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

PROGRESSIVE INSURANCE
PO BOX 2930
CLINTON, IA 52733-2930

NAME, ADDRESS & PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE

PROGRESSIVE INSURANCE
PO BOX 2930
CLINTON, IA 52733-2930

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
11/17/2022			05/06/2022	22-9438092

PROVIDER'S NAME AND ADDRESS

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

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
RITA MONAS, 19 AVENUE LOUISE, MASSAPEQUA PARK, NY 11762

2. AGE	3. SEX	4. OCCUPATION (IF KNOWN)
06/22/1958	Female	

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR?
DATE: 05/06/2022

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

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

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

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:

12. PATIENT WAS DISABLED (UNABLE TO WORK)
FROM: 11/14/2022 THROUGH: 11/14/2022

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

NOTE: COMPLETE REVERSE SIDE AND SIGN.

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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
11/14/2022	S&M Pharmacy 68-50 Main Street Flushing, NY 11367	DICLOFENAC SOL 1.5% #150 NDC#65162-0911-74		1000.17
			TOTAL CHARGES TO DATE $	1000.17

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)

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