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
Fatimah Asadullah	6103659782	04/17/2023	Edwin Ortiz

E. CLAIM NUMBER	F. APPLICANT FOR BENEFITS (Name and address)	G. AS ASSIGNEE
8759947910000006	SINGH PT PLLC AHUJA, GURPREET 9413 120th St SUITE 1 Apt 1 South Richmond Hill NY 11419-1376	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	$ 1,958.24	[ ] 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

[ ] 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 APT 1 SUITE 1 South Richmond Hill, NY 11419-1376	05/07/2024-06/13/2024 26. Date of bill 09/19/2024	 30. Amount of bill $1958.24
24. Type of service rendered MEDICAL	27. Date bill received by insurer 06/19/2024 28. Date final verification requested	31. Amount paid by insurer $0.00 32. Amount in dispute $1958.24

33. State reason for denial, fully and explicitly (attach extra sheets if needed):
SEE ATTACHED EOB GK0513328

07/15/2024	Sonia Santiago, NY PIP Examiner	516-714-7909
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.

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DENIAL OF CLAIM FORM - PAGE TWO

IF YOU WISH TO CONTEST THIS DENIAL, YOU HAVE THE FOLLOWING OPTIONS:

1. Should you wish to take this matter up with the New York State Department of Financial Services, you may file with the Department either on its website at http://www.dfs.ny.gov/consumer/fileacomplaint.htm or you may write to the Consumer Assistance Unit, New York State Department of Financial Services, at: One State Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 1399 Franklin Ave, Garden City, NY 11530; or 535 Washington Street, Suite 305, Buffalo, NY 14203.

   Although the Department of Financial Services will attempt to resolve disputed claims, it cannot order or require an insurer to pay a disputed claim. If you wish to file a written complaint, send one copy of this Denial of Claim Form with copies of other pertinent documents with a letter fully explaining your complaint to the Department of Financial Services at one of the above addresses.

   If you choose this option, you may at a later date still submit this dispute to arbitration or bring a lawsuit; or

2. **You may submit this dispute to arbitration.** If you wish to submit this claim to arbitration, then mail or e-mail a copy of this Denial of Claim Form along with a complete submission of all other pertinent documents and a table of contents listing your submissions, in duplicate together with a $40 filing fee, payable by check, money order, or credit card to the American Arbitration Association (AAA) to:

   AMERICAN ARBITRATION ASSOCIATION (AAA)
   NEW YORK INSURANCE CASE MANAGEMENT CENTER
   120 BROADWAY
   NEW YORK, NEW YORK 10271
   nyicmc.filingsubmissions@adr.org

Please contact the American Arbitration Association's customer service department at (917) 438-1660 with any questions about case filing.

A complete copy of this filing, listing all bills and proofs as well as a table of contents listing your submissions must be provided to the AAA and the insurer at the time of filing for arbitration. The filing must be complete with all necessary documentation, as any late submission may not be admissible at arbitration. The filing fee will be returned to you if the arbitrator awards you any portion of your claim. However, you may be assessed the costs of the arbitration proceeding if the arbitrator finds your claim to be frivolous, without factual or legal merit or was filed for the purpose of harassing the respondent. The decision of an arbitrator is binding, except for limited grounds for review set forth in the Law and regulations promulgated thereunder.

If you are contesting the denial of claim and wish to submit the dispute to arbitration, state on accompanying sheets the reason(s) you believe the denied or overdue benefits should be paid. Attach proof of disability and verification of loss of earnings in dispute, sign below, and send the completed form to the American Arbitration Association at the address given in item 2 above.

Loss of earnings: Date claim made: _____ Gross earnings per month $ _____

Period of dispute: From _____ Through _____ Amount claimed: $ _____

Health Services: (Attach bills in dispute and list each one separately)

Name of Provider(s)	Date of Service	Amount of Bill	Amount in Dispute	Date Claim Mailed

Other Necessary Expenses: (Attach bills in dispute and list each one separately)

Type of Expenses Claimed	Amount Claimed	Date Incurred	Date Claim Mailed	Amount in Dispute

Other: (attach additional sheet if necessary)

- Upon your request, if you file for arbitration within 90 days of the date of this denial or the claim becoming overdue, your case will be scheduled for arbitration on a priority basis.

- You qualify for **special expedited arbitration** if the insurer has determined that your written justification for submitting late notice of claim failed to meet a "reasonableness standard". Your specific request for special expedited arbitration must be filed within 30 days of the date of denial. Your filing must be complete and contain all information that you are submitting at the time of filing.

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3. **You may bring a lawsuit to recover the amount of benefits you claim to be entitled to.**

THE UNDERSIGNED AFFIRMS AND CERTIFIES AS TRUE UNDER THE PENALTY OF PERJURY THAT THIS FILING IS BEING MADE IN GOOD FAITH AND THAT UPON INFORMATION, BELIEF AND REASONABLE INQUIRY THE DOCUMENTS BEING SUBMITTED HEREWITH ARE NOT FRAUDULENT AND THAT EXACT COPIES OF ALL DOCUMENTS PROVIDED HEREWITH HAVE BEEN MAILED TO THE INSURER AGAINST WHOM THE ARBITRATION IS BEING REQUESTED. UNLESS DISCLOSED WITH THIS SUBMISSION, THE DISPUTED AMOUNTS REMAIN UNPAID TO THE APPLICANT BY ANY PAYOR AND THERE HAS BEEN NO OTHER FILING OF AN ARBITRATION REQUEST OR LAWSUIT TO RESOLVE THE DISPUTED MATTERS CONTAINED IN THIS SUBMISSION.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

<table>
<tr><td>ARBITRATION REQUESTED BY:

LAST NAME FIRST NAME</td><td colspan="2">NAME OF LAW FIRM, IF ANY</td></tr>
<tr><td>TELEPHONE NUMBER:</td><td colspan="2" rowspan="3">ADDRESS</td></tr>
<tr><td>FAX NUMBER:</td></tr>
<tr><td>E-MAIL ADDRESS:</td></tr>
<tr><td>SIGNATURE</td><td>ARE YOU AN ATTORNEY?
YES ☐
NO ☐</td><td>DATE</td></tr>
</table>

IMPORTANT NOTICE TO APPLICANT

If box number 3 ("Policy not in force on date of accident") on the front of this form is checked as a reason for this denial, you may be entitled to No-Fault benefits from the Motor Vehicle Accident Indemnification Corporation (M.V.A.I.C.) (646-205-7800) located at 100 William Street, New York, New York 10038. The Insurance Law requires that you must file an Affidavit of Intention to Make Claim with M.V.A.I.C. Therefore, it is in your best interest to contact the M.V.A.I.C. immediately and file such an affidavit, even if you intend to contest this denial.

GEICO
geico.com

EOR #: GK0513328

EXPLANATION OF REVIEW

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New York

Receive Date : 06/19/2024

Service Provider : **SINGH PT PLLC AHUJA, GURPREET**

9413 120th St SUITE 1 Apt 1

South Richmond Hill, NY 11419-1376

Case Number :

Billing Provider : **SINGH PT PLLC**

82-3149702 9413 120th St SUITE 1 APT 1

South Richmond Hill, NY 11419-1376

Dates Of Service : 05/07/2024 - 06/13/2024

Claim Number : 8759947910000006

Date Of Loss : 04/17/2023

Patient : **ORTIZ, EDWIN**

200 THROOP AVE APT 10A

Brooklyn, NY 11206-5728

Patient Account # :

Adjuster Name : Sonia Santiago

Carrier : **GEICO**

PO Box 9507

Fredericksburg, VA 22403

Diagnostic Codes	Description
M54.2	Cervicalgia

LINE	DOS	PROC CODE	MOD	DESCRIPTION	UNITS	CHARGE	REDUCTION	*PEN REDUCTION	PROVIDER REIMBURSE	EXPLANATION
1	05/07/24	97112		Neuromuscular reeducation	1.0	$37.15	$37.15	$0.00	$0.00	DF06
2	05/07/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
3	05/07/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
4	05/07/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
5	05/16/24	97112		Neuromuscular reeducation	1.0	$37.15	$37.15	$0.00	$0.00	DF06
6	05/16/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
7	05/16/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
8	05/16/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
9	05/29/24	97112		Neuromuscular reeducation	1.0	$37.15	$37.15	$0.00	$0.00	DF06
10	05/29/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
11	05/29/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
12	05/29/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
13	06/10/24	97112		Neuromuscular reeducation	1.0	$37.15	$37.15	$0.00	$0.00	DF06
14	06/10/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06

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For questions regarding payment and this EOR, please call your GEICO adjuster Sonia Santiago at 516-714-7909 x7909.

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Claim Number : 8759947910000006 **Total Charges** : $1,958.24 **EOR #** GK0513328

Billing Provider : SINGH PT PLLC

Service Provider : SINGH PT PLLC AHUJA, GURPREET

Patient Name : ORTIZ, EDWIN **Dates of Service** : 05/07/2024 - 06/13/2024

LINE	DOS	PROC CODE	MOD	DESCRIPTION	UNITS	CHARGE	REDUCTION	*PEN REDUCTION	PROVIDER REIMBURSE	EXPLANATION
15	06/10/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
16	06/10/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
17	05/08/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
18	05/08/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
19	05/08/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
20	05/08/24	97110		Therapeutic exercises	1.0	$37.91	$37.91	$0.00	$0.00	DF06
21	05/10/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
22	05/10/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
23	05/10/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
24	05/10/24	97110		Therapeutic exercises	1.0	$37.91	$37.91	$0.00	$0.00	DF06
25	05/13/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
26	05/13/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
27	05/13/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
28	05/13/24	97110		Therapeutic exercises	1.0	$37.91	$37.91	$0.00	$0.00	DF06
29	05/15/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
30	05/15/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
31	05/15/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
32	05/15/24	97110		Therapeutic exercises	1.0	$37.91	$37.91	$0.00	$0.00	DF06
33	05/21/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
34	05/21/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
35	05/21/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
36	05/21/24	97110		Therapeutic exercises	1.0	$37.91	$37.91	$0.00	$0.00	DF06
37	05/22/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
38	05/22/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
39	05/22/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
40	05/22/24	97110		Therapeutic exercises	1.0	$37.91	$37.91	$0.00	$0.00	DF06

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Claim Number : 8759947910000006	**Total Charges** : $1,958.24	**EOR #** GK0513328	
Billing Provider : SINGH PT PLLC			
Service Provider : SINGH PT PLLC AHUJA, GURPREET			
Patient Name : ORTIZ, EDWIN	**Dates of Service** : 05/07/2024 - 06/13/2024		

LINE	DOS	PROC CODE	MOD	DESCRIPTION	UNITS	CHARGE	REDUCTION	*PEN REDUCTION	PROVIDER REIMBURSE	EXPLANATION
41	05/24/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
42	05/24/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
43	05/24/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
44	05/24/24	97110		Therapeutic exercises	1.0	$37.91	$37.91	$0.00	$0.00	DF06
45	05/30/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
46	05/30/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
47	05/30/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
48	05/30/24	97110		Therapeutic exercises	1.0	$37.91	$37.91	$0.00	$0.00	DF06
49	05/31/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
50	05/31/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
51	05/31/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
52	05/31/24	97110		Therapeutic exercises	1.0	$37.91	$37.91	$0.00	$0.00	DF06
53	06/03/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
54	06/03/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
55	06/03/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
56	06/03/24	97110		Therapeutic exercises	1.0	$37.91	$37.91	$0.00	$0.00	DF06
57	06/04/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
58	06/04/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
59	06/04/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
60	06/04/24	97110		Therapeutic exercises	1.0	$37.91	$37.91	$0.00	$0.00	DF06
61	06/06/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
62	06/06/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
63	06/06/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
64	06/06/24	97110		Therapeutic exercises	1.0	$37.91	$37.91	$0.00	$0.00	DF06
65	06/11/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
66	06/11/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06

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Claim Number : 8759947910000006	**Total Charges** : $1,958.24	**EOR #** GK0513328	
Billing Provider : SINGH PT PLLC			
Service Provider : SINGH PT PLLC AHUJA, GURPREET			
Patient Name : ORTIZ, EDWIN	**Dates of Service** : 05/07/2024 - 06/13/2024		

LINE	DOS	PROC CODE	MOD	DESCRIPTION	UNITS	CHARGE	REDUCTION	*PEN REDUCTION	PROVIDER REIMBURSE	EXPLANATION
67	06/11/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
68	06/11/24	97110		Therapeutic exercises	1.0	$37.91	$37.91	$0.00	$0.00	DF06
69	06/13/24	97140		Manual therapy 1/> regions	1.0	$40.40	$40.40	$0.00	$0.00	DF06
70	06/13/24	97010		Hot or cold packs therapy	1.0	$5.25	$5.25	$0.00	$0.00	DF06
71	06/13/24	97014		Electric stimulation therapy	1.0	$25.40	$25.40	$0.00	$0.00	DF06
72	06/13/24	97110		Therapeutic exercises	1.0	$37.91	$37.91	$0.00	$0.00	DF06
Total Lines :	72					$1,958.24	$1,958.24	$0.00	$0.00	

