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
GEICO
P.O. BOX 9507

FREDERICKSBURG, VA 22403-9526 NAIC NUMBER: 35882

For American Arbitration Association use

A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT	D. INJURED PERSON
Janice O[redacted]	444355[redacted]	10/29/2018	Janice O[redacted]

E. CLAIM NUMBER	F. APPLICANT FOR BENEFITS (Name and address)	G. AS ASSIGNEE
056592172[redacted]	DR GEORGE M RIZOS RIZOS, GEORGE 390 Merrick Ave East Meadow NY 11554-2701	Yes [X] 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:

[X] 2. A portion of your claim is denied as follows:

[ ]	A. Loss of Earnings	$	[ ]	D. Interest	$
[X]	B. Health Service Benefits	$ 137.84	[ ]	E. Attorney's Fee	$
[ ]	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

[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	29. Date final verification received
GEORGE M RIZOS DC 390 MERRICK AVE East Meadow, NY 11554-2701	11/14/2018-11/16/2018 26. Date of bill 11/26/2018	30. Amount of bill $137.84
24. Type of service rendered MEDICAL	27. Date bill received by insurer 11/27/2018	31. Amount paid by insurer $0.00
	28. Date final verification requested	32. Amount in dispute $137.84

33. State reason for denial, fully and explicitly (attach extra sheets if needed):
SEE ATTACHED EOB GN8146623

12/11/2018
DATE

Lidia Castillo, NY PIP Examiner
Name and Title of Representative of Insurer

516[redacted]
Telephone No. & Ext.

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

Telephone No. & Ext.

NYS FORM NF-10 (Rev 3/2013)

Claim Number : 0565921720101033	**Total Charges** : $137.84	**EOR #** GN8146623	
Billing Provider : GEORGE M [redacted] DC			
Service Provider : DR GEORGE M [redacted]			
Patient Name : [redacted], JANICE	**Dates of Service** : 11/14/2018 - 11/16/2018		

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EOR Check Amount : $ 0.00

EXPLANATION	EXPLANATION FOR THE REVIEW AMOUNT	REF LINE NUMBER
BA	Billed Amount.	1, 4, 5
NY_IVM	When an initial evaluation is performed, the maximum allowance including treatment is 13.5 units.	2, 3
DF10	At the Policyholder's request, this policy carries a $200 deductible, which has been applied to your bill. Please only bill the patient $119.58. The remainder of the deductible is $80.42. This bill was No-fault rated at $119.58.	1, 2, 3, 4, 5

Comments:

Track your medical claims submitted to GEICO by enrolling in our online Medical Provider Claim Tracking website at: https://partners.geico.com/mpctweb.

For questions regarding payment and this EOR, please call your GEICO adjuster Lidia Castillo at 516-714-7011 x[redacted].