HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

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

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): 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 (X)

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 (X) 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:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) ( ) YES (X) NO

a. INSURED'S DATE OF BIRTH MM DD YY: 01 27 2005 SEX M ( ) F (X)

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? ( ