

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW**  
**VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE**  
 (This form is not for verification of hospital treatment)

NAME AND ADDRESS OF INSURER OR SELF-INSURER <b>Erie Ins. Co. of New York</b> <b>PO BOX 22840</b> <b>ROCHESTER NY 14692-2840</b>	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE
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DATE <b>03/07/2024</b>	POLICYHOLDER <b>Devante Davis</b>	POLICY NUMBER	ACCIDENT DATE <b>08/23/2023</b>	CLAIM NUMBER <b>A0000525037</b>
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PROVIDER'S NAME AND ADDRESS <b>J SPORTS MEDICINE P.C.</b> <b>444 Market St, Suite 5</b> <b>Saddle Brook, NJ 07663-0400</b> Phone: <b>201-880-1400</b> Fax: <b>201-604-5451</b>
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KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 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 THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME <b>Devante Davis</b>	PATIENT'S ADDRESS <b>1169 Bedford AVE BROOKLYN, NY 11216</b>		
2. DATE OF BIRTH <b>01/09/1997</b>	3. SEX <b>M</b>	4. OCCUPATION (IF KNOWN)	
5. DIAGNOSIS AND CONCURRENT CONDITIONS			
1. M54.12 - R/O CERVICAL RADICULOPATHY 2. M50.20 - OTHER CERVICAL DISC DISPLACEMENT, UNSPECIFIED CERVICAL REGION 3. M50.90 - Cervical disc disorder		4. M54.9 - DORSALGIA, UNSPECIFIED 5. M54.16 - R/O LUMBAR RADICULOPATHY 6. M51.26 - OTHER INTERVERTEBRAL DISC DISPLACEMENT, LUMBAR REGION	
6. WHEN DID SYMPTOMS FIRST APPEAR? <b>08/23/2023</b>		7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? <b>12/06/2023</b>	
8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? Yes                      No                      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 IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY? Yes                      No                      NOT DETERMINABLE AT THIS TIME X IF Yes, describe:			
12. PATIENT WAS DISABLED (UNABLE TO WORK) From: _____ Through: _____		13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON: Date: _____	