Reimbursement Amount	:	$	**0.00**
Previous Reimbursement Amount	:	$	**0.00**
Difference in Reimbursement Amount	:	$	**0.00**
Apportionment Amount	:	$	**0.00**
Less Deductible	:	$	**0.00**
Limited Benefits/Copay	:	$	**0.00**
EOR Check Amount	:	$	**0.00**

EXPLANATION	EXPLANATION FOR THE REVIEW AMOUNT	REF LINE NUMBER
NY_FSL	Provider's fee exceeds the maximum allowance under the applicable fee schedule and is reduced accordingly. As per section 5108 of the New York State Insurance Law, Providers shall not exceed the charges permissible under the schedules prepared and established by the chairman of the Worker's Compensation Board.	1, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 2, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 3, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 4, 40, 41,

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Claim Number	: 8759947910000006	**Total Charges**	: $1,958.24	**EOR #**	GK0513328
Billing Provider	: SINGH PT PLLC				
Service Provider	: SINGH PT PLLC AHUJA, GURPREET				
Patient Name	: ORTIZ, EDWIN	**Dates of Service**	: 05/07/2024 - 06/13/2024		

EXPLANATION	EXPLANATION FOR THE REVIEW AMOUNT	REF LINE NUMBER
		42, 43, 44, 45, 46, 47, 48, 49, 5, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 6, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 7, 70, 71, 72, 8, 9
DF06	Based on the results of a health service examination by Dr(s). HOWARD A KIERNAN on 06/20/2023 , it has been determined that no further Orthopedic Surgery, Massage Therapy, Diagnostic Testing, Supplies, and Physical Therapy treatment is necessary for the injuries suffered by Edwin Ortiz related to the accident. Accordingly, all Orthopedic Surgery, Massage Therapy, Diagnostic Testing, Supplies, and Physical Therapy benefits will be denied effective 12:01 a.m. on 07/02/2023. A copy of the health service examination report will be provided upon written request. Additionally Edwin Ortiz was found to be no longer disabled from accident related injuries. Therefore, all lost wage benefits and/or household help benefits will also terminate on 07/02/2023.	1, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 2, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 3, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 4, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 5, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 6, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 7, 70, 71, 72, 8, 9

Comments:

Track your medical claims submitted to GEICO by enrolling in our online Medical Provider Claim Tracking website at: https://partners.geico.com/mpctweb.

Medical Providers: Submit your medical claims and documentation to GEICO electronically. Contact our clearinghouse at: www.cariskic.com or call 888-207-6366.

For questions regarding payment and this EOR, please call your GEICO adjuster Sonia Santiago at 516-714-7909 x7909.

INVOICE NUMBER 0032675

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:
GEICO General Insurance Co.
GEICO NY PIP
PO Box 9507 Fredericksburg, VA 22403-9526

NAME OF INSURER'S CLAIM REPRESENTATIVE:

DATE	POLICY HOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
06/19/2024			04/17/2023	8759947910000006

PROVIDER'S NAME AND ADDRESS:
SINGH PT PLLC
9413 120 STREET SUITE 1
QUEENS, NY 11419 Tel: 718-530-8881

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 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: ORTIZ EDWIN 200 THROOP AVE, Brooklyn, NY 11206		
2. DATE OF BIRTH 09/04/1996	3. SEX MALE	4. OCCUPATION (if known)

5. DIAGNOSIS AND CONCURRENT CONDITIONS:
M54.5-Low Back Pain
M54.2-Neck Pain
M25.569-Knee Pain
M25.669-Stiffness of Knee Joint

6. WHEN DID SYMPTOMS FIRST APPEAR? DATE: 04/17/2023

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE:

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: _____

Continue on next page

PATIENT'S NAME : ORTIZ EDWIN INVOICE NUMBER 0032675

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

X YES ____ NO If 'YES', describe your recommendation below: Physical therapy

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICES RENDERED	FEE SCHEDULE TREATMENT CODES	CHARGE FOR EACH PROCEDURE	TOTAL CHARGE PER DAY
05/07/2024	9413 120 STREET SUITE 1 QUEENS, NY	Neuromuscular Reeducation	97112	$37.15	
	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	**$108.20**
05/08/2024	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Therapeutic exercises	97110	$37.91	**$108.96**
05/10/2024	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Therapeutic exercises	97110	$37.91	**$108.96**
05/13/2024	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Therapeutic exercises	97110	$37.91	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	**$108.96**
05/15/2024	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Therapeutic exercises	97110	$37.91	**$108.96**

PATIENT'S NAME : ORTIZ EDWIN INVOICE NUMBER 0032675

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICES RENDERED	FEE SCHEDULE TREATMENT CODES	CHARGE FOR EACH PROCEDURE	TOTAL CHARGE PER DAY
05/16/2024	9413 120 STREET SUITE 1 QUEENS, NY	Neuromuscular Reeducation	97112	$37.15	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	**$108.20**
05/21/2024	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Therapeutic exercises	97110	$37.91	**$108.96**
05/22/2024	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Therapeutic exercises	97110	$37.91	**$108.96**
05/24/2024	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Therapeutic exercises	97110	$37.91	**$108.96**
05/29/2024	9413 120 STREET SUITE 1 QUEENS, NY	Neuromuscular Reeducation	97112	$37.15	
	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	**$108.20**

PATIENT'S NAME : ORTIZ EDWIN INVOICE NUMBER 0032675

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICES RENDERED	FEE SCHEDULE TREATMENT CODES	CHARGE FOR EACH PROCEDURE	TOTAL CHARGE PER DAY
05/30/2024	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Therapeutic exercises	97110	$37.91	**$108.96**
05/31/2024	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Therapeutic exercises	97110	$37.91	**$108.96**
06/03/2024	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Therapeutic exercises	97110	$37.91	**$108.96**
06/04/2024	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Therapeutic exercises	97110	$37.91	**$108.96**
06/06/2024	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Therapeutic exercises	97110	$37.91	**$108.96**

PATIENT'S NAME : ORTIZ EDWIN INVOICE NUMBER 0032675

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICES RENDERED	FEE SCHEDULE TREATMENT CODES	CHARGE FOR EACH PROCEDURE	TOTAL CHARGE PER DAY
06/10/2024	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Neuromuscular Reeducation	97112	$37.15	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	**$108.20**
06/11/2024	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Therapeutic exercises	97110	$37.91	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	**$108.96**
06/13/2024	9413 120 STREET SUITE 1 QUEENS, NY	Myoficial Release	97140	$40.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Hot pack	97010	$5.25	
	9413 120 STREET SUITE 1 QUEENS, NY	Electrical stimulation	97014	$25.40	
	9413 120 STREET SUITE 1 QUEENS, NY	Therapeutic exercises	97110	$37.91	**$108.96**
				TOTAL CHARGES TO DATE :	**$1,958.24**

PATIENT'S NAME : ORTIZ EDWIN INVOICE NUMBER 0032675

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

Treating Provider's Name	Title	License or Certificate No.	Business Relation (check applicable box)		
			Employee	Independent Contractor	Other (specify)
GURPREET SINGH AHUJA	Physical Therap	041534			Owner

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).
GURPREET SINGH AHUJA Physical Therapist 041534

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION ? YES [X] NO [ ]

19. ESTIMATE DURATION OF FUTURE TREATMENT : Not determined at this time

PATIENT: Your health provider may agree to accept for health services performed directly from your insurer **(Authorization to Pay Benefits)** so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and healyh provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. _____ (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)

I authorize payment of health benefits to the undersigned health care provider or supplier of services described below. I retain all rights, privileges and remedies to which I am entitled under Article 51 (The No-Fault provision) of the insurance law.

PRINT NAME _____ (Patient) SIGNED _____ (Patient) Date

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider **(Assignment of Benefits).** If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in #21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21.___X____ (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

I hereby assign to the health care provider indicated below all right, privileges and remedies to payment for health care services provided by the assignee to which I am entitled under article 51 (the No-Fault statute) of the insurance law. The assignee hereby certifies that they have not received any payment from or on behalf of the assignor and shall not pursue payment directly from the assignor for services provided by said assignee for injuries sustained due to the motor vehicle accident, notwithstanding any other agreement to the contrary. This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

PRINT NAME ORTIZ EDWIN (Patient (Assignor)) SIGNED Signature on File (Patient) Date

PRINT NAME SINGH PT PLLC (Provider of Health Care Service (Assignee)) SIGNED Signature on File (Provider of Health Care Service) Date

Has an original authorization or assignment previously been executed? [X] Yes [ ] No

Is the original signature of the parties on file? [X] Yes [ ] No

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH A[PPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLE OR AN INSURANCE COMPANY COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME. AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

DATE	PROVIDER SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY
06/19/2024	GURPREET SINGH AHUJA	TIN: **82-3149702** Lic# 041534	Physical Therapist