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 the behalf of the injured person.

Name, address and NAIC number of insurer or name and address of self-insurer	For American Arbitration Association Use
STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, NAIC 25178 PIPMPC B2 Office - BSPA/PHX PO Box 106170 Atlanta, GA 30348-6170	

A. Policyholder	B. Policy Number	C. Date of Accident	D. Injured Person
MANTILLA, DORA Y	3213-907-32	05-02-2023	Dora Y Mantilla

E. Claim Number	F. Applicant for Benefits (Name and Address)	G. As Assignee
32-49F0-02R	Phoenix Medical Services Pc PO BOX 9415 NEW YORK, NY 10087-4415	(•) Yes ( ) No

TO APPLICANT: SEE REVERSE SIDE IF YOU WISH TO CONTEST THIS DENIAL.

YOU ARE ADVISED THAT FOR REASONS NOTED BELOW:

- [x] 1. Your entire claim is denied as follows:
- [ ] 2. A portion of your claim is denied as follows:
  - [ ] a. Loss of Earnings $
  - [x] b. Health Service Benefits $ 687.85
  - [ ] c. Other Necessary Expenses $
  - [ ] d. Interest $
  - [ ] e. Attorney's Fee $
  - [ ] f. Death Benefit $

REASON(S) FOR DENIAL OF CLAIM (Check reason 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	28. Date final verification requested	31. Amount paid by insurer
Phoenix Medical Services Pc 1800A NEW YORK AVE HUNTINGTON STATION, NY 11746	03-13-2024 - 03-13-2024		$0.00
	26. Date of bill 03-13-2024	29. Date final verification received	
	27. Date bill received by insurer 04-09-2024	30. Amount of bill $687.85	32. Amount of dispute $687.85

24.Type of service rendered
20552,99070,99214,76942

33. State reason for denial, fully and explicitly (attach extra sheets if needed): See Attached Explanation of Review
060524RM07-1

CC:

Date:		Name and Title of Representative of Insurer
06-05-2024		Michele Morrison
Telephone No. (844) 292-8615	Ext. 5188845414	Claims Address of Insurer PO Box 106170 Atlanta, GA 30348-6170