



HEALTH INSURANCE CLAIM FORM

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

Cigna Health
P.O. Box. 188061
Chattanooga TN 37422-8061

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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) 4863108242																
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Scott, Kylie												3. PATIENT'S BIRTH DATE MM DD YY 01 27 2005						SEX M ☐ F ☒						4. INSURED'S NAME (Last Name, First Name, Middle Initial) Test, Kylie													
5. PATIENT'S ADDRESS (No., Street) 80 Lafayette Street, #1808												6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐												7. INSURED'S ADDRESS (No., Street) 80 Lafayette Street, #1808													
CITY New York						STATE NY						8. RESERVED FOR NUCC USE												CITY New York						STATE NY							
ZIP CODE 10013						TELEPHONE (Include Area Code) ()																		ZIP CODE 10013						TELEPHONE (Include Area Code) (123) 552-2084							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State) c. OTHER ACCIDENT? ☐ YES ☒ NO 10d. RESERVED FOR LOCAL USE												11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY 01 27 2005 SEX M ☐ F ☒ b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, complete items 9, 9a and 9d.													
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 02-06-2025																								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 FROM MM DD YY TO MM DD YY													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												17a. 71b. NPI												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? ☐ YES ☐ NO \$ CHARGES												22. RESUBMISSION CODE ORIGINAL REF. NO.													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 10 A. W57.XXXA B. C. D. E. F. G. H. I. J. K. L.												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. ICD-9 Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #											
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25. FEDERAL TAX I.D. NUMBER 123412342												SSN EIN ☐ ☒		26. PATIENT'S ACCOUNT NO. AB10002						27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO						28. TOTAL CHARGE \$ 249 56				29. AMOUNT PAID \$				30. BALANCE DUE \$ 249 56			
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 SIGNED DATE 09-11-2025												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.													