NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

(This form is not for verification of hospital treatment)

NAME AND ADDRESS OF INSURER OR SELF-INSURER	NAME, ADDRESS & PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE
ADDRESSOFINSURER|NameOfInsurance	REPRESENTATIVE|NameClaimRePresntative

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
Date|InitDate	PolicyHolder|PolicyHolder	PolicyNumberr|PolicyNc	DOA|AcciedentDate	ClaimNumber|ClaimNo

PROVIDER'S NAME AND ADDRESS

S&M Pharmacy
68-50 Main Street
Flushing, NY 11367
11-2200797

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE COMPLETED FORM MUST BE SUBMITTED TO INSURER NO LATER THAN 180 DAYS AFTER TREATMENT DATE.**

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
   PatientNameAddress|PatientNameAddress

2. AGE	3. SEX	4. OCCUPATION (IF KNOWN)
AGE|DOB	SEX|Sex	OCCUPATION|Occupation

5. DIAGNOSIS AND CONCURRENT CONDITIONS
   5|Diagnosis

6. WHEN DID SYMPTOMS FIRST APPEAR?
   DATE: 6|FirstSymptomsDate

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: 7|FirstConsultDate

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?
   ☐ YES ☐ NO IF "YES", state when and describe: 8|SimilerConditionDesc

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?
   ☐ YES ☐ NO IF "NO", explain: 9|AutomobileAccidentDesc

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

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?
    ☐ YES ☐ NO ☐ NOT DETERMINABLE AT THIS TIME
    IF "YES", DESCRIBE:
    11|PermanentDisablityDesc

12. PATIENT WAS DISABLED (UNABLE TO WORK)
    FROM: 12DateFrom|EnabletoV THROUGH: 12DateTo|EnabletoWo

13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON: 13DateWorkOn|(DATE)

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?
    ☐ YES ☐ No IF "YES", DESCRIBE YOUR RECOMMENDATION BELOW: 14|ReqRehabDesc

NOTE: COMPLETE REVERSE SIDE AND SIGN.

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

15. REPORT OF SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
15DOS1|DateC	S&M Pharmacy 68-50 Main Street Flushing, NY 11367	15DOT1|TreatmentDesc	15FEE1	15Charges1|Charges
15DOS2|DateC		15DOT2|TreatmentDesc	15FEE2	15Charges2|Charges
15DOS3|DateC		15DOT3|TreatmentDesc	15FEE3	15Charges3|Charges
15DOS4|DateC		15DOT4|TreatmentDesc	15FEE4	15Charges4|Charges
			TOTAL CHARGES TO DATE $	15TotalCharges

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NUMBER	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)
16Name|TreatingProviderName	16Title|Title	16LicNo|LicenceForCeriNo	☐	☐	16Other|BusinessRelati

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

S&M Pharmacy Inc., License #12722

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO

19. ESTIMATED DURATION OF FUTURE TREATMENT

Uncertain

(OPTIONAL) 20.
I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

SIGNED _____
(PATIENT)

OR

(OPTIONAL) 21. ASSIGNMENT OF NO-FAULT BENEFITS:
I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW. THIS AGREEMENT SHALL BECOME NULL AND VOID IF AT ANY TIME IT IS DETERMINED THAT BENEFITS ARE NOT PAYABLE DUE TO THE FOLLOWING CIRCUMSTANCES: LACK OF COVERAGE, VIOLATION OF A POLICY CONDITION, OR DETERMINATION THAT THE TREATMENTS/SERVICES RENDERED ARE NOT RELATED TO SAID MOTOR VEHICLE ACCIDENT. ANY PAYMENT PURSUANT TO THIS ASSIGNMENT SHALL NOT EXCEED THE HEALTH CARE PROVIDER'S PERMISSABLE CHARGES UNDER SAID ARTICLE 51. THE PROVIDER OF HEALTH SERVICES CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE INJURED PARTY AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE INJURED PARTY FOR SERVICES PROVIDED DUE TO INJURIES SUSTAINED IN RELATION TO THE AUTOMOBILE ACCIDENT.

SIGNED _____
(PATIENT)

SIGNED _____
(PROVIDER OF HEALTH CARE SERVICE)

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY
		112200797	NPI 1841359627