American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Pitch Medical PC (Applicant)	AAA Case No.	17-23-1302-2364
	Applicant's File No.	DK23-369063
- and -	Insurer's Claim File No.	2-221603-01
	NAIC No.	36030
Maya Assurance Company (Respondent)		

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: EB

1. Hearing(s) held on 08/20/2024
   Declared closed by the arbitrator on 09/20/2024

   Evan Polanskiy Esq from Korsunskiy Legal Group P.C. participated virtually for the Applicant

   Arthur De Martini Esq from De Martini & Yi, LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,801.56**, was AMENDED and permitted by the arbitrator at the oral hearing.

   At the time of the hearing Applicant amended amount in dispute to $1,750.98. Respondent contends that Applicant billed for services in excess of the fee schedule.

   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 November 4, 2022, in which the Assignor (EB), a 50-year-old-male was involved. Thereafter, Assignor sought private medical attention and was eventually evaluated by Dr. Lyudmila Poretskaya M.D. with complaints of pain in the neck, mid and lower back, bilateral shoulders, and

bilateral knees. Eventually patient was recommended to undergo shockwave therapy which was performed on 2/2/23 and 2/7/23. Respondent denied Applicant's bills for shockwave therapy based on Applicant's failure to appear at two scheduled EUO's on 3/24/23 and 4/20/23. Respondent also contends that Applicant billed for services in excess of the fee schedule.

The issue presented at the hearing is whether Assignor violated condition precedent to coverage by failing to attend at two scheduled EUOs, and whether Respondent has been able to establish its burden that it timely mailed the requests for the scheduled EUOs and that the Assignor failed to appear

The second issue presented at the hearing is whether Respondent's denial based on Assignor's failure to appear at two scheduled EUOs is subject to the preclusion rule since it was issued late

The issue presented at the hearing is whether Respondent made out a prima facie case of lack of medical necessity, and if so, whether Applicant rebutted it.

The third issue presented at the hearing is whether Respondent was able to establish its burden in coming forward with competent evidentiary proof to support its fee schedule defenses

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. This hearing was conducted 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])*.

At the time of the initial hearing Respondent was asked by this Arbitrator to submit a brief regarding timeliness of the denial when it is initially denied based on W/C, and thereafter denied on EUO no-show. Respondent contends that coverage needs to be established first, and then the claim can be processed. As such, the denial based on the EUO no-show is timely. Respondent was allotted 2 weeks to submit a brief. Applicant

was allowed to submit a response to the brief addressing the issue of the timeliness of the denial. Applicant contends that all defenses must be addressed in the initial timely denial to be preserved. Applicant was granted 2 weeks to submit a response to Respondent's brief. Respondent did not submit a brief as Requested by this Arbitrator. However, Applicant did submit a brief in response to the arguments raised by the Respondent at the hearing. The arguments raised by the Applicant in its brief are contained in this award.

EUO No-show of Applicant

Respondent denied Applicant's bills for dates of service of 2/2/23 and 2/7/23 based on Applicant's failure to appear at scheduled EUOs on 3/24/23 and 4/7/23.

The Mandatory Personal Injury Endorsement, outlined in 11 NYCRR §65-1.1 confers upon the insurer the right to request the eligible injured person or that person's assignee or representative to submit to examinations under oath as may reasonably be required.

The No - Fault regulations as set forth at 11 NYCRR § 65 - 1.1, under Conditions, states as follows:

> *"Action against Company:*
> *No action shall lie against the company unless, as a condition precedent thereto, there shall have been full compliance with the terms of this coverage."*
> *New York State Regulation 68-A, Section 65-1.1, Conditions, Proof of Claim, provides, in pertinent part: "Upon request by the company, the eligible injured person, that person's assignee or that person's representative shall (A) execute a written proof of claim under oath; (B) as may reasonably be required submit to examination under oath by any person named by the company and subscribe the same … and (C) provide any other pertinent information that may assist the company in determining the amount due and payable."*

An insurer has the right to make such a request before or after the claim (bill) is received. *Stephen Fogel Psychological, P.C. v. Progressive Casualty Ins. Co., 35 A.D.3d 720, 827 N.Y.S.2d 217 (App. Div, 2nd Dept, 2006).*

Attendance at an EUO is a condition of coverage under the insurance regulations, see 11 NYCRR § 65-1.1, thus, an eligible injured party's failure to comply with a request for an EUO precludes an action against an insurer for payment of health services. Applying the above sections of the No-Fault regulations, when an Assignor (eligible injured party) fails to comply with Respondent's (insurer) timely requests for an EUO, and the requests strictly comply with the governing regulations, the Respondent (insurer) is entitled to dismissal of an action by the Applicant (provider) as the (eligible injured party's assignee) Assignor seeking No-Fault benefits.

Insurance Regulation 68-C Section 65-3.5 (b) of the No-Fault Regulations states:

> *"Subsequent to the receipt of one or more of the completed verification fo rms, any additional verification required by the insurer to establish proof of claim shall be requested within 15 business days of receipt of the prescribed verification forms."*

Section 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."*

An insurer may deny claims based on the failure to appear for an EUO as it constitutes a breach of a condition precedent to coverage. See *Mega Billing, Inc. v. State Farm Fire & Casualty Company, 35 Misc.3d 145(A), 2012 N.Y. Slip Op. 51014(U) (App Term, 2nd, 11th and 13th Jud. Dists. 2012).*If a patient fails to comply with an insurer's timely and valid requests for EUOs and the requests conform to the governing regulations, the insurer is entitled to dismissal of the complaint. *Morris Med., P.C. v. Amex Assurance Co., 2012 NY Slip Op 52260(U) (App Term 2d, 11th & 13th Jud Dists 2012); Arco Med. N.Y., P.C. v. Lancer Ins. Co., 2012 NY Slip Op 22278 (App Term 2d, 11th & 13th Jud Dists 2012); All Boro Psychological Servs., P.C. v State Farm Mut. Auto. Ins. Co., 36 Misc 3d 135(A) (App. Term 2d Dept 2012).* To substantiate a defense premised on a patient's failure to appear for EUOs, an insurer must show that it timely mailed the EUO notices and that the patient failed to appear. *Dover Acupuncture, P.C. v. State Farm Mut. Auto. Ins. Co., 28 Misc.3d 140(A) (App Term 1st Dept 2010).* The insurer must further establish that the scheduling letters were properly and timely addressed and contained the required notice regarding reimbursement of travel expenses and lost wages. *Matter of Venditti (General Acc. Ins.), 236 A.D.2d 759 (3d Dept 1997).*

Included in Respondent's submission are the subject EUO notices, properly addressed to Assignor, mailing logs documenting mailing of said notices, as well as affirmations from the attorneys present at the scheduled times of the EUO attesting to Assignor's nonappearance. Applicant has not presented any evidence in opposition.

However, at the time of the hearing Applicant's challenged the sufficiency of the EUO appointment dates. Specifically, Applicant's attorney argued that there had not been enough notice given to Applicant to appear at the EUO. The scheduling EUO letters

were dated 3/14/22 for EUO on 3/24/23, and on 3/28/23 for an EUO on 4/7/23. Taking into consideration the 5 days for mailing, would give Applicant just 5 days from receipt of the EUO notice to the actual appointment for the EUO. Applicant argued that this is insufficient notice to Applicant.

Upon review of the evidence submitted and the arguments presented I find the following. The contact information for the Attorneys for the Respondent is listed on the EUO notices. The notices do state: "*If you need to change the venue of the EUO, or if you need to appear by video, you must contact this office prior to the EUO date but not later than 3:00PM of the business day prior to the EUO."* Applicant argued that this did not give proper notice to Applicant to re-schedule the EUO for a different date. I disagree.

Respondent's proof of mailing is sufficient to give rise to a rebuttal presumption that the notices were received. *New York Presbyterian Hospital v Allstate Ins. Co., 2006 NY Slip Op 03558, 29 AD 2d 547 (2nd Dept 2006); Residential Holding Corp. v Scottsdale Insurance Company, 286 A.D.2d 679, 729 N.Y.S.2d 776 (2dDept. 2001).* Applicant was on notice of the EUO request since the Applicant failed to appear at the initial EUO and further the Applicant had the opportunity to communicate with the Respondent in the matter schedule a date, time and/or location for the EUO that is convenient for the Applicant. The proof is sufficient to establish that the notice was received but there is no proof that the Applicant attempted to communication with Respondent or Respondent's attorney's office regarding the EUO. *See AAA CASE # 17-22-1280-6640.*

Applicant's attorney further argued that Respondent's denials predicated upon Applicant's failure to appear at the scheduled EUOs for dates of service of 2/14/23 and 2/16/23 cannot be sustained since they were issued late. Both bills were received by the Respondent on 2/28/23. Both bills were denied on 4/20/23. Since Respondent has 30 days per regulation to pay or deny the bill, Respondent was under an obligation to issue a denial on 3/30/23.

Respondent contends that the denials were issued in a timely manner.

EUO No-show defense:

Respondent received Applicant's bill for date of service of 2/2/23 on 2/7/23. Respondent issued a denial on 3/6/23. Respondent received Applicant's bill for date of service of 2/7/23 on 2/16/23. Respondent issued a denial on 2/21/23. Both denials state:

> *"Workers Compensation: Pursuant to a letter from Veterans Radio Dispatch Corp., the insured was active and taking calls on the day of the accident 11/04/22 up until the collision. The insured was in the course of employment at*

the time of the motor vehicle accident and is eligible for Black Car Fund. The insured was attached to a radio base as an employee. Accordingly, this claim should be submitted to the Black Car Fund. The driver needs to report this to the Black Car Fund as the Black Car Fund coverage is primary. If an offset to the Black Car Fund loss wage benefit becomes applicable and warrants secondary benefits from the No-Fault coverage of this policy, that portion of this claim will be recognized and reviewed at the time of request or written submission for such benefit. The insured must contact the Black Car Fund to report a claim for injuries. Contact ¹ 212-269-4800, 30 Wall Street 10th Fl. NY, NY 10005. PLEASE DO NOT SUBMIT ANY MEDICAL BILLS TO MAYA ASSURANCE."

Thereafter, Respondent issued another denial for both dates of service on 4/20/23. These denials for dates of service of 2/2/23 and 2/7/23 state the following:

"WORKERS COMP DENIAL DATED 03/06/23 HAS BEEN RESCINDED EFFECTIVE 03/21/23: Two attempts were made to perform an examination under oath of the medical provider. Request letters were sent to the medical provider and the medical provider failed to appear for the scheduled Examination under Oath on 03/24/23 8 04/07/23 which is a violation of the prescribed policy endorsements included in Reg. 68. The company's rights have been prejudiced. All benefits for this medical provider will be denied to the date of loss."

Applicant noted that the issue of whether or not the Respondent can after the Workman's Compensation board defense is rescinded can start again with the verification process, long after the time to request verification has expired. The regulations and the case law are very clear that Respondent does not get another bite of the apple so to speak, it cannot request verification that it could have timely requested after it received the bill, even if there was what appeared to be an obvious and valid potential workman's compensation claim to investigate.

Arbitrator Rhonda Barry has previously addressed similar issued in *AAA Case # 17-21-1209-9199*. In that case, she held the following:

"Respondent may not rescind an earlier denial and request further verification. There is

nothing in the Insurance Law or regulations that allows Respondent to re-process a claim and

seek additional verification. Respondent had the opportunity to request additional verification at

the time the claim was initially submitted. Arbitrator Rosenberg determined, "applicant asserts

the bills at issue were not timely denied based upon the lack of medical necessity

defense. Indeed, review of the submission reveals denials were issued [previously] based upon

a Workers Compensation defense. It was not until [later] that a peer review was performed, and

the denial was issued. Respondent asserts that it rescinded the previous denials and that the

late denials and defend should be permitted. However, there is nothing in the regulations which

permit such practice, and therefore, Respondent is bound to the four corners of the original

denial of claim form."

In *Neptune Medical Care, PC v. Ameriprise Auto and Home Insurance, 48 Misc. 3d 139 (A),*

2015 NY Slip Op 51220 (U) (App. Term 2d, 11th and 13th Districts, 8/5/15), the court determined that even if an insurer tolled the 30 day period within which it was required to pay or deny a bill by timely requesting verification pursuant to 11 NYCRR 65 - 3.8 (a) the regulations do not provide that such a toll grants an insurer additional opportunities to make request for verification that would otherwise be untimely. And the EUO was requested more than 15 days after receipt of the claim does not toll the time within which to pay or deny the claim. Once the claim specific denial is issued respondent is precluded from asserting as an alternative defense

noncompliance with verification. See, *Triangle R Inc. v. Praetorian Insurance Company, 29 Misc. 3d 138 (A), 920 NYS 2d 245 (App. Term 1st Dept. 2010); Huntington Hospital v. New York Central Mutual Fire Insurance Company, 2012 NY Slip Op 52274 (U) (App. Term 9th and 10th*

District 2012)."

In the *AAA Case# 17-23-1307-5890,* Arbitrator Kate Cifarelli also held:

"A Workers' Compensation decision was issued on 12/11/20, denying Workers' Compensation

benefits. On 3/04/21, Respondent issued a letter to Applicant advising that the Workers'

Compensation denial is withdrawn, seeking an evaluation report from the referring physician

and other MRI reports. A second letter was issued on 4/08/21. Based upon Respondent's NF-10

denial, verification was received on 4/26/21 and a denial was issued on 5/27/21 pursuant to the

peer review report prepared by Harry Jackson, M.D. It is also undisputed that a lack of medical

necessity defense must be preserved in a timely denial. See *Liberty Queens Medical, P.C. v.*

Liberty Mutual Ins. Co., 2002 N.Y. Slip Op. 40420(U), 2002 WL 31108069 (App. Term 2d & 11th Dists. June 27, 2002); see AJS Chiropractic, P.C. v. Travelers Ins. Co., 25 Misc.3d 140(A), 906 N.Y.S.2d 770 (Table), 2009 N.Y. Slip. Op. 52446(U), 2009 WL 4639680 (App. Term 2d, 11th & 13th Dists. Dec. 1, 2009). The denial was issued thirty-one (31) days after verification was completed. Therefore, not only was the first denial untimely, and the subsequent verification

requests improper (see *Neptune Medical Care, P.C. v. Ameriprise Auto & Home Ins., 48 Misc.3d 139(A), N.Y.S.3d (Table), 2015 N.Y. Slip Op. 51220(U), 2015 WL 4939009 (App. Term 2d, 11th & 13th Dists. Aug. 5, 2015*), but the lack of medical necessity defense denial was also untimely on its face. Respondent failed to properly preserve a defense. "

Upon review of the evidence submitted and the arguments presented at the hearing I find Applicant to be correct. I agree with the decision by Arbitrator Barry as well as the holding in *Neptune Medical Care, PC v. Ameriprise Auto and Home Insurance* discussed above. ***Supra.*** The ***Neptune*** court held that even if the insurer had tolled the 30-day period within which it was required to pay or deny the bills at issue by issuing requests for verification, those verification requests do not allow the insurer to make subsequent verification requests that would otherwise be untimely. The claim was originally denied by the Respondent based on the founded belief that Workers' Compensation Board was the proper forum for this claim since the EIP was in the course of employment at the time of the accident. Respondent did not raise any other defenses in that denial and is therefore precluded from raising them in a new denial by rescinding its original denial. Respondent cannot "piggyback" on the prior defense, just to rescind it and deny the claim anew, on an entirely different defense.

Under *General Acc. Ins. Co. v. Cirucchi, 46 N.Y.2d 862 (1979)*, a carrier's defenses are limited to those raised within the four corners of the denial, and the defenses must be stated with specificity. Since Respondent's reason for the original denial is a Worker's Compensation defense, Respondent's defense is limited to that issue.

As such, I agree with Applicant and find Respondent's denials for dates of service of 2/14/23 and 2/16/23, which were secondarily denied to Applicant's failure to appear at two scheduled EUOs on 3/24/23 and 4/7/23 to be untimely.

Furthermore, in *Unitrin*, supra, the Court determined that the insurance company had the right to deny all claims retroactively to the date of loss, regardless of whether the denials were specific or timely issued.

There is undoubtedly a difference between the First Department's holding which is of the opinion that a breach of a policy condition is not subject to the preclusion rule while the Second Department's decision is that a breach of a policy condition may be subject to the preclusion rule.

I will follow the holding in *Westchester Medical Center v. Lincoln General Insurance Company, 2009 NY Slip Op 2598, 60 A.D.3d 1045, 877 N.Y.S.2d 340 (2'd Dep't 2009)* where the Court held that where an insurers denial of liability was based upon a claimant's failure to appear at an examination under oath, such an alleged breach does not serve to vitiate the medical provider's right to recover no fault benefits or to toll the 30-day statutory period (See *Mount Sinai Hosp. v Triboro Coach, 263 AD2d 11, 17, 699 NYS2d 77 [1999]*). Rather, such denial was subject to the preclusion remedy. (See *Central Gen. Hosp. v Chubb Group of Ins. Cos., 90 NY2d at 199; Zappone v Home Ins. Co., 55 NY2d 131, 136-137, 432 NE2d 783, 447 NYS2d 911 [1982]; cf. Presbyterian Hosp. in City of N.Y. v Maryland Cas. Co., 90 NY2d 274, 279-280, 683 NE2d 1, 660 NYS2d 536 [1997])*."

Respondent failed to issue a claim specific denial in a timely manner and as such pursuant to *Westchester Medical Center v. Lincoln General Insurance Company*, Assignor's non-appearance at the EUOs is subject to the preclusion rule.

Based on the decision in *Westchester* I find that Respondent's denial based on Assignor's failure to appear at two scheduled EUOs is precluded for dates of service of 2/14/23 and 2/16/23.

As such, Applicant's claim for reimbursement for dates of service of 2/2/23 and 2/7/23 is granted.

Respondent further argued that Applicant billed for services in excess of the fee schedule.

Fee Schedule

The rates charged by Applicant must be in accordance with Insurance Law § 5108, as the charges for services rendered "shall not exceed the charges permissible under the schedules prepared and established by the chairman of the Workers Compensation Board for Industrial Accidents, except where the insurer or arbitrator determines that unusual procedures or unique circumstances justify the excess charge."
In addition, § 5108 (c) states that, "no provider of health services… may demand or request any payment in addition to the charges authorized pursuant to this section."

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, *Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006)*. If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, *Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).*

Effective April 1, 2013 11 NYCRR 65-3.8(g)(1) has been amended so that the application of the New York State Worker's Compensation fee schedule is no longer a precludable defense and no payment is due on those claims in excess of the fee schedule. Per 11 NYCRR 65-3.8(g), where the services were rendered after April 1, 2013, a defense of excessive fees is not subject to preclusion *Surgicare Surgical Associates v. National Interstate Ins. Co.*, Misc.3d, N.Y.S.3d, 2015 N.Y. Slip Op. 25338 (App. Term 1st Dept. Oct. 8, 2015), aff'g, 46 Misc.3d 736, 997 N.Y.S.2d 296 (Civ. Ct. Bronx Co. 2014) (New Jersey fee schedule). The insurer is entitled to reduce the bills to the proper fee schedule amount.

For dates of service of 2/2/23 and 2/7/23 Applicant billed for shockwave therapy for 2 units performed on each date of service. Respondent contends that Applicant is entitled to reimbursement for only 1 unit on each date of service.

However, Respondent does not submit a Certified Coder's affidavit in support of its fee schedule defense. As such, I find that Respondent failed to sustain its defense since Respondent failed to reach its burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, *Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co. Supra.*

Accordingly, Applicant's claim for reimbursement is granted in the amount of $1,750.98 (as reduced by Applicant).

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 applicant is AWARDED the following:

A.

Medical		**From/To**	**Claim Amount**	**Amount Amended**	**Status**
	Pitch Medical PC	**02/02/23 - 02/02/23**	**$1,400.78**	**$700.39**	**Awarded: $700.39**
	Pitch Medical PC	**02/07/23 - 02/07/23**	**$1,400.78**	**$1,050.59**	**Awarded: $1,050.59**
Total			**$2,801.56**		**Awarded: $1,750.98**

B. The insurer shall also compute and pay the applicant interest set forth below. 06/05/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   Since the motor vehicle accident occurred after April 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. 11 NYCRR 65-3.9(a). In accordance with 11 NYCRR 65-3.9c, interest

shall be paid on the claims totaling $1,750.98 from the date the arbitration was commenced.

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

Respondent shall pay Applicant an attorney's fee upon the amount awarded plus the interest, as calculated in section "B" above, and in accordance with 11 NYCRR 65-4.6(e), i.e., 20 percent of the amount of first party benefits, plus interest thereon. The minimum attorney's fee payable shall be in accordance with 11 NYCRR 65-4.6c. For cases filed after February 4, 2015, there is no minimum attorney's fee but there is a maximum fee of $1,360.00. However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b)."

D. The respondent shall also pay the applicant forty dollars ($40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

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.

10/22/2024
(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:
228f5013b14a0457089764946b4479e4

Electronically Signed

Your name: Evelina Miller
Signed on: 10/22/2024