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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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GOVERNMENT EMPLOYEES INSURANCE
COMPANY, GEICO INDEMNITY COMPANY,
GEICO GENERAL INSURANCE COMPANY and
GEICO CASUALTY COMPANY,

Docket No.: _____()

Plaintiffs,

**Plaintiffs Demand a Trial by
Jury**

-against-

CHAI DIAGNOSTICS LLC, SINAI DIAGNOSTICS LLC,
BLK DIAGNOSTICS LLC, REFUAH DIAGNOSTICS
LLC, ARTUR KOFMAN, DANIEL BOGATIN, GARY
BOGATIN, ADDE KHANATAYEV, ALEKSANDR
LIKHTENSTEIN, and JOHN DOE DEFENDANTS “1”-
“10”

Defendants.

----- X

Plaintiffs Government Employees Insurance Company, GEICO Indemnity Company,
GEICO General Insurance Company and GEICO Casualty Company (collectively “GEICO” or
“Plaintiffs”), as and for their Complaint against defendants Chai Diagnostics LLC, Sinai
Diagnostics LLC, BLK Diagnostics LLC, Refuah Diagnostics LLC, Artur Kofman, Daniel
Bogatin, Gary Bogatin, Adde Khanatayev, and Aleksandr Likhtenstein (collectively, the
“Defendants”) hereby allege as follows:

NATURE OF THE ACTION

1. This action seeks to recover more than \$340,000.00 that the Defendants wrongfully obtained from GEICO by submitting and causing to be submitted, hundreds of fraudulent no-fault insurance charges relating to medically unnecessary, illusory, and otherwise unreimbursable healthcare services, including the technical component of sympathetic skin response (“SSR”) tests, transcranial doppler tests (“TCD”), videonystagmus tests (“VNG”), and ultrasound tests (collectively, the “Fraudulent Services”), which allegedly were provided to New York automobile accident victims insured by GEICO (“Insureds”).

2. Defendants Chai Diagnostics LLC (“Chai”), Sinai Diagnostics LLC (“Sinai”), BLK Diagnostics LLC (“BLK”), and Refuah Diagnostics LLC (“Refuah”) (together, the “Provider Defendants”) are New York entities that have billed GEICO and other New York automobile insurers for the excessive and medically useless Fraudulent Services. The Provider Defendants are not owned by licensed healthcare professionals, and none of the entities are licensed professional corporations in New York State. Defendants Artur Kofman (“Kofman”), Daniel Bogatin (“D. Bogatin”), and Gary Bogatin (“G. Bogatin”), together with Defendants Adde Khanatayev (“Khanatayev”) and Aleksandr Likhtenstein (“Likhtenstein”), used the Provider Defendants to create fraudulent “billing opportunities” for alleged healthcare services that were unnecessary and provided, to the extent provided at all, without any legitimate referral from a physician, without any determination of medical need, and without any supervision by a licensed healthcare professional.

3. The Defendants operated the Provider Defendants on a transient basis in the New York metropolitan area, using illegal referral and kickback arrangements to permit the Provider Defendants to access a steady stream of patients and render, or purport to render, expensive

neurological and other testing services without regard to patient care, all to exploit New York's no-fault insurance system for financial gain.

4. By this action, GEICO seeks to recover the monies stolen from it, totaling more than \$340,000.00, and further seeks a declaration that it is not legally obligated to pay reimbursement of more than \$1 million in pending no-fault insurance claims that have been submitted by or on behalf of the Provider Defendants because:

- (i) the Fraudulent Services were not medically necessary and were provided – to the extent provided at all – pursuant to pre-determined fraudulent protocols designed solely to financially enrich the Defendants, rather than to treat or otherwise benefit the Insureds;
- (ii) the Fraudulent Services were provided – to the extent provided at all – pursuant to the dictates of laypersons not licensed to render healthcare services, without supervision by a licensed professional, and as a result of illicit kickback arrangements; and
- (iii) the Fraudulent Services, in certain cases, were never actually provided in the first instance.

5. The Defendants fall into the following categories:

- (i) Defendants Chai Diagnostics LLC (“Chai”), Sinai Diagnostics LLC (“Sinai”), BLK Diagnostics LLC (“BLK”), and Refuah Diagnostics LLC (“Refuah”) are the entities through which the Fraudulent Services purportedly were performed and were billed to New York automobile insurance companies, including GEICO.
- (ii) Artur Kofman (“Kofman”), Daniel Bogatin (“D. Bogatin”), Gary Bogatin (“G. Bogatin”), Adde Khanatayev (“Khanatayev”), and Aleksandr Likhtenstein (“Likhtenstein”) are members of some, or all, of the Provider Defendants.
- (iii) John Doe Defendants “1” through “10” are individuals and/or entities who participated in the fraudulent scheme perpetrated against GEICO by, among other things, assisting with the provision of medically unnecessary services, engaging in illegal financial and kickback arrangements to obtain patient referrals for the Provider Defendants, and spearheading the pre-determined fraudulent protocols used to maximize profits without regard to genuine patient care.

6. As discussed herein, the Defendants at all relevant times have known that: (i) the Fraudulent Services were not medically necessary and were provided – to the extent provided at all – pursuant to pre-determined fraudulent protocols designed solely to financially enrich the Defendants, rather than to treat or otherwise benefit the Insureds who purportedly were subjected to them; (ii) the Fraudulent Services were provided – to the extent provided at all – pursuant to the dictates of unlicensed laypersons and as a result of illicit kickback arrangements; and (iii) the Fraudulent Services, in certain instances, never were actually provided in the first instance.

7. As such, the Defendants do not now have – and never had – any right to be compensated for the Fraudulent Services billed to GEICO through the Provider Defendants.

8. The charts annexed hereto as Exhibits “1” through “4” set forth a representative sample of the fraudulent claims that have been identified to date that Defendants submitted, or caused to be submitted, to GEICO.

9. The Defendants’ fraudulent scheme began as early as 2020 and continued uninterrupted through the present day, as the Provider Defendants continue to attempt collection on the pending charges for the Fraudulent Services.

10. As a result of Defendants’ fraudulent scheme, GEICO has incurred damages of more than \$340,000.00.

THE PARTIES

I. Plaintiffs

11. Plaintiffs Government Employees Insurance Company, GEICO Indemnity Company, GEICO General Insurance Company, and GEICO Casualty Company are Nebraska corporations with their principal places of business in Chevy Chase, Maryland. GEICO is

authorized to conduct business and to issue automobile insurance policies in the State of New York.

II. Defendants

12. Defendant Kofman resides in and is a citizen of New York. Kofman is a member of all four Provider Defendants: Chai, Sinai, BLK, and Refuah.

13. Defendant D. Bogatin resides in and is a citizen of New York. D. Bogatin is a member of all four Provider Defendants: Chai, Sinai, BLK, and Refuah.

14. Defendant G. Bogatin, resides in and is a citizen of New York. G. Bogatin is a member of all four Provider Defendants: Chai, Sinai, BLK, and Refuah.

15. Defendant Khanatayev resides in and is a citizen of New York. Khanatayev is a member of Sinai.

16. Defendant Likhtenstein resides in and is a citizen of New York. Likhtenstein is a member of BLK.

17. Defendant Chai is a limited liability company that was formed in New York on or about March 30, 2021, has its principal place of business in New York, and has Kofman, D. Bogatin, and G. Bogatin as its members. Chai has been used by Kofman, D. Bogatin, G. Bogatin, and John Doe Defendants “1”-“10” to submit fraudulent billing to GEICO and other insurers.

18. Defendant Sinai is a limited liability company that was formed in New York on or about December 10, 2020, has its principal place of business in New York, and has Kofman, G. Bogatin, D. Bogatin, and Khanatayev as its members. Sinai has been used by Kofman, G. Bogatin, D. Bogatin, Khanatayev, and John Doe Defendants “1”-“10” to submit fraudulent billing to GEICO and other insurers.

19. Defendant BLK is a limited liability company that was formed in New York on or about February 10, 2021, has its principal place of business in New York, and has Kofman, D. Bogatin, G. Bogatin, and Likhtenstein as its members. BLK has been used by Kofman, D. Bogatin, G. Bogatin, Likhtenstein, and John Doe Defendants “1”-“10” to submit fraudulent billing to GEICO and other insurers.

20. Defendant Refuah is a limited liability company that was formed in New York on or about July 23, 2019, has its principal place of business in New York, and has Kofman, D. Bogatin, and G. Bogatin as its members. Refuah has been used by Kofman, D. Bogatin, G. Bogatin, and John Doe Defendants “1”-“10” to submit fraudulent billing to GEICO and other insurers.

21. Upon information and belief, John Doe Defendants “1” through “10” reside in and are citizens of New York. John Doe Defendants “1” through “10” are unlicensed, non-professional individuals and entities, presently not identifiable, who knowingly participated in the fraudulent scheme by, among other things, assisting with the provision of medically unnecessary services, engaging in illegal financial and kickback arrangements to obtain patient referrals for the Provider Defendants, and spearheading the pre-determined fraudulent protocols used to maximize profits without regard to genuine patient care.

JURISDICTION AND VENUE

22. This Court has jurisdiction over the subject matter of this action under 28 U.S.C. § 1332(a)(1) because the matter in controversy exceeds the sum or value of \$75,000.00, exclusive of interest and costs, and is between citizens of different states.

23. Pursuant to 28 U.S.C. § 1331, this Court also has jurisdiction over claims brought under 18 U.S.C. § 1961 et seq. (the Racketeer Influenced and Corrupt Organizations [“RICO”] Act) because they arise under the laws of the United States.

24. In addition, this Court has supplemental jurisdiction over the subject matter of the claims asserted in this action pursuant to 28 U.S.C. § 1367.

25. Venue in this District is appropriate pursuant to 28 U.S.C. § 1391, as the Eastern District of New York is the District where one or more of the Defendants reside and because this is the District where a substantial amount of the activities forming the basis of the Complaint occurred.

ALLEGATIONS COMMON TO ALL CLAIMS

26. GEICO underwrites automobile insurance in the State of New York.

I. An Overview of the Pertinent Laws Governing No-Fault Reimbursement

27. New York’s “No-Fault” laws are designed to ensure that injured victims of motor vehicle accidents have an efficient mechanism to pay for and receive the healthcare services that they need.

28. Under New York’s Comprehensive Motor Vehicle Insurance Reparations Act (N.Y. Ins. Law §§ 5101, et seq.) and the regulations promulgated pursuant thereto (11 N.Y.C.R.R. §§ 65, et seq.) (collectively referred to as the “No-Fault Laws”), automobile insurers are required to provide Person Injury Protection Benefits (“No-Fault Benefits”) to Insureds.

29. No-Fault Benefits include up to \$50,000.00 per Insured for medically necessary expenses that are incurred for healthcare goods and services, including the technical component of those healthcare services. See N.Y. Ins. Law § 5102(a).

30. Pursuant to the No-Fault Laws, healthcare services providers are not eligible to bill for or to collect No-Fault Benefits if they fail to meet any New York State or local licensing requirements necessary to provide the underlying healthcare services.

31. For instance, the implementing regulation adopted by the Superintendent of Insurance, 11 N.Y.C.R.R. § 65-3.16(a)(12) states, in pertinent part, as follows:

A provider of healthcare services is not eligible for reimbursement under section 5102(a)(1) of the Insurance Law if the provider fails to meet any applicable New York State or local licensing requirement necessary to perform such service in New York or meet any applicable licensing requirement necessary to perform such service in any other state in which such service is performed.

(Emphasis added).

32. In State Farm Mut. Auto. Ins. Co. v. Mallela, 4 N.Y.3d 313, 320 (2005), the New York Court of Appeals confirmed that healthcare services providers that fail to comply with licensing requirements are ineligible to collect No-Fault Benefits, and that insurers may look beyond a facially-valid license to determine whether there was a failure to abide by state and local law. In Andrew Carothers, M.D., P.C. v. Progressive Ins. Co., 33 N.Y.3d 389, 393 (2019), the New York Court of Appeals reiterated that only licensed physicians may practice medicine in New York because of the concern that unlicensed physicians are “not bound by ethical rules that govern the quality of care delivered by a physician to a patient.”

33. In New York, only a licensed healthcare professional may: (i) practice the pertinent healthcare profession; (ii) own and control a professional corporation authorized to operate a professional healthcare practice; (iii) employ and supervise other healthcare professionals; and (iv) absent statutory exceptions not applicable in this case, derive economic benefit from professional healthcare services. It is a crime in New York to practice medicine without a license and/or to aid or abet a person to practice without a license. See e.g., New York Education Law § 6512.

34. New York law prohibits licensed healthcare services providers, including physicians, from paying or accepting kickbacks in exchange for referrals for healthcare services. See, e.g., N.Y. Educ. Law §§ 6509(10), 6509-a, 6530(18), 6531; 8 N.Y.C.R.R. § 29.1(b)(3).

35. Prohibited kickbacks include more than a simple payment of a specific monetary amount, it includes “exercising undue influence on the patient, including the promotion of the sale of services, goods, appliances, or drugs in such manner as to exploit the patient for the financial gain of the licensee or of a third party.” See N.Y. Educ. Law §§ 6509-a, 6530(17); 8 N.Y.C.R.R. § 29.1(b)(2).

36. Pursuant to a duly executed assignment, a healthcare services provider may submit claims directly to an insurance company and receive payment for medically necessary goods and services, using the claim form required by the New York State Department of Insurance (known as “Verification of Treatment by Attending Physician or Other Provider of Health Service” or, more commonly, as an “NF-3”).

37. Alternatively, a healthcare services provider may submit claims using the Healthcare Financing Administration insurance claim form (known as the “HCFA-1500” or “CMS-1500” form).

38. In New York, claims for No-Fault Benefits are governed by the New York Workers’ Compensation Fee Schedule (the “Fee Schedule”).

39. When a healthcare services provider submits a claim for No-Fault Benefits using the current procedural terminology (“CPT”) codes set forth in the Fee Schedule, it represents that: (i) the service described by the specific CPT code was performed on the patient; (ii) the service described by the specific CPT code was performed in a competent manner and in accordance with

applicable laws and regulations; (iii) the service described by the specific CPT code was reasonable and medically necessary; and (iv) the service and the attendant fee were not excessive.

40. Under the Fee Schedule, No-Fault Benefits for medically necessary expenses can include certain services that have both a technical and a professional component.

41. The technical component of a medically necessary service generally includes the act of physically administering the service and may be performed by an individual who is not a licensed healthcare professional.

42. The professional component of a medically necessary service must be provided by a physician or other qualified healthcare professional and generally includes services such as test result interpretation and/or the provision of a written report.

43. To ensure that Insureds' \$50,000.00 in No-Fault Benefits are not artificially depleted by inflated charges for services containing a technical component and a professional component, the Fee Schedule specifies the maximum charges that may be submitted by a healthcare services provider for such services.

44. More specifically, for medically necessary services designated as having both a technical component and a professional component, the Fee Schedule specifies the percentage of the total charge that is allocated to the performance of the technical component and the percentage of the total charge that is allocated to the performance of the professional component. This is commonly referred to as the "PC/TC Split."

45. For example, pursuant to the Fee Schedule, if an Insured were to receive a VNG that qualified for reimbursement under CPT code 92540, the Fee Schedule designates an 83/17 PC/TC Split. In other words, one provider may bill 83% of the total permissible charge for the provision of

the professional component of the VNG and another provider may bill 17% of the total permissible charge for the provision of the technical component of the same VNG.

46. Similarly, if an Insured were to receive a TCD that qualified for reimbursement under CPT code 93890, the Fee Schedule designates a 25/75 PC/TC Split. In other words, one provider may bill 25% of the total permissible charge for the provision of the professional component of the TCD and another provider may bill 75% of the total permissible charge for the provision of the technical component of the same TCD.

47. Pursuant to Section 403 of the New York State Insurance Law, the NF-3 forms submitted by healthcare services providers to GEICO, and to all other insurers, must be verified subject to the following warning:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

48. Similarly, all HCFA-1500 (CMS-1500) forms submitted by a healthcare services provider to GEICO, and to all other automobile insurers, must be verified by the healthcare services provider subject to the following warning:

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

II. The Defendants' Fraudulent Scheme

A. Overview of the Defendants' Fraudulent Scheme

49. Beginning in 2020 and continuing through the present day, Defendants implemented a complex fraudulent scheme in which they used the Provider Defendants to exploit patients for financial gain by billing the New York automobile insurance industry for hundreds of

thousands of dollars for medically unnecessary, illusory, and otherwise unreimbursable health care services.

50. In New York, only a licensed healthcare professional may practice a healthcare profession, own and control a professional corporation authorized to operate a professional healthcare practice, employ and supervise other healthcare professionals, and derive direct economic benefit from healthcare professional services, absent statutory exceptions not applicable in this case.

51. Nevertheless, the Defendants, none of whom are professional corporations or licensed healthcare providers, used the façade of four corporate entities to create fraudulent “billing opportunities” for health care services by operating the Provider Defendants on a transient basis in the New York metropolitan area and having them purport to provide the technical portion of various neurological and other testing services (i.e., the “Fraudulent Services”) to automobile accident victims, including GEICO’s Insureds, without any legitimate referral, determination of medical need, or supervision by a licensed professional.

52. The Fraudulent Services billed under the names of the Provider Defendants were not medically necessary, used fabricated data, and were provided – to the extent provided at all – pursuant to pre-determined fraudulent protocols designed solely to financially enrich the Defendants, rather than to treat or otherwise benefit the Insureds.

53. Further, the Fraudulent Services billed under the names of the Provider Defendants were provided – to the extent provided at all – pursuant to the dictates of unlicensed laypersons, not permitted by law to render or control the provision of healthcare services, rather than the result of any legitimate referral from a licensed professional.

54. The Defendants also used sham referral forms that contained “copied” or “stamped” signatures of an alleged referring practitioner, to create the appearance of medical need and oversight by a licensed professional in order to support the billing for the Fraudulent Services through the Provider Defendants. In keeping with the fact that Defendants used sham referral forms, it is entirely implausible – to the point of absurdity – that the Provider Defendants would have any legitimate basis to provide the Fraudulent Services, in the form of the technical component of highly specialized diagnostic tests, including SSR tests, TCD, VNG, and ultrasound tests, to numerous individuals involved in automobile accidents.

55. The Provider Defendants operated from over forty (40) “No-Fault” medical clinics located throughout the New York metropolitan area, including clinics at the following locations (collectively, the “Clinics”):

- 1 Fulton Avenue, Hempstead;
- 105-10 Flatlands Avenue, Brooklyn;
- 10825 Merrick Boulevard, Jamaica;
- 11 E Hawthorne Avenue, Valley Stream;
- 1100 Pelham Parkway, Bronx;
- 513 Church Avenue, Brooklyn;
- 146 Empire Boulevard, Bronx;
- 1568 Ralph Avenue, Brooklyn;
- 160-59 Rockaway Boulevard, Jamaica;
- 1650 Eastern Parkway, Brooklyn;
- 175 Fulton Avenue, Hempstead;
- 1767 Southern Boulevard, Bronx;
- 1975 Linden Boulevard, Elmont;
- 2184 Flatbush Avenue, Brooklyn;
- 2354 Westchester Avenue, Bronx;
- 2488 Grand Concourse, Bronx;
- 2598 3rd Avenue, Bronx;
- 3027 Avenue V, Brooklyn;
- 3041 Avenue U, Brooklyn;
- 31 Guy Lombardo Avenue, Freeport;
- 318 Seguire Avenue, Staten Island;
- 3626 Bailey Avenue, Bronx;
- 3805 Church Avenue, Brooklyn;

- 4014A Boston Road, Bronx;
- 409 Rockaway Avenue, Brooklyn;
- 420 Doughty Boulevard, Inwood;
- 4226 3rd Avenue, Bronx;
- 4250 White Plains Road, Bronx;
- 430 W Merrick Road, Valley Stream;
- 5402 Flatlands Avenue, Brooklyn;
- 550 Remsen Avenue, Brooklyn;
- 599-601 Southern Boulevard, Bronx;
- 60 Belmont Avenue, Brooklyn;
- 607 Westchester Avenue, Bronx;
- 611 E 76th Street, Brooklyn;
- 615 Seneca Avenue, Ridgewood;
- 62-69 99th Street, Rego Park;
- 647 Bryant Avenue, Bronx;
- 665 Pelham Parkway North, Bronx;
- 717 Southern Boulevard, Bronx;
- 8217 Woodhaven Boulevard, Queens;
- 893 Central Avenue, Woodmere;
- 9208 Jamaica Avenue, Queens; and
- 97-01 101st Avenue, Jamaica

56. In order to obtain access to the Clinics' patient base (i.e., Insureds), the Owner Defendants and Provider Defendants entered into illegal financial and kickback arrangements with the unlicensed persons who provided access to the patients that were treated, or who purported to be treated, at the Clinics.

57. The Owner Defendants and the Provider Defendants thereafter created fraudulent "billing opportunities" for health care services by subjecting Insureds at the Clinics to various medically unnecessary and illusory healthcare services, including purported diagnostic tests with no clinical basis, all to maximize profits without regard to genuine patient care.

58. In an attempt to conceal their wrongdoing, Defendants exploited the provision of the Fee Schedule that allows a professional healthcare practice to separately report the professional component and technical component of TCDs, VNGs, ultrasounds, and SSRs, using that as a basis to submit separate billing for the Fraudulent Services through the Provider Defendants.

59. Nevertheless, the Fraudulent Services billed under the names of the Provider Defendants were medically unnecessary and provided – to the extent provided at all – not only without any legitimate referral from a licensed professional, but also without any direction or supervision by a licensed professional regarding the nature, performance and quality of the technical services allegedly rendered by the Provider Defendants.

60. In keeping with the fact that the Fraudulent Services were performed without the supervision of a licensed professional, the healthcare providers that billed GEICO for the professional component of the Fraudulent Services did not make any determination as to the medical necessity of the services, did not conduct any examination of the Insureds, did not interact with the Insureds, and were not present when the Provider Defendants purported to administer the technical component of the highly specialized diagnostic tests (*i.e.*, the Fraudulent Services).

61. To further conceal their wrongdoing, Defendants elected to bill for the Fraudulent Services through four separate entities with unique tax identification numbers – Chai, Sinai, Refuah, and BLK – in order to limit the volume of bills submitted under a single tax identification number, in an attempt to avoid attracting the attention and scrutiny of the insurance industry to the volume of fraudulent billing originating from any one entity.

B. The Illegal Kickback and Referral Arrangements at the Clinics

62. Though ostensibly organized to provide a range of healthcare services to Insureds at a single location, the Clinics in actuality were organized to supply “one-stop” shops for no-fault insurance fraud.

63. Unlicensed laypersons, rather than the healthcare professionals working in the Clinics, created and controlled the patient base at the Clinics, and dictated fraudulent protocols used to maximize profits without regard to actual patient care.

64. The Clinics provided facilities for the Provider Defendants, as well as a “revolving door” of medical professional corporations, chiropractic professional corporations, physical therapy professional corporations and/or a multitude of other purported healthcare providers, all geared towards exploiting New York’s no-fault insurance system.

65. In fact, GEICO received billing from many of the Clinics from an ever-changing number of fraudulent healthcare providers, starting and stopping operations without any purchase or sale of a “practice”; without any legitimate transfer of patient care from one professional to another; and without any legitimate reason for the change in provider name beyond circumventing insurance company investigations and continuing the fraudulent exploitation of New York’s no-fault insurance system.

66. For example, GEICO has received billing for purported healthcare services rendered at the Clinic located at 60 Belmont Avenue, Brooklyn from a “revolving door” of more than 45 different healthcare services providers.

67. Additionally, GEICO has received billing for purported healthcare services rendered at the Clinic located at 146 Empire Boulevard, Bronx from a “revolving door” of more than 40 different healthcare services providers.

68. Additionally, GEICO has received billing for purported healthcare services rendered at the Clinic located at 1975 Linden Boulevard, Elmont from a “revolving door” of more than 40 different healthcare services providers.

69. Unlicensed laypersons, rather than the healthcare professionals working in the Clinics, created and controlled the patient base at the Clinics, and directed fraudulent protocols used to maximize profits without regard to genuine patient care.

70. For example, Phelan Clancy, NP, stated under oath that she resigned from the Clinic located at 1975 Linden Boulevard, Elmont after discovering, among other things, that her name, license, and tax identification number were being used to bill for services that she never performed, authorized, or supervised; that a stamped, forged and/or unauthorized copy of her signature was used to issue referrals for healthcare goods without her knowledge or consent; and that there was a written list on the wall at the Clinic that outlined the required prescribing/referral protocol and the quotas that had to be met.

71. In further keeping with the fact that unlicensed laypersons controlled many of the Clinics and directed fraudulent protocols used to maximize profits without regard to genuine patient care, one of the Clinics from which the Provider Defendants purported to operate is identified in United States of America v. Anthony Rose, et al., 19-cr-00789 (PGG)(S.D.N.Y.) (“USA v. Rose”) as being controlled by laypersons and as receiving patients as a result of illegal kickback and referral arrangements. The Government affidavits unsealed in USA v. Rose include excerpts of wiretaps and other evidence indicating that, among dozens of other locations, patients were steered to 1767 Southern Boulevard, Bronx – a layperson controlled Clinic where the Provider Defendants purported to administer Fraudulent Services to Insureds.

72. In addition, and in keeping with the fact that unlicensed laypersons controlled many of the Clinics and that the Defendants paid illegal kickbacks in exchange for patient referrals, GEICO has identified in a series of related investigations that a group of unlicensed laypersons combined to misappropriate and illegally use the name, New York license, signature and other relevant information of healthcare professionals based out of Maryland, New York and Missouri to bill GEICO for services purportedly performed at, among other locations: (i) 10825 Merrick Boulevard, Jamaica; (ii) 146 Empire Boulevard, Brooklyn; (iii) 160-59 Rockaway Boulevard,

Jamaica; (iv) 1975 Linden Boulevard, Elmont; (v) 2598 3rd Avenue, Bronx; (vi) 3027 Avenue V, Brooklyn; (vii) 3041 Avenue U, Brooklyn; (viii) 3626 Bailey Avenue, Bronx; (ix) 4226 3rd Avenue, Bronx; (x) 60 Belmont Avenue, Brooklyn; (xi) 611 E. 76th Street, Brooklyn; (xii) 615 Seneca Avenue, Ridgewood; (xiii) 82-17 Woodhaven Boulevard, Glendale; and (xiv) 9208 Jamaica Avenue, Queens. See Gov't Emples. Ins. Co., et al. v. Gary Grody a/k/a Lance Grody, et al., Dkt. No. 22-cv-03598 (BMC)(E.D.N.Y.); Gov't Emples. Ins. Co., et al. v. Gary Grody a/k/a Lance Grody, et al., Dkt. No. 22-cv-06187(KAM)(PK) (E.D.N.Y.); Gov't Emples. Ins. Co., et al. v. Susan J. Polino PhD., et al., Dkt. No. 1:22-cv-05178(ARR)(PK) (E.D.N.Y.); Gov't Emples. Ins. Co., et al. v. Poonawala, et al., Dkt. No. 1:22-cv-03063(PKC)(VMS) (E.D.N.Y.); Gov't Emples. Ins. Co., et al. v. Bily-Linder, et al., Dkt. No. 1:23-cv-00515(FB)(RML) (E.D.N.Y.).

73. In order to obtain access to the Clinics' patient base (i.e., Insureds) and create fraudulent "billing opportunities" for healthcare services, the Owner Defendants entered into illegal financial arrangements with unlicensed persons, including John Doe Defendants "1"- "10", who "brokered" or "controlled" patients that were treated, or who were purported to be treated, at the Clinics.

74. The Clinics willingly provided access to the Owner Defendants and the Provider Defendants in exchange for kickbacks because the Clinics were facilities that sought to profit from the "treatment" of individuals covered by No-Fault insurance and therefore catered to high volumes of Insureds at the locations.

75. The financial arrangements into which the Owner Defendants and the Provider Defendants entered included the payment of fees ostensibly to "rent" space or personnel from the Clinics or for ostensibly legitimate services.

76. However, the financial arrangements into which the Owner Defendants and the Provider Defendants entered were actually “pay-to-play” arrangements that caused unlicensed laypersons to steer Insureds to the Provider Defendants for medically unnecessary services at the Clinics.

77. In keeping with the fact that the ostensibly legitimate “rent” payments by the Owner Defendants and the Provider Defendants were actually disguised kickbacks in exchange for patient referrals, certain of the supposed “rent” payments were illegally exchanged for cash at a check-cashing facility in New Jersey by an individual named Alla Kuratova (“Kuratova”), who was previously indicted for recruiting individuals to act as phony patients in connection with an illegal prescription drug trafficking ring.

78. For a period of over five years, Kuratova illegally exchanged more than \$35 million worth of checks for cash at various New Jersey check-cashing facilities.

79. When deposed in connection with a separate no-fault insurance fraud action, Kuratova invoked her Fifth Amendment privilege against self-incrimination when asked whether the millions of dollars’ worth of checks were exchanged for cash to funnel money to unlicensed individuals that controlled medical clinics in exchange for patient referrals.

80. In further keeping with the fact that the payments made by the Owner Defendants and the Provider Defendants were actually disguised kickbacks in exchange for patient referrals, the Provider Defendants provided no legitimate or necessary services that warranted other providers at the Clinics to bring in the Provider Defendants to the Clinics to administer the Fraudulent Services.

81. The Owner Defendants and the Provider Defendants made the various kickback payments in exchange for having Insureds referred to the Provider Defendants for the medically

unnecessary Fraudulent Services at the Clinics, regardless of the individual's symptoms, presentment, or actual need for additional treatment.

82. The amount of kickbacks paid by the Owner Defendants and the Provider Defendants generally was based on the volume of Insureds that were steered to the Provider Defendants for the purported medically unnecessary services.

83. The Insureds that visited the Clinics had no scheduled appointments with the Provider Defendants.

84. Having no scheduled appointments, the Insureds were simply directed by the Clinics, and the unlicensed persons associated therewith, to subject themselves to treatment by whatever technician was working for the Provider Defendants that day, because of the kickbacks paid by the Owner Defendants and the Provider Defendants.

85. The unlawful kickback and payment arrangements were essential to the success of the Defendants' fraudulent scheme. The Defendants derived significant financial benefit from the relationships because without access to the Insureds, the Defendants would not have had the ability to execute the fraudulent treatment and billing protocol and bill GEICO and other insurers.

86. In fact, as a result of the unlawful financial arrangements, the Provider Defendants were able to submit more than \$1.8 million in fraudulent billing to GEICO for the medically useless services.

87. At all times the Defendants knew that the kickback and referral arrangements were illegal and therefore, took affirmative steps to conceal the existence of the fraudulent scheme.

88. In fact, Defendants split the billing for the Fraudulent Services across multiple entities in order to limit the amount of billing submitted by each Provider Defendant.

89. Defendants conducted their scheme through multiple entities using different tax identification numbers, in order to reduce the volume of fraudulent billing submitted through any single entity using any single tax identification number, avoid detection, and thereby perpetuate their fraudulent scheme and increase their ill-gotten gains.

C. The Defendants' Fraudulent Testing and Billing Protocol

90. Regardless of the nature of the accidents or the actual medical needs of the Insureds, the Defendants purported to subject virtually every Insured to a pre-determined fraudulent testing protocol without regard for the Insureds' individual symptoms or presentment.

91. In a legitimate clinical setting, when an individual injured in a motor vehicle accident seeks treatment from a healthcare services provider, the patient's subjective complaints would be evaluated, an objective evaluation would be performed, and the treating provider would direct a specific course of treatment based upon the patients' individual symptoms and presentation.

92. Here, by contrast, the Provider Defendants performed SSR and/or TCD and/or VNG and/or ultrasound tests on virtually every Insured, regardless of their individual symptoms and presentation, and typically absent any documented medical justification.

93. No legitimate physician or other healthcare provider would permit the fraudulent testing and billing protocol described below to proceed under his or her auspices. Rather, the Defendants orchestrated the fraudulent testing and billing protocol described below because they sought to profit from the fraudulent billing submitted to GEICO and other insurers.

1. The Fraudulent Charges for the Technical Component of SSR

94. The Defendants purported to subject virtually every Insured to fraudulent and medically unnecessary sympathetic skin response tests ("SSR").

95. Following the SSR, the Defendants then submitted billing to GEICO for the technical component of the SSR through Sinai, Refuah, and BLK, typically resulting in charges of more than \$300.00 for each session of SSR that Defendants purported to administer to each Insured.

96. The charges for the technical component of the SSR were fraudulent in that the SSR were medically unnecessary and were performed – to the extent they were performed at all – pursuant to the payments that were provided to the Clinics.

97. An individual's autonomic nervous system is responsible for regulating involuntary physiologic processes such as perspiration, heart rate, blood pressure, respiration, and digestion.

98. The autonomic nervous system is divided into two parts: the sympathetic nervous system and the parasympathetic nervous system.

99. In sum, the sympathetic nervous system is responsible for an individual's "fight or flight" response, and the parasympathetic nervous system is responsible for an individual's "rest and digest" response.

100. SSR evaluates the sympathetic nervous system by measuring the potential generated in skin sweat glands in response to a stimulus.

101. SSR's medical utility is primarily limited to patients with systemic diseases, such as diabetic neuropathy, Parkinson's, and amyotrophic lateral sclerosis (ALS).

102. SSR has extremely limited medical utility in diagnosing or treating injuries that could causally be related to an automobile accident.

103. In keeping with the fact that SSR has extremely limited medical utility in diagnosing or treating injuries that could causally be related to an automobile accident, virtually none of the examinations that the Insureds purportedly underwent prior to receiving the SSR

documented any findings with respect to the Insureds' autonomic nervous system that would warrant SSR testing.

104. Moreover, there are a substantial number of variables that can affect whether, how, and to what extent an individual is injured in a given motor vehicle accident.

105. An individual's age, height, weight, general physical condition, location within the vehicle, and the location of the impact all will affect whether, how, and to what extent an individual is injured in a motor vehicle accident.

106. It is extremely improbable – to the point of absurdity – that multiple Insureds involved in the same motor vehicle accident who treated at a specific No-Fault Clinic would routinely require SSR at or about the same time.

107. Even so, and in keeping with the fact that the SSR purportedly administered by the Provider Defendants were not medically necessary and were performed pursuant to predetermined protocols designed to maximize profits, the Defendants routinely provided SSR to multiple Insureds involved in the same accident at or about the same time.

108. For example:

- (i) On July 25, 2021, two Insureds, SM and KB, were involved in the same motor vehicle accident. Thereafter, SM and KB both – incredibly – received SSR provided by Sinai on the exact same date, August 30, 2021.
- (ii) On September 7, 2021, two Insureds, JAR and MP, were involved in the same motor vehicle accident. Thereafter, JAR and MP both – incredibly – received SSR provided by Sinai on the exact same date, September 20, 2021.
- (iii) On September 5, 2021, two Insureds, FP and DM, were involved in the same motor vehicle accident. Thereafter, FP and DM both – incredibly – received SSR provided by Sinai on the exact same date, September 23, 2021.
- (iv) On October 10, 2022, two Insureds, CC and AR, were involved in the same motor vehicle accident. Thereafter, CC and AR both – incredibly – received SSR provided by Sinai on the exact same date, November 7, 2022.

- (v) On March 18, 2023, two Insureds, DB and AM, were involved in the same motor vehicle accident. Thereafter, DB and AM both – incredibly – received SSR provided by Refuah on the exact same date, March 27, 2023.
- (vi) On May 28, 2021, two Insureds, JAA and GT, were involved in the same motor vehicle accident. Thereafter, JAA and GT both – incredibly – received SSR provided by Sinai on the exact same date, June 21, 2021.
- (vii) On May 23, 2021, two Insureds, KN and AN, were involved in the same motor vehicle accident. Thereafter, KN and AN both – incredibly – received SSR provided by BLK on the exact same date, June 14, 2021.
- (viii) On August 6, 2021, three Insureds, ED, WA, and OP, were involved in the same motor vehicle accident. Thereafter, ED, WA, and OP all – incredibly – received SSR provided by BLK on the exact same date, August 17, 2021.
- (ix) On January 20, 2021, two Insureds, WA and KL, were involved in the same motor vehicle accident. Thereafter, WA and KL both – incredibly – received SSR provided by Refuah on the exact same date, February 22, 2021.
- (x) On June 22, 2023, two Insureds, SJ and AY, were involved in the same motor vehicle accident. Thereafter, SJ and AY both – incredibly – received SSR provided by Refuah on the exact same date, August 9, 2023.

109. These are only representative examples. In many of the claims identified in Exhibits “2” through “4”, two or more Insureds who were involved in the same underlying motor vehicle accident received SSR through Sinai, BLK, and Refuah at or about the same time, despite the fact that the Insureds were differently situated.

110. Because the Defendants knew that the SSR was useless, the results that the Defendants purported to obtain from the tests were typically not incorporated into any Insured’s treatment plan.

111. The SSR was purportedly rendered and then billed to GEICO pursuant to the Defendants’ fraudulent treatment and billing protocols designed solely to financially enrich the Defendants, rather than to benefit any of the Insureds who supposedly were subjected to the tests.

