MICHAEL A. SIRAGUSA
ERIE COUNTY ATTORNEY

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE
DEPARTMENT OF LAW

MICHELLE M. PARKER
FIRST ASSISTANT COUNTY ATTORNEY

JEREMY C. TOTH
SECOND ASSISTANT COUNTY ATTORNEY

July 18, 2013

Mr. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street. 4th Floor
Buffalo, New York 14202

Dear Mr. Graber:

In compliance with the Resolution passed by the Erie County Legislature on June 25, 1987, regarding notification of lawsuits and claims filed against the County of Erie, enclosed please find a copy of the following:

File Name:	*Medical Care of Western New York, a/a/o Brown, Jeffrey v. Erie County*
Document Received:	Summons with Notice
Name of Claimant:	Medical Care of WNY 656 Elmwood Avenue Buffalo, New York 14222
Claimant's attorney:	Daniel Morris, Esq. The Morris Law Firm, P.C. 40 North Forest Road Williamsville, New York 14221

Should you have any questions, please call.

Very truly yours,

MICHAEL A. SIRAGUSA
Erie County Attorney

By: Michelle Parker
Michelle M. Parker
First Assistant County Attorney

MMP:dld

Enc.

'13/7/8

File No.: 13-7255

CITY OF BUFFALO
BUFFALO CITY COURT : COUNTY OF ERIE

MEDICAL CARE OF WESTERN NEW YORK a/a/o JEFFREY BROWN
656 Elmwood Avenue
Buffalo, NY 14222

Plaintiff

v.

ERIE COUNTY
69 Delaware Avenue
Suite 300
Buffalo, NY 14202

Defendant

SUMMONS SERVED WITH COMPLAINT

Index No.: 3507/13

This paper received at the Erie County Attorney's Office from John Celano on the 12th day of July, 2013 at 1:10 a.m./p.m.

Assistant County Attorney
Michael Liszewski

TO THE ABOVE NAMED DEFENDANT:

YOU ARE HEREBY SUMMONED AND REQUIRED to serve upon the plaintiffs attorneys, at the address stated below, a written Answer to the attached Complaint.

If this Summons is not personally delivered to you within the State of New York, you must respond within thirty (30) days after service is complete, as provided by law.

If you do not respond to the attached Complaint within the time limitation stated above a Judgment will be entered against you, by default for the relief demanded in the Complaint, without further notice to you.

This action is brought in the City of Buffalo because defendant conducts business within the city.

DATED: Thursday, May 9, 2013

Daniel Morris, Esq.
The Morris Law Firm, P.C.
40 North Forest Road
Williamsville, NY 14221

COPY

2013 MAY 16 PM 12:18

File No.: 13-7255

CITY OF BUFFALO
BUFFALO CITY COURT : COUNTY OF ERIE

MEDICAL CARE OF WESTERN NEW YORK a/a/o JEFFREY BROWN

Plaintiff

v.

ERIE COUNTY

Defendant

COMPLAINT

Index No.:

Plaintiff, complaining of Defendant, shows to the Court and alleges:

AS AND FOR A FIRST CAUSE OF ACTION

1. Plaintiff-Assignor was injured in an automobile accident on March 17, 2007.

2. Defendant is an insurance company licensed to do business in the State of New York.

3. Defendant transacts business in the City of Buffalo.

4. At the time of the accident there existed an insurance policy containing benefits under the New York State No-Fault Law issued by Defendant.

5. One of the benefits was payment of health service expenses.

6. As a result of the aforementioned accident, Defendant was obligated to provide No-Fault benefits to JEFFREY BROWN.

7. By denying payment for those services that are the subject of this lawsuit the Defendant has acted in bad faith.

8. MEDICAL CARE OF WESTERN NEW YORK is authorized to provide health services in the State of New York.

9. MEDICAL CARE OF WESTERN NEW YORK is the assignee of JEFFREY BROWN.

10. Plaintiff-Assignee rendered necessary health services to the Assignor.

11. The attached bills are for the services at issue.

12. Said bill or bills was submitted together with the proper No-Fault verification forms.

13. Said bill or bills was submitted to Defendant within the time period required by law.

14. There has been no payment of said bill, and the full amount remains outstanding.

15. Plaintiff-Assignee is entitled to payment of the bill, statutory interest at the rate of two percent (2%) per month pursuant to 11 NYCRR 65-3.9 until the amount due is paid in full computed from thirty days after the date the claim was submitted to Defendant.

