

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Be Active PT, PC  
(Applicant)

- and -

Hereford Insurance Company  
(Respondent)

AAA Case No. 17-21-1226-1488

Applicant's File No. OS-55665

Insurer's Claim File No. 9151702

NAIC No. 24309

**ARBITRATION AWARD**

I, Evelina Miller, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD**:

Injured Person(s) hereinafter referred to as: DC

1. Hearing(s) held on 11/15/2022, 01/31/2023  
Declared closed by the arbitrator on 01/31/2023

Olga Sklyut Esq from Law Office of Olga Sklyut P.C participated virtually for the Applicant

Andrew Schiavone Esq from Law Offices of Rubin & Nazarian participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$688.40**, was NOT AMENDED at the oral hearing.  
Stipulations WERE NOT made by the parties regarding the issues to be determined.
3. Summary of Issues in Dispute

The dispute arises from the underlying automobile accident on August 30, 2020, in which the Assignor (DC), a 50-year-old-male was involved. Thereafter, Assignor sought private medical attention and was eventually evaluated by Applicant with complaints of pain in the neck, left shoulder, lower back and pain in the left knee. Eventually patient was recommended to undergo P.T. treatment which was performed on the patient on 3/2/21 through 3/17/21. The bill in dispute is for P.T. treatment which was performed on the patient on 3/2/21 through 3/17/21. Upon receipt of Applicant's bills Respondent issued verification requests. Respondent contends that Applicant is not entitled to

reimbursement for bills for dates of 3/2/21 through 3/17/21 as Applicant failed to respond to the insurer's verification requests within 120 days pursuant to 11 NYCRR § 65- 3.5 (o).

The issue presented at hearing is whether Applicant substantially complied with Respondent's verification requests, or whether Applicant properly objected to the reasonableness of the request thus preserving the issue for arbitration

#### 4. Findings, Conclusions, and Basis Therefor

I have reviewed the submissions contained in MODRIA which are maintained by the American Arbitration Association. These submissions are the record in this case. My decision is based on my review of that file, as well as the arguments of the parties at the hearing. At the time of the hearing all the parties appeared via ZOOM.

I find that Applicant establishes its prima facie showing of entitlement to recover first-party no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms, setting forth the fact and amount of the loss sustained, had been mailed and received and that payment of no-fault benefits were overdue. See *Mary Immaculate Hospital v. Allstate Insurance Co.*, 5 A.D.3d 742, (2d Dept., 2004). Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense. See *Citywide Social Work & Psy. Serv. P.L.L.C v. Travelers Indemnity Co.*, 3 Misc. 3d 608, 2004, NY Slip Op 24034 [Civ. Ct., Kings County 2004]).

Upon receipt of bills at issue delay letters were sent out on 4/30/21 and 5/19/21 advising the Applicant that the claim was delayed pending the following:

*"The Internal Revenue Service ("IRS") requires that Hereford Insurance Company gather a Taxpayer Identification Number ("TIN") from all of its payees in order to file accurate and timely information returns. Please note that failure to provide a timely an accurately completed W-9 form, will result in Hereford Insurance Company withholding a portion of the funds due and submitting the funds withheld to the IRS. In order to avoid back up withholding against remuneration payable to you or your organization, please complete and return the W-9 for us to within 15 calendar days from the date of this letter. The W9 form is available online IRS.GOV/FORMS, Our processing of your claim is delayed because we have not received an acceptable/completed W9 form in file as indicated below:*  
*- We have never been provided a W9 for the medical provider."*

There was no issue raised at the hearing regarding the timeliness of the relevant verification requests.

At the time of the hearing Respondent argued that Applicant has not submitted W9 forms, and as such Respondent issued payment to Applicant on 10/21/21 and a payment to the IRS for the withholding portion of the funds due.

At the time of the initial hearing Applicant argued that Respondent should not have reduced the payment to Applicant by the withholding to the IRS since Respondent has not substantiated its contention that it is under an obligation to withhold money to pay to the IRS. Applicant also argued that the language of the verification request is improper and as such the verification is a nullity.

Upon review of the evidence this Arbitrator determined that the claim is premature for arbitration since the W9 form was still outstanding, and Respondent had not denied Applicant's claim based on failure to comply with outstanding verification within 120 days.

The case was continued for Applicant to upload the relevant W9 form. The question of whether the verification itself is valid was left for the next hearing date.

Applicant did upload the W9 form on 1/31/23.

At the time of this hearing Respondent reviewed the uploaded W9 form and noted that it is dated 10/28/22, which is after the dates of service in dispute. Therefore, there is no indication as to whether the information stated on the W9 form was valid at the time the services were performed. Respondent noted that Applicant has not substantially complied with the outstanding verification, and as such, Respondent properly issued payment to Applicant minus the IRS withholding on 10/21/21.

At the time of this hearing Applicant's argument was two-fold. Applicant initially argued that the language of the verification requests invalidated the requests. As such, Applicant argued that Respondent failed to properly toll its regulatory 30-day time period to pay or deny the bill. Accordingly, Applicant argued that, Respondent's denial cannot be sustained.

The second arguments raised by Applicant is that Respondent has not provided sufficient proof that it must withhold a certain amount from Applicant's reimbursement, and pay it to the IRS if the W9 is not provided.

It is the Respondent's burden initially to prove that it timely mailed its request and follow-up request for verification to the health care provider. See, e.g., *Proscan*

*Imaging, P.C. v. Travelers Indemnity Co.*, 28 Misc.3d 127(A), 2010 N.Y. Slip Op. 51176(U), 2010 WL 2681691 (App. Term 2d, 11th & 13th Dists. July 7, 2010).

In this case, it was uncontested that the Respondent mailed timely requests for verification requesting the items listed above. The verification requests contain the correct address as well as proper language. I find the verification requests to be timely issued.

"Pursuant to Insurance Law § 5106(a) and the Insurance regulations, an insurer must either pay or deny a claim for motor vehicle no-fault benefits, in whole or in part, within 30 days after an applicant's proof of claim is received (*see* Insurance Law § 5106[a]; 11 NYCRR 65-3.8[c]; *see also* 11 NYCRR 65-3.5)." *Infinity Health Products, Ltd. v. Eveready Ins. Co.*, 67 A.D.3d 862, 864, 890 N.Y.S.2d 545, 547 (2d Dept. 2009). "The 30-day period in which to either pay or deny a claim is extended where the insurer makes a request for additional verification within the requisite 15-[business] daytime period (*see Montefiore Med. Ctr. v. Government Empls. Ins. Co.*, 34 AD3d 771; *New York & Presbyt. Hosp. v. Allstate Ins. Co.*, 31 AD3d 512)." *Kingsbrook Jewish Medical Center v. Allstate Insurance Co.*, 61 A.D.3d 13, 17-18, 871 N.Y.S.2d 680, 683 (2d Dept. 2009). If the requested verification is not received within 30 days, the insurer must send a follow-up letter or with within 10 days thereafter (*see* 11 NYCRR 65.15[e][2])." *New York & Presbyterian Hospital v. American Transit Insurance Co.*, 287 A.D.2d 699, 700, 733 N.Y.S.2d 80, 81-82 (2d Dept. 2001). "Thus, a timely additional verification request tolls the insurer's time within which to pay or deny a claim (*see Fair Price Med. Supply Corp. v. Travelers Indem. Co.*, 10 NY3d at 563; *New York & Presbyt. Hosp. v. Countrywide Ins. Co.*, 44 AD3d 729, 730)." *Kingsbrook Jewish Medical Center v. Allstate Insurance Co.*, *supra* at 18, 871 N.Y.S.2d at 683 (2d Dept. 2009).

**11 NYCRR § 65-3.6 (b) of the No-Fault Regulation states:**

*"Verification requests. At a minimum, if any requested verifications has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was requested, either by telephone call, properly documented in the file, or by mail. At the same time the insurer shall inform the applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested."*

**11 NYCRR § 65- 3.5 (o) provides that:**

*"An applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. The insurer shall advise the applicant in the verification request that the insurer may deny the claim if the applicant does not provide within 120 calendar days from the date of the initial request either all such*

*verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply."*

**11 NYCRR § 65-3.8 (b)(3) then provides that:**

*".....An insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply, provided that the verification request so advised the applicant as required in section 65-3.5(o) of this Subpart."*

Even if an insurance company's initial request for verification is sent more than 15 business days after receipt of the claim, it is not "a nullity" so long as it is made before the 30-day claim denial window has expired. See *11 NYCRR 65-3.8 (j)*; *Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co.*, 9 N.Y.3d 312, 320 (2007); *Nyack Hosp. v. General Motors Acceptance Corp.*, 8 N.Y.3d 294, 300 (2007). Compare *O & M Medical, P.C. v. Travelers Indemnity Ins. Co.*, 2015 NY Slip Op 50476(U) (App Term 2d, 11th & 13th Jud Dists. March 26, 2015).

An insurer is not obligated to pay or deny a claim until it has received verification of all relevant information requested. *11 NYCRR § 65.15(g)(1)(I); 2(iii)*. See *Hosp. for Joint Diseases v. New York Cent. Mut. Fire Ins. Co.*, 2007 NY Slip Op 08038 (App. Div. 2d Dept.); *Mount Sinai Hosp. v. Chubb Group of Ins. Cos.*, 2007 NY Slip Op 06650 (App. Div. 2d Dept.); *New York & Presbyterian Hosp. v. Progressive Cas. Ins. Co.*, 2004 NY Slip Op 01750 (2d Dept. May 26, 2004); *Eagle Surgical Supply, Inc. v. Travelers Indem. Co.*, 2010 NY Slip Op 51775(U) (App Term 2d Dept. Oct. 5, 2010); *Beta Supply, Inc. v. Government Empls. Ins. Co.*, 2008 NY Slip Op 51406(U) (App Term 1st Dept., July 16, 2008); *Bronx Expert Radiology P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op 51227(U) (App Term 1st Dept. June 29, 2006); *Elite Chiropractic Servs., PC v Travelers Ins. Co.*, 9 Misc 3d 137(A), 2005 NY Slip Op. 51735(U) (2005).

In support of the arguments raised Applicant submits numerous arbitration awards in its favor.

Applicant submits an award by Arbitrator Heidi Obiajulu in AAA Case #41-20-1107-1226, Prestige Medical P.C. v. Hereford, where Arbitrator Obiajulu was presented with the same issue as in this case. In that case, Arbitrator Obiajulu held the following:

*"Applicant's attorney contends that Respondent must follow the verification protocol detailed in the No-fault regulations, which includes the time limitations. She notes that 11 NYCRR sections 65-3.5(b) and 65-3.6(b), an applicant has at least 60-days from when the verification is sent to comply. She notes that section 65-3.6(b) provides that an insurer is to send a follow-up verification after 30-days have expired from the sending of the original verification.*

*Then, Applicant's attorney argues that Respondent is to send a follow-up verification for the missing information within 10-days, giving the applicant an additional 30-days to comply.*

*She notes that in this case, Applicant provided the requested W-9 form on June 03, 2011. Also, she argues that Respondent's request for its W-9 was a pretext because the TIN was on the bottom of the claim form. Therefore, she contends that Respondent's 30-days to pay or deny its claim expired and that it is precluded from asserting any defense to this claim. Further, Applicant's attorney argues that Respondent failed to demonstrate that it was obligated by any law to submit the two payments to the IRS and that it was obligated to submit full reimbursement to Applicant. Finally, regarding Respondent's argument of unjust enrichment, Applicant's attorney contends that Respondent can seek to recover the payment.*

*Reviewing the entire record, I find in favor of Applicant. In this case, Respondent failed to meet its burden of proof in establishing that it was required under federal law to send taxes to the Treasury Department in the amount of 28% of Applicant's charges. In this case, Respondent solely submitted verifications requesting the W-9 form and TIN number and advising Applicant that it would withhold 28% of the reimbursement if the information was not submitted within 15-days. This language amounts to a verification that violates the verification protocol set forth in the No-fault regulations. The No-fault regulations allows an applicant 30-days to provide requested information. Also, the verification protocol provides for a follow-up requirement, which allows an applicant another 30-days to comply. In this case, Respondent attempted to coerce Applicant into an earlier compliance. Arguably, Respondent may have been within its rights to withhold the allowance after the expiration of the second 30-days. However, it seems clear that Respondent violated the verification protocol when it sent the payments to the Treasury Department before it complied with the verification protocol. Notably, Respondent failed to submit any statute, case law or legal precedent that demonstrated that it was obligated to withhold and send the payments to the IRS. Although, there is some validity to Respondent's arguments of possible unjust enrichment to Applicant, when an insurer ignores the mandates of the No-fault law and regulations, it does so at its own peril. Therefore, I find that Applicant is entitled to reimbursement in the amount of \$126.18."*

Applicant submits an award by Arbitrator Lisa Capruso AAA Case #17-15-1024-1682 in Sr. Wellness PT PC v. Hereford Insurance Company. In that case Arbitrator Capruso was presented with a similar fact pattern as present in this case. She cited to the decision by Arbitrator Obiajulu AAA Case # 41-20-1107-1226 which is cited above. She then added the following:

*"I agree with the analysis set forth by Arbitrator Obiajulu. In addition, I agree with Applicant's argument that the Respondent's verification requests for the Applicant's TIN was unnecessary as this information is clearly included on the NF3 forms. There was no basis on which to issue these verification requests. Moreover, the verification requests that were submitted into evidence were not in*

*connection with this claim or this Assignor's bill. I find that the Respondent improperly issued the balance to the IRS and Applicant is entitled to the additional reimbursement."*

Finally, Applicant submits an award by Arbitrator Cathryn Ann Cohen in AAA Case #17-16-1036-2776 in F-R Mobile Physician P.C. v. Utica Mutual Insurance Company. In this case, just like in the others cited above, Arbitrator Cohen was presented with the same issue as raised in this case. Here, Arbitrator Cohen held the following:

*"Here, upon receipt of Applicant's bill if Respondent required additional information, that being an updated W-9 form, it was incumbent upon the Respondent to send a verification request to the Applicant for the relevant information. This Respondent did not do. Instead, Respondent issued partial payment by check in the amount of \$246.87 unilaterally reducing Applicant's fees by withholding 28% and sending the \$96.01 to the IRS without complying with verification protocols thereby denying Applicant an opportunity to provide the needed information which Respondent concedes would have permitted the Respondent to pay Applicant 100% of the bill. The verbiage on the check stub is not a proper verification request. As stated by Arbitrator Obiajulu in an award addressing the same issue (412011071226), in pertinent part, "it seems clear that Respondent violated the verification protocol when it sent the payments to the Treasury Department before it complied with the verification protocol" adding further, "Although there is some validity to Respondent's arguments of possible unjust enrichment to Applicant when an insurer ignores the mandates of the No-Fault law and regulations, it does so at its own peril." I concur with the opinion of Arbitrator Obiajulu. Since Respondent never requested verification upon receipt of Applicant's bill for Applicant's W-9 form, the determination by Respondent to issue partial payment withholding a portion and sending it to the IRS was arbitrary and without factual basis, as such Respondent's reduction in fees is unsupported (see, Gaba Medical, P.C. v Progressive Specialty Ins. Co. 2012 NY Slip Op 51448(U)). Applicant is entitled to the unpaid balance of its bill."*

Respondent argues in rebuttal that it was entitled to send the withholding to the IRS because Applicant failed to comply with its direction in its verification request to submit the W-9 upon receipt of the verification. Respondent contends that the IRS reporting requirements take precedence over the No-fault regulations and law. She contends that an insurer is required to comply with IRS reporting requirements and that Respondent was compelled to send the IRS the payments since Applicant failed to provide its W-9 as requested. Finally, she contends that reimbursing Applicant will lead to unjust enrichment since Applicant need solely file a request for a refund with the IRS. Consequently, she contends that Applicant's claim should be denied in its entirety.

