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
Progressive Casualty Ins. Co **725 BROADWAY** **ALBANY NY 12207**		

DATE	POLICYHOLDER	POLICY NUMBER	ACCIDENT DATE	CLAIM NUMBER
02/21/2024	**Miguel Collado**	**962654719**	**03/13/2023**	**235970170**

PROVIDER'S NAME AND ADDRESS
J SPORTS MEDICINE P.C.
444 Market St, Suite 5
Saddle Brook, NJ 07663-0400
Phone: **201-880-1400** Fax: **201-604-5451**

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 OR 180 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	PATIENT'S ADDRESS	
Miguel Collado	**4107 10th Street Long Island City, NY 11101**	
2. DATE OF BIRTH	3. SEX	4. OCCUPATION (IF KNOWN)
12/29/1973	**M**	

5. DIAGNOSIS AND CONCURRENT CONDITIONS

1. M54.12 - R/O CERVICAL RADICULOPATHY	**4**.
2. M54.9 - DORSALGIA, UNSPECIFIED	**5**.
3. M54.16 - R/O LUMBAR RADICULOPATHY	**6**.

6. WHEN DID SYMPTOMS FIRST APPEAR?	7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?
03/13/2023	**12/03/2023**

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 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)	13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:
From:_____ Through:_____	Date: