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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

- X

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

Docket No.: _____( )

Plaintiffs,

-against-

Plaintiffs Demand a Trial by Jury

ANTHONY PALMIERI, GEMINI DIAGNOSTIC IMAGING, INC., PROMETHEUS IMAGING LLC, TITAN DIAGNOSTIC IMAGING SERVICES, INC., and JOHN DOE DEFENDANTS "1"-"10"

Defendants.

- X

COMPLAINT

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 Anthony Palmieri, Gemini Diagnostic Imaging, Inc., Prometheus Imaging LLC, Titan Diagnostic Imaging Services, Inc., and John Doe Defendants "1" through "10" (collectively, "Defendants"), hereby allege as follows:

NATURE OF THE ACTION

1. This action seeks to terminate a large fraudulent scheme perpetrated by the Defendants who exploited the New York "No-Fault" insurance system by submitting more than $5.6 million in fraudulent billing to GEICO for medically unnecessary, illusory, and otherwise non-reimbursable healthcare services involving purported transcranial doppler tests ("TCD"), spinal ultrasound tests, vascular and cardiac diagnostic tests, and videonystagmus tests ("VNG") (collectively, the "Fraudulent Services"), which allegedly were provided to New York automobile accident victims insured by GEICO ("Insureds").

2. Defendant Anthony Palmieri ("Palmieri") is not a licensed healthcare provider, yet used the façade of three corporate entities, including Defendants Gemini Diagnostic Imaging, Inc. ("Gemini"), Prometheus Imaging LLC ("Prometheus"), and Titan Diagnostic Imaging Services Inc. ("Titan") (together, 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 Provider Defendants operated on a transient basis, with Palmieri and the Provider Defendants entering into illegal, collusive arrangements with numerous No-Fault medical clinics in the New York metropolitan area, using illegal referral and kickback arrangements to permit Palmieri and the Provider Defendants to access a steady stream of patients and bill GEICO and other New York automobile insurers for the excessive and medically useless Fraudulent Services, solely for financial gain.

4. By this action, GEICO seeks to recover the monies stolen from it, amounting to at least $290,000.00, and further seeks a declaration that it is not legally obligated to pay

reimbursement of more than $4,400,000.00 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 Defendants, rather than to treat or otherwise benefit the Insureds; and

(ii) the Fraudulent Services were provided – to the extent provided at all – pursuant to the dictates of laypersons not licensed to render or control healthcare services, without supervision by a licensed professional, and as a result of illicit kickback arrangements.

5. The Defendants fall into the following categories:

(i) Defendants Gemini Diagnostic Imaging, Inc. ("Gemini"), Prometheus Imaging LLC ("Prometheus"), and Titan Diagnostic Imaging Services, Inc. ("Titan") are the entities through which the Fraudulent Services purportedly were performed and billed to New York automobile insurance companies, including GEICO;

(ii) Defendant Anthony Palmieri is the owner of the Provider Defendants; and

(iii) John Doe Defendants "1" through "10" are individuals and 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 were subjected to them; and (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.

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 2019 and continues 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 $290,000.00.

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 Palmieri resides in and is a citizen of New Jersey. Palmieri serves as the nominal owner of the Provider Defendants.

13. In addition to the Provider Defendants, Palmieri owned an additional company by the name of Veritas Imaging, Inc. ("Veritas").

14. In 2019, Palmieri pled guilty to one count of conspiracy to commit health care fraud in connection with services billed to Medicare by Veritas, was sentenced to six months

imprisonment, and ordered to pay over $195,000.00 in restitution to Medicare. See United States v. Palmieri, No. 18-CR-897 (S.D.N.Y. 2019).

15. Defendant Gemini is a New York corporation incorporated on or about April 20, 2021, with its principal place of business in New York, and purports to be owned and controlled by Palmieri. Gemini has been used by Palmieri and John Doe Defendants "1"-"10" to submit fraudulent billing to GEICO and other insurers.

16. Defendant Prometheus is a limited liability company that was formed in Delaware on or about December 21, 2016, registered in New York on or about May 23, 2019, has its principal place of business in New York, and has Palmieri as its sole member. Prometheus has been used by Palmieri and John Doe Defendants "1"-"10" to submit fraudulent billing to GEICO and other insurers.

17. Defendant Titan is a New York corporation incorporated on or about November 14, 2019, with its principal place of business in New York, and purports to be owned and controlled by Palmieri. Titan has been used by Palmieri and John Doe Defendants "1"-"10" to submit fraudulent billing to GEICO and other insurers.

18. Upon information and belief, John Doe Defendants "1" through "10" reside in and are citizens of New York. John Doe Defendants "1"-"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

19. 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.

20. 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.

21. 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.

22. Venue in this District is appropriate pursuant to 28 U.S.C. § 1391, as the Eastern District of New York is the District where a substantial amount of the activities forming the basis of the Complaint occurred.

ALLEGATIONS COMMON TO ALL CLAIMS

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

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

24. 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.

25. 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 Personal Injury Protection Benefits ("No-Fault Benefits") to Insureds.

26. 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).

27. 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.

28. 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).

29. 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."

30. 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.

31. The practice of medicine is defined to include "diagnosing, treating, operating, or prescribing for any human disease, pain, injury, deformity or physical condition." New York Education Law § 6521. It is a crime in New York to practice medicine without a license and/or to aid or abet a person to practice medicine without a license. See e.g., New York Education Law § 6512.

32. 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).

33. 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 a 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).

34. 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").

35. 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).

36. In New York, claims for No-Fault Benefits are governed by the New York Workers' Compensation Fee Schedule (the "Fee Schedule").

37. 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 attendant fee were not excessive.

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

39. 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.

40. 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.

41. 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.

42. 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."

43. For example, 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.

44. 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.

45. 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

46. Beginning in 2019 and continuing through the present day, Defendants devised and 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 millions of dollars for medically unnecessary, illusory, and otherwise non-reimbursable health care services.

47. In New York, only licensed healthcare professionals 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.

48. Nevertheless, the Defendants, none of whom are professional corporations or licensed healthcare providers, used the façade of three corporate entities to create fraudulent "billing opportunities" for health care services and generate large profits 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 diagnostic tests (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.

49. Palmieri, exploiting the provision of the Fee Schedule that allows two providers to separately bill the professional component and the technical component of certain healthcare services, used sham "referral forms" 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.

50. In keeping with the fact that Palmieri and the Provider Defendants used sham "referral forms" to create the appearance of medical need, it is entirely implausible – to the point of absurdity – that the Provider Defendants would have any basis to provide the huge volume of Fraudulent Services, in the form of the technical component of very specialized diagnostic tests, including but not limited to transcranial doppler tests, vascular and cardiac diagnostic tests, and videonystagmus tests, to individuals involved in automobile accidents.

51. Palmieri did not operate the Provider Defendants at any single, fixed location.

52. Palmieri, instead, operated the Provider Defendants on an itinerant basis from various "No-Fault" medical clinics, primarily located in Brooklyn, Queens, and Bronx, where the Provider Defendants received steady volumes of patients through no efforts of their own, including at the following clinics (collectively, the "Clinics"):

- 1 Fulton Avenue, Hempstead;
- 127 Post Avenue, Westbury;
- 132-28 41st Avenue, Flushing;
- 1336 Utica Avenue, Brooklyn;
- 1339 E. Gun Hill Road, Bronx;
- 13525 79th Street, Howard Beach;
- 137-42 Guy Brewer Boulevard, Jamaica;
- 14 Bruckner Boulevard, Bronx;
- 145 East 98th Street, Brooklyn;
- 146 Empire Boulevard, Brooklyn;
- 152-80 Rockaway Boulevard, Jamaica;
- 1568 Ralph Avenue, Brooklyn;
- 1601 Gravesend Neck Drive, Brooklyn;
- 16059 Rockaway Boulevard, Jamaica;
- 1849 Utica Avenue, Brooklyn;
- 1975 Linden Boulevard, Elmont;
- 204-12 Hillside Avenue, Queens;
- 2098 Rockaway Parkway, Brooklyn;
- 225-21 Linden Boulevard, Queens;
- 2386 Jerome Avenue, Bronx;
- 2426 Eastchester Road, Bronx;
- 243-51 Merrick Boulevard, Jamaica;
- 3027 Avenue V, Brooklyn;
- 3060 East Tremont Avenue, Bronx;
- 31 Guy Lombardo Avenue, Freeport;
- 318 Seguine Avenue, Staten Island;
- 4009 Church Avenue, Brooklyn;
- 4131 Richmond Avenue, Staten Island;
- 420 Doughty Boulevard, Inwood;
- 60 Belmont Avenue, Brooklyn;
- 611E 76th Street, Brooklyn;
- 62-69 99th Street, Flushing;
- 632 Utica Avenue, Brooklyn;
- 788 Southern Boulevard, Bronx;

- 79-45 Metropolitan Avenue, Flushing;
- 82-17 Woodhaven Boulevard, Glendale;
- 823 56th Street, Brooklyn;
- 85-55 Little Neck Parkway, Bellerose Terrace;
- 900B E. Tremont Avenue, Bronx;
- 903 Sheridan Avenue, Bronx; and
- 9413 Flatlands Avenue, Brooklyn

53. Palmieri and the Provider Defendants, in order to obtain access to the Clinics' patient base (i.e., Insureds), 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.

54. Palmieri 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.

55. The Fraudulent Services billed under the names of the Provider Defendants 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.

56. 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.

57. To further the Defendants' wrongdoing, Palmieri used sham "referral forms" that were often unsigned, in the name of physical therapists who had no basis or sufficient expertise to order the TCD, spinal ultrasound tests, vascular/cardiac diagnostic tests, or VNG, and/or were

simply forged and unauthorized by the practitioner whose name appeared on the form, upon information and belief.

58. Moreover, the Fraudulent Services billed under the names of the Provider Defendants were provided – to the extent provided at all – not only without any legitimate referral from a licensed professional and a determination of medical need, 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.

59. In keeping with the fact that the Fraudulent Services were provided 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, the professional component of many of the Fraudulent Services was purportedly provided by a retired physician living in Florida. The retired physician never examined the patients, never made a referral for the purported diagnostic services, never made a determination as to the medical necessity of the services, and never supervised the performance of the technical component of those services.

60. To further conceal their wrongdoing, Palmieri elected to bill for the Fraudulent Services through three separate entities with unique tax identification numbers – Titan, Gemini, and Prometheus – 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

61. 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.

62. 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.

63. 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.

64. 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.

65. 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.

66. 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.

67. 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.

68. Additionally, GEICO has received billing for purported healthcare services rendered at the Clinic located at 2098 Rockaway Parkway, Brooklyn from a "revolving door" of more than 70 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. In 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, multiple Clinics from which the Provider Defendants purported to operate are 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 the following layperson-controlled Clincs: (i) 204-12 Hillside Avenue, Queens; and (ii) 2426 Eastchester Road, Bronx – both locations where the Provider Defendants purported to administer Fraudulent Services to Insureds.

71. In further 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) 127 Post Avenue, Westbury; (ii) 1339 E. Gun Hill Road, Bronx; (iii) 13525 79th Street, Howard Beach; (iv) 137-42

Guy Brewer Boulevard, Jamaica; (v) 14 Bruckner Boulevard, Bronx; (vi) 146 Empire Boulevard, Brooklyn; (vii) 16059 Rockaway Boulevard, Jamaica; (viii) 1849 Utica Avenue, Brooklyn; (ix) 1975 Linden Boulevard, Elmont; (x) 2098 Rockaway Parkway, Brooklyn; (xi) 225-21 Linden Boulevard, Queens; (xii) 2386 Jerome Avenue, Bronx; (xiii) 3027 Avenue V, Brooklyn; (xiv) 3060 East Tremont Avenue, Bronx; (xv) 60 Belmont Avenue, Brooklyn; (xvi) 611 E. 76th Street, Brooklyn; (xvii) 632 Utica Avenue, Brooklyn; (xviii) 788 Southern Boulevard, Bronx; (xix) 79-45 Metropolitan Avenue, Flushing; and (xx) 82-17 Woodhaven Boulevard, Glendale. 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.).

72. In order to obtain access to the Clinics' patient base (i.e., Insureds) and create fraudulent "billing opportunities" for healthcare services, Palmieri 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.

73. The Clinics willingly provided access to Palmieri 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.

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

75. However, the financial arrangements into which Palmieri 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.

76. In keeping with the fact that that Palmieri and the Provider Defendants entered into illegal "pay-to-play" arrangements, multiple checks issued by, and to, the Provider Defendants were illegally exchanged for cash at a check-cashing facility in New Jersey in furtherance of the Defendants' fraudulent scheme.

77. Many of these checks were exchanged for cash 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 cash-checking 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 Palmieri 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. Palmieri 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 Palmieri 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 testing by whatever technician was working for the Provider Defendants that day, because of the kickbacks paid by Palmieri 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 $5,600,000.00 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 examination would be performed, and the treating provider would direct a specific course of testing and treatment based upon the patients' individual symptoms and the findings on examination.

92. Here, by contrast, the Provider Defendants performed VNG and/or TCD and/or spinal ultrasound tests and/or cardiac and vascular diagnostic tests on virtually every Insured, without any legitimate referral from a qualified licensed professional, regardless of the Insureds' individual symptoms and the findings on examination, and typically absent any documented medical justification whatsoever.

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 illegal practice of medicine and the fraudulent billing submitted to GEICO and other insurers.

1. The Fraudulent Charges for the Technical Component of TCD

94. The Defendants subjected many Insureds to fraudulent and medically unnecessary Transcranial Doppler Testing ("TCD").

95. The Defendants then submitted billing to GEICO for the technical component of the TCD through the Provider Defendants, typically resulting in hundreds of dollars' worth of charges for each session of TCD that the Provider Defendants purported to administer to each Insured.

96. 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.

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

98. 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.

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

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

101. 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.

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

103. In keeping with the fact that the TCD billed by the Provider Defendants 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 typically failed to screen for the symptoms or signs that would warrant TCD.

104. To the extent that anyone actually conducted medical examinations that assessed the Insureds' head pain and neurological symptoms, in many cases 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.

105. 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.

106. 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.

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

108. Even so, and in keeping with the fact that the TCD 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 TCD to multiple Insureds involved in the same accident at or about the same time.

109. For example:

(i) On November 20, 2019, two Insureds, OM and MM, were involved in the same motor vehicle accident. Thereafter, OM and MM both – incredibly – received TCD provided by Titan on the exact same date, November 25, 2019.

(ii) On May 13, 2020, two Insureds, LR and JJA, were involved in the same motor vehicle accident. Thereafter, LR and JJA both – incredibly – received TCD provided by Titan on the exact same date, June 17, 2020.

(iii) On April 3, 2020, two Insureds, MO and CG, were involved in the same motor vehicle accident. Thereafter, MO and CG both – incredibly – received TCD provided by Prometheus on the same exact date, May 4, 2020.

(iv) On November 9, 2020, two Insureds, NP and OP, were involved in the same motor vehicle accident. Thereafter, NP and OP both – incredibly – received TCD provided by Prometheus on the same exact date, November 19, 2020.

(v) On April 21, 2021, two Insureds, MR and ES, were involved in the same motor vehicle accident. Thereafter, MR and ES both – incredibly – received TCD provided by Gemini on the same exact date, May 4, 2021.

110. These are only representative examples. In many of the claims identified in Exhibits "1" through "4," two or more Insureds who were involved in the same underlying motor vehicle accident received TCD through the Provider Defendants at or about the same time, despite the fact that Insureds were differently situated.

111. The TCD was part of the Defendants' fraudulent testing and billing protocols, and were administered solely to financially enrich the Defendants, rather than to benefit any of the Insureds who were subjected to these purported tests.

2. The Fraudulent Charges for the Technical Component of VNG

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

113. Following the VNG, the Defendants then submitted billing to GEICO for the technical component of the VNG through Titan, typically resulting in hundreds of dollars' worth of charges for each session of VNG that Titan purported to administer to each Insured.

114. 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.

115. 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.

116. 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).

117. 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.

118. 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.

119. 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.

120. 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, an MRI of the brain may be ordered. If a patient does not respond to conservative care and the MRI is negative, the patient may be evaluated by an ENT or neurologist to determine if VNG is warranted.

121. 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.

122. Moreover, as previously discussed, 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.

123. It is extremely improbable – to the point of impossibility – that multiple Insureds involved in the same automobile accident would routinely require VNG at or about the same time.

124. Even so, and in keeping with the fact that the VNG tests were not medically necessary and were performed pursuant to predetermined protocols to maximize profits, the Defendants provided VNG to multiple Insureds involved in the same accident at or about the same time.

125. For example:

(i) On March 21, 2022, two Insureds, ML and SL, were involved in the same motor vehicle accident. Thereafter, ML and SL both – incredibly – received VNG provided by Titan on the same exact date, May 19, 2022.

(ii) On May 20, 2022, two Insureds, JP and SC, were involved in the same motor vehicle accident. Thereafter, JP and SC both – incredibly – received VNG provided by Titan on the same exact date, June 16, 2022.

(iii) On March 19, 2022, three Insureds, DW, CD, and FR, were involved in the same motor vehicle accident. Thereafter, DW, CD, and FR all – incredibly – received VNG provided by Titan on the same exact date, June 8, 2022.

(iv) On February 19, 2023, three Insureds, RR, DC, and SM were involved in the same motor vehicle accident. Thereafter, RR, DC, and SM all –

incredibly – received VNG provided by Titan on the same exact date, March 15, 2023.

(v) On December 20, 2022, two Insureds, NF and WL, were involved in the same motor vehicle accident. Thereafter, NF and WL both – incredibly – received VNG provided by Titan on the same exact date, February 1, 2023.

126. These are only representative examples. In many of the clams identified in Exhibit "4" two or more Insureds who had been involved in the same underlying accident received VNG through Titan at or about the same time, despite the fact that the Insureds were differently situated.

127. Indeed, even if an Insured reported the existence of some general form of dizziness or balance disorder, 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.

128. In further keeping with the fact the VNG 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 Titan purported to generate from the test, unreliable and useless.

129. Because the VNG was unreliable and useless, the data that Titan purported to obtain from the tests was 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.

130. As with the other Fraudulent Services, the VNG was part of the Defendants' predetermined fraudulent testing and billing protocols, and was designed solely to financially enrich the Defendants, rather than to benefit any of the Insureds who were subjected to the purported tests.

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

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

132. For these services, the Defendants typically billed GEICO under CPT code(s) 76800, 76881, and 76999 through the Provider Defendants.

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

134. 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.

135. 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.

136. 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".

137. 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".

138. 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".

139. Despite the lack of medical value or utility in the context of No-Fault automobile accident victims suffering from 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.

4. The Fraudulent Charges for the Technical Component of Cardiac and Vascular Diagnostic Testing

140. As part-and-parcel of their fraudulent scheme, the Defendants purported to subject many Insureds to medically unnecessary cardiac and vascular tests ("Cardiovascular Testing").

141. The charges for the Cardiovascular Testing were fraudulent in that the tests were medically unnecessary and were performed – to the extent performed at all – pursuant to the kickbacks that Palmieri and the Provider Defendants paid that provided Palmieri and the Provider Defendants with access to the Clinics' patients.

142. The charges for the Cardiovascular Testing were also fraudulent in that the tests, in addition to being medically unnecessary, had no plausible connection to the injuries purportedly suffered by Insureds as a result of their motor vehicle accidents.

143. Palmieri and the Provider Defendants billed for the technical component of the Cardiovascular Testing to GEICO using CPT codes 93040, 93306, 93880, 93925, 93930, 93970,

and/or 93978 generally resulting in hundreds of dollars' worth of charges for each round of Cardiovascular Testing they purported to provide.

a. Legitimate Uses for Cardiovascular Testing

144. Cardiovascular Testing, as employed by the Defendants, encompasses numerous tests designed to evaluate, diagnose, and aid in the treatment of heart disease and conditions involving abnormal blood flow, including atherosclerosis, aneurysm, varicose veins, or blood clots.

145. For example, an echocardiogram may be medically necessary to assist in the diagnosis and treatment of a heart valve disorder.

146. Cardiovascular testing is not typically required to diagnose, or aid in the treatment of, injuries resulting from motor vehicle accidents.

b. The Defendants' Fraudulent Cardiovascular Testing Charges

147. Palmieri and the Provider Defendants performed the Cardiovascular Testing pursuant to referrals purportedly issued by licensed healthcare providers as part of a predetermined protocol.

148. To the extent the referring healthcare providers conducted medical examinations that assessed the Insureds' cardiovascular symptoms, virtually none of the Insureds who received Cardiovascular Testing from the Provider Defendants reported any symptoms that would medically justify the Cardiovascular Testing.

149. In fact, prior to being subjected to the Defendants' protocol of medically unnecessary Cardiovascular Testing, Insureds – in virtually every instance – never even saw a cardiologist.

150. Moreover, virtually none of the Insureds who received the Cardiovascular Testing reported any cardiovascular symptoms warranting the tests, much less symptoms that plausibly resulted from their respective motor vehicle accidents.

151. In keeping with the predetermined nature of the Cardiovascular Testing purportedly provided to Insureds, in certain instances the referring healthcare provider was a chiropractor or physical therapist who could not legitimately, by training or qualification, assess the need or refer patients for Cardiovascular Testing.

152. In even more egregious cases, the diagnoses and test results documented in the referring healthcare providers' examination reports directly contradicted the need for the Cardiovascular Testing; nevertheless, Palmieri and the Provider Defendants routinely subjected Insureds to medically unnecessary Cardiovascular Testing.

153. For example:

(i) On December 26, 2020, an Insured named KP was purportedly involved in a motor vehicle accident. On April 8, 2021, KP underwent an examination with Emmons Avenue Medical Office and Ruben Oganesov, M.D. At that visit, Dr. Oganesov did not document any chest pain or any other symptoms causally related to the motor vehicle accident that would justify a referral for Cardiovascular Testing. Nevertheless, on May 4, 2021, KP was subjected to an echocardiogram billed under CPT code 93306, a duplex scan of extremity veins billed under CPT code 93970, and a bilateral duplex scan of upper extremity arteries billed under CPT code 93930 by Gemini pursuant to a referral purportedly issued by Dr. Oganesov.

(ii) On July 15, 2021, an Insured named EA was purportedly involved in a motor vehicle accident. On November 4, 2021, EA underwent an examination with Tri-Borough NY Medical Practice and Deonarine Rampershad, NP. At that visit, Deonarine Rampershad, NP did not document any chest pain or any other symptoms causally related to the motor vehicle accident that would justify a referral for Cardiovascular Testing. Nevertheless, on November 4, 2021, EA was subjected to a bilateral duplex scan of upper extracranial arteries billed under CPT code 93880, a duplex scan of extremity veins billed under CPT code 93970, and a bilateral duplex scan of upper extremity arteries billed under CPT code

93930 by Gemini pursuant to a referral purportedly issued by a healthcare provider associated with New Arena PT PC.

(iii) On September 17, 2021, an Insured named CC was purportedly involved in a motor vehicle accident. On October 29, 2021, CC underwent an examination with Hong Pak, M.D. PC and Hong Pak, M.D. At that visit, Dr. Pak did not document any chest pain or any other symptoms causally related to the motor vehicle accident that would justify a referral for Cardiovascular Testing. Nevertheless, on November 10, 2021, CC was subjected to a bilateral duplex scan of upper extracranial arteries billed under CPT code 93880, a duplex scan of extremity veins billed under CPT code 93970, and a bilateral duplex scan of upper extremity arteries billed under CPT code 93930 by Prometheus pursuant to a referral purportedly issued by a healthcare provider associated with New Arena PT PC.

(iv) On July 2, 2021, an Insured named JM was purportedly involved in a motor vehicle accident. On October 13, 2021, JM underwent an examination with Tri-Borough NY Medical Practice PC and Carline Boubert PA. At that visit, Carline Boubert PA did not document any chest pain or any other symptoms causally related to the motor vehicle accident that would justify a referral for Cardiovascular Testing. Nevertheless, on October 19, 2021, JM was subjected to a bilateral duplex scan of upper extracranial arteries billed under CPT code 93880, a duplex scan of extremity veins billed under CPT code 93970, and a bilateral duplex scan of upper extremity arteries billed under CPT code 93930 by Gemini pursuant to a referral purportedly issued by Tri-Borough NY Medical Practice PC.

