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, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
GEICO INSURANCE COMPANY P.O. BOX 9507, FREDERICKSBURG, VA, 22403	

DATE	POLICYHOLDER	[illegible]	[illegible]	[illegible]
03/18/2024			18 Jan 2024	0577255160101026

PROVIDER'S NAME AND ADDRESS*
Roots Pharmacy INC C/O The Tadchiev Law Firm, P.C. 299 Jericho Turnpike, Floral Park, NY, 11001

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 BUT NO LATER THAN 45 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. 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 **NATALIE HAMILTON-DAVIS**
13-83 EGGERT PLACE, FAR ROCKAWAY, NY, 11691

2. DATE OF BIRTH	3. SEX	4. OCCUPATION (IF KNOWN)
21 Sep 1974	Female	

5. DIAGNOSIS AND CONCURRENT CONDITIONS
V49.9XXA Car occupant (driver) (passenger) injured in unspecified traffic accident, initial encounter,

6. WHEN DID SYMPTOMS FIRST APPEAR?
DATE: 18 Jan 2024

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)

CONTINUE ON PAGE 2