HEALTH INSURANCE CLAIM FORM

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

1199 Local Benefit Fund
P.O. Box 1007
New York NY 10108-1007

PICA

PICA

CARRIER

1. MEDICARE ( ) (Medicare #) MEDICAID ( ) (Medicaid #) TRICARE ( ) (ID#/DoD#) CHAMPVA ( ) (Member ID#) GROUP HEALTH PLAN ( ) (ID#) FECA BLK LUNG ( ) (ID#) OTHER (X) (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): demo, test

3. PATIENT'S BIRTH DATE MM 01 DD 01 YY 2011 SEX M (X) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial): demo, test

5. PATIENT'S ADDRESS (No., Street): teting

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

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

CITY: test STATE: AL

8. RESERVED FOR NUCC USE

CITY: test STATE: AL

ZIP CODE: 12345 TELEPHONE (Include Area Code): ( )

ZIP CODE: 12345 TELEPHONE (Include Area Code): (123) 133-4455

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 (X)

a. INSURED'S DATE OF BIRTH MM 01 DD 01 YY 2011 SEX M (X) F ( )

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ( ) NO (X)

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 (X) *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 05-06-2025

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: Irtaza Tariq

17a.

17b. NPI 1942681200

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 05 06 2025	05 06 2025	11		96900		A	52 20	1		NPI	1942681200
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN (X): 123412342

26. PATIENT'S ACCOUNT NO.: AB10925

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

28. TOTAL CHARGE $ 52 20

29. AMOUNT PAID $

30. BALANCE DUE $ 52 20

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.)

Irtaza Tariq 05-06-2025

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

AB Dermatology, LHR
41 10th, DHA
New York NY 10018

a. 17123617 b.

33. BILLING PROVIDER INFO & PH # (123) 123-1234

AB Dermatology, LHR
41 10th, DHA
New York NY 10018

a. 17123617 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)