American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Adult Health NP NYC PC (Applicant)	AAA Case No.	17-25-1426-7194
	Applicant's File No.	186661
- and -	Insurer's Claim File No.	0796599206
	NAIC No.	19232
Allstate Fire & Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Anne Malone, 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: EIP

1. Hearing(s) held on 11/04/2026
   Declared closed by the arbitrator on 11/04/2026

   Aleksey Selipanov, Esq. from The Law Offices of John Gallagher, PLLC participated virtually for the Applicant

   Morenike Erinkitola, Esq. from Law Offices Of Richard Schoenberg participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$520.96**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount claimed was amended by the applicant to $396.17 to conform to the appropriate fee schedule. The respondent did not agree to this amended amount.

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

3. Summary of Issues in Dispute

   The 28 year old EIP reported involvement in a motor vehicle accident on June 17, 2025; reported injury and underwent an office visit and trigger point injection with guidance provided by the applicant on June 23, 2026.

The applicant submitted a claim for these medical services, for which the respondent made partial payment for the office visit provided by a NP pursuant to the appropriate fee schedule. The respondent delayed payment for the injection with guidance pending its investigation and attendance by the EIP at an EUO to verify proof of claim.

Respondent also requested documents and information related to the happening of the accident, photographs and insurance information.

In an addition, in the Explanation of Benefits dated October 7, 2025, the respondent asserted that the bills and reports submitted contained material misrepresentations of fact, that the services were not performed and that the reports and bills did not accurately represent the scope of services rendered to the EIP.

The issues to be determined at this hearing are:

Whether the respondent established that the claim is premature.

Whether the respondent established that the services at issue were not provided to the EIP.

4. Findings, Conclusions, and Basis Therefor

This hearing was held on Zoom and the decision is based upon the documents reviewed in the Modria File as well as the arguments made by counsel and/or representative at the arbitration hearing. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived.

Premature Claim

The respondent submitted an NF-10 and Explanation of Bill Processing and Request for Information dated August 20, 2025 which delayed payment for services rendered by the applicant on June 23, 2025 pending its investigation. Also submitted were an initial and second request for the EUO of the EIP.

If an insurer requires any additional information to evaluate the proof of claim, such request for verification must be made within 15 business days of the receipt of the bill in order to toll the 30 day period to pay or deny the claim. See 11 NYCRR 65-3.5(b); See also New York Hosp. Med. Ctr. of Queens v. Allstate Ins. Co., 2014 NY Slip Op 00640 (2d Dept. 2014.)

Where there is a timely original request for verification, but no response to the original request for verification is received within 30 days, or the response to the

verification request is incomplete, then the insurer, within 10 calendar days after the expiration of that 30 day period, must follow up with a second request for verification. Id.

If there is no response to the second or follow up request for verification, the time in which the insurer must decide whether to pay or deny the claim is indefinitely tolled. Id.

Therefore, when a no-fault medical service provider fails to respond to the requests for verification the claim is premature and should be denied without prejudice.

In the instant matter according to the NF-10 and the EOB the bill at issue was dated July 8, 2025 and was received by the respondent on that date.

On August 1, 2025, the respondent sent its first request for documents and information related to this claim and for the EUO of the EIP to be held on September 8, 2025. When no response was received,the respondent sent a second request September 10, 2025 for an EUO on October 7, 2025. The respondent provided proof of mailing for the EUO and documents/and information requests.

Based on the proofs submitted, the first request for the EUO and documents/information was late. It was dated and mailed more than 15 business days after receipt of the bill by the respondent.

In addition, according to the NF-10 submitted by the respondent the bill was received on July 8, 2025 and the NF-10 is dated October 7, 2025.

The penalty for an insurer's failure to issue a timely and proper denial of claim is that it will be precluded from objecting to the claim. In Viviane Etienne Med. Care, P.C. v Country-Wide Ins. Co., 114 A.D.3d 33 (2d Dept. 2013) the Appellate Division held that:

Challenges and objections regarding whether the services were

in fact rendered, were causally related to a covered accident or

were medically necessary are not available to the defendant insurer

after the onset of litigation unless the insurer proffered a timely and

proper denial of claim within the prescribed time frame.

Under these circumstances, since the respondent did not issue a proper and timely denial within the prescribed time frame of 30 days from receipt of the bill in question, therefore, it has not preserved any defense, except for fee schedule, if applicable.

The fee schedule issue was resolved by the amendment of the amount in dispute at the hearing.

Based on the foregoing, the respondent has failed to establish any defense to this claim.

Accordingly, the applicant is awarded $396.17 in disposition of this claim.

Any further issues submitted in the record are held to be moot and/or waived insofar as they were not raised at the time of this hearing. This decision is in full disposition of all claims for no-fault benefits presently before this Arbitrator.

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**
	Adult Health NP NYC PC	**06/23/25 - 06/23/25**	**$520.96**	**$396.17**	**Awarded: $396.17**
Total			**$520.96**		**Awarded: $396.17**

B. The insurer shall also compute and pay the applicant interest set forth below. 11/03/2025 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR Interest shall be calculated "at a rate of two percent per month, calculated on a *pro rata* basis using a 30 day month." See 11 NYCRR §64-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits" calculated pursuant to Insurance Department regulations. Where a claim is untimely denied, or not denied or paid, interest shall accrue as of the 30th day following the date the claim is presented by the claimant to the insurer for payment. Where a claim is timely denied, interest shall accrue as of the date an action is commenced or an arbitration requested, unless an action is commenced or an arbitration requested within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. See, 11 NYCRR §65-3.9(c.) The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial was timely. LMK Psychological Servs. P.C. v. State Farm Mut. Auto. Ins. Co., 12 NY3d 217 (2009.)

C. Attorney's Fees

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

Applicant is awarded statutory attorney's fees pursuant to the no fault regulations. For cases filed after February 4, 2015 the attorney's fee shall be calculated as follows: 20% of the amount of first-party benefits awarded, plus interest thereon subject to no minimum fee and a maximum of $1,360.00. See 11 NYCRR §65-4.6(d.)

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 CT
SS :
County of Fairfield

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

11/28/2026
(Dated)

Anne Malone

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:
93fde8bc644b9a32baec143e0bb30d6e

Electronically Signed

Your name: Anne Malone
Signed on: 11/28/2026