In support of its contention that it must comply with its obligation to submit a withholding of 24% to the IRS if the payee does not provide a W9 form, Respondent

submits an affidavit by Edward Makela, a Controller at the Hereford Insurance Company, Respondent here. In his affidavit Mr. Makela states that he has personal knowledge of Hereford Insurance Company accounting practice and procedures as well as unrestricted access to Hereford Insurance Company's accounting records.

He notes that as required by the IRS, Hereford Insurance Company withholds Federal Income Tax from non-payroll payments at the current rate of 24% if the payee did not provide a Tax ID number or if IRS notifies them that the Tax Id number provided is incorrect.

Once Federal Income Tax is withheld by Hereford Insurance Company for non-payroll payments, Hereford Insurance Company has to file a Form 945 annually with the IRS. The annual filing of Form 945 is due by February 1 of the following calendar year (e.g. - February 1, 2021 for 2021 withholdings.)

Hereford Insurance Company makes periodic estimated 945 Federal Income Tax Withholding deposits with the IRS based on claims activity during the year. This is ensure there is always enough funds on file with the IRS to avoid underpayment penalty.

At the end of the year and before the Form 945 is filed, the Accounting Department prepares a reconciliation of the total Backup Withholding recorded during the year and the amounts being reported on Form 945. Any and all reconciling items are resolved before the Form 945 is filed.

The backup withholding check was issued on 10/21/21 for \$165.22 for Backup Withholding for BE ACTIVE P.T. P.C. The payment is referenced in row 104....The total backup withholding amount for the month of October is \$663.33.

Hereford Insurance Company withheld \$165.22 representing 24% of \$523.18 from its payment for BE ACTIVE P.T. P.C. on October 21, 2021. The amount of \$165.22. was then remitted to the IRS.

Respondent also submits an award by Eylan Schulman, AAA Case #17-21-1223-5287 in Arte Medical Primary Care, P.C. v. Hereford Insurance Company. In that case Arbitrator Schulman was presented with the same issue as presented in this case. Arbitrator Schulman held the following:

*"Similar to Arbitrator Greta Vilar's analysis in AAA No. 17-19-1115-9718, "the respondent has admitted an affidavit of its no-fault adjuster addressing the reason for the withholding. The affidavit explains that pursuant to IRS rule 307 pertaining to backup withholding, it can be applied to payments reported on a*



*W9. Pursuant to the affidavit, the IRS withholding rules state that prior to receiving payment, a W9 must be furnished by the payment recipient to the payer. If no W9 is provided, the payer is required to withhold a flat 28% rate from payment for backup withholding. The respondent argues that this is exactly how the claim was processed in the instant case.. The applicant argued that the respondent was not entitled to backup withholding from its bill, and points out that it did eventually provide the requested W9 to the respondent. However, the applicant has presented no evidence to support its argument that backup withholding was inappropriate in this case . . . The IRS rules specifically state that until the point in time when the W9 is received, backup withholding is a requirement. The applicant has advanced no convincing argument why this should not have been applied in the instant case."*

*The analysis and reasoning by Arbitrator Vilar is incorporated by reference herein. For the same reasons, I find that Respondent properly processed the bill at issue and demonstrated it paid Applicant the proper amount under the Fee Schedule. Applicant had the benefit of a credit with the IRS for the amount paid on their behalf - the 28% - and they had the right to balance-out in their tax return filing process. Based on the foregoing, the claim is denied."*

Based on my review of the evidence submitted and the arguments presented at the hearing I find the following. Initially I find that the holding by Arbitrator Lisa Capruso AAA Case #17-15-1024-1682 in Sr. Wellness PT PC v. Hereford Insurance Company is not applicable here. In that case since *the verification requests that were submitted into evidence were not in connection with the claim at issue or Applicant's bill*. This is not the case here. Respondent issued 2 verification requests for the specific bills at issue.

Additionally, the holding by Arbitrator Cathryn Ann Cohen in AAA Case #17-16-1036-2776 in F-R Mobile Physician P.C. v. Utica Mutual Insurance Company is not applicable here either. In that case Respondent did not issue verification requests. Rather Respondent partially reimbursed Applicant and noted in its denial the reason for the partial payment. The verification protocols were not followed in that case by the Respondent at all. In the case at issue Respondent issued two timely verification requests for the specific bills at issue to the Applicant. As such, the holding in the case AAA Case #17-16-1036-2776 in F-R Mobile Physician P.C. v. Utica Mutual Insurance Company is not applicable here either.

Regarding Applicant's first contention that the language of the verification requests invalidated the requests. As such, Applicant argued that Respondent failed to properly toll its regulatory 30-day time period to pay or deny the bill. Accordingly, Applicant argued that Respondent's denial cannot be sustained. As noted by Arbitrator Heidi Obiajulu in AAA Case #41-20-1107-1226, Prestige Medical P.C. v. Hereford, 11 NYCRR sections 65-3.5(b) and 65-3.6(b), instructs that applicant has at least 60-days from when the verification is sent to comply. She notes that section 65-3.6(b) provides that an insurer is to send a follow-up verification after 30-days have expired from the sending of the original verification. She found that the language used by the Respondent

which states that the information must be submitted within 15 days to be improper verification language. She noted that this language amounts to a verification that violates the verification protocol set forth in the No-fault regulations. The No-fault regulations allows an applicant 30-days to provide requested information. Also, the verification protocol provides for a follow-up requirement, which allows an applicant another 30-days to comply. In that case, she found that Respondent attempted to coerce Applicant into an earlier compliance.

Initially I would like to note that in the case addressed by Arbitrator Obiajulu Applicant did provide the W9 form to the Respondent. Here Applicant failed to do so. As such, the case at issue is distinguishable from the AAA Case #41-20-1107-1226, Prestige Medical P.C. v. Hereford. Furthermore, I respectfully disagree with Arbitrator Obiajulu and find the verification requests issued by the Respondent to be proper in language and form. I find the "comply within 15 days" language to be an immaterial defect. I do not find any coercion on behalf of the Respondent into an earlier compliance. There is nothing in the request which indicates that Applicant would suffer a detriment if it does not comply with the request.

Furthermore, had Respondent attempted to enforce Applicant's non-compliance with the request within 15 days I would find this to be improper since there is no way for the Respondent to circumvent the timeline created by the Regulation *11 NYCRR sections 65-3.5(b) and 65-3.6(b)*. This was not the case here. More importantly, Respondent issued requests for verification on 4/30/21 and thereafter on 5/19/21. However, Respondent issued payment to Applicant on 10/21/21. Notably, the 120 days expired on 8/28/21. Therefore, Respondent had waited until 2 months after the 120 days had expired to issue payment to Applicant and the withholding payment to the IRS. Respondent gave Applicant ample time to comply with the Request.

More importantly, with respect to a verification request and notice, an insurer's non-substantive technical or immaterial defect or omission, as well as an insurer's failure to comply with a prescribed time frame, shall not negate an applicant's obligation to comply with the request or notice. 11 NYCRR 65-3.5(p). I find the questionable language "15 days to comply with the request" to be an immaterial defect in this particular case.

"Even when a claimant believes it need not comply with a verification request, the claimant still has a duty to communicate with the insurer regarding the request (see, Dilon Medical Supply Corp. v. Travelers Insurance Co., 7 Misc. 3d 927). It is well established that the purpose of the No Fault statute is to ensure prompt resolution of claims by accident victims. The parties' obligations are centered on good faith and common sense. Any questions concerning a communication should be addressed by further communication, not inaction. (see, Dilon Medical Supply Corp. v. Travelers Insurance Co., supra). **If a Plaintiff deems a Verification Request to be defective and or unreasonable, it is incumbent on that Plaintiff to convey that information to the**

**Defendant and to state the reasons thereof, thereby giving the Defendant the opportunity to respond accordingly. The Defendant should not be put in a position to second guess the reason or reasons why the Plaintiff has failed to respond to the request."** Canarsie Chiropractic, P.C. v. State Farm Mutual Automobile Ins. Co., 27 Misc.3d 1228(A), 911 N.Y.S.2d 691 (Table), 2010 N.Y. Slip Op. 50950(U) at 2, 2010 WL 2105860 (Civ. Ct. Kings Co., Sylvia G. Ash, J., May 25, 2010).

There is no indication in the record that Applicant attempted to respond to Respondent's verification requests in any way. There is no indication that Applicant objected to the language of the requests thereby preserving the issue of propriety of verification requests for arbitration.

A claimant "cannot simply rest on its laurels and ignore a verification request. . . . Since the plaintiff desires to be paid, the onus is on it to ensure that the defendant has all of the required information to verify and pay the claim. Plaintiff completely ignored its burden and commenced this action prematurely." D & R Medical Supply, Inc. v. Clarendon Nat. Ins. Co., 22 Misc.3d 1127(A), 881 N.Y.S.2d 362 (Table), 2009 N.Y. Slip Op. 50306(U), 2009 WL 485262 (Civ. Ct. Kings Co., Genine D. Edwards, J., Feb. 26, 2009).

More importantly, in the prior hearing for this case Applicant was given ample opportunity by this Arbitrator to submit the W9 form, yet Applicant failed to do so. Applicant did submit a W9 form which is not dated contemporaneously with the dates of treatment. This form is irrelevant here.

In regards to the second issued raised by Applicant. Applicant argued that Respondent failed to prove that it is under an obligation to submit withholdings to the IRS I disagree with Applicant. Respondent submits an affidavit by a Controller at Hereford, Mr. Edward Makela who goes into detail as to how and why the withholdings are collected and submitted to the IRS. I find his affidavit to be credible and persuasive. Additionally, Respondent provides proof that the withholding was submitted as payment to the IRS. As such, I find that Respondent did indeed prove that it is under an obligation to comply with tax laws set out by the IRS if the W9 is not provided by the payee.

Finally, I would like to address the issue which was not raised by the Applicant in this case but was raised in the cases cited by Applicant. The tax ID number of the provider is located in the NF3. Some Arbitrators held that this information would be sufficient and the W9 would not be required since Respondent was in possession of this information. Again, I disagree. The W9 is a specific form required by the IRS as discussed in the affidavit by Mr. Makela. The W9 form requires identification and a **certification** by the taxpayer. The taxpayer provides the EIN number and certifies under penalties of perjury that the information on the W9 is correct. There is no certification on the NF3 provided. The EIN number on the NF3 can be incorrect.

Based on the above, I find that Respondent properly withheld the 24% due to the IRS, since Applicant failed to provide relevant information within 120 days, and additionally after specifically requested by this Arbitrator.

As such, I find that Applicant is not entitled to further reimbursement.

Applicant's claim is dismissed with prejudice.

5. Optional imposition of administrative costs on Applicant.  
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**

- ☐ The policy was not in force on the date of the accident
- ☐ The applicant was excluded under policy conditions or exclusions
- ☐ The applicant violated policy conditions, resulting in exclusion from coverage
- ☐ The applicant was not an "eligible injured person"
- ☐ The conditions for MVAIC eligibility were not met
- ☐ The injured person was not a "qualified person" (under the MVAIC)
- ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
- ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of NY

SS :

County of Kings

I, Evelina Miller, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

03/02/2023

(Dated)

Evelina Miller

**IMPORTANT NOTICE**

*This award is payable within 30 calendar days of the date of transmittal of award to parties.*

*This award is final and binding unless modified or vacated by a master arbitrator. Insurance Department Regulation No. 68 (11 NYCRR 65-4.10) contains time limits and grounds upon which this award may be appealed to a master arbitrator. An appeal to a master arbitrator must be made within 21 days after the mailing of this award. All insurers have copies of the regulation. Applicants may obtain a copy from the Insurance Department.*

## **ELECTRONIC SIGNATURE**

**Document Name:** Final Award Form  
**Unique Modria Document ID:**  
c2f6af999f02c4e9387cc9f8a4c94c80

### **Electronically Signed**

Your name: Evelina Miller  
Signed on: 03/02/2023