

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 06/19/2024	POLICY HOLDER	POLICY NUMBER	DATE OF ACCIDENT 04/17/2023	CLAIM NUMBER 8759947910000006
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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 <input type="checkbox"/> NO <input checked="" type="checkbox"/> If 'YES', state when and describe:			
9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> If 'NO', explain:			
10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
11. WILL INJURY RESULT INSIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY? YES <input type="checkbox"/> NO <input type="checkbox"/> If 'YES', describe: NOT DETERMINABLE AT THIS TIME <input checked="" type="checkbox"/>			
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