(v) On January 7, 2023, an Insured named CW was purportedly involved in a motor vehicle accident. On February 23, 2023, CW underwent an examination with Jordan Fersel MD PC. At that visit, Jordan Fersel MD PC did not document any chest pain or any other symptoms causally related to the motor vehicle accident that would justify a referral for Cardiovascular Testing. Nevertheless, on March 14, 2023, CW was subjected to a bilateral duplex scan of upper extremity arteries billed under CPT code 93930 by Titan pursuant to a referral purportedly issued by Dr. Fersel.

154. These are only representative examples.

155. In virtually all the claims identified in Exhibits "1" through "4", the Insureds who received Cardiovascular Testing from the Provider Defendants did so despite not exhibiting any chest pain or any other cardiovascular symptoms that would warrant Cardiovascular Testing, much less symptoms plausibly related to the Insureds' motor vehicle accidents.

156. Although virtually none of the Insureds who received Cardiovascular Testing displayed symptoms warranting the testing, Palmieri and the Provider Defendants submitted, or caused to be submitted, hundreds of thousands of dollars in bills for Cardiovascular Testing to GEICO, as part of the Fraudulent Services.

c. The Lack of Causality Between Insureds' Motor Vehicle Accidents and Symptoms Purportedly Warranting Cardiovascular Testing

157. New York No-Fault Insurance is designed to provide reimbursement for medically necessary expenses on account of personal injuries arising out of the use or operation of a motor vehicle. See N.Y. Ins. Law § 5102.

158. Outside an emergency room context, cardiovascular testing is not typically required to diagnose, or aid in the treatment of, injuries resulting from motor vehicle accidents.

159. Moreover, as previously discussed, there are a substantial number of variables that can affect whether, how, and to what extent an individual is injured in an automobile accident. These variables include, but are not limited to, an individual's age, height, weight, general physical condition, location within the vehicle, and the location of the impact.

160. Outside of an emergency room context, it is entirely implausible – to the point of absurdity – that multiple Insureds involved in the same automobile accident would require Cardiovascular Testing at or about the same time.

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

162. For example:

(i) On March 14, 2021, two Insureds – GP and MLP – were involved in the same automobile accident. Thereafter, GP and MLP both – incredibly – were purportedly subjected to Cardiovascular Testing by Gemini on June 8, 2021.

(ii) On October 28, 2021, two Insureds – CV and JP – were involved in the same automobile accident. Thereafter, CV and JP both – incredibly – were purportedly subjected to Cardiovascular Testing by Prometheus on December 1, 2021.

(iii) On May 31, 2021, three Insureds – MP, MS, and MR – were involved in the same automobile accident. Thereafter, MP, MS, and MR all – incredibly – were purportedly subjected to Cardiovascular Testing by Prometheus on June 17, 2021.

(iv) On September 5, 2020, two Insureds – CPG and KG – were involved in the same automobile accident. Thereafter, CPG and KG both – incredibly – were purportedly subjected to Cardiovascular Testing by Titan on September 23, 2020.

(v) On September 30, 2020, two Insureds – NR and SS – were involved in the same automobile accident. Thereafter, NR and SS both – incredibly – were purportedly subjected to Cardiovascular Testing by Titan on November 23, 2020.

163. These are only representative examples.

164. In many of the claims identified in Exhibits "1"-"4", two or more Insureds involved in the same underlying accident received Cardiovascular Testing from Palmieri and the Provider Defendants at or about the same time, despite the fact that the Insureds were differently situated.

165. In keeping with the fact that the Cardiovascular Testing that supposedly was provided by the Defendants was medically unnecessary, upon information and belief, no physician or healthcare provider associated with the Defendants properly prepared the Insureds for the tests or conducted any sort of pre-test evaluation or screening. This, in turn, rendered the data that the Provider Defendants purported to obtain from the tests unreliable and useless.

166. Because the Defendants knew the Cardiovascular Testing were unreliable and useless, the results that the Provider Defendants purported to obtain from the tests were typically not incorporated into any Insured's treatment plan.

167. As with the other Fraudulent Services, the Cardiovascular Testing 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.

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

168. To support their fraudulent charges, the Defendants systematically submitted or caused to be submitted hundreds of NF-3, 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.

169. The Defendants' 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 the Defendants, rather than to treat or otherwise benefit the Insureds; and

(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 or control healthcare services, without supervision by a licensed professional, and as a result of illegal kickback arrangements amongst the Defendants and others.

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

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

171. 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.

172. 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 three 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.

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

174. 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.

175. 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.

176. 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.

177. 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.

178. 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 $290,000.00 based upon the fraudulent charges.

179. 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 Palmieri
(Declaratory Judgment – 28 U.S.C. §§ 2201 and 2202)

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

181. There is an actual case in controversy between GEICO, the Provider Defendants, and Palmieri regarding more than $4,400,000.00 in pending fraudulent No-Fault billing for the Fraudulent Services that have been submitted to GEICO under the name of the Provider Defendants.

182. The Provider Defendants and Palmieri have no right to receive payment for any pending bills submitted to GEICO because Palmieri and the Provider 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.

183. The Provider Defendants and Palmieri 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 or control healthcare services, without supervision by a licensed professional, and as a result of unlawful kickback and financial arrangements.

184. Accordingly, GEICO requests a judgement pursuant to the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202, declaring that Palmieri and the Provider Defendants have no right to receive payment for any pending bills submitted to GEICO under the names of the Provider Defendants.

AS AND FOR A SECOND CAUSE OF ACTION
Against Palmieri
(Violation of RICO, 18 U.S.C. § 1962(c))

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

186. Titan, Prometheus, and Gemini constitute an association-in-fact "enterprise" (the "Palmieri Fraud Enterprise") as that term is defined in 18 U.S.C. § 1961(4), that engages in, and the activities of which affect, interstate commerce. The members of the Palmieri Fraud Enterprise are and have been associated through time, joined in purpose, and organized in a manner amenable to hierarchal and consensual decision making, with each member fulfilling a specific and necessary

role to carry out and facilitate its common purpose. Specifically, Titan, Prometheus, and Gemini ostensibly are independent entities – with different names and tax identification numbers – that were used as vehicles to achieve a common purpose – namely, to facilitate the submission of fraudulent charges to GEICO. The Palmieri Fraud Enterprise has been operated under three separate names and tax identification numbers in order to reduce the number of bills submitted under any individual name in an attempt to avoid attracting the attention and scrutiny of GEICO and other insurers to the volume of billing and the pattern of fraudulent charges originating from any one business. Accordingly, the carrying out of this scheme would be beyond the capacity of each member of the Palmieri Fraud Enterprise acting singly or without aid of each other.

187. The Palmieri Fraud Enterprise is distinct from and has an existence beyond the pattern of racketeering that is described herein, namely by recruiting, employing overseeing and coordinating many individuals who have been responsible for facilitating and performing a wide variety of administrative and other functions beyond the acts of mail fraud (i.e., the submission of the fraudulent bills to GEICO and other insurers), by creating and maintaining patient files and other records, by recruiting and supervising personnel, by negotiating and executing various contracts, by maintaining the bookkeeping and accounting functions necessary to manage the receipt and distribution of insurance proceeds, and by retaining collection lawyers whose services also were used to generate payments from insurance companies to support all of the aforesaid functions.

188. Palmieri has been employed by and/or associated with the Palmieri Fraud Enterprise.

189. Palmieri knowingly has conducted and/or participated, directly or indirectly, in the conduct of the Palmieri Fraud Enterprise's affairs through a pattern of racketeering activity,

consisting of repeated violations of the federal mail fraud statute, 18 U.S.C. § 1341, based upon the use of the United States mails to submit or cause to be submitted hundreds of fraudulent charges on a continuous basis for over two years seeking payments for Fraudulent Services that Titan, Prometheus, and Gemini were 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 financially enrich Defendants; (iii) Titan, Prometheus, and Gemini obtained their patients through the Defendants' illegal kickback scheme; and (iv) the billed-for-services were provided, to the extent provided at all, pursuant to the dictates of laypersons not authorized to practice medicine. The fraudulent billings and corresponding mailings 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".

190. The Palmieri Fraud Enterprise'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 are the regular ways in which Palmieri operated the Palmieri Fraud Enterprise, inasmuch as Titan, Prometheus, and Gemini never were eligible to bill for or collect No-Fault Benefits, and acts of mail fraud therefore were essential in order for the Palmieri Fraud Enterprise to function. Furthermore, the intricate planning required to carry out and conceal the predicate acts of mail fraud implies a threat of continued criminal activity, as does the fact that Defendants continue to attempt collection on the fraudulent billing submitted through Titan, Prometheus, and Gemini to the present day.

191. The Palmieri Fraud Enterprise 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 the Palmieri Fraud Enterprise in pursuit of inherently unlawful goals – namely, the theft of money from GEICO and other insurers through fraudulent No-Fault billing.

192. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least $290,000.00 pursuant to the fraudulent bills submitted by the Defendants through Titan, Prometheus, and Gemini.

193. 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 Palmieri and John Doe Defendants "1" through "10"
(Violation of RICO, 18 U.S.C. § 1962(d))

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

195. Palmieri and John Doe Defendants "1" through "10" are employed by and/or associated with the Palmieri Fraud Enterprise.

196. Palmieri and John Doe Defendants "1" through "10" knowingly have agreed, combined and conspired to conduct and/or participate, directly or indirectly, in the conduct of the Palmieri Fraud Enterprise's affairs through a pattern of racketeering activity consisting of repeated violations of the federal mail fraud statute, 18 U.S.C. § 1341, based upon the use of the United States mails to submit or cause to be submitted hundreds of fraudulent charges on a continuous basis for over two years seeking payments for Fraudulent Services that Titan, Prometheus, and Gemini were 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) Titan, Prometheus, and Gemini obtained their patients through the Defendants' illegal kickback scheme; and (iv) the billed-for-services were provided, to the extent provided at all, pursuant to the dictates of laypersons not authorized to practice medicine. The fraudulent billings and corresponding mailings 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".

197. Palmieri and John Doe Defendants "1" through "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 fraudulent charges to GEICO.

198. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least $290,000.00 pursuant to the fraudulent bills submitted by Defendants through Titan, Prometheus, and Gemini.

199. 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 Gemini and Palmieri
(Common Law Fraud)

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

201. Gemini and Palmieri 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.

202. 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 provided pursuant to the dictates of laypersons and 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.

203. Gemini and Palmieri intentionally made the above-described false and fraudulent statements and concealed material facts in a calculated effort to induce GEICO to pay charges through Gemini that were not compensable under the No-Fault Laws.

204. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least $60,000.00 pursuant to the fraudulent billing submitted by Defendants.

205. The chart annexed hereto as Exhibit "2" sets forth a representative sample of the fraudulent claims that have been identified to date that the Defendants submitted, or caused to be submitted, to GEICO through Gemini.

206. The extensive fraudulent conduct by Gemini and Palmieri demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

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

AS AND FOR A FIFTH CAUSE OF ACTION
Against Gemini and Palmieri
(Unjust Enrichment)

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

209. As set forth above, Gemini and Palmieri have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of GEICO.

210. When GEICO paid the bills and charges submitted by or on behalf of Gemini 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.

211. Gemini and Palmieri have been enriched at GEICO's expense by GEICO's payments, which constituted a benefit that Gemini and Palmieri voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

212. Gemini and Palmieri's retention of GEICO's payments violates the fundamental principles of justice, equity, and good conscience.

213. By reason of the above, Gemini and Palmieri have been unjustly enriched in an amount to be determined at trial, but in no event less than $60,000.00.

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

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

215. John Doe Defendants "1" through "10" knowingly aided and abetted the fraudulent scheme that was perpetrated on GEICO by Gemini and Palmieri.

216. The acts of John Doe Defendants "1" through "10" in furtherance of the fraudulent scheme included, among other things, knowingly referring Insureds to Gemini 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.

217. 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 Gemini 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 Gemini.

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

219. The conduct of John Doe Defendants "1" through "10" caused GEICO to pay more than $60,000.00 pursuant to the fraudulent bills submitted through Gemini.

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

221. 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 Prometheus and Palmieri
(Common Law Fraud)

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

223. Prometheus and Palmieri 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.

224. 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 provided pursuant to the dictates of laypersons and 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.

225. Prometheus and Palmieri 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 Prometheus that were not compensable under the No-Fault Laws.

226. 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.

227. The chart annexed hereto as Exhibit "3" sets forth a representative sample of the fraudulent claims that have been identified to date that the Defendants submitted, or caused to be submitted, to GEICO through Prometheus.

228. The extensive fraudulent conduct by Prometheus and Palmieri demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

229. 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 EIGHTH CAUSE OF ACTION
Against Prometheus and Palmieri
(Unjust Enrichment)

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

231. As set forth above, Prometheus and Palmieri have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of GEICO.

232. When GEICO paid the bills and charges submitted by or on behalf of Prometheus 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.

233. Prometheus and Palmieri have been enriched at GEICO's expense by GEICO's payments, which constituted a benefit that Prometheus and Palmieri voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

234. Prometheus and Palmieri's retention of GEICO's payments violates the fundamental principles of justice, equity, and good conscience.

235. By reason of the above, Prometheus and Palmieri 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 NINTH CAUSE OF ACTION
Against John Doe Defendants "1"-"10"
(Aiding and Abetting Fraud)

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

237. John Doe Defendants "1" through "10" knowingly aided and abetted the fraudulent scheme that was perpetrated on GEICO by Prometheus and Palmieri.

238. The acts of John Doe Defendants "1" through "10" in furtherance of the fraudulent scheme included, among other things, knowingly referring Insureds to Prometheus 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.

239. 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 Prometheus 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 Prometheus.

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

241. 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 Prometheus.

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

243. 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 TENTH CAUSE OF ACTION
Against Palmieri
(Violation of RICO, 18 U.S.C. § 1962(c))

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

245. Titan is an ongoing "enterprise," as that term is defined in 18 U.S.C. § 1961(4), that engages in activities which affect interstate commerce.

246. Palmieri knowingly has conducted and/or participated, directly or indirectly, in the conduct of Titan's affairs through a pattern of racketeering activity consisting of repeated violations of the federal mail fraud statute, 18 U.S.C. § 1341, based upon the use of the United States mails to submit or cause to be submitted hundreds of fraudulent charges on a continuous basis for over two years seeking payments that Titan 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 financially enrich Defendants; (iii) Titan obtained its patients through the Defendants' illegal kickback scheme; and (iv) Titan provided its services, to the extent provided at all, pursuant to the dictates of laypersons not authorized to practice medicine. The fraudulent

billings and corresponding mailings 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".

247. Titan'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 are the regular ways in which Palmieri operated Titan, inasmuch as Titan never was eligible to bill for or collect No-Fault Benefits and acts of mail fraud therefore were essential in order for Titan to function. Furthermore, the intricate planning required to carry out and conceal the predicate acts of mail fraud implies a threat of continued criminal activity, as does the fact that Defendants continue to attempt collection on the fraudulent billing submitted through Titan to the present day.

248. Titan 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 Titan in pursuit of inherently unlawful goals – namely, the theft of money from GEICO and other insurers through fraudulent no-fault billing.

249. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least $220,000.00 pursuant to the fraudulent bills submitted by the Defendants through Titan.

250. 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 ELEVENTH CAUSE OF ACTION
Against Palmieri and John Doe Defendants "1"-"10"
(Violation of RICO, 18 U.S.C. § 1962(d))

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

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

253. Palmieri and John Doe Defendants "1"-"10" are employed by and/or associated with the Titan enterprise.

254. Palmieri and John Doe Defendants "1"-"10" knowingly have agreed, combined and conspired to conduct and/or participate, directly or indirectly, in the conduct of Titan's affairs through a pattern of racketeering activity consisting of repeated violations of the federal mail fraud statute, 18 U.S.C. § 1341, based upon the use of the United States mails to submit or cause to be submitted hundreds of fraudulent charges on a continuous basis for over two years seeking payments that Titan 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) Titan obtained its patients through the Defendants' illegal kickback scheme; and (iv) the billed-for-services were provided, to the extent provided at all, pursuant to the dictates of laypersons not authorized to practice medicine. The fraudulent bills and corresponding mailings submitted to GEICO that comprise the pattern of racketeering activity identified through the date of this Complaint are described in the chart annexed hereto as Exhibit "4".

255. Palmieri 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.

256. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least $220,000.00 pursuant to the fraudulent bills submitted by Defendants through Titan.

257. 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 TWELFTH CAUSE OF ACTION
Against Titan and Palmieri
(Common Law Fraud)

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

259. Titan and Palmieri 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.

260. 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 provided pursuant to the dictates of laypersons and 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.

261. Titan and Palmieri 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 Titan that were not compensable under the No-Fault Laws.

262. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least $220,000.00 pursuant to the fraudulent billing submitted by Defendants.

263. The extensive fraudulent conduct by Titan and Palmieri demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

264. 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 Titan and Palmieri
(Unjust Enrichment)

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

266. As set forth above, Titan and Palmieri have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of GEICO.

267. When GEICO paid the bills and charges submitted by or on behalf of Titan 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.

268. Titan and Palmieri have been enriched at GEICO's expense by GEICO's payments, which constituted a benefit that Titan and Palmieri voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

269. Titan and Palmieri's retention of GEICO's payments violates the fundamental principles of justice, equity, and good conscience.

270. By reason of the above, Titan and Palmieri have been unjustly enriched in an amount to be determined at trial, but in no event less than $220,000.00.

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

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

272. John Doe Defendants "1" through "10" knowingly aided and abetted the fraudulent scheme that was perpetrated on GEICO by Titan and Palmieri.

273. The acts of John Doe Defendants "1" through "10" in furtherance of the fraudulent scheme included, among other things, knowingly referring Insureds to Titan 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.

274. 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 Titan 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 Titan.

275. John Doe Defendants "1" through "10" aided and abetted the fraudulent scheme in a calculated effort to induce GEICO into paying charges to Titan for medically unnecessary,

illusory, and otherwise non-reimbursable Fraudulent Services because they sought to continue profiting through the fraudulent scheme.

276. The conduct of John Doe Defendants "1" through "10" caused GEICO to pay more than $220,000.00 pursuant to the fraudulent bills submitted through Titan.

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

278. 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

279. Pursuant to Federal Rule of Civil Procedure 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 Palmieri and the Provider Defendants a declaration pursuant to the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202, that Palmieri 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 Palmieri, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of $290,000.00, 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 Palmieri and John Doe Defendants "1"-"10", compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of

$290,000.00, 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 Gemini and Palmieri compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of $60,000.00, together with punitive damages, costs, interest, and other and further relief as the Court deems proper;

E. On the Fifth Cause of Action against Gemini and Palmieri, more than $60,000.00 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 $60,000.00, 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 Prometheus and Palmieri 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 such other and further relief as the Court deems just and proper;

H. On the Eighth Cause of Action against Prometheus and Palmieri, more than $16,000.00 in compensatory damages, plus costs and interest and such other and further relief as the Court deems just and proper;

I. On the Ninth 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;

J. On the Tenth Cause of Action against Palmieri, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of $220,000.00, together with treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c) plus interest;

K. On the Eleventh Cause of Action against Palmieri and John Doe Defendants "1"-"10", compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of $220,000.00, together with treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c) plus interest;

L. On the Twelfth Cause of Action against Titan and Palmieri compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of $220,000.00, together with punitive damages, costs, interest, and such other and further relief as the Court deems just and proper;

M. On the Thirteenth Cause of Action against Titan and Palmieri, more than $220,000.00 in compensatory damages, plus costs and interest and such other and further relief as this Court deems just and proper; and

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 $220,000.00, together with punitive damages, costs, interest, and such other and further relief as this Court deems just and proper.

Dated: March 25, 2024
Uniondale, New York

RIVKIN RADLER LLP

By: */s/ Michael Sirignano*
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Barry I. Levy, Esq.
Sean Gorton, Esq.
926 RXR Plaza

Uniondale, New York 11556
(516) 357-3000

Counsel for Plaintiffs Government Employees Insurance Company, GEICO Indemnity Company, GEICO General Insurance Company and GEICO Casualty Company

4889-4983-5403, v. 6

JS 44 (Rev. 4-29-21)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

Government Employees Insurance Company, et al.

(b) County of Residence of First Listed Plaintiff Douglas, Nebraska
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
Rivkin Radler LLP
926 RXR Plaza, Uniondale NY 11556

DEFENDANTS

Anthony Palmieri, et al.

County of Residence of First Listed Defendant Monmouth, New Jersey
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*
Unknown

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

Does this action include a motion for temporary restraining order or order to show cause? Yes___ No_X__"

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☒ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding | ☐ 2 Removed from State Court | ☐ 3 Remanded from Appellate Court | ☐ 4 Reinstated or Reopened | ☐ 5 Transferred from Another District *(specify)* | ☐ 6 Multidistrict Litigation - Transfer | ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
18 U.S.C. 1962(c) and (d)

Brief description of cause:
Insurance fraud case involving civil RICO/common law fraud/unjust enrichment/declaratory judgment

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $ $290,000.00

CHECK YES only if demanded in complaint:
JURY DEMAND: ☑ Yes ☐ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE 03/25/2024

SIGNATURE OF ATTORNEY OF RECORD /s/ Michael Sirignano

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

CERTIFICATION OF ARBITRATION ELIGIBILITY

Local Arbitration Rule 83.7 provides that with certain exceptions, actions seeking money damages only in an amount not in excess of $150,000, exclusive of interest and costs, are eligible for compulsory arbitration. The amount of damages is presumed to be below the threshold amount unless a certification to the contrary is filed.

Case is Eligible for Arbitration ☐

I, Michael A. Sirignano, counsel for Plaintiffs, do hereby certify that the above captioned civil action is ineligible for compulsory arbitration for the following reason(s):

☑ monetary damages sought are in excess of $150,000, exclusive of interest and costs,

☐ the complaint seeks injunctive relief,

☑ the matter is otherwise ineligible for the following reason Declaratory relief is sought

DISCLOSURE STATEMENT - FEDERAL RULES CIVIL PROCEDURE 7.1

Identify any parent corporation and any publicly held corporation that owns 10% or more or its stocks:

See attached Disclosure Statement

RELATED CASE STATEMENT (Section VIII on the Front of this Form)

Please list all cases that are arguably related pursuant to Division of Business Rule 50.3.1 in Section VIII on the front of this form. Rule 50.3.1 (a) provides that "A civil case is "related" to another civil case for purposes of this guideline when, because of the similarity of facts and legal issues or because the cases arise from the same transactions or events, a substantial saving of judicial resources is likely to result from assigning both cases to the same judge and magistrate judge." Rule 50.3.1 (b) provides that " A civil case shall not be deemed "related" to another civil case merely because the civil case: (A) involves identical legal issues, or (B) involves the same parties." Rule 50.3.1 (c) further provides that "Presumptively, and subject to the power of a judge to determine otherwise pursuant to paragraph (d), civil cases shall not be deemed to be "related" unless both cases are still pending before the court."

NY-E DIVISION OF BUSINESS RULE 1(c)

1.) Is the civil action being filed in the Eastern District removed from a New York State Court located in Nassau or Suffolk County? ☐ Yes ☑ No

2.) If you answered "no" above:

a) Did the events or omissions giving rise to the claim or claims, or a substantial part thereof, occur in Nassau or Suffolk County? ☐ Yes ☑ No

b) Did the events or omissions giving rise to the claim or claims, or a substantial part thereof, occur in the Eastern District? ☑ Yes ☐ No

c) If this is a Fair Debt Collection Practice Act case, specify the County in which the offending communication was received: .

If your answer to question 2 (b) is "No," does the defendant (or a majority of the defendants, if there is more than one) reside in Nassau or Suffolk County, or, in an interpleader action, does the claimant (or a majority of the claimants, if there is more than one) reside in Nassau or Suffolk County? ☐ Yes ☐ No

(Note: A corporation shall be considered a resident of the County in which it has the most significant contacts).

BAR ADMISSION

I am currently admitted in the Eastern District of New York and currently a member in good standing of the bar of this court.

☑ Yes ☐ No

Are you currently the subject of any disciplinary action (s) in this or any other state or federal court?

☐ Yes (If yes, please explain ☑ No

I certify the accuracy of all information provided above.

Signature: /s/ Michael Sirignano