HEALTH INSURANCE CLAIM FORM

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

PICA

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

CARRIER

PICA

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): 123123123132
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Abdul, Tests	3. PATIENT'S BIRTH DATE MM 01 DD 02 YY 2025 SEX M ⊗ F ○	4. INSURED'S NAME (Last Name, First Name, Middle Initial): Abdul, Tests
5. PATIENT'S ADDRESS (No., Street): Address	6. PATIENT RELATIONSHIP TO INSURED: Self ⊗ Spouse ○ Child ○ Other ○	7. INSURED'S ADDRESS (No., Street): Address
CITY: Lahore STATE: AK	8. RESERVED FOR NUCC USE	CITY: Lahore STATE: AK
ZIP CODE: 54002 TELEPHONE (Include Area Code): (111) 111-1111		ZIP CODE: 54002 TELEPHONE (Include Area Code): (111) 111-1111
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 01 DD 02 YY 2025 SEX M ⊗ F ○
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ○ YES ⊗ NO PLACE (State)	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: 09-11-2025

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. 71b. 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. L23.81 C. L23.1 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 09 11 2025	09 11 2025	11		99203	25	B C	250 70	1		NPI	1710448691
2 09 11 2025	09 11 2025	11		10040		A	258 50	1		NPI	1710448691
3 09 11 2025	09 11 2025	11		11102		A	500 00	1		NPI	1710448691
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 123412342 ○ ⊗	26. PATIENT'S ACCOUNT NO.: AB10930	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ⊗ YES ○ NO	28. TOTAL CHARGE: $ 1009 20	29. AMOUNT PAID: $	30. BALANCE DUE: $ 1009 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.) Farhan Munawar 09-11-2025 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