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.

| | | |
|---|---|---|
| NAME, ADDRESS AND NAIC NUMBER OF INSURER OR NAME AND ADDRESS OF SELF-INSURER | LIBERTY MUTUAL INSURANCE COMPANY - VIA<br>PO BOX 7214<br>LONDON, KY 40742 | For American Arbitration Association |

Doc ID: LU05

| A. POLICYHOLDER | B. POLICY NUMBER | C. DATE OF ACCIDENT | D. INJURED PERSON |
|---|---|---|---|
| | | 05/28/2023 | BOLIVAR, DIANA<br>742 127TH STREET<br>COLLEGE POINT, NY 11356 |
| **E. CLAIM NUMBER** | **F. APPLICANT FOR BENEFITS (Name and address)** | | **G. AS ASSIGNEE** |
| AB949507799 | BORUKHOV RADIOLOGY PLLC DBA HIGHLINE RADIO<br>13821 Queens Blvd<br>Briarwood, NY 11435 | | 1.Yes ☒ 2.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:

☒ 2. A portion of your claim is denied as follows:

| | | | |
|---|---|---|---|
| ☐ A. Loss of Earnings: | $ | ☐ D. Interest: | $ |
| ☒ B. Health Service Benefits: | $ 1933.08 | ☐ E. Attorney's Fees: | $ |
| ☐ 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

☒ 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 _____

☒ 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)<br>Borukhov, David<br>138-21 Queens BLVD<br>Briarwood, NY 11435 | 25. Period of bill-treatment dates<br>06/29/2023 - 06/29/2023 | 29. Date final verification received |
| | 26. Date of bill<br>07/10/2023 | 30. Amount of bill<br>$1933.08 |
| 24. Type of service rendered<br>Medical | 27. Date received by insurer<br>04/11/2024 | 31. Amount paid by insurer<br>$0.00 |
| | 28. Date final verification requested | 32. Amount in dispute<br>$1933.08 |

33. State reason for denial, fully and explicitly (attach extra sheets if needed): SEE ATTACHED EOR FOR EXPLANATION OF REDUCTION

**See the attached explanation of review for docid LU0527223**

04/13/2024 DICKEL, LORRAINE

DATE Name, and Title of Representative of Insurer Telephone No & Ext.

LIBERTY MUTUAL INSURANCE PO BOX 7214 LONDON, KY 40742

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