GEICO
geico.com

- Government Employees Insurance Company
- GEICO General Insurance Company
- GEICO Indemnity Company
- GEICO Casualty Company

Buffalo/New Jersey Claims, PO BOX 9515
Fredericksburg, VA 22403-9515

Date

Date Loss Reported to GEICO:

Company Name:
Claim Number:
Loss Date:
Policyholder:
Policy Number:
Driver:
Prizm, LLC Acct No:
Injured Party:

To Whom It May Concern,

Personal Injury Protection (PIP) is the portion of the auto policy that provides coverage for medical expenses. These medical expenses are subject to policy limits, deductibles, co-payments and any applicable medical fee schedules. Additionally, these medical expenses must be for services that are deemed reasonable, medically necessary and causally related to the motor vehicle accident. With the adoption of the Automobile Cost Reduction Act of 1998, several important changes have been made in the way a claim is processed. Additional information regarding Decision Point Review/Pre-Certification can be accessed on the Internet at the New Jersey Department of Banking and Insurances website at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm.

Prizm, LLC has been selected by GEICO General Insurance Company to implement their plan as required by the Automobile Cost Reduction Act. Prizm, LLC will review treatment plan requests for Decision Point Review/Pre-Certification, perform Medical Bill Repricing and Audits of provider bills, coordinate Independent Medical Exams and Peer Reviews, and provide Case Management Services.

If certain medically necessary services are performed without notifying GEICO General Insurance Company or Prizm, LLC a penalty/co-payment may be applied. Medical care rendered in the first 10 days following the covered loss or any care received during an emergency situation is not subject to Decision Point Review/Pre-certification. However, for benefits to be paid, the treatment must be reasonable, medically necessary, and related to the subject motor vehicle accident. In addition, in order for a provider to receive direct payment for rendering services to you, regardless of whether it is within or beyond the first 10 days, the provider must submit to GEICO a fully executed Conditional Assignment of Benefits. This is true in all events.

The Plan Administrator is Prizm, LLC.

Mailing Instructions:

All Decision Point Review, pre-certification and internal appeals related documents are to be submitted to:

Prizm, LLC
1015 Briggs Road
Suite 100
Mt. Laurel, NJ 08054
Phone Number: 856-596- 5600
Fax Number: 856-596-6300
Email Address Documents@Prizmllc.com

All other mail is to be submitted to:

GEICO
P.O. Box 9515
Fredericksburg, VA 22403
Fax Number: 516-213-1484

Submission of Treatment Plan Requests for Decision Point Review/Pre-Certification

Please bring the "Attending Provider Treatment Plan" form to your treating provider for completion. This completed form along with any applicable medical documentation should be forwarded to Prizm, LLC by fax (856-596-6300), or mail (1015 Briggs Road, Ste. 100, Mt. Laurel, NJ 08054) or email to TreatmentRequests@Prizmllc.com. This form can be accessed on Prizm, LLC's web site at www. Prizmllc.com. Any questions regarding your treatment request can be directed to Prizm, LLC at 856-596-5600 during regular business hours of Monday through Friday 8:00 AM to 5:00 PM, EST except for Federally Declared Holidays and any time when our offices are closed due to a declared state of emergency.

Decision Point Review

Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance has published standard courses of treatment, known as **Care Paths**, for soft tissue injuries, collectively referred to as **Identified Injuries**. Additionally, guidelines for certain diagnostic tests have been established by the New Jersey Department of Banking and Insurance according to N.J.A.C. 11:3-4. *Decision Points* are intervals within the Care Paths where treatment can be evaluated for a decision about the continuation or choice of further treatment. At Decision Points, the eligible injured person or the health care provider must provide Prizm, LLC with information regarding further treatment the health care provider intends to provide.

In accordance with N.J.A.C. 11:3-4.5, the administration of any of the following diagnostic tests is subject to Decision Point Review, regardless of diagnosis.

