INVOICE NUMBER 0032675

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 General Insurance Co.
GEICO NY PIP
PO Box 9507 Fredericksburg, VA 22403-9526

NAME OF INSURER'S CLAIM REPRESENTATIVE:

DATE	POLICY HOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
06/19/2024			04/17/2023	8759947910000006

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: ORTIZ EDWIN
200 THROOP AVE, Brooklyn, NY 11206

2. DATE OF BIRTH	3. SEX	4. OCCUPATION (if known)
09/04/1996	MALE	

5. DIAGNOSIS AND CONCURRENT CONDITIONS:
M54.5-Low Back Pain
M54.2-Neck Pain
M25.569-Knee Pain
M25.669-Stiffness of Knee Joint

6. WHEN DID SYMPTOMS FIRST APPEAR?
DATE: 04/17/2023

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

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: _____

Continue on next page