HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

BCBS of NY Empire
P.O. Box 11810
Albany NY 12211-0810

CARRIER

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1. MEDICARE ○ (Medicare #) MEDICAID ○ (Medicaid #) TRICARE ○ (ID#/DoD#) CHAMPVA ○ (Member ID#) GROUP HEALTH PLAN ○ (ID#) FECA BLK LUNG ○ (ID#) OTHER ⊗ (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
	1000	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
testing, test	11 11 2000 M ⊗ F ○	testing, test
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self ⊗ Spouse ○ Child ○ Other ○	13 main street
CITY / STATE	8. RESERVED FOR NUCC USE	CITY: New York / STATE: NY
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE: 10013 / TELEPHONE: (888) 888-8888
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ○ YES ⊗ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX: 11 11 2000 M ⊗ F ○
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) ○ YES ⊗ NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ○ YES ⊗ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ○ YES ⊗ NO *If yes*, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: On File DATE: 04-03-2025

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	15. OTHER DATE MM DD YY QUAL	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ○ YES ○ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 10 A. L70.0 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04 03 2025	04 03 2025	11		99203	25	A	250 70	1		NPI	1033436019
2 04 03 2025	04 03 2025	11		15792		A	996 48	1		NPI	1033436019
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
123412342 ○ ⊗	AB9623	⊗ YES ○ NO	$ 1247 18	$	$ 1247 18

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
Ghufran G Khan 04-03-2025 SIGNED DATE	AB Dermatology, LHR 41 10th, DHA New York NY 10018 a. 17123617 b.	(123) 123-1234 AB Dermatology, LHR 41 10th, DHA New York NY 10018 a. 17123617 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION