

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 Erie Ins. Co. of New York PO BOX 22840 ROCHESTER NY 14692-2840	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE
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DATE 01/02/2024	POLICYHOLDER Devante Davis	POLICY NUMBER	ACCIDENT DATE 08/23/2023	CLAIM NUMBER A0000525037
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PROVIDER'S NAME AND ADDRESS J SPORTS MEDICINE P.C. 444 Market St, Suite 5 Saddle Brook, NJ 07663-0400 Phone: 201-880-1400 Fax: 201-604-5451
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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 Devante Davis	PATIENT'S ADDRESS 1169 Bedford AVE BROOKLYN, NY 11216		
2. DATE OF BIRTH 01/09/1997	3. SEX M	4. OCCUPATION (IF KNOWN)	
5. DIAGNOSIS AND CONCURRENT CONDITIONS			
1. M54.12 - R/O CERVICAL RADICULOPATHY		4.	
2. M54.9 - DORSALGIA, UNSPECIFIED		5.	
3. M54.16 - R/O LUMBAR RADICULOPATHY		6.	
6. WHEN DID SYMPTOMS FIRST APPEAR? 08/23/2023		7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? 12/06/2023	
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: _____	