

**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 )

STATEFARM INS  
P.O. BOX 106170 ATLANTA, GA 30348-6170

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
10/19/22	SARNI, SALVATORE - 14391		06/03/22	3235N580L

DYNAMIC MEDICAL IMAGING PC  
C/O R. FRIEDMAN LAW GP 400 GARDEN CITY PLZ, #500  
GARDEN CITY, NY 11530 516-714-5975

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 AND ADDRESS**

SALVATORE SARNI

98-76 QUEENS BLVD REGO PARK, NY 11374

<b>2. DATE OF BIRTH</b> 02/16/1966	<b>3. SEX</b> M	<b>4. OCCUPATION (IF KNOWN)</b>
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**5. DIAGNOSIS AND CONCURRENT CONDITIONS**

1) S40.012A 2) M24.812

**6. WHEN DID SYMPTOMS FIRST APPEAR?**  
DATE: 06/03/22

**7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?** DATE: 09/27/22

**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 ☐

IF "YES", describe:

NOT DETERMINABLE AT THIS TIME

☒

**12. PATIENT WAS DISABLED (UNABLE TO WORK)**

FROM: \_\_\_\_\_ THROUGH: \_\_\_\_\_

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

\_\_\_\_\_  
(DATE)

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