Instructions

The **Verification of Treatment by Attending Physician or Other Provider of Health Service** is completed by your doctor. It is used to describe your medical care and how those services are related to your injury. You will need to print this form and give the form to your doctor. Your doctor will need to complete the form and return it to GEICO.

(Form Below)

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	Name, Address & Phone Number of Insurer's Claims Representative
Government Employees Insurance Co. 750 Woodbury Road Woodbury, New York 11797-2589	GEICO P.O. Box 9507 Fredericksburg, VA 22403-9526 877-892-1789 or Partners.Geico.com

Date	Policyholder	Policy No.	Date of Accident	Claim Number

Provider's Name and Address

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 OR 180 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

2. Date of Birth	3. Sex	4. Occupation (if known)

5. Diagnosis and Concurrent Conditions:

6. When did symptoms first appear?
Date:_____

7. When did patient first consult you for this condition? Date _____:

8. Has patient ever had same or similar condition? ☐ Yes ☐ No IF "YES", state when and describe:

9. Is condition solely a result of this automobile accident? ☐ Yes ☐ No IF "NO", explain:

10. Is condition due to injury arising out of patient's employment? ☐ Yes ☐ No

11. Will injury result in significant disfigurement or permanent disability?
☐ Yes ☐ No ☐ Not determinable at this time
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)

14. Will the patient require rehabilitation and/or occupational therapy as a result of the injuries sustained in this accident? ☐ Yes ☐ No
If "Yes", describe your recommendation below:

CONTINUED ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

(Page 2)

15. REPORT OF SERVICES RENDERED - ATTACH ADDITIONAL SHEETS IF NECESSARY

Date of Service	Place of Service Including Zip Code	Description of Treatment or Health Service Rendered	Fee Schedule Treatment Code	Charges
			TOTAL CHARGES TO DATE $	

16. If treating provider is different than billing provider complete the following:

Treating Provider's Name	Title	License or Certification No.	Business Relationship Check Applicable Box		
			Employee	Independent Contractor	Other (Specify)

17. If the provider of service is a professional service corporation or doing business under an assumed name (DBA), list the owner and professional licensing credentials of all owners (Provide an additional attachment if necessary).

18. Is patient still under your care for this condition? ☐ Yes ☐ No

19. Estimated duration of future treatment

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits)** so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. _____**(IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN ITEM #21)**

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME_____SIGNED_____

PATIENT PATIENT DATE

PATIENT: Your health provider may agree to have you assign you right to no-fault benefits from your insurer directly to your health provider **(Assignment of Benefits).** If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in #21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. _____**(IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)**

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51(THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR.

PRINT NAME :_____SIGNED:_____

PATIENT (ASSIGNOR) PATIENT DATE

PRINT NAME:_____SIGNED:_____

PROVIDER OF HEALTH CARE SERVICE (ASSIGNEE) PROVIDER OF HEALTH CARE SERVICE DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☐ YES ☐ NO

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

Date	Provider's Signature	IRS/TIN Identification No.	WCB Rating Code If None, Specialty