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 behalf of the injured person.

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NAME, ADDRESS AND NAIC NUMBER OF INSURER OR NAME AND ADDRESS OF SELF-INSURER	
GEICO P.O. BOX 9507 FREDERICKSBURG, VA 22403-9526 NAIC NUMBER: 22055	For American Arbitration Association use

A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT	D. INJURED PERSON
Farzana A Khan	6125658010	04/01/2023	Ariba Rafiq

E. CLAIM NUMBER	F. APPLICANT FOR BENEFITS (Name and address)	G. AS ASSIGNEE
8779369790000001	SINGH PT PLLC AHUJA, GURPREET 9413 120 STREET SUITE 1 Queens NY 11419	Yes [X] No [ ]

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:

[X] 2. A portion of your claim is denied as follows:

[ ] A.	Loss of Earnings	$	[ ] D.	Interest	$
[X] B.	Health Service Benefits	$ 1,304.48	[ ] E.	Attorney's Fee	$
[ ] C.	Other Necessary Expenses	$	[ ] F.	Death Benefit	$

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

POLICY ISSUES

[ ] 3. Policy not in force on date of accident

[ ] 4. Injured person excluded under policy conditions or exclusion

[X] 5. Policy conditions violated:
- [ ] a. No reasonable justification given for late notice of claim
- [ ] b. Reasonable justification not established -- **You may qualify for special expedited arbitration** -- See page 2 of this form for instructions.

[ ] 6. Injured person not an "Eligible Injured Person"

[ ] 7. Injuries did not arise out of use or operation of a motor vehicle

[ ] 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage

LOSS OF EARNINGS BENEFITS DENIED

[ ] 9. Period of disability contested: period in dispute
From _____ Through _____

[ ] 10. Claimed loss not proven

[ ] 11. Exaggerated earnings claim
of $ _____ per month denied

[ ] 12. Statutory offset taken

[ ] 13. Other, explained below

OTHER REASONABLE AND NECESSARY EXPENSES DENIED

[ ] 14. Amount of claim exceeds daily limit of coverage

[ ] 15. Unreasonable or unnecessary expenses

[ ] 16. Incurred after one year from date of accident

[ ] 17. Other, explained below

HEALTH SERVICE BENEFITS DENIED

[X] 18. Fees not in accordance with fee schedules

[ ] 19. Excessive treatment, service or hospitalization
From _____ Through _____

[ ] 20. Treatment not related to accident

[ ] 21. Unnecessary treatment, service or hospitalization
From _____ Through _____

[X] 22. Other, explained below

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

23. Provider of Health Service (Name, Address and Zip Code)	25. Period of bill-treatment dates	29. Date final verification received
SINGH PT PLLC 9413 120th St STE 1 Queens, NY 11419	04/08/2024-05/01/2024	
	26. Date of bill 05/02/2024	30. Amount of bill $1304.48
24. Type of service rendered MEDICAL	27. Date bill received by insurer 05/03/2024	31. Amount paid by insurer $0.00
	28. Date final verification requested	32. Amount in dispute $1304.48

33. State reason for denial, fully and explicitly (attach extra sheets if needed):
SEE ATTACHED EOB GK0268700

05/22/2024	Azeen Popal, NY PIP Examiner	516-714-0493
DATE	Name and Title of Representative of Insurer	Telephone No. & Ext.

Name and address of Insurer claim processor (Third Party Administrator), if applicable — Telephone No. & Ext.