

WILMER LEON ROJAS-179-TQ314

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
 (This form is not for verification of hospital treatment)

NAME AND ADDRESS OF INSURER OR SELF-INSURER* GEICO INSURANCE COMPANY P.O. BOX 9507, FREDERICKSBURG, VA, 22403		NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*		
DATE 03/18/2024	POLICYHOLDER	POLICY NUMBER 6129758493	DATE OF ACCIDENT 08 Dec 2023	CLAIM NUMBER 8783032820000002

PROVIDER'S NAME AND ADDRESS* Roots Pharmacy INC C/O The Tatchiev Law Firm, P.C. 299 Jericho Turnpike, Floral Park, NY, 11001

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO 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 THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS WILMER LEON ROJAS 91-11 116TH STREET, RICHMOND HILL, NY, 11418			
2. DATE OF BIRTH 06 Dec 1994	3. SEX Male	4. OCCUPATION (IF KNOWN)	
5. DIAGNOSIS AND CONCURRENT CONDITIONS V49.9XXA Car occupant (driver) (passenger) injured in unspecified traffic accident, initial encounter,			

6. WHEN DID SYMPTOMS FIRST APPEAR? DATE: 08 Dec 2023	7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: _____
8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> IF YES, state when and describe: _____	
9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> IF "NO", explain: _____	
10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY? YES <input type="checkbox"/> NO <input type="checkbox"/> NOT DETERMINABLE AT THIS TIME <input checked="" type="checkbox"/> IF "YES", describe: _____	
12. PATIENT WAS DISABLED (UNABLE TO WORK) FROM: _____ THROUGH: _____	13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON: _____ (DATE)

CONTINUE ON PAGE 2