Diagnostic Tests which are subject to Decision Point Review according to N.J.A.C. 11:3-4.5

1. Needle Electromyography (EMG)
2. Somatosensory Evoked Potential (SSEP)
3. Visual Evoked Potential (VEP)
4. Brain Audio Evoked Potential (BAEP)
5. Brain Evoked Potentials (BEP)
6. Nerve Conduction Velocity (NCV)

7. H-Reflex Studies
8. Electroencephalogram (EEG)
9. Videofluroscopy
10. Magnetic Resonance Imaging (MRI)
11. Computer Assisted Tomograms (CT, CAT Scan)
12. Dynatron/Cybex Station/Cybex Studies
13. Sonogram/Ultrasound
14. Brain Mapping
15. Thermography/Thermograms

Pre-Certification

Pursuant to N.J.A.C. 11:3-4.7, the New Jersey Department of Banking and Insurance, Prizm, LLC's Pre-Certification Plan requires pre-authorization of certain treatment/diagnostic tests or services. Failure to pre-certify these services may result in penalties/co-payments even if services are deemed medically necessary. If the eligible injured person does not have an Identified Injury, your treating provider is required to obtain Pre-Certification of treatment, diagnostic tests, services, prescriptions, durable medical equipment or other potentially covered expenses as noted below:

1. Non-emergency inpatient and outpatient hospital care
2. Non-emergency surgical procedures
3. Extended Care Rehabilitation Facilities
4. Outpatient care for soft-tissue/disc injuries of the person's neck, back and related structures not included within the diagnoses covered by the Care Paths.
5. Physical, Occupational, Speech, Cognitive, Rehabilitation or other restorative therapy or therapeutic or body part manipulation except as provided for identified injuries in accordance with Decision Point Review.
6. Outpatient psychological/psychiatric treatment/testing or other services
7. All pain management services except as provided for identified injuries in accordance with Decision Point Review
8. Home Health Care
9. Acupuncture
10. Durable Medical Equipment (including orthotics or prosthetics) with a cost or monthly rental in excess of $100.00 or rental in excess of 30 days
11. Non-Emergency Dental Restorations
12. Temporomandibular disorder; any oral facial syndrome
13. Non-medical products, devices, services and activities, and associated supplies, not exclusively used for medical purposes or as durable medical goods, with an aggregate cost or monthly rental in excess of $ 100.00 or rental in excess of 30 days, including but not limited to:
    (a) Vehicles
    (b) Modifications to vehicles
    (c) Durable goods
    (d) Furnishings
    (e) Improvements or modifications to real or personal property
    (f) Fixtures
    (g) Spa/gym memberships
    (h) Recreational activities and trips
    (i) Leisure activities and trips

Decision Point Review Pre-Certification Process

On behalf of GEICO General Insurance Company, Prizm, LLC will review all treatment plan requests and medical documentation submitted. A decision will be rendered within three business days of receipt of a completed "Attending Provider Treatment Plan" form request with supporting medical documentation. If additional information is requested, the decision

will be rendered within three days of our receipt of the additional information. In the event that GEICO General Insurance Company or Prizm, LLC does not receive sufficient medical information accompanying the request for treatment, diagnostic tests or services to make a decision, an administrative denial will be rendered, until such information is received. If a decision is not rendered within three business days of receipt of an "Attending Provider Treatment Plan" form, your treating health care provider may render medically necessary treatment until a decision is rendered.

Please note that the denial of Decision Point Review and Pre-certification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

Voluntary Pre-Certification

We encourage you to participate in a voluntary pre-certification process by bringing a treatment plan request form to your provider or have them contact us for all services requested. Prizm, LLC will utilize nationally accepted criteria to authorize a mutually agreeable course of treatment. In consideration for your participation in this voluntary pre-certification process, the bills your provider submits, when consistent with the agreed plan, will not be subject to review or audit as long as they are in accordance with the policy limits, deductibles, and any applicable PIP fee schedule. This process increases the communication between the patient, provider and Prizm, LLC to develop a comprehensive treatment plan with the avoidance of unnecessary interruptions in care.

Independent Medical Examinations

Prizm, LLC or GEICO General Insurance Company may request an Independent Medical Examination. At times, this examination may be necessary to reach a decision in response to the treatment plan request or internal appeal request by the treating provider. This examination will be scheduled with a provider in the same discipline and at a location reasonably convenient to the injured person. Prizm, LLC will schedule the appointment for the examination within 7 days of the day of the receipt of the request unless otherwise agreed by the insured/designee to extend the timeframe. Medically necessary treatment may proceed while the examination is being scheduled and until the Independent Medical Examination results become available. Upon completion of the Independent Medical Examination, your provider will be notified of the results via fax or mail within three business days of the examination. A copy of the examining report is available to you, your designee or your treating provider upon receipt of your written request.

Prizm, LLC will notify you or your designee and the treating provider of the scheduled physical or mental examination and of the consequences for unexcused failure to appear at two or more appointments. If you, the injured party, have two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to you or your designee, and all the providers treating you for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. This notification will place you on notice that all future treatment diagnostic testing or durable medical equipment required for the diagnosis and (related diagnosis) contained in the attending physicians treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.

Voluntary Network Services

Prizm, LLC has established a network of approved vendors for diagnostic imaging studies for all MRI's and CAT Scans, durable medical equipment with a cost or monthly rental over $100.00, prescription drugs and all electrodiagnostic testing, listed in N.J.A.C 11:3-4.5(b) 1-3, (unless performed in conjunction with a needle EMG by your treating provider). If you, the injured party utilize one of the pre-approved networks, the 30% co-payment will be waived. If any of the electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b) are performed by the treating provider in conjunction with the needle EMG, the 30% co-

payment will not apply. In cases of prescriptions, the $10.00 co-pay of GEICO General Insurance Company will be waived if obtained from one of the pre-approved networks.

To secure a list of preferred provider networks for Diagnostic tests (MRI's and CAT Scans), Durable Medical Equipment, Prescription Drugs, and Electrodiagnostic Testing, please visit Prizm, LLC website @ www.Prizmllc.com , contact Prizm, LLC by phone at 856-596-5600, via fax at 856-596-6300, or in writing at 1015 Briggs Road, Mt. Laurel, NJ 08054.

Penalty Notification

Failure to submit request for Decision Point Review or Pre-Certification where required, or failure to submit clinically supported findings that support the treatment, diagnostic testing, or durable medical goods requested will result in a co-payment of 50%. This co-payment is in addition to any co-payment stated in the insured's policy.

If you do not utilize a network provider/facility to obtain those services, tests or equipment listed in the voluntary utilization review program section, payment for those services rendered will result in a co-payment of 30% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment, tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

Any reduction shall be applied prior to any other deductible or co-payment requirement.

Assignment of Benefits

Please read the Assignment of PIP Benefits section in your policy carefully. All assignments are subject to all requirements, duties and conditions of the policy. In addition a condition of the assignment of benefits, a provider must agree to comply with all procedures of the Decision Point Review Plan, Decision Point Review and precertification requirements (collectively, "Plan"). The provider must agree to initiate all Precertification and Decision Point Review requests as required by the Plan. In the event the provider fails to comply with the conditions of the Plan, and such failure results in the imposition of a co-payment penalty, the provider will hold you harmless for such co-payment penalty insofar as the provider will not seek payment from you for any unpaid portion of the medical services arising from such co-payment penalty. Additional conditions that also apply to the provider include:

a. Submission of disputes as defined in the Plan to the Internal Dispute Resolution Process set forth therein. After final determination, submission of disputes not resolved by the Internal Dispute Resolution Process to the Personal Injury Protection Dispute Resolution Process set forth in N.J.A.C. 11:3-5.
b. Submission of all disputes not subject to the Internal Dispute Resolution Process to the Personal Injury Protection Dispute Resolution Process set forth in N.J.A.C 11:3-5.
c. Submission of complete and legible medical records with clinically supported findings to support the diagnosis, the causal relationship to the motor vehicle accident and the care plan.
d. Compliance with a request by GEICO to (i.) Submit to an examination under oath, and (ii.) Provide GEICO with any other pertinent information/documentation requested.
e. Agreement not to pursue payment directly from the patient and to hold the

patient harmless for any denial of coverage arising from the failure to comply with the conditions established by the Plan and under the Conditional Assignment of benefits. The conditional Assignment of benefits may be revoked by the assignee,
and the assignee shall be entitled to pursue payment from the patient, when benefits are not payable due to lack of coverage/or violation of a policy condition by the patient.

GEICO's Conditional Assignment of Benefits is the only valid assignment of benefits. The assignee agrees that GEICO has the right to reject, terminate or revoke the GEICO Conditional Assignment of Benefits. An assignment of benefits may require GEICO's written consent.

INTERNAL APPEAL PROCESS

Pre-Service Appeal
Each issue shall be required to receive an internal appeal review by the insurer prior to making a request for Alternative Dispute Resolution.
A pre-service appeal is an appeal of decision point review and/or precertification denials or modification prior to performance or issuance of the requested medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment and prescriptions. In order to be considered a valid pre-service appeal all the requirements listed below must be met:

1. Prizm, LLC must be notified within thirty (30) days after receipt of the written denial or modification of requested services.

2. An appeal must be communicated to Prizm, LLC in writing with supporting documentation and reasons for the appeal. Submission of information identical to the initial documentation submitted in support of the initial request shall not be accepted as an appeal request.

3. The appeal must be submitted on the New Jersey PIP Pre-Service Appeal Form and all applicable fields 1-34 must be completed in order to be considered. If either the New Jersey PIP Pre-Service Appeal Form is not submitted or if any applicable fields of the New Jersey PIP Pre-Service Appeal Form are not completed then the Appeal may be administratively denied. In addition, the original APTP form, APTP decision/response document, and appeal rationale narrative document must be included with the submission of the New Jersey PIP Pre-Service Appeal Form or the Pre-Service Appeal may be administratively denied.

4. Appeals must be submitted to Prizm, LLC via fax at 856-596-6300, or in writing at PO Box 5480, Mt. Laurel, NJ 08054.

5. Only those providers who have a valid Assignment of Benefits are permitted to file an appeal. Providers who are assigned benefits or who have a valid Proof of Assignment from the insured/eligible injured person, must make and complete an internal appeal prior to making a request for dispute resolution.

6. Filing an appeal as stated in numbers 1-5 is a condition precedent to filing through Alternative Dispute Resolution.

7. All available required information about a dispute should be submitted as part of the internal appeals process. Only with a showing of substantial good cause should additional required information not submitted as part of the internal appeals process be submitted in arbitration for the first time.

Medical necessity appeals of denial of Decision Point Review or Precertification requests must be made as a Pre-Service Appeal.

A decision shall be issued by the insurer to the provider who submitted the Pre-Service Appeal no later than fourteen (14) days after receipt of the New Jersey PIP Pre-Service Appeal Form and any supporting documentation.

Post-Service Appeal
A Post-Service Appeal is an appeal made subsequent to the performance or issuance of the services.

In order to be considered a valid post-service appeal, all of the requirements listed below must be met:

1. A post-service appeal shall be submitted to the Prizm, LLC in writing within ninety (90) days of the issuance of the decision that is being appealed and at least forty five (45) days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or any other litigation against us. If a post-service appeal form is submitted outside of this period of time then it will be administratively denied.

2 The appeal must be submitted on the New Jersey PIP Post-Service Appeal Form and all applicable fields 1-38 shall be completed. If either the New Jersey PIP Post-Service Appeal Form is not submitted or the applicable fields are not completed then the Appeal may be administratively denied. In addition, the original bill (HCFA or UB), explanation of benefit/payment (EOB), and appeal rationale narrative document must be included with the submission of the New Jersey PIP Post-Service Appeal Form or the Post-Service Appeal may be administratively denied.

3. An appeal must be communicated in writing with supporting documentation and reasons for the appeal. Submission of information identical to the initial documentation submitted in support of the billed services shall not be accepted as an appeal request.

4. Appeals must be submitted to .Prizm, LLC, via fax at 856-596-6300, or in writing at PO Box 5480, Mt. Laurel, NJ 08054.

5. Only those providers who have a valid Assignment of Benefits are permitted to file an appeal. Providers who are assigned benefits or who have a valid Proof of Assignment from the insured/eligible injured party must make and complete an internal appeal prior to making a request for dispute resolution.

6. Filing an appeal as stated in numbers 1-5 is a condition precedent to filing through Alternative Dispute Resolution.

7. All available required information about a dispute should be submitted as part of the internal appeals process. Only with a showing of substantial good cause should additional required information not submitted as part of the internal appeals process be submitted in arbitration for the first time.

Medical necessity appeals of denial of Decision Point Review or Precertification requests cannot be made as a Post-Service Appeal.

A decision shall be issued by the insurer to the provider who submitted the Post-Service appeal no later than thirty (30) days after receipt of the New Jersey PIP Post Service Appeal Form and any supporting documentation.

Any dispute which has not been submitted to the appeal process shall not be a valid part of

any arbitration or litigation. Proof of a timely-filed appeal is required documentation when an Alternate Dispute Resolution demand is made. Any request for dispute resolution may include a request for review by a medical review organization.

The staff at Prizm, LLC remains available to you and your doctor in order to assist with the Decision Point Review/Pre-Certification Process.

Should you have any questions or require any further information not available through the websites, don't hesitate to contact us or Prizm, LLC.

Sincerely,

Examiner, Examiner Code
1-800-841-3000
Claims Department

Encl: Assignment of Benefits Form

GEICO
PERSONAL INJURY PROTECTION BENEFITS

CONDITIONAL ASSIGNMENT OF BENEFITS

Policy Number: ______________________ **Claim Number:** ______________________

Patient's Name: ______________________ **Provider's Name:** ______________________

I authorize and request Government Employees Insurance Company, GEICO General Insurance Company, GEICO Indemnity Company and/or GEICO Casualty Company (collectively referred to as "GEICO") to pay directly to the above-named medical provider, the amount due to me under the terms of the above- referenced policy as a result of medical care rendered by that medical provider and all medical staff associated with the provider's office.

______________________ ______________________
Patient's Signature or Parent/Legal Guardian Date

I have read the information contained in the GEICO informational letter concerning the Decision Point Review Plan, Decision Point Review and precertification requirements (collectively, "**Plan**") and, as a condition precedent to GEICO's acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1. I (We) have fully complied and will comply with all the requirements of the Plan.
2. I (We) have complied and will comply with the terms and conditions of the GEICO policy.
3. I (We) will initiate all pre-certification review and decision point review requests as required by the Plan.
4. I (We) will submit disputes as defined in the Plan to the Internal Dispute Resolution Process set forth therein. After final determination, I (we) will submit disputes not resolved by the Internal Dispute Resolution process to the personal injury protection dispute resolution process set forth in N.J.A.C. 11:3-5.
5. I (We) will submit all disputes not subject to the Internal Dispute Resolution Process to the personal injury protection dispute resolution process set forth in N.J.A.C. 11:3-5.
6. I (We) will submit complete and legible medical records with clinically supported findings to support the diagnosis, causal relationship to the accident, and care plan.
7. I (We) will comply with a request to (i) submit to an examination under oath, and (ii) provide GEICO with any other pertinent information/documentation that it requests.
8. In the event that I (we) fail to comply with paragraphs one (1) though (6) above, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty.

I (we) agree that this assignment is the only valid assignment of benefits. I (we) agree that this assignment of benefits may require GEICO's written consent. I (we) agree that GEICO has the right to reject, terminate or revoke this assignment of benefits.

______________________ Date: ______________________
Provider's Signature

______________________ TIN Number: ______________________
Provider's Name (Please Print)

Provider's Address: ______________________ ______________________

New Jersey Law requires the following to appear on this form:
"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

This form is accessible at http://www.geico.com/information/states/nj/personal-injury-protection/