INVOICE NUMBER 0010448

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

(This form is not verification of hospital treatment)

NAME AND ADDRESS OF INSURER:
Liberty Mutual Fire Insurance Co.
P.O BOX 515097
LOS ANGELES, CA 90051

NAME OF INSURER'S CLAIM REPRESENTATIVE:

DATE	POLICY HOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
7/10/23		AS2-661-067369-013	6/ 1/2023	AB949507799

PROVIDER'S NAME AND ADDRESS:
Borukhov Radiology PLLC dba Highline Radiology
138-21 QUEENS BLVD
BRIARWOOD, NY 11435 Tel: 718-480-1250

KINDLY COMPLETE AND SUBMIT THIS FORM S SOON AS POSSIBLE. PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NOT 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 THE ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS: BOLIVAR URREGO DIANA 742 147TH ST, COLLEGE POINT, NY 11356		
2. DATE OF BIRTH 2/23/93	3. SEX MALE	4. OCCUPATION (if known)

5. DIAGNOSIS AND CONCURRENT CONDITIONS:
S83.429A-Knee Sprain/Strain
S43.50XA-Shoulder Sprain/Strain
S23.3XXA-Thoracic Sprain/Strain
S33.5XXA-Lumbar Sprain
M25.559-Hip Pain

6. WHEN DID SYMPTOMS FIRST APPEAR?
DATE: 6/ 1/2023

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?
DATE: 6/29/2023

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 INSIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?
YES [ ] NO [ ] **If 'YES', describe:** NOT DETERMINABLE AT THIS TIME [X]

12. PATIENT WAS DISABLE (Unable to work)
FROM: _____ THROUGH: _____

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

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