust so as to reimburse GEICO Indemnity Company to the extent of any payments made on my behalf.

Any recovery by GEICO Indemnity Company shall be reduced on a pro rata basis for any attorney's fees in obtaining the recovery from another source to comply with M.R.S. § 2910-A(1)(C). With the exception if GEICO Indemnity Company pursues recovery directly against the tortfeasor (M.R.S. § 2910(A)(3))

I understand that GEICO Indemnity Company does not assert a priority over me in recovery of any such medical payments.

I acknowledge and agree to the above.

_____
Printed Name

_____
Signature

_____
Date

For your protection, Maine law requires the following to appear on this form: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

C36-ME (09-19)

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Claim No. _____ DATE _____

HIPAA COMPLIANT AUTHORIZATION

List below the names and addresses of all persons (Doctors, Dentists, Hospitals, Nurses, Funeral Directors, etc.) who rendered, or who are rendering services in connection with injuries sustained in this accident.

NAME AND ADDRESS

_____

_____

_____

_____

_____

To Whom It May Concern:

For purposes of evaluating a claim made by me, or on my behalf, and/or for preparing for, conducting, and/or participating in any mediation, arbitration, hearing, trial, or other proceeding associated with my claim, you are hereby authorized to furnish to Government Employees Insurance Company, GEICO General Insurance Company, GEICO Indemnity Company, GEICO Casualty Company, or any of its representatives (individually and collectively referred to as "GEICO") any and all medical information which may be requested concerning my physical and/or mental condition and treatment (excluding "psychotherapy notes" as defined in 45 CFR 164.501) to include, diagnosis, prognosis, and any and all records, files, or other documentation concerning the treatment, prescription, consultation or other advisory visits or events (collectively referred to as the "Records") that pertain to:

- _____,
  [PATIENT: WRITE YOUR BIRTH DATE ABOVE]
- DOB: _____,
  [*PATIENT: WRITE YOUR BIRTH DATE ABOVE]*
- SSN: _____.
  [PATIENT: WRITE YOUR SOCIAL SECURITY NUMBER ABOVE]
- The Records shall specifically include, but shall not be limited to, such condition and treatment as may pertain to the automobile accident/loss/claim of ***[PATIENT: INDICATE THE DATE OF THE AUTOMOBILE ACCIDENT/LOSS/CLAIM IN THE FOLLOWING SPACE]***
  _____, 20_____.

The information covered by this HIPAA Compliant Authorization includes, but is not limited to, reports, records, test results, X-rays, and any other diagnostic testing, whether in your possession or available to you. I understand that the information in the Records may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, behavioral health care/psychiatric care (excluding "psychotherapy notes" as defined in 45 CFR 164.501), and treatment for alcohol and/or drug abuse, and/or substance abuse. Copies of this Authorization shall be considered as valid as the original. This information is being requested for the purpose of evaluating a claim made by me, or on my behalf, and/or for preparing for, conducting, and/or participating in any mediation, arbitration, hearing, trial, or other proceeding associated with my claim. This Authorization shall be valid for the period of thirty months from the date signed. This is not a release of claims for damages. I further understand that I am entitled to a copy of this Authorization and acknowledge receipt by signing below. I acknowledge that the information disclosed pursuant to this Authorization may be re-disclosed by GEICO pursuant to applicable law and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA). I also authorize GEICO to further re-disclose the records received pursuant to this authorization, including, but not limited to, information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, behavioral health care/psychiatric care

Claim No. _____ **DATE** _____

(excluding "psychotherapy notes" as defined in 45 CFR 164.501), and treatment for alcohol and/or drug abuse, and/or substance abuse, as may be necessary for the purpose of evaluating a claim made by me, or on my behalf, and/or for preparing for, conducting, and/or participating in any mediation, arbitration, hearing, trial, or other proceeding associated with my claim. This HIPAA Compliant Authorization shall also allow GEICO's representatives, agents, consultants, or health care professionals, or any physicians appointed by it, to examine the records produced concerning said condition or treatment.

Revocation Section: I acknowledge that I have the right to revoke this Authorization at any time. A revocation of this Authorization must be in writing and sent via regular U.S. mail, postage prepaid, to the Company Representative who requested this authorization and to the medical provider. The revocation of this Authorization will be effective upon receipt and will be prospective only. Revocation may be the basis for denial of insurance coverage or benefits.

I understand that I may refuse authorization to disclose all or some of my health care information but that refusal may result in denial of coverage or a claim or other adverse consequences. I acknowledge that I am aware that the consequences of my not signing this Authorization can include a delay in the processing/resolution of the claim, a potential denial of the claim, or other consequences recognized by applicable state law and/or the insurance policy at issue.

_____ _____

[SIGNATURE OF PATIENT] **[PRINT NAME OF PATIENT]**

_____

[DATE]

Personal Representative's Section: A personal representative executing this form on behalf of the patient warrants that he or she has authority to sign this form on the basis of:

_____.

_____ _____

(SIGNATURE: PERSONAL REPRESENTATIVE) **(PRINT NAME OF PERSONAL REPRESENTATIVE)**

_____

(DATE)

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GOVERNMENT EMPLOYEES INSURANCE COMPANIES
ATTENDING PHYSICIAN'S REPORT

Date	Our Policyholder	Date of Accident	Claim No.

To assist us in determining what payments may be due to/for the injured party, the Attending Physician should complete this report and return it directly to:

GOVERNMENT EMPLOYEES INSURANCE COMPANIES
PO BOX 9107
MACON, GA 31208-9107

1. Patient's Name and Address:			
2. Age:	3. Sex:		4. Occupation:
5. History of occurrence, as described by Patient:			
6. Diagnosis and Concurrent Conditions:			
7. Date symptoms first appeared:		8. Date when Patient first consulted you for this condition:	
9. Has Patient ever had same or similar condition? ☐ YES ☐ NO If yes, state when and describe:			
10. Is condition solely a result of this accident? ☐ YES ☐ NO If no, explain:			
11. Is condition due to injury or sickness arising out of Patient's employment? ☐ YES ☐ NO If yes, explain:			
12. Will injury result in permanent disfigurement or disability? ☐ YES ☐ NO If yes, describe:			
13. Was Patient hospitalized as a result of this injury? ☐ YES ☐ NO If yes, where:			
14. Was Patient unable to work? ☐ YES ☐ NO If yes, FROM: THROUGH:		15. If still disabled, date Patient should be able to return to work:	
16. Report of Services:			

Date of Service	Place of Service	Description of Surgical or Medical Service	Charges
			$
			$
			$
		TOTAL CHARGES TO DATE	$

17. Is this Patient still under your care for this condition? ☐ YES ☐ NO	Estimated Future Charges: $
18. Is any part of your bill covered by MEDICARE or MEDICAID? ☐ YES ☐ NO	

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Date Physician's Name (print) Physician's Signature IRS/TIN Identification No.

Number Street City or Town State Zip Code

C-257 ME (04-09)

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GOVERNMENT EMPLOYEES INSURANCE COMPANIES
STATEMENT OF CLAIM UNDER MEDICAL PAYMENTS COVERAGE

Company: _____ Claim No.: _____

Date and Time of Accident: _____

Policyholder's Name: _____ Policy No.: _____

Name of Injured Party: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security No.: _____ (E-Mail): _____ Occupation: _____

Employer's Name and Address: _____

Person Injured Was: (Check One) ☐ Pedestrian ☐ Occupant of Vehicle
☐ Occupant of a vehicle other than the policyholder's

IF A PEDESTRIAN: State relationship of injured person to policyholder: _____

Seat Belts Installed? ☐ Yes ☐ No In Use? ☐ Yes ☐ No

IF OCCUPANT OF A VEHICLE OTHER THAN POLICYHOLDER'S: State fully the reason why the injured person was in the vehicle. Please provide the name and address of the owner of the vehicle, the name and address of the owner's insurance company and the owner's policy/file number:

_____

_____

Describe fully the extent of injuries sustained: _____

_____

_____

Have you made a claim, agreed to a settlement, signed a release or obtained a judgment against anyone who may be legally liable for the damages from such injuries? _____ (If yes, please furnish full details below and on the reverse side, if necessary.)

Are any of the expenses claimed herein covered by Blue Cross or any other Group plan, Government policy or plan (e.g. Medicare or Medicaid), or any other insurance policy? _____ (If yes, give details and advise below if you have collected or are making claim for any of these expenses.)

Signature_____ Date_____

Important - To be eligible for benefits:

1. Complete and sign this application.
2. Sign the attached authorization.
3. Return promptly with any medical bills you have received to date.

For your protection, Maine law requires the following to appear on this form:
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C-34 ME (08-11) NS

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