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|--------------------------------|--|-----------------------------------|---|
| A. POLICYHOLDER                | B. POLICY NUMBER   | C. DATE OF ACCIDENT<br>05/28/2023 | D. INJURED PERSON<br>BOLIVAR, DIANA<br>742 127TH STREET<br>COLLEGE POINT, NY 11356          |
| E. CLAIM NUMBER<br>AB949507799 | F. APPLICANT FOR BENEFITS (Name and address)<br>BORUKHOV RADIOLOGY PLLC DBA HIGHLINE RADIO<br>13821 Queens Blvd<br>Briarwood, NY 11435 |                                   | G. AS ASSIGNEE<br>1. Yes <input checked="" type="checkbox"/> 2. No <input type="checkbox"/> |

## DENIAL OF CLAIM FORM - Box 33 REASON FOR DENIAL



- ♦ Reference Document Number: LU0527223
- ♦ The benefits for this patient/claim are exhausted.