2. The Fraudulent Charges for the Technical Component of TCD

112. The Defendants also subjected many Insureds to fraudulent and medically unnecessary Transcranial Doppler Testing (“TCD”).

113. The Defendants then submitted billing to GEICO for the technical component of the TCD through Chai, typically resulting in identical charges of \$1,155.24 for each session of TCD that Chai purported to administer to each Insured.

114. The charges for the technical component of the TCD were fraudulent in that the TCD was medically unnecessary and was performed – to the extent that it was performed at all – pursuant to the payments that were provided to the Clinics.

115. TCD is a technique that uses sound waves to evaluate blood flow in and around the brain.

116. TCD typically uses a doppler transducer that enables recording of blood flow velocities within intracranial arteries through selected cranial foramina and thin regions of the skull. Mapping of the sampled velocities as a color display of spectra locates the major brain arteries in three dimensions.

117. TCD obtains information about the physiology of blood flow through the intracranial cerebrovascular system.

118. Headaches, dizziness, and/or head trauma alone are not indications for TCD studies of the intracranial cerebrovascular system.

119. Rather – in a legitimate healthcare setting – TCD evaluation of the intracranial cerebrovascular system is generally used in connection with the following:

- (i) Vasospasm, following a ruptured brain aneurysm;
- (ii) Sickle cell anemia, to determine a patient’s risk of stroke;

- (iii) Ischemic stroke;
- (iv) Intracranial stenosis or blockage of the blood vessels;
- (v) Cerebral microemboli; and/or
- (vi) Patent Foramen Ovale, a hole in the heart that does not close properly after birth, which may provoke embolic stroke.

120. Depending on the types of measurement needed, TCD studies can take at least 45 minutes, if not more.

121. In keeping with the fact that the TCD billed by Chai was medically useless and performed pursuant to predetermined treatment protocols rather than to benefit any of the Insureds subjected to the Fraudulent Services, the medical examinations performed prior to the TCD failed to screen for the symptoms or signs that would warrant TCD.

122. To the extent that anyone actually conducted medical examinations that assessed the Insureds' neurological symptoms, in virtually every case where the Defendants purported to provide TCD, the Insured did not suffer any sort of injury as a result of the motor vehicle accident that would warrant the TCD.

123. Indeed, in many cases, Insureds who received TCD from Chai did not report suffering any sort of head injury in the examination reports that preceded the purported referral for TCD.

124. For example:

- (i) On September 21, 2022, a patient named AH was purportedly involved in a motor vehicle accident. On September 30, 2022, AH underwent a medical examination with Jordan Fersel, M.D. at Jordan Fersel, M.D. PC at which AH reported no head injury. Nevertheless, pursuant to a referral purportedly issued by Jordan Fersel, M.D., on October 13, 2022, AH underwent TCD that was purportedly administered by Chai.
- (ii) On August 28, 2022, a patient named JE was purportedly involved in a motor vehicle accident. On September 26, 2022, JE underwent a medical

examination with Jean-Pierre Georges Barakat, M.D. at Far Rockaway Medical PC at which JE reported no head injury. Nevertheless, pursuant to a referral purportedly issued by Jean-Pierre Georges Barakat, M.D., on October 19, 2022, JE underwent TCD that was purportedly administered by Chai.

- (iii) On December 5, 2020, a patient named MP was purportedly involved in a motor vehicle accident. On May 24, 2021, MP underwent a medical examination with Jean-Pierre Georges Barakat, M.D. at Far Rockaway Medical PC at which MP reported no head injury. Nevertheless, pursuant to a referral purportedly issued by Jean-Pierre Georges Barakat, M.D., on May 26, 2021, MP underwent TCD that was purportedly administered by Chai.
- (iv) On March 26, 2021, a patient named DI was purportedly involved in a motor vehicle accident. On April 8, 2021, DI underwent a medical examination with Jordan Fersel, M.D. at Jordan Fersel, M.D. PC at which DI reported no head injury. Nevertheless, pursuant to a referral purportedly issued by Jordan Fersel, M.D., on April 14, 2021, DI underwent TCD that was purportedly administered by Chai.
- (v) On April 7, 2021, a patient named JL was purportedly involved in a motor vehicle accident. On April 30, 2021, JL underwent an examination with Walter Mendoza, D.C. at Walter E Mendoza Chiropractor at which JL reported no head injury. Nevertheless, pursuant to a referral purportedly issued by Walter Mendoza, D.C., on May 3, 2021, JL underwent TCD that was purportedly administered by Chai.

125. These are only representative examples.

126. Indeed, even had the Insureds displayed symptoms warranting TCD – and they typically did not – in a legitimate clinical setting, the healthcare provider would initially administer a TCD of the intracranial arteries, billed under CPT code 93886, and would only proceed to perform a vasoreactivity test billed under CPT code 93890, or a microemboli study billed under CPT code 93892 if the Insured displayed symptoms or findings warranting that additional testing. Nevertheless, the technicians working for Chai purported to perform all three studies on virtually every Insured who received TCD.

127. Additionally, the technical component of the TCD as provided by Chai generated “TCD Exam Data,” an example of which is below:

TCD Exam Data:
(In the report, the unit of Peak/Mean/Dias is cm/s, Depth's unit is mm, others have no unit)

Vessel	Depth	Peak	Mean	Dias	PI	RI	SBI	S/D	HR	DIR
RMCA	52	75	52	40	0.68	0.47	0.35	1.88	146	Toward
RACA	62	33	24	19	0.59	0.42	0.34	1.74	146	Reverse
RPCA	67	38	26	20	0.69	0.47	0.09	1.90	117	Toward
LMCA	52	83	57	44	0.68	0.47	0.08	1.89	107	Toward
LACA	62	34	21	15	0.89	0.56	0.46	2.27	110	Reverse
LPCA	67	38	26	20	0.69	0.47	0.31	1.90	110	Toward
ROA	47	22	16	13	0.56	0.41	0.63	1.69	105	Toward
LOA	47	22	15	12	0.65	0.45	0.40	1.83	64	Toward
RVA	62	33	22	17	0.72	0.48	0.31	1.94	122	Reverse
LVA	62	30	21	16	0.68	0.47	0.40	1.88	117	Reverse
BA	75	27	21	18	0.43	0.33	0.18	1.50	142	Reverse
vmr pre	52	78	53	40	0.72	0.49	0.39	1.95	97	Toward
vmr hold	52	70	52	43	0.52	0.39	0.06	1.63	107	Toward
vmr after	52	78	53	41	0.69	0.47	0.45	1.90	182	Toward
hits	52	78	51	38	0.78	0.51	0.45	2.05	125	Toward

128. The “Depth” measurement contained in the “TCD Exam Data” purports to measure the size of each Insured’s head, as well as the location of blood vessels therein.

129. However, virtually every Insured subjected to the TCD purportedly had one of a finite set of depth measurements, with many presenting identical depth measurements. In other words, according to the “TCD Exam Data” generated by Chai, many of the Insureds had identically-sized heads with identically-located blood vessels.

130. For example:

- (i) On July 30, 2022, an Insured named VM was involved in a motor vehicle accident. On October 6, 2022, VM received TCD provided by Chai. As a result of that TCD, Chai generated “TCD Exam Data” with the following depth values: 52, 62, 67, 52, 62, 67, 47, 47, 62, 62, 75, 52, 52, 52, 52.
- (ii) On September 21, 2022, an Insured named AH was involved in a motor vehicle accident. On October 13, 2022, AH received TCD provided by Chai. As a result of that TCD, Chai generated “TCD Exam Data” with the following depth values: 52, 62, 67, 52, 62, 67, 47, 47, 62, 62, 75, 52, 52, 52, 52.

- (iii) On August 28, 2022, an Insured named JE was involved in a motor vehicle accident. On October 19, 2022, JE received TCD provided by Chai. As a result of that TCD, Chai generated “TCD Exam Data” with the following depth values: 52, 62, 67, 52, 62, 67, 47, 47, 62, 62, 75, 52, 52, 52, 52.
- (iv) On April 26, 2022, an Insured named CA was involved in a motor vehicle accident. On May 18, 2022, CA received TCD provided by Chai. As a result of that TCD, Chai generated “TCD Exam Data” with the following depth values: 52, 62, 67, 52, 62, 67, 47, 47, 62, 62, 75, 52, 52, 52, 52.
- (v) On April 12, 2022, an Insured named RL was involved in a motor vehicle accident. On May 11, 2022, RL received TCD provided by Chai. As a result of that TCD, Chai generated “TCD Exam Data” with the following depth values: 52, 62, 67, 52, 62, 67, 47, 47, 62, 62, 75, 52, 52, 52, 52.
- (vi) On December 5, 2020, an Insured named PM was involved in a motor vehicle accident. On May 26, 2021, PM received TCD provided by Chai. As a result of that TCD, Chai generated “TCD Exam Data” with the following depth values: 52, 62, 67, 52, 62, 67, 47, 47, 62, 62, 75, 52, 52, 52, 52.
- (vii) On April 27, 2022, an Insured named MW was involved in a motor vehicle accident. On July 13, 2022, MW received TCD provided by Chai. As a result of that TCD, Chai generated “TCD Exam Data” with the following depth values: 52, 62, 67, 52, 62, 67, 47, 47, 62, 62, 75, 52, 52, 52, 52.
- (viii) On April 23, 2022, an Insured named MT was involved in a motor vehicle accident. On June 20, 2022, MT received TCD provided by Chai. As a result of that TCD, Chai generated “TCD Exam Data” with the following depth values: 52, 62, 67, 52, 62, 67, 47, 47, 62, 62, 75, 52, 52, 52, 52.
- (ix) On March 26, 2021, an Insured named SH was involved in a motor vehicle accident. On April 14, 2021, SH received TCD provided by Chai. As a result of that TCD, Chai generated “TCD Exam Data” with the following depth values: 52, 62, 67, 52, 62, 67, 47, 47, 62, 62, 75, 52, 52, 52, 52.
- (x) On March 26, 2021, an Insured named DI was involved in a motor vehicle accident. On April 14, 2021, DI received TCD provided by Chai. As a result of that TCD, Chai generated “TCD Exam Data” with the following depth values: 52, 62, 67, 52, 62, 67, 47, 47, 62, 62, 75, 52, 52, 52, 52.

131. These are only representative examples.

132. It is extremely improbable – to the point of impossibility – that such a large number of Insureds who were subjected to TCD would present with identical depth measurements.

133. As with the other Fraudulent Services, the TCD was purportedly rendered and then billed to GEICO pursuant to the Defendants' fraudulent treatment and billing protocols designed solely to financially enrich the Defendants, rather than to benefit any of the Insureds who supposedly were subjected to the tests.

3. The Fraudulent Charges for the Technical Component of VNG

134. The Defendants also purported to subject many Insureds to fraudulent and medically unnecessary videonystagmography tests ("VNG").

135. The VNG were typically provided at or around the same time as the Defendants subjected the Insureds to the medically unnecessary TCD.

136. Following the VNG, the Defendants then submitted billing to GEICO for the technical component of the VNG through Chai, typically resulting in identical charges of \$233.21 for each session of VNG that Chai purported to administer to each Insured.

137. The charges for the technical component of the VNG were fraudulent in that the VNG were medically unnecessary and were performed – to the extent they were performed at all – pursuant to the payments that were provided to the Clinics.

138. VNG consists of tests that can be used to determine the cause of a patient's vertigo or balance disorder in cases where there are no readily recognizable contributing factors to the patient's condition.

139. In other words, VNG is not used to confirm the existence of dizziness or balance disorder, but rather to identify the origin of the condition in the relatively rare cases where it cannot be determined by an ear, nose, and throat ("ENT") specialist or a neurological medical examination. Generally, VNG is employed to determine the source of the generation of vertigo (i.e., the inner ear or brain).

140. VNG involves the recording of involuntary eye movements, called nystagmus, using video imaging technology. The nystagmus is recorded and analyzed using sophisticated video goggles which are equipped with infrared video cameras. The patient wears those goggles while being subjected to various stimuli, which duplicates the extraocular movement portion of the physical examination.

141. There are four main components to VNG: (i) the saccade test, which evaluates rapid eye movements between fixation points, (ii) the tracking test, which evaluates movement of the eyes as they pursue a visual target; (iii) the positional test, which measures eye movements associated with positions of the head; and (iv) the caloric test, which measures responses to warm or cold water or air circulated through the ear canal. The cameras record the eye movements and display them on a video/computer screen. This allows the physician to see how the eyes move, which helps the physician assess the source of vertigo, which in turn helps the physician assess the cause of the balance disorder.

142. To properly administer VNG, the patient must be prepared appropriately. This preparation typically requires: (i) 72 hours of abstention from medication (with the exception of heart, high blood pressure and anticonvulsant medications); (ii) 24 hours of abstention from stimulants such as caffeine, as well as alcohol; and (iii) three hours of food abstention. In addition, patients must be provided with a pre-test history and examination to determine – among other things – the nature of the problematic symptoms and the patient’s eye movements.

143. In keeping with the fact that VNG tests were medically unnecessary, upon information and belief, no physician or healthcare services provider associated with the Defendants properly prepared the Insureds for the tests. This, in turn, rendered the data that Chai purported to generate from the test unreliable and useless.

144. VNG should not be used as a first-line diagnostic procedure when a patient reports dizziness as a result of an automobile accident. In a legitimate healthcare setting, the diagnostic process for a patient reporting dizziness following a motor vehicle accident should begin with a physical examination, including an ENT and neurological examination, followed by conservative care. If the patient does not respond to conservative care or the physical examination was abnormal, an MRI of the brain may be ordered. If a patient does not respond to conservative care and the brain MRI is negative, the patient may be evaluated by an ENT or neurologist to determine if VNG is warranted.

145. Virtually none of the Insureds were referred to receive VNG by an ENT or a neurologist, many did not undergo conservative care prior to undergoing VNG with the Defendants, and few – if any – received a brain MRI prior to undergoing VNG.

146. To the extent that anyone actually conducted medical examinations that assessed the Insureds' neurological symptoms, many of the Insureds to whom the Defendants purported to provide VNG did not report experiencing dizziness, imbalance, or vertigo in the examination reports that preceded the VNG.

147. For example:

- (i) On March 7, 2021, a patient named KH was purportedly involved in a motor vehicle accident. On July 12, 2021, KH underwent a medical examination with Jean Pierre Georges Barakat, M.D. at Far Rockaway Medical, P.C., at which KH reported no dizziness, imbalance, or vertigo. Nevertheless, on July 28, 2021, KH underwent VNG that was provided by Chai.
- (ii) On April 10, 2021, a patient named DT was purportedly involved in a motor vehicle accident. On April 22, 2021, DT underwent a medical examination with Jordan Fersel, M.D. at Jordan Fersel M.D., P.C., at which DT reported no dizziness, imbalance, or vertigo. Nevertheless, on April 28, 2021, DT underwent VNG that was provided by Chai.
- (iii) On April 10, 2021, a patient named ST was purportedly involved in a motor vehicle accident. On April 22, 2021, ST underwent a medical examination

with Jordan Fersel, M.D. at Jordan Fersel M.D., P.C., at which DT reported no dizziness, imbalance, or vertigo. Nevertheless, on June 30, 2021, DT underwent VNG that was provided by Chai.

- (iv) On March 27, 2021, a patient named AA was purportedly involved in a motor vehicle accident. On April 15, 2021, AA underwent a medical examination with Yasmeeen Khan, M.D. at YK Medical, PLLC, at which AA reported no dizziness, imbalance, or vertigo. Nevertheless, on April 30, 2021, AA underwent VNG that was provided by Chai.
- (v) On March 21, 2021, a patient named FY was purportedly involved in a motor vehicle accident. On March 25, 2021, FY underwent a medical examination with Jordan Fersel, M.D. at Jordan Fersel M.D., P.C., at which FY reported no dizziness, imbalance, or vertigo. Nevertheless, on April 14, 2021, FY underwent VNG that was provided by Chai.

148. These are only representative examples.

149. Indeed, even if an Insured reported the existence of some general form of dizziness or balance disorder – and they typically did not – the VNG was medically unnecessary because the cause of the Insured’s dizziness or imbalance could be identified through the examinations routinely purportedly provided prior to the VNG, and the patient histories that were purportedly taken during every initial examination and follow-up examinations.

150. Because the VNG was unreliable and useless, the data that the Defendants purported to obtain from the tests were virtually never incorporated into the Insured’s treatment plan. Even in cases where the VNG returned a positive result, the Insured rarely – if ever – underwent any form of vestibular rehabilitation, balance retraining, or any therapy to address their putative balance issues.

151. In keeping with the fact that the VNG was unreliable and useless, the technical component of the VNG as provided by Chai generated test reports that virtually always contained the following preprinted boilerplate test results:

Oculomotor Tests:

1. Visual pursuit- Smooth accurate pursuit movements with normal gain.
2. Saccades - Normal peak velocity and normal delay.
3. Visual optokinetic Test - OPK nystagmus is rhythmic, with normal and symmetric waveform morphology.

Gaze:

1. Spontaneous Nystagmus - not present.
 2. Gaze Evoked Nystagmus - there was no nystagmus appears in any position of gaze.
- Rotational tests- Active head rotation tests (AHR) in the horizontal and vertical directions were within normal thresholds.

Torsion Tests: - Normal waveform morphology.

Positioning and Positional Subtests:

Dix-Hallpikes (left, right): Negative for Hallpike findings and benign paroxysmal positioning vertigo (BPPV) diagnosis. No nystagmus evoked.

Positional Tests: Positional testing was unremarkable in all head and body positions.

Bithermal Caloric Tests: The responses to warm and cool caloric were without unilateral weakness bilaterally. Caloric fixation suppression was normal for all four irrigations.

152. As with the other Fraudulent Services, the VNG was purportedly rendered and then billed to GEICO pursuant to the Defendants' fraudulent treatment and billing protocols designed solely to financially enrich the Defendants, rather than to benefit any of the Insureds who supposedly were subjected to the tests.

4. The Fraudulent Charges for the Technical Component of Ultrasound Tests

153. The Defendants also purported to subject many Insureds to multiple fraudulent and medically unnecessary ultrasound tests.

154. For these services, the Defendants typically billed GEICO under CPT code(s) 76800 and 76881 through Chai.

155. To the extent any such testing is actually performed, Defendants often provided spinal ultrasound testing.

156. An ultrasound is a noninvasive imaging technique that relies on detection of the reflections or echoes generated as high-frequency sound waves are passed into the body. Physicians commonly use this technique for a number of imaging purposes such as investigation of abdominal and pelvic masses, cardiac echocardiography, and prenatal fetal imaging.

157. Nevertheless, there is no support for the use of spinal ultrasound tests in the evaluation of patients with back pain or radicular symptoms. The procedure is worthless and of no clinical value in the manner administered by the Provider Defendants to purportedly diagnose and treat Insureds presenting with back pain or radicular symptoms, allegedly caused by automobile accidents.

158. The American Institute of Ultrasound Medicine (“AIUM”), which consists of thousands of healthcare professionals and is dedicated to advancing the safe and effective use of ultrasound medicine, determined that “the use of non-operative spinal/paraspinal ultrasound in adults...for diagnostic evaluation, including pain or radiculopathy syndromes, and for monitoring of therapy has no proven clinical utility.” See Exhibit “5”.

159. The American Academy of Neurology (“AAN”) issued a report that evaluated the use of spinal ultrasound for diagnosing back pain and radicular disorders. The report concluded that there is no support for the use of diagnostic ultrasound in the evaluation of patients with back pain or radicular symptoms. The procedure cannot be recommended for use in the clinical evaluation of such patients. See Exhibit “6”.

160. Consistent with the above-referenced authorities, the New York State Workers Compensation Board, Mid & Low Back Injury Medical Treatment Guidelines also state that “Diagnostic ultrasound is not recommended for patient with back pain.” See Exhibit “7”.

161. Despite the lack of medical value or utility in the context of No-Fault automobile accident victims purportedly presenting with spinal/paraspinal injuries, the Defendants have submitted, or caused to be submitted, thousands of dollars in bills for spinal and paraspinal ultrasound tests to GEICO, as part of the Fraudulent Services.

162. As with the other Fraudulent Services, the ultrasounds were purportedly rendered and then billed to GEICO pursuant to the Defendants' fraudulent treatment and billing protocols designed solely to financially enrich the Defendants, rather than to benefit any of the Insureds who supposedly were subjected to the tests.

III. The Fraudulent Billing the Defendants Submitted and Caused to be Submitted to GEICO

163. To support their fraudulent charges, the Defendants systematically submitted or caused to be submitted hundreds of NF-3 forms, HCFA-1500 forms, and/or treatment reports through the Provider Defendants to GEICO seeking payment for the Fraudulent Services for which the Defendants were not entitled to receive payment.

164. The billing forms (i.e., NF-3 and/or HCFA-1500 forms) and treatment reports were submitted to GEICO by and on behalf of the Provider Defendants through either the United States mail or through interstate facsimile transmissions.

165. The billing forms (i.e., NF-3 and/or HCFA-1500 forms) and treatment reports submitted to GEICO by and on behalf of the Provider Defendants were false and misleading in the following material respects:

- (i) The billing forms and supporting documentation submitted by and on behalf of the Provider Defendants uniformly misrepresented to GEICO that the Fraudulent Services were medically necessary. In fact, the Fraudulent Services, to the extent provided at all, were not medically necessary and were provided pursuant to pre-determined fraudulent protocols designed solely to financially enrich Defendants, rather than to treat or otherwise benefit the Insureds;
- (ii) The billing forms and supporting documentation submitted by and on behalf of the Provider Defendants uniformly fraudulently concealed the fact that the Fraudulent Services were provided – to the extent provided at all – pursuant to the dictates of laypersons not licensed to render healthcare services, without supervision by a licensed professional, and as a result of illegal kickback arrangements amongst the Defendants and others; and

- (iii) The billing forms and supporting documentation submitted by and on behalf of the Provider Defendants uniformly fraudulently concealed the fact that the Fraudulent Services, in many cases, never were actually provided in the first instance.

IV. The Defendants' Fraudulent Concealment and GEICO's Justifiable Reliance

166. Defendants legally and ethically were obligated to act honestly and with integrity in connection with the billing they submitted, or caused to be submitted, to GEICO.

167. To induce GEICO to promptly pay the fraudulent charges for the Fraudulent Services, the Defendants systematically concealed their fraud and went to great lengths to accomplish this concealment.

168. Specifically, the Defendants knowingly misrepresented and concealed facts related to their relationship as part of an integrated scheme, by purporting to operate the Provider Defendants as four separate entities, and further, concealed their collusive relationships with the Clinics to prevent discovery of the fact that the Defendants unlawfully exchanged kickbacks for patient referrals.

169. Further, the Defendants entered into complex financial arrangements that were designed to – and did – conceal the fact that the Defendants unlawfully exchanged kickbacks for patient referrals.

170. Additionally, the Defendants knowingly misrepresented and concealed facts in order to prevent GEICO from discovering that the Fraudulent Services were medically unnecessary and provided, to the extent provided at all, pursuant to predetermined protocols designed to maximize the charges that could be submitted, rather than to benefit the Insureds who supposedly received the Fraudulent Services.

171. The Defendants hired law firms to pursue collection of the fraudulent charges from GEICO and other insurers. These law firms routinely filed expensive and time-consuming litigation against GEICO and other insurers if the charges were not promptly paid in full.

172. The Defendants' ongoing collection efforts through numerous separate No-Fault collection proceedings, which proceedings may continue for years, are an essential part of the fraudulent scheme since Defendants know it is impractical for an arbitrator or civil court judge in a single No-Fault arbitration or civil court proceeding, typically involving a single bill, to uncover or address the Defendants' large-scale, complex fraud scheme involving numerous patients across numerous different clinics located throughout the New York metropolitan area.

173. GEICO is under statutory and contractual obligations to promptly and fairly process claims within 30 days. GEICO takes steps to timely respond to all claims and to ensure that No-Fault claim denial forms or requests for additional verification of No-Fault claims are properly addressed and mailed in a timely manner.

174. The facially-valid documents submitted to GEICO in support of the fraudulent charges at issue, combined with the material misrepresentations and fraudulent litigation activity described above, were designed to and did cause GEICO to rely upon them. As a result, GEICO incurred damages of more than \$340,000.00 based upon the fraudulent charges.

175. Based upon the Defendants' material misrepresentations and other affirmative acts to conceal their fraud from GEICO, GEICO did not discover and could not reasonably have discovered that its damages were attributable to fraud until shortly before it filed this Complaint.

AS AND FOR A FIRST CAUSE OF ACTION
Against the Provider Defendants and the Owner Defendants
(Declaratory Judgment – 28 U.S.C. §§ 2201 and 2202)

176. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

177. There is an actual case in controversy between GEICO, the Provider Defendants and the Owner Defendants regarding more than \$1 million in pending fraudulent No-Fault billing for the Fraudulent Services that have been submitted to GEICO under the name of the Provider Defendants.

178. The Provider Defendants and the Owner Defendants have no right to receive payment for any pending bills submitted to GEICO because the Provider Defendants and the Owner Defendants billed GEICO for the Fraudulent Services that were not medically necessary and were provided pursuant to predetermined fraudulent protocols designed to exploit patients for financial gain, without regard to genuine patient care.

179. The Provider Defendants and the Owner Defendants have no right to receive payment for any pending bills submitted to GEICO because the Fraudulent Services were provided – to the extent provided at all – pursuant to the dictates of laypersons not licensed to render healthcare services, without supervision by a licensed professional, and as a result of unlawful kickback and financial arrangements.

180. The Provider Defendants and the Owner Defendants have no right to receive payment for any pending bills submitted to GEICO because the Fraudulent Services, in many cases, never were actually provided in the first instance.

181. Accordingly, GEICO requests a judgment pursuant to the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202, declaring that the Owner Defendants have no right to receive

payment for any pending bills submitted to GEICO under the names of any of the Provider Defendants.

AS AND FOR A SECOND CAUSE OF ACTION
Against Kofman, D. Bogatin, and G. Bogatin
(Violation of RICO, 18 U.S.C. § 1962(c))

182. GEICO incorporates, as though fully set forth herein, each and every allegation set forth above.

183. Chai is an ongoing “enterprise,” as that term is defined in 18 U.S.C. § 1961(4), that engages in activities which affect interstate commerce.

184. Kofman, D. Bogatin, and G. Bogatin knowingly have conducted and/or participated, directly or indirectly, in the conduct of Chai’s affairs through a pattern of racketeering activity consisting of repeated violations of the federal mail fraud statute, 18 U.S.C. § 1341, and federal wire fraud statute, 18 U.S.C. § 1343, based upon the use of the United States mails and interstate wires to submit or cause to be submitted hundreds of fraudulent charges on a continuous basis for over two years seeking payments that Chai was not eligible to receive under the No-Fault Laws because: (i) the billed-for-services were not medically necessary; (ii) the billed-for-services were performed and billed pursuant to a pre-determined, fraudulent treatment and billing protocol designed solely to enrich Defendants; (iii) in many cases, the Fraudulent Services were never actually performed in the first instance; and (iv) Chai obtained its patients through the Defendants’ illegal kickback scheme. The fraudulent billings and corresponding mailings/interstate wire transmissions submitted to GEICO that comprise, in part, the pattern of racketeering activity identified through the date of this Complaint are described in the chart annexed hereto as Exhibit “1”.

185. Chai's business is racketeering activity, inasmuch as the enterprise exists for the purpose of submitting fraudulent charges to insurers. The predicate acts of mail fraud and wire fraud are the regular ways in which Kofman, D. Bogatin, and G. Bogatin operated Chai, inasmuch as Chai never was eligible to bill for or collect No-Fault Benefits and acts of mail fraud and wire fraud therefore were essential in order for Chai to function. Furthermore, the intricate planning required to carry out and conceal the predicate acts of mail fraud and wire fraud implies a threat of continued criminal activity, as does the fact that Defendants continue to attempt collection on the fraudulent billing submitted through Chai to the present day.

186. Chai is engaged in inherently unlawful acts inasmuch as it continues to attempt collection on fraudulent billing submitted to GEICO and other insurers. These inherently unlawful acts are taken by Chai in pursuit of inherently unlawful goals – namely, the theft of money from GEICO and other insurers through fraudulent no-fault billing.

187. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$64,000.00 pursuant to the fraudulent bills submitted by the Defendants through Chai.

188. By reason of its injury, GEICO is entitled to treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c), and any other relief the Court deems just and proper.

AS AND FOR A THIRD CAUSE OF ACTION
Against Kofman, D. Bogatin, G. Bogatin, and John Doe Defendants "1"- "10"
(Violation of RICO, 18 U.S.C. § 1962(d))

189. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

190. Chai is an ongoing “enterprise,” as that term is defined in 18 U.S.C. § 1961(4), that engaged in activities which affected interstate commerce.

191. Kofman, D. Bogatin, G. Bogatin, and John Doe Defendants “1”-“10” knowingly have agreed, combined and conspired to conduct and/or participate, directly or indirectly, in the conduct of Chai’s affairs through a pattern of racketeering activity consisting of repeated violations of the federal mail fraud statute, 18 U.S.C. § 1341, and federal wire fraud statute, 18 U.S.C. § 1343, based upon the use of the United States mails and interstate wires to submit or cause to be submitted hundreds of fraudulent charges on a continuous basis for over two years seeking payments that Chai was not eligible to receive under the No-Fault Laws because: (i) the billed-for-services were not medically necessary; (ii) the billed-for-services were performed and billed pursuant to a pre-determined, fraudulent treatment and billing protocol designed solely to enrich Defendants; (iii) in many cases, the Fraudulent Services were never actually performed in the first instance; and (iv) Chai obtained its patients through the Defendants’ illegal kickback scheme. The fraudulent billings and corresponding mailings/interstate wire transmissions submitted to GEICO that comprise, in part, the pattern of racketeering activity identified through the date of this Complaint are described in the chart annexed hereto as Exhibit “1”.

192. Kofman, D. Bogatin, G. Bogatin, and John Doe Defendants “1”-“10” knew of, agreed to, and acted in furtherance of the common overall objective (i.e., to defraud GEICO and other insurers of money) by submitting or facilitating the submission of the fraudulent charges to GEICO.

193. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$64,000.00 pursuant to the fraudulent bills submitted by Defendants through Chai.

194. By reason of its injury, GEICO is entitled to treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c), and any other relief the Court deems just and proper.

AS AND FOR A FOURTH CAUSE OF ACTION
Against Kofman, D. Bogatin, G. Bogatin, and Chai
(Common Law Fraud)

195. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

196. Kofman, D. Bogatin, G. Bogatin, and Chai intentionally and knowingly made false and fraudulent statements of material fact to GEICO and concealed material facts from GEICO in the course of their submission of hundreds of fraudulent bills seeking payment for the Fraudulent Services.

197. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that Defendants were acting lawfully and, therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) and 11 N.Y.C.R.R. § 65-3.16(a)(12), when, in fact the Fraudulent Services purportedly provided were the result of unlawful kickback and financial arrangements; (ii) in every claim, the representation that the billed-for services were medically necessary when, in fact, the Fraudulent Services were not medically necessary and were provided pursuant to fraudulent predetermined treatment and billing protocols designed to exploit the patients for financial gain, without regard for genuine patient care; and (iii) in every claim, the representation that the billed-for services were medically necessary when, in fact, the Fraudulent Services, in many cases, never were actually provided in the first instance.

198. Kofman, D. Bogatin, G. Bogatin, and Chai intentionally made the above-described false and fraudulent statements and concealed material facts in a calculated effort to induce GEICO to pay charges submitted through Chai that were not compensable under the No-Fault Laws.

199. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$64,000.00 pursuant to the fraudulent billing submitted by Defendants.

200. The extensive fraudulent conduct by Kofman, D. Bogatin, G. Bogatin, and Chai demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

201. Accordingly, by virtue of the foregoing, GEICO is entitled to compensatory and punitive damages, together with interest and costs, and any other relief the Court deems just and proper.

AS AND FOR A FIFTH CAUSE OF ACTION
Against Kofman, D. Bogatin, G. Bogatin, and Chai
(Unjust Enrichment)

202. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

203. As set forth above, Kofman, D. Bogatin, G. Bogatin, and Chai have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of GEICO.

204. When GEICO paid the bills and charges submitted by or on behalf of Chai for No-Fault Benefits, it reasonably believed that it was legally obligated to make such payments based on the Defendants' improper, unlawful, and/or unjust acts.

205. Kofman, D. Bogatin, G. Bogatin, and Chai have been enriched at GEICO's expense by GEICO's payments, which constituted a benefit that Kofman, D. Bogatin, G. Bogatin, and Chai voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

206. Kofman, D. Bogatin, G. Bogatin, and Chai's retention of GEICO's payments violates the fundamental principles of justice, equity, and good conscience.

207. By reason of the above, Kofman, D. Bogatin, G. Bogatin, and Chai have been unjustly enriched in an amount to be determined at trial, but in no event less than \$64,000.00.

AS AND FOR A SIXTH CAUSE OF ACTION
Against John Doe Defendants "1"- "10"
(Aiding and Abetting Fraud)

208. GEICO incorporates, as though fully set forth herein, each and every allegation set forth above.

209. John Doe Defendants "1" through "10" knowingly aided and abetted the fraudulent scheme that was perpetrated on GEICO by Kofman, D. Bogatin, G. Bogatin, and Chai.

210. The acts of John Doe Defendants "1" through "10" in furtherance of the fraudulent scheme included, among other things, knowingly referring Insureds to Chai in exchange for illegal kickbacks and knowingly participating and assisting in subjecting the Insureds to a predetermined fraudulent treatment protocol to maximize profits without regard to patient care.

211. The conduct of John Doe Defendants "1" through "10" in furtherance of the fraudulent scheme was significant and material. The conduct of John Doe Defendants "1" through "10" was a necessary part of and was critical to the success of the fraudulent scheme because, without their actions, there would have been no opportunity for Chai to begin operating and billing for high volumes of the Fraudulent Services, to obtain referrals of patients at the No-Fault Clinics,

subject those patients to the Fraudulent Services, and obtain payment from GEICO and other insurers for the Fraudulent Services billed through Chai.

212. John Doe Defendants “1” through “10” aided and abetted the fraudulent scheme in a calculated effort to induce GEICO into paying charges to Chai for medically unnecessary, illusory, and otherwise non-reimbursable Fraudulent Services because they sought to continue profiting through the fraudulent scheme.

213. The conduct of John Doe Defendants “1” through “10” caused GEICO to pay more than \$64,000.00 pursuant to the fraudulent bills submitted through Chai.

214. This extensive fraudulent conduct demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

215. Accordingly, by virtue of the foregoing, GEICO is entitled to recover compensatory and punitive damages, together with interest and costs, and any other relief the Court deems just and proper.

AS AND FOR A SEVENTH CAUSE OF ACTION
Against Kofman, D. Bogatin, G. Bogatin, and Khanatayev
(Violation of RICO, 18 U.S.C. § 1962(c))

216. GEICO incorporates, as though fully set forth herein, each and every allegation set forth above.

217. Sinai is an ongoing “enterprise,” as that term is defined in 18 U.S.C. § 1961(4), that engages in activities which affect interstate commerce.

218. Kofman, D. Bogatin, G. Bogatin, and Khanatayev knowingly have conducted and/or participated, directly or indirectly, in the conduct of Sinai’s affairs through a pattern of racketeering activity consisting of repeated violations of the federal mail fraud statute, 18 U.S.C. § 1341, and federal wire fraud statute, 18 U.S.C. § 1343, based upon the use of the United States

mails and interstate wires to submit or cause to be submitted hundreds of fraudulent charges on a continuous basis for over two years seeking payments that Sinai was not eligible to receive under the No-Fault Laws because: (i) the billed-for-services were not medically necessary; (ii) the billed-for-services were performed and billed pursuant to a pre-determined, fraudulent treatment and billing protocol designed solely to enrich Defendants; and (iii) Sinai obtained its patients through the Defendants' illegal kickback scheme. The fraudulent billings and corresponding mailings/interstate wire transmissions submitted to GEICO that comprise, in part, the pattern of racketeering activity identified through the date of this Complaint are described in the chart annexed hereto as Exhibit "2".

219. Sinai's business is racketeering activity, inasmuch as the enterprise exists for the purpose of submitting fraudulent charges to insurers. The predicate acts of mail fraud and wire fraud are the regular ways in which Kofman, D. Bogatin, G. Bogatin, and Khanatayev operated Sinai, inasmuch as Sinai never was eligible to bill for or collect No-Fault Benefits and acts of mail fraud and wire fraud therefore were essential in order for Sinai to function. Furthermore, the intricate planning required to carry out and conceal the predicate acts of mail fraud and wire fraud implies a threat of continued criminal activity, as does the fact that Defendants continue to attempt collection on the fraudulent billing submitted through Sinai to the present day.

220. Sinai is engaged in inherently unlawful acts inasmuch as it continues to attempt collection on fraudulent billing submitted to GEICO and other insurers. These inherently unlawful acts are taken by Sinai in pursuit of inherently unlawful goals – namely, the theft of money from GEICO and other insurers through fraudulent no-fault billing.

221. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$147,000.00 pursuant to the fraudulent bills submitted by the Defendants through Sinai.

222. By reason of its injury, GEICO is entitled to treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c), and any other relief the Court deems just and proper.

AS AND FOR AN EIGHTH CAUSE OF ACTION
Against Kofman, D. Bogatin, G. Bogatin, Khanatayev, and John Doe Defendants "1"- "10"
(Violation of RICO, 18 U.S.C. § 1962(d))

223. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

224. Sinai is an ongoing "enterprise," as that term is defined in 18 U.S.C. § 1961(4), that engaged in activities which affected interstate commerce.

225. Kofman, D. Bogatin, G. Bogatin, Khanatayev, and John Doe Defendants "1"- "10" knowingly have agreed, combined and conspired to conduct and/or participate, directly or indirectly, in the conduct of Sinai's affairs through a pattern of racketeering activity consisting of repeated violations of the federal mail fraud statute, 18 U.S.C. § 1341, and federal wire fraud statute, 18 U.S.C. § 1343, based upon the use of the United States mails and interstate wires to submit or cause to be submitted hundreds of fraudulent charges on a continuous basis for over two years seeking payments that Sinai was not eligible to receive under the No-Fault Laws because: (i) the billed-for-services were not medically necessary; (ii) the billed-for-services were performed and billed pursuant to a pre-determined, fraudulent treatment and billing protocol designed solely to enrich Defendants; and (iii) Sinai obtained its patients through the Defendants' illegal kickback scheme. The fraudulent billings and corresponding mailings/interstate wire transmissions

submitted to GEICO that comprise, in part, the pattern of racketeering activity identified through the date of this Complaint are described in the chart annexed hereto as Exhibit “2”.

226. Kofman, D. Bogatin, G. Bogatin, Khanatayev, and John Doe Defendants “1”-“10” knew of, agreed to, and acted in furtherance of the common overall objective (i.e., to defraud GEICO and other insurers of money) by submitting or facilitating the submission of the fraudulent charges to GEICO.

227. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$147,000.00 pursuant to the fraudulent bills submitted by Defendants through Sinai.

228. By reason of its injury, GEICO is entitled to treble damages, costs, and reasonable attorneys’ fees pursuant to 18 U.S.C. § 1964(c), and any other relief the Court deems just and proper.

AS AND FOR A NINTH CAUSE OF ACTION
Against Kofman, D. Bogatin, G. Bogatin, Khanatayev, and Sinai
(Common Law Fraud)

229. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

230. Kofman, D. Bogatin, G. Bogatin, Khanatayev, and Sinai intentionally and knowingly made false and fraudulent statements of material fact to GEICO and concealed material facts from GEICO in the course of their submission of hundreds of fraudulent bills seeking payment for the Fraudulent Services.

231. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that Defendants were acting lawfully and, therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) and

11 N.Y.C.R.R. § 65-3.16(a)(12), when, in fact the Fraudulent Services purportedly provided were the result of unlawful kickback and financial arrangements; and (ii) in every claim, the representation that the billed-for services were medically necessary when, in fact, the Fraudulent Services were not medically necessary and were provided pursuant to fraudulent predetermined treatment and billing protocols designed to exploit the patients for financial gain, without regard for genuine patient care.

232. Kofman, D. Bogatin, G. Bogatin, Khanatayev, and Sinai intentionally made the above-described false and fraudulent statements and concealed material facts in a calculated effort to induce GEICO to pay charges submitted through Sinai that were not compensable under the No-Fault Laws.

233. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$147,000.00 pursuant to the fraudulent billing submitted by Defendants.

234. The extensive fraudulent conduct by Kofman, D. Bogatin, G. Bogatin, Khanatayev, and Sinai demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

235. Accordingly, by virtue of the foregoing, GEICO is entitled to compensatory and punitive damages, together with interest and costs, and any other relief the Court deems just and proper.

AS AND FOR A TENTH CAUSE OF ACTION
Against Kofman, D. Bogatin, G. Bogatin, Khanatayev, and Sinai
(Unjust Enrichment)

236. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

237. As set forth above, Kofman, D. Bogatin, G. Bogatin, Khanatayev, and Sinai have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of GEICO.

238. When GEICO paid the bills and charges submitted by or on behalf of Sinai for No-Fault Benefits, it reasonably believed that it was legally obligated to make such payments based on the Defendants' improper, unlawful, and/or unjust acts.

239. Kofman, D. Bogatin, G. Bogatin, Khanatayev, and Sinai have been enriched at GEICO's expense by GEICO's payments, which constituted a benefit that Kofman, D. Bogatin, G. Bogatin, Khanatayev, and Sinai voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

240. Kofman, D. Bogatin, G. Bogatin, Khanatayev, and Sinai's retention of GEICO's payments violates the fundamental principles of justice, equity, and good conscience.

241. By reason of the above, Kofman, D. Bogatin, G. Bogatin, Khanatayev, and Sinai have been unjustly enriched in an amount to be determined at trial, but in no event less than \$147,000.00.

AS AND FOR AN ELEVENTH CAUSE OF ACTION
Against John Doe Defendants "1"- "10"
(Aiding and Abetting Fraud)

242. GEICO incorporates, as though fully set forth herein, each and every allegation set forth above.

243. John Doe Defendants "1" through "10" knowingly aided and abetted the fraudulent scheme that was perpetrated on GEICO by Kofman, D. Bogatin, G. Bogatin, Khanatayev, and Sinai.

244. The acts of John Doe Defendants "1" through "10" in furtherance of the fraudulent scheme included, among other things, knowingly referring Insureds to Sinai in exchange for illegal

kickbacks and knowingly participating and assisting in subjecting the Insureds to a predetermined fraudulent treatment protocol to maximize profits without regard to patient care.

245. The conduct of John Doe Defendants “1” through “10” in furtherance of the fraudulent scheme was significant and material. The conduct of John Doe Defendants “1” through “10” was a necessary part of and was critical to the success of the fraudulent scheme because, without their actions, there would have been no opportunity for Sinai to begin operating and billing for high volumes of the Fraudulent Services, to obtain referrals of patients at the No-Fault Clinics, subject those patients to the Fraudulent Services, and obtain payment from GEICO and other insurers for the Fraudulent Services billed through Sinai.

246. John Doe Defendants “1” through “10” aided and abetted the fraudulent scheme in a calculated effort to induce GEICO into paying charges to Sinai for medically unnecessary, illusory, and otherwise non-reimbursable Fraudulent Services because they sought to continue profiting through the fraudulent scheme.

247. The conduct of John Doe Defendants “1” through “10” caused GEICO to pay more than \$147,000.00 pursuant to the fraudulent bills submitted through Sinai.

248. This extensive fraudulent conduct demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

249. Accordingly, by virtue of the foregoing, GEICO is entitled to recover compensatory and punitive damages, together with interest and costs, and any other relief the Court deems just and proper.

AS AND FOR A TWELFTH CAUSE OF ACTION
Against Kofman, D. Bogatin, G. Bogatin, Likhtenstein, and BLK
(Common Law Fraud)

250. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

251. Kofman, D. Bogatin, G. Bogatin, Likhtenstein, and BLK intentionally and knowingly made false and fraudulent statements of material fact to GEICO and concealed material facts from GEICO in the course of their submission of hundreds of fraudulent bills seeking payment for the Fraudulent Services.

252. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that Defendants were acting lawfully and, therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) and 11 N.Y.C.R.R. § 65-3.16(a)(12), when, in fact the Fraudulent Services purportedly provided were the result of unlawful kickback and financial arrangements; and (ii) in every claim, the representation that the billed-for services were medically necessary when, in fact, the Fraudulent Services were not medically necessary and were provided pursuant to fraudulent predetermined treatment and billing protocols designed to exploit the patients for financial gain, without regard for genuine patient care. The fraudulent claims submitted to GEICO through BLK are described, in part, in the chart annexed hereto as Exhibit “3”.

253. Kofman, D. Bogatin, G. Bogatin, Likhtenstein, and BLK intentionally made the above-described false and fraudulent statements and concealed material facts in a calculated effort to induce GEICO to pay charges submitted through BLK that were not compensable under the No-Fault Laws.

254. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$16,000.00 pursuant to the fraudulent billing submitted by Defendants.

255. The extensive fraudulent conduct by Kofman, D. Bogatin, G. Bogatin, Likhtenstein, and BLK demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

256. Accordingly, by virtue of the foregoing, GEICO is entitled to compensatory and punitive damages, together with interest and costs, and any other relief the Court deems just and proper.

AS AND FOR A THIRTEENTH CAUSE OF ACTION
Against Kofman, D. Bogatin, G. Bogatin, Likhtenstein, and BLK
(Unjust Enrichment)

257. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

258. As set forth above, Kofman, D. Bogatin, G. Bogatin, Likhtenstein, and BLK have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of GEICO.

259. When GEICO paid the bills and charges submitted by or on behalf of BLK for No-Fault Benefits, it reasonably believed that it was legally obligated to make such payments based on the Defendants' improper, unlawful, and/or unjust acts.

260. Kofman, D. Bogatin, G. Bogatin, Likhtenstein, and BLK have been enriched at GEICO's expense by GEICO's payments, which constituted a benefit that Kofman, D. Bogatin, G. Bogatin, Likhtenstein, and BLK voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

261. Kofman, D. Bogatin, G. Bogatin, Likhtenstein, and BLK's retention of GEICO's payments violates the fundamental principles of justice, equity, and good conscience.

262. By reason of the above, Kofman, D. Bogatin, G. Bogatin, Likhtenstein, and BLK have been unjustly enriched in an amount to be determined at trial, but in no event less than \$16,000.00.

AS AND FOR A FOURTEENTH CAUSE OF ACTION
Against John Doe Defendants "1"- "10"
(Aiding and Abetting Fraud)

263. GEICO incorporates, as though fully set forth herein, each and every allegation set forth above.

264. John Doe Defendants "1" through "10" knowingly aided and abetted the fraudulent scheme that was perpetrated on GEICO by Kofman, D. Bogatin, G. Bogatin, Likhtenstein, and BLK.

265. The acts of John Doe Defendants "1" through "10" in furtherance of the fraudulent scheme included, among other things, knowingly referring Insureds to BLK in exchange for illegal kickbacks and knowingly participating and assisting in subjecting the Insureds to a predetermined fraudulent treatment protocol to maximize profits without regard to patient care.

266. The conduct of John Doe Defendants "1" through "10" in furtherance of the fraudulent scheme was significant and material. The conduct of John Doe Defendants "1" through "10" was a necessary part of and was critical to the success of the fraudulent scheme because, without their actions, there would have been no opportunity for BLK to begin operating and billing for high volumes of the Fraudulent Services, to obtain referrals of patients at the No-Fault Clinics, subject those patients to the Fraudulent Services, and obtain payment from GEICO and other insurers for the Fraudulent Services billed through BLK.

267. John Doe Defendants “1” through “10” aided and abetted the fraudulent scheme in a calculated effort to induce GEICO into paying charges to BLK for medically unnecessary, illusory, and otherwise non-reimbursable Fraudulent Services because they sought to continue profiting through the fraudulent scheme.

268. The conduct of John Doe Defendants “1” through “10” caused GEICO to pay more than \$16,000.00 pursuant to the fraudulent bills submitted through BLK.

269. This extensive fraudulent conduct demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

270. Accordingly, by virtue of the foregoing, GEICO is entitled to recover compensatory and punitive damages, together with interest and costs, and any other relief the Court deems just and proper.

AS AND FOR A FIFTEENTH CAUSE OF ACTION
Against Kofman, D. Bogatin, and G. Bogatin
(Violation of RICO, 18 U.S.C. § 1962(c))

271. GEICO incorporates, as though fully set forth herein, each and every allegation set forth above.

272. Refuah is an ongoing “enterprise,” as that term is defined in 18 U.S.C. § 1961(4), that engages in activities which affect interstate commerce.

273. Kofman, D. Bogatin, and G. Bogatin knowingly have conducted and/or participated, directly or indirectly, in the conduct of Refuah’s affairs through a pattern of racketeering activity consisting of repeated violations of the federal mail fraud statute, 18 U.S.C. § 1341, and federal wire fraud statute, 18 U.S.C. § 1343, based upon the use of the United States mails and interstate wires to submit or cause to be submitted hundreds of fraudulent charges on a continuous basis for over two years seeking payments that Refuah was not eligible to receive under

the No-Fault Laws because: (i) the billed-for-services were not medically necessary; (ii) the billed-for-services were performed and billed pursuant to a pre-determined, fraudulent treatment and billing protocol designed solely to enrich Defendants; and (iii) Refuah obtained its patients through the Defendants' illegal kickback scheme. The fraudulent billings and corresponding mailings/interstate wire transmissions submitted to GEICO that comprise, in part, the pattern of racketeering activity identified through the date of this Complaint are described in the chart annexed hereto as Exhibit "4".

274. Refuah's business is racketeering activity, inasmuch as the enterprise exists for the purpose of submitting fraudulent charges to insurers. The predicate acts of mail fraud and wire fraud are the regular ways in which Kofman, D. Bogatin, and G. Bogatin operated Refuah, inasmuch as Refuah never was eligible to bill for or collect No-Fault Benefits and acts of mail fraud and wire fraud therefore were essential in order for Refuah to function. Furthermore, the intricate planning required to carry out and conceal the predicate acts of mail fraud and wire fraud implies a threat of continued criminal activity, as does the fact that Defendants continue to attempt collection on the fraudulent billing submitted through Refuah to the present day.

275. Refuah is engaged in inherently unlawful acts inasmuch as it continues to attempt collection on fraudulent billing submitted to GEICO and other insurers. These inherently unlawful acts are taken by Refuah in pursuit of inherently unlawful goals – namely, the theft of money from GEICO and other insurers through fraudulent no-fault billing.

276. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$119,000.00 pursuant to the fraudulent bills submitted by the Defendants through Refuah.

277. By reason of its injury, GEICO is entitled to treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c), and any other relief the Court deems just and proper.

AS AND FOR A SIXTEENTH CAUSE OF ACTION
Against Kofman, D. Bogatin, G. Bogatin, and John Doe Defendants "1"- "10"
(Violation of RICO, 18 U.S.C. § 1962(d))

278. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

279. Refuah is an ongoing "enterprise," as that term is defined in 18 U.S.C. § 1961(4), that engaged in activities which affected interstate commerce.

280. Kofman, D. Bogatin, G. Bogatin, and John Doe Defendants "1"- "10" knowingly have agreed, combined and conspired to conduct and/or participate, directly or indirectly, in the conduct of Refuah's affairs through a pattern of racketeering activity consisting of repeated violations of the federal mail fraud statute, 18 U.S.C. § 1341, and federal wire fraud statute, 18 U.S.C. § 1343, based upon the use of the United States mails and interstate wires to submit or cause to be submitted hundreds of fraudulent charges on a continuous basis for over two years seeking payments that Refuah was not eligible to receive under the No-Fault Laws because: (i) the billed-for-services were not medically necessary; (ii) the billed-for-services were performed and billed pursuant to a pre-determined, fraudulent treatment and billing protocol designed solely to enrich Defendants; and (iii) Refuah obtained its patients through the Defendants' illegal kickback scheme. The fraudulent billings and corresponding mailings/interstate wire transmissions submitted to GEICO that comprise, in part, the pattern of racketeering activity identified through the date of this Complaint are described in the chart annexed hereto as Exhibit "4".

281. Kofman, D. Bogatin, G. Bogatin, and John Doe Defendants “1”-“10” knew of, agreed to, and acted in furtherance of the common overall objective (i.e., to defraud GEICO and other insurers of money) by submitting or facilitating the submission of the fraudulent charges to GEICO.

282. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$119,000.00 pursuant to the fraudulent bills submitted by Defendants through Refuah.

283. By reason of its injury, GEICO is entitled to treble damages, costs, and reasonable attorneys’ fees pursuant to 18 U.S.C. § 1964(c), and any other relief the Court deems just and proper.

AS AND FOR A SEVENTEENTH CAUSE OF ACTION
Against Kofman, D. Bogatin, G. Bogatin, and Refuah
(Common Law Fraud)

284. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

285. Kofman, D. Bogatin, G. Bogatin, and Refuah intentionally and knowingly made false and fraudulent statements of material fact to GEICO and concealed material facts from GEICO in the course of their submission of hundreds of fraudulent bills seeking payment for the Fraudulent Services.

286. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that Defendants were acting lawfully and, therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) and 11 N.Y.C.R.R. § 65-3.16(a)(12), when, in fact the Fraudulent Services purportedly provided were the result of unlawful kickback and financial arrangements; and (ii) in every claim, the

representation that the billed-for services were medically necessary when, in fact, the Fraudulent Services were not medically necessary and were provided pursuant to fraudulent predetermined treatment and billing protocols designed to exploit the patients for financial gain, without regard for genuine patient care.

287. Kofman, D. Bogatin, G. Bogatin, and Refuah intentionally made the above-described false and fraudulent statements and concealed material facts in a calculated effort to induce GEICO to pay charges submitted through Refuah that were not compensable under the No-Fault Laws.

288. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$119,000.00 pursuant to the fraudulent billing submitted by Defendants.

289. The extensive fraudulent conduct by Kofman, D. Bogatin, G. Bogatin, and Refuah demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

290. Accordingly, by virtue of the foregoing, GEICO is entitled to compensatory and punitive damages, together with interest and costs, and any other relief the Court deems just and proper.

AS AND FOR AN EIGHTEENTH CAUSE OF ACTION
Against Kofman, D. Bogatin, G. Bogatin, and Refuah
(Unjust Enrichment)

291. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

292. As set forth above, Kofman, D. Bogatin, G. Bogatin, and Refuah have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of GEICO.

293. When GEICO paid the bills and charges submitted by or on behalf of Refuah for No-Fault Benefits, it reasonably believed that it was legally obligated to make such payments based on the Defendants' improper, unlawful, and/or unjust acts.

294. Kofman, D. Bogatin, G. Bogatin, and Refuah have been enriched at GEICO's expense by GEICO's payments, which constituted a benefit that Kofman, D. Bogatin, G. Bogatin, and Refuah voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

295. Kofman, D. Bogatin, G. Bogatin, and Refuah's retention of GEICO's payments violates the fundamental principles of justice, equity, and good conscience.

296. By reason of the above, Kofman, D. Bogatin, G. Bogatin, and Refuah have been unjustly enriched in an amount to be determined at trial, but in no event less than \$119,000.00.

AS AND FOR A NINETEENTH CAUSE OF ACTION
Against John Doe Defendants "1"- "10"
(Aiding and Abetting Fraud)

297. GEICO incorporates, as though fully set forth herein, each and every allegation set forth above.

298. John Doe Defendants "1" through "10" knowingly aided and abetted the fraudulent scheme that was perpetrated on GEICO by Kofman, D. Bogatin, G. Bogatin, and Refuah.

299. The acts of John Doe Defendants "1" through "10" in furtherance of the fraudulent scheme included, among other things, knowingly referring Insureds to Refuah in exchange for illegal kickbacks and knowingly participating and assisting in subjecting the Insureds to a predetermined fraudulent treatment protocol to maximize profits without regard to patient care.

300. The conduct of John Doe Defendants "1" through "10" in furtherance of the fraudulent scheme was significant and material. The conduct of John Doe Defendants "1" through

“10” was a necessary part of and was critical to the success of the fraudulent scheme because, without their actions, there would have been no opportunity for Refuah to begin operating and billing for high volumes of the Fraudulent Services, to obtain referrals of patients at the No-Fault Clinics, subject those patients to the Fraudulent Services, and obtain payment from GEICO and other insurers for the Fraudulent Services billed through Refuah.

301. John Doe Defendants “1” through “10” aided and abetted the fraudulent scheme in a calculated effort to induce GEICO into paying charges to Refuah for medically unnecessary, illusory, and otherwise non-reimbursable Fraudulent Services because they sought to continue profiting through the fraudulent scheme.

302. The conduct of John Doe Defendants “1” through “10” caused GEICO to pay more than \$119,000.00 pursuant to the fraudulent bills submitted through Refuah.

303. This extensive fraudulent conduct demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

304. Accordingly, by virtue of the foregoing, GEICO is entitled to recover compensatory and punitive damages, together with interest and costs, and any other relief the Court deems just and proper.

JURY DEMAND

305. Pursuant to Fed. R. Civ. P. 38(b), Plaintiffs demand a trial by jury.

WHEREFORE, Plaintiffs Government Employees Insurance Company, GEICO Indemnity Company, GEICO General Insurance Company and GEICO Casualty Company demand that a Judgment be entered in their favor:

A. On the First Cause of Action against the Owner Defendants and the Provider Defendants a declaration pursuant to the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202,

that the Owner Defendants and the Provider Defendants have no right to receive payment for any pending bills submitted to GEICO;

B. On the Second Cause of Action against Kofman, D. Bogatin, and G. Bogatin, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of \$64,000.00, together with treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c) plus interest;

C. On the Third Cause of Action against Kofman, D. Bogatin, G. Bogatin, and John Doe Defendants "1"- "10", compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of \$64,000.00, together with treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c) plus interest;

D. On the Fourth Cause of Action against Kofman, D. Bogatin, G. Bogatin, and Chai, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of \$64,000.00, together with punitive damages, costs, interest, and other and further relief as the Court deems proper;

E. On the Fifth Cause of Action against Kofman, D. Bogatin, G. Bogatin, and Chai, more than \$64,000.00 in compensatory damages, plus costs and interest and such other and further relief as this Court deems just and proper;

F. On the Sixth Cause of Action against John Doe Defendants "1"- "10", compensatory damages in an amount to be determined at trial but in excess of \$64,000.00, together with punitive damages, costs, interest, and such other and further relief as this Court deems just and proper;

G. On the Seventh Cause of Action against Kofman, D. Bogatin, G. Bogatin, and Khanatayev, compensatory damages in favor of GEICO in an amount to be determined at trial but

in excess of \$147,000.00, together with treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c) plus interest;

H. On the Eighth Cause of Action against Kofman, D. Bogatin, G. Bogatin, Khanatayev, and John Doe Defendants "1"- "10", compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of \$147,000.00, together with treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c) plus interest;

I. On the Ninth Cause of Action against Kofman, D. Bogatin, G. Bogatin, Khanatayev, and Sinai, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of \$147,000.00, together with punitive damages, costs, interest, and other and further relief as the Court deems proper;

J. On the Tenth Cause of Action against Kofman, D. Bogatin, G. Bogatin, Khanatayev, and Sinai, more than \$147,000.00 in compensatory damages, plus costs and interest and such other and further relief as this Court deems just and proper;

K. On the Eleventh Cause of Action against John Doe Defendants "1"- "10", compensatory damages in an amount to be determined at trial but in excess of \$147,000.00, together with punitive damages, costs, interest, and such other and further relief as this Court deems just and proper;

L. On the Twelfth Cause of Action against Kofman, D. Bogatin, G. Bogatin, Likhtenstein, and BLK, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of \$16,000.00, together with punitive damages, costs, interest, and other and further relief as the Court deems proper;

M. On the Thirteenth Cause of Action against Kofman, D. Bogatin, G. Bogatin, Likhtenstein, and BLK more than \$16,000.00 in compensatory damages, plus costs and interest and such other and further relief as this Court deems just and proper;

N. On the Fourteenth Cause of Action against John Doe Defendants “1”-“10”, compensatory damages in an amount to be determined at trial but in excess of \$16,000.00, together with punitive damages, costs, interest, and such other and further relief as this Court deems just and proper;

O. On the Fifteenth Cause of Action against Kofman, D. Bogatin, and G. Bogatin, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of \$119,000.00, together with treble damages, costs, and reasonable attorneys’ fees pursuant to 18 U.S.C. § 1964(c) plus interest;

P. On the Sixteenth Cause of Action against Kofman, D. Bogatin, G. Bogatin, and John Doe Defendants “1”-“10”, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of \$119,000.00, together with treble damages, costs, and reasonable attorneys’ fees pursuant to 18 U.S.C. § 1964(c) plus interest;

Q. On the Seventeenth Cause of Action against Kofman, D. Bogatin, G. Bogatin, and Refuah, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of \$119,000.00, together with punitive damages, costs, interest, and other and further relief as the Court deems proper;

R. On the Eighteenth Cause of Action against Kofman, D. Bogatin, G. Bogatin, and Refuah more than \$119,000.00 in compensatory damages, plus costs and interest and such other and further relief as this Court deems just and proper; and

S. On the Nineteenth Cause of Action against John Doe Defendants “1”-“10”, compensatory damages in an amount to be determined at trial but in excess of \$119,000.00, together with punitive damages, costs, interest, and such other and further relief as this Court deems just and proper.

Dated: April 11, 2024
Uniondale, New York

RIVKIN RADLER LLP

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