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	For American Arbitration Association use

A. POLICYHOLDER	B. POLICY NUMBER	C. DATE OF ACCIDENT	D. INJURED PERSON
E. CLAIM NUMBER	F. APPLICANT FOR BENEFITS (Name and address)		G. AS ASSIGNEE YES ☐ 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 $_____
☐ B. Health Service Benefits $_____
☐ C. Other Necessary Expenses $_____
☐ D. Interest $_____
☐ E. Attorney's Fee $_____
☐ 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)	25. Period of bill - treatment dates	29. Date final verification received
	26. Date of bill	30. Amount of bill $
24. Type of service rendered	27. Date bill received by insurer	31. Amount paid by insurer $
	28. Date final verification requested	32. Amount in dispute $

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

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

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