INVOICE NUMBER 0031242

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
GEICO GENERAL INSURANCE CO
PO BOX 9507
FREDERICKSBRG VA 22403-9526

NAME OF INSURER'S CLAIM REPRESENTATIVE:

DATE	POLICY HOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
05/02/2024	KHAN, FARZANA	6125658010	04/01/2023	8779369790000001

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: RAFIQ ARIBA
94-19 110TH ST, Queens, NY 11419

2. DATE OF BIRTH	3. SEX	4. OCCUPATION (if known)
10/06/2009	FEMALE	

5. DIAGNOSIS AND CONCURRENT CONDITIONS:
M54.5-Low Back Pain
M54.2-Neck Pain
S13.4XXA-Cervical Sprain/Strain
S33.5XXA-Lumbar Sprain/Strain

6. WHEN DID SYMPTOMS FIRST APPEAR?
DATE: 04/01/2023

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?
DATE: 04/04/2023

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: _____

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