16. Plaintiff-Assignee hired the law firm of The Morris Law Firm, P.C., to collect the above overdue No-Fault benefits and is entitled to recover attorney's fees pursuant to 11 NYCRR 65-4.6 calculated at twenty percent (20%) of the overdue claim and statutory interest thereupon, with a minimum fee of eighty dollars ($80.00)

WHEREFORE, Plaintiff demands judgment against Defendant for the payment of the bills in full totaling $187.47 and interest and for attorney's fees in under the applicable statutes together with the costs and disbursements of this action.

DATE: May 9, 2013

Daniel Morris, Esq.
The Morris Law Firm, P.C.
40 North Forest Road
Williamsville, NY 14221
Phone: (716) 839-7777
Fax: (716) 633-2878

2013 MAY 16 PM 12:16

'13/7/8

1500 P

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

FCS ADMINISTRATORS WC
PO BOX 1248

WILLIAMSVILLE, NY 14231

PICA

1 MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER [X] (ID)

1a INSURED'S I.D. NUMBER (For Program in Item 1): 7A66886

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): BROWN, JEFFREY

3 PATIENT'S BIRTH DATE MM 11 DD 03 YY 1974 SEX M [X] F

4 INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5 PATIENT'S ADDRESS (No., Street): 46 MARNE RD

6 PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7 INSURED'S ADDRESS (No., Street): SAME

CITY: BUFFALO STATE: NY

8 PATIENT STATUS: Single Married Other [X] Employed Full-Time Student Part-Time Student

CITY: SAME STATE:

ZIP CODE: 14215 TELEPHONE (Include Area Code): (716) 5702483

ZIP CODE: SAME TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11 INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [X] NO

a. INSURED'S DATE OF BIRTH MM 03 DD 1974 SEX M [X] F

b OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? [X] YES NO PLACE (State)

b EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: FCS ADMINISTRATORS WC

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d RESERVED FOR LOCAL USE

d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 11122010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED: SIGNATURE ON FILE

14 DATE OF CURRENT: MM 03 DD 07 YY 2007 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20 OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1,2,3 or 4 to item 24E by Line)

1. 953 0
2. 953 2
3. 728 85
4. 844 9

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 11 12 10	11 12 10	11		97110		1234	27 00	1	N	ZZ	208D00000X
									N	NPI	1164409991
2 11 12 10	11 12 10	11		97124		1234	15 84	1	N	ZZ	208D00000X
									N	NPI	1164409991
3 11 29 10	11 29 10	11		97110		1234	54 00	2	N	ZZ	208D00000X
									N	NPI	1164409991
4 11 29 10	11 29 10	11		97124		1234	15 84	1	N	ZZ	208D00000X
									N	NPI	1164409991
5 02 07 11	02 07 11	11		99214		1234	74 79	1	N	NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 161568888 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 14414

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO

28. TOTAL CHARGE: $ 187 47

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 187 47

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse apply to this bill and are made a part thereof.)

MICHAEL D CALABRESE PHYSIC

03222013

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

MEDICAL CARE OF WNY AT BUFFALO
656 ELMWOOD AVENUE
BUFFALO NY 142221836
a. 1992782601 b.

33. BILLING PROVIDER INFO & PH #: (716) 8830515

MEDICAL CARE OF WNY
656 ELMWOOD AVENUE
BUFFALO NY 142221836
a. 1164409991 b. 2219320000X

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

'13/7/8

File No.: 13-7255

CITY OF BUFFALO
BUFFALO CITY COURT : COUNTY OF ERIE

MEDICAL CARE OF WESTERN NEW YORK a/a/o JEFFREY BROWN

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