

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
DENIAL OF CLAIM FORM**

TO INSURER: Complete this form, including item 33. Send two copies to applicant. Upon the request of the injured person, the insurer should send to the injured person a copy of all prescribed claim forms and documents submitted by or on the behalf of the injured person.

NAME, ADDRESS AND NAIC NUMBER OF INSURER OR NAME AND ADDRESS OF SELF-INSURER PROGRESSIVE DIRECT INSURANCE CO NAIC# 16322 PO Box 2930 Clinton, IA 52733-2930		For American Arbitration Association use	
A. POLICYHOLDER BANKS, AALIYAL	B. POLICY NUMBER 969960423-0	C. DATE OF ACCIDENT 06/10/2023	D. INJURED PERSON AALIYAL S BANKS
E. CLAIM NUMBER 23-3448926	F. APPLICANT FOR BENEFITS (Name and address) HUDSON VALLEY CHIROPRACTIC HEALTH SERVICES 210 FINLEY AVE STATEN ISLAND, NY 10306		G. AS ASSIGNEE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

- ☒ 1. Your entire claim is denied as follows:
☐ 2. A portion of your claim is denied as follows:

- | | |
|---------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> A. Loss of Earnings \$ _____ | <input type="checkbox"/> D. Interest \$ _____ |
| <input type="checkbox"/> B. Health Service Benefits \$57.30 | <input type="checkbox"/> E. Attorney's Fee \$ _____ |
| <input type="checkbox"/> C. Other Necessary Expenses \$ _____ | <input type="checkbox"/> F. Death Benefit \$ _____ |

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

POLICY ISSUES

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> 3. Policy not in force on date of accident
<input checked="" type="checkbox"/> 4. Injured person excluded under policy conditions or exclusion
<input checked="" type="checkbox"/> 5. Policy conditions violated:
<input type="checkbox"/> a. No reasonable justification given for late notice of claim
<input type="checkbox"/> b. Reasonable justification not established -- You may qualify for special expedited arbitration --
See page 2 of this form for instructions. | <input type="checkbox"/> 6. Injured person not an "Eligible Injured Person"
<input type="checkbox"/> 7. Injuries did not arise out of use or operation of a motor vehicle
<input type="checkbox"/> 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

LOSS OF EARNINGS BENEFITS DENIED

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> 9. Period of disability contested: period in dispute
From _____ Through _____
<input type="checkbox"/> 10. Claimed loss not proven | <input type="checkbox"/> 11. Exaggerated earnings claim of \$ _____ per month denied
<input type="checkbox"/> 12. Statutory offset taken
<input type="checkbox"/> 13. Other, explained below |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

OTHER REASONABLE AND NECESSARY EXPENSES DENIED

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> 14. Amount of claim exceeds daily limit of coverage
<input type="checkbox"/> 15. Unreasonable or unnecessary expenses | <input type="checkbox"/> 16. Incurred after one year from the date of accident
<input type="checkbox"/> 17. Other, explained below |
|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|

HEALTH SERVICE BENEFITS DENIED

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> 18. Fees not in accordance with fee schedules
<input type="checkbox"/> 19. Excessive treatment, service or hospitalization
From _____ Through _____ | <input type="checkbox"/> 20. Treatment not related to accident
<input type="checkbox"/> 21. Unnecessary treatment, service or hospitalization
From _____ Through _____
<input checked="" type="checkbox"/> 22. Other, explained below SEE 33 BELOW |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

COMPLETE ITEMS 23 THROUGH 32 IF CLAIM FOR HEALTH SERVICE BENEFITS IS DENIED

23. Provider of Health Service (Name, Address and ZIP Code) HUDSON VALLEY CHIROPRACTIC HEALTH SERVICES 210 FINLEY AVE STATEN ISLAND, NY 10306	25. Period of bill – treatment dates 10/16/2023 – 10/16/2023	29. Date final verification received 10/20/2023
24. Type of service rendered No-Fault	26. Date of bill 10/30/2023	30. Amount of bill \$57.30
	27. Date bill received by insurer 11/06/2023	31. Amount paid by insurer \$0.00
	28. Date final verification requested 10/03/2023	32. Amount in dispute \$57.30

33. State reason for denial, fully and explicitly (attach extra sheets if needed): SEE ATTACHED

11/15/2023 DATE	HOLLY LEBLANC, Claims Department Name and Title of Representative of Insurer	1-800-627-4581 Telephone No. & Ext.
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Name and address of Insurer claim processor (Third Party Administrator), if applicable

Telephone No. & Ext.