

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Brooklyn Medical Practice, PC
(Applicant)

- and -

Hereford Insurance Company
(Respondent)

AAA Case No. 17-25-1427-6207

Applicant's File No. AR25-27651

Insurer's Claim File No. FLT001022

NAIC No. 24309

ARBITRATION AWARD

I, Lisa Abrams, 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: IP

1. Hearing(s) held on 04/29/2026
Declared closed by the arbitrator on 04/29/2026

Jeffrey Kramer from Law Office of Jeffrey M. Kramer participated virtually for the Applicant

David Tetlak from Law Offices of Ruth Nazarian participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,327.82**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant withdrew, without prejudice, its claims for date of service October 2, 2023. Applicant also amended the amount in dispute from \$1,327.82 to \$168.20.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

This arbitration arises out of medical treatment for the IP (GLMM), a 21-year-old female, related to injuries the IP sustained in a motor vehicle accident that occurred on September 14, 2023. Applicant seeks reimbursement for services performed on behalf of the IP from September 19, 2023 through September 29, 2023. According to Respondent,

it sought additional verification, but Applicant failed to provide the requested information. The issues in dispute are whether Applicant complied with Respondent's verification requests and whether the arbitration is premature.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic case file maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

It is well settled that an insurer is not obligated to pay or deny a claim until it has received verification of all relevant information requested. *See, Mount Sinai Hosp. v. Chubb Grp. of Ins. Companies*, 43 A.D.3d 889 (2nd Dept. 2007); *Hosp. for Joint Diseases v. New York Cent. Mut. Fire Ins. Co.*, 44 A.D.3d 903 (2nd Dept. 2007).

An insurer can extend or toll its time to pay or deny a claim by demanding verification within 30 days of receipt of the claim. *Victory Med. Diagnostics, P.C. v. Nationwide Prop. & Cas. Ins. Co.*, 36 Misc.3d 568, 57 (Dist. Ct. 2012) *citing Nyack Hosp. v. General Motors Acceptance Corp.*, 8 N.Y.3d 294 (2007). No-Fault regulations do not specifically define or limit the information or documentation an insurer may request through verification. In fact, the regulations provide that an insurer can request "... all items necessary to verify the claim directly from the parties from whom such verification was requested." 11 NYCRR 65-3.5(c).

Once verification has been received, an insurer has 30 days within which to make a determination on the claim. *Liberty Queens Medical, P.C. v. Tri-State Consumer Ins.*, 188 Misc.2d 835, 839 (Dist. Ct. Nassau Co. 2001). As long as a medical provider's documentation is arguably responsive to an insurer's verification request, the insurer must act within 30 days of the medical provider's response, or it will be precluded from presenting any non-coverage defenses; an insurer must affirmatively act once it receives a response to its verification request. *All Health Medical Care, P.C. v. Government Employees Ins. Co.*, 2 Misc.3d 907 (Civ. Ct. Queens Co. 2004).

Requests for verification, however, are not without restraint. The regulations provide that an insurer should not "... demand verification of facts unless there are good reasons to do so." 11 NYCRR 65-3.2(c). Indeed, no-fault decisions require that good cause or a reasonable basis be shown to obtain further verification. *See, State Farm Mutual Insurance Co. v. Mallela*, 4 N.Y.3d 313 (2005) (in order for a request for verification to be valid concerning a request for applicant's bank records, tax returns, and licensing status, a respondent must "show good cause" by putting forth proof that demonstrates "behavior tantamount to fraud."); *Dynamic Medical Imaging P.C. a/a/o v. State Farm Mut. Auto. Ins. Co.*, 29 Misc.2d. 278 (Dist. Ct. Nassau Co. July 15, 2010); *A.B. Medical*

Services PLLC v. Highlands Insurance Co., N.Y.L.J., May 27, 2003 (Civ. Ct. New York Co. 2003) (the burden is on Respondent to prove that the verification requests are valid). *See also, Concourse Chiropractic, PLLC v. State Farm Mutual Ins. Co.*, 35 Misc.3d 1213(A) (Dist. Ct. Nassau Co. Apr. 16, 2012); *Midborough Acupuncture P.C. v. State Farm Ins. Co.*, 21 Misc.3d. 10, 12 (App. Term 2nd Dept. 2008).

Respondent asserts that Applicant failed to respond to the verification issued on December 6, 2023 and January 12, 2024. Respondent sought the initial consultation report. Respondent contends that Applicant failed to respond to the verification requests and that additional verification requests remain outstanding to date.

At the hearing, counsel for Applicant argued that it responded to Respondent's verification request by fax on February 12, 2024 and has provided sufficient proof of faxing. I find as a matter of fact that Applicant provided sufficient proof that the verification request was responded to on February 12, 2024. In fact, Applicant's proof clearly makes a connection to the verification response and Applicant has provided the requested documentation. Respondent has no other defense to Applicant's claim. Therefore, this matter is ripe for arbitration and I find for Applicant in the amended amount.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot, without merit, and/or waived insofar as not raised at the time of the hearing.

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
	Brooklyn Medical Practice, PC	09/19/23 - 09/29/23	\$168.20		Awarded: \$168.20
	Brooklyn Medical Practice, PC	10/02/23 - 10/02/23	\$964.74		Withdrawn without prejudice
	Brooklyn Medical Practice, PC	10/02/23 - 10/02/23	\$194.88		Withdrawn without prejudice
Total			\$1,327.82		Awarded: \$168.20

B. The insurer shall also compute and pay the applicant interest set forth below. 11/07/2025 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from the initiation date for this case until the date that payment is made at two percent per month, simple interest, on a *pro rata* basis using a thirty-day month. See 11 NYCRR 65-3.9.

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of that sum total, subject to a minimum of \$60 and a maximum of \$850. See, 11 NYCRR 65-4.6 (c) and (e). However, if the benefits and interest awarded thereon is equal to or less than the Respondent's written offer during the conciliation process, the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b). For cases filed after February 4, 2015, there is no minimum fee and a maximum fee of \$1,360.00.

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 Nassau

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

04/30/2026
(Dated)

Lisa Abrams

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:
23b441f0441821775c9ae18bf057161d

Electronically Signed

Your name: Lisa Abrams
Signed on: 04/30/2026