

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.

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 Fatimah Asadullah	B. POLICY NUMBER 6103659782	C. DATE OF ACCIDENT 04/17/2023	D. INJURED PERSON Edwin Ortiz
E. CLAIM NUMBER 8759947910000006	F. APPLICANT FOR BENEFITS (Name and address) SINGH PT PLLC AHUJA, GURPREET 9413 120th St SUITE 1 Apt 1 South Richmond Hill NY 11419-1376		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 checked="" type="checkbox"/> B. Health Service Benefits | \$ 1,958.24 | <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 type="checkbox"/> 3. Policy not in force on date of accident | <input type="checkbox"/> 6. Injured person not an "Eligible Injured Person" |
| <input type="checkbox"/> 4. Injured person excluded under policy conditions or exclusion | <input type="checkbox"/> 7. Injuries did not arise out of use or operation of a motor vehicle |
| <input 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"/> 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"/> 11. Exaggerated earnings claim
of \$ _____ per month denied |
| <input type="checkbox"/> 10. Claimed loss not proven | <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"/> 16. Incurred after one year from date of accident |
| <input type="checkbox"/> 15. Unreasonable or unnecessary expenses | <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"/> 20. Treatment not related to accident |
| <input type="checkbox"/> 19. Excessive treatment, service or hospitalization
From _____ Through _____ | <input type="checkbox"/> 21. Unnecessary treatment, service or hospitalization
From _____ Through _____ |
| | <input checked="" type="checkbox"/> 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) SINGH PT PLLC 9413 120th St APT 1 SUITE 1 South Richmond Hill, NY 11419-1376	25. Period of bill-treatment dates 05/07/2024-06/13/2024	29. Date final verification received
24. Type of service rendered MEDICAL	26. Date of bill 09/19/2024	30. Amount of bill \$1958.24
	27. Date bill received by insurer 06/19/2024	31. Amount paid by insurer \$0.00
	28. Date final verification requested	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
DATE

Sonia Santiago, NY PIP Examiner
Name and Title of Representative of Insurer

516-714-7909
Telephone No. & Ext.

Name and address of Insurer claim processor (Third Party Administrator), if applicable

Telephone No. & Ext.