# 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.

*20000175994791000000 6C00001*

| NAME, ADDRESS AND NAIC NUMBER OF INSURER OR NAME AND ADDRESS OF SELF-INSURER | |
|---|---|
| GEICO<br>P.O. BOX 9507<br><br>FREDERICKSBURG, VA 22403-9526 NAIC NUMBER: 22055 | For American Arbitration Association use |

| A. POLICYHOLDER | B. POLICY NUMBER | C. DATE OF ACCIDENT | D. INJURED PERSON |
|---|---|---|---|
| Fatimah Asadullah | 6103659782 | 04/17/2023 | Edwin Ortiz |

| E. CLAIM NUMBER | F. APPLICANT FOR BENEFITS (Name and address) | G. AS ASSIGNEE |
|---|---|---|
| 8759947910000006 | SINGH PT PLLC AHUJA, GURPREET<br>9413 120th St SUITE 1 Apt 1<br>South Richmond Hill NY 11419-1376 | Yes [X]<br>No [ ] |

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:

[X] 2. A portion of your claim is denied as follows:

| | | | | | |
|---|---|---|---|---|---|
| [ ] A. | Loss of Earnings | $ | [ ] D. | Interest | $ |
| [X] B. | Health Service Benefits | $ 1,958.24 | [ ] E. | Attorney's Fee | $ |
| [ ] C. | Other Necessary Expenses | $ | [ ] F. | Death Benefit | $ |

REASON(S) FOR DENIAL OF CLAIM (Check reasons and explain below in item 33)

**POLICY ISSUES**

[ ] 3. Policy not in force on date of accident

[ ] 4. Injured person excluded under policy conditions or exclusion

[ ] 5. Policy conditions violated:
- [ ] a. No reasonable justification given for late notice of claim
- [ ] b. Reasonable justification not established -- **You may qualify for special expedited arbitration** -- See page 2 of this form for instructions.

[ ] 6. Injured person not an "Eligible Injured Person"

[ ] 7. Injuries did not arise out of use or operation of a motor vehicle

[ ] 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage

**LOSS OF EARNINGS BENEFITS DENIED**

[ ] 9. Period of disability contested: period in dispute
From _____ Through _____

[ ] 10. Claimed loss not proven

[ ] 11. Exaggerated earnings claim
of $ _____ per month denied

[ ] 12. Statutory offset taken

[ ] 13. Other, explained below

**OTHER REASONABLE AND NECESSARY EXPENSES DENIED**

[ ] 14. Amount of claim exceeds daily limit of coverage

[ ] 15. Unreasonable or unnecessary expenses

[ ] 16. Incurred after one year from date of accident

[ ] 17. Other, explained below

**HEALTH SERVICE BENEFITS DENIED**

[X] 18. Fees not in accordance with fee schedules

[ ] 19. Excessive treatment, service or hospitalization
From _____ Through _____

[ ] 20. Treatment not related to accident

[ ] 21. Unnecessary treatment, service or hospitalization
From _____ Through _____

[X] 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) | 25. Period of bill-treatment dates | 29. Date final verification received |
|---|---|---|
| SINGH PT PLLC<br><br>9413 120th St APT 1 SUITE 1<br>South Richmond Hill, NY 11419-1376 | 05/07/2024-06/13/2024<br>26. Date of bill<br>09/19/2024 | <br>30. Amount of bill<br>$1958.24 |
| 24. Type of service rendered<br>MEDICAL | 27. Date bill received by insurer<br>06/19/2024<br>28. Date final verification requested | 31. Amount paid by insurer<br>$0.00<br>32. Amount in dispute<br>$1958.24 |

33. State reason for denial, fully and explicitly (attach extra sheets if needed):
**SEE ATTACHED EOB GK0513328**

| 07/15/2024 | Sonia Santiago, NY PIP Examiner | 516-714-7909 |
|---|---|---|
| DATE | Name and Title of Representative of Insurer | Telephone No. & Ext. |

Name and address of Insurer claim processor (Third Party Administrator), if applicable — Telephone No. & Ext.