

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

Doc ID: LU05

A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT 05/28/2023	D. INJURED PERSON BOLIVAR, DIANA 742 127TH STREET COLLEGE POINT, NY 11356
E. CLAIM NUMBER AB949507799	F. APPLICANT FOR BENEFITS (Name and address) BORUKHOV RADIOLOGY PLLC DBA HIGHLINE RADIO 13821 Queens Blvd Briarwood, NY 11435		G. AS ASSIGNEE 1.Yes <input checked="" type="checkbox"/> 2.No <input type="checkbox"/>

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:

<input type="checkbox"/> A. Loss of Earnings:	\$	<input type="checkbox"/> D. Interest:	\$
<input checked="" type="checkbox"/> B. Health Service Benefits:	\$ 1933.08	<input type="checkbox"/> E. Attorney's Fees:	\$
<input type="checkbox"/> C. Other Necessary Expenses:	\$	<input type="checkbox"/> F. Death Benefit:	\$

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

<input type="checkbox"/> 3. Policy not in force on date of accident	POLICY ISSUES
<input type="checkbox"/> 4. Injured person excluded under policy conditions or exclusion	<input type="checkbox"/> 6. Injured person not an "Eligible Injured Person"
<input type="checkbox"/> 5. Policy conditions violated: <input type="checkbox"/> a. No reasonable justification given for late notice of claim. <input type="checkbox"/> b. Reasonable justification not established. <b>You may qualify for special expedited arbitration.</b> See page 2 of this form for instructions.	<input type="checkbox"/> 7. Injuries did not arise out of use or operation of a motor vehicle
	<input type="checkbox"/> 8. Claim not within the scope of your election under Optional Basic Economic Loss coverage
LOSS OF EARNINGS BENEFITS DENIED	
<input type="checkbox"/> 9. Period of disability contested: period in dispute From _____ Through _____	<input type="checkbox"/> 11. Exaggerated earnings claim of \$ _____ per month denied
<input type="checkbox"/> 10. Claimed loss not proven	<input type="checkbox"/> 12. Statutory offset taken
	<input type="checkbox"/> 13. Other, explained below:
OTHER REASONABLE AND NECESSARY EXPENSES DENIED	
<input type="checkbox"/> 14. Amount of claim exceeds daily limit of coverage	<input type="checkbox"/> 16. Incurred after one year from date of accident
<input type="checkbox"/> 15. Unreasonable or unnecessary expenses	<input type="checkbox"/> 17. Other, explained below
HEALTH SERVICE BENEFITS DENIED	
<input checked="" type="checkbox"/> 18. Fees not in accordance with fee schedules	<input type="checkbox"/> 20. Treatment not related to accident
<input type="checkbox"/> 19. Excessive treatment, service or hospitalization From _____ Through _____	<input type="checkbox"/> 21. Unnecessary treatment, service or hospitalization From _____ Through _____
	<input checked="" type="checkbox"/> 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) Borukhov, David 138-21 Queens BLVD Briarwood, NY 11435	25. Period of bill-treatment dates 06/29/2023 - 06/29/2023	29. Date final verification received
24. Type of service rendered Medical	26. Date of bill 07/10/2023	30. Amount of bill \$1933.08
	27. Date received by insurer 04/11/2024	31. Amount paid by insurer \$0.00
	28. Date final verification requested	32. Amount in dispute \$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

LIBERTY MUTUAL INSURANCE

PO BOX 7214

LONDON, KY 40742

Telephone No & Ext.

Name and address of Insurer claim processor (Third Party Administrator), if applicable

Telephone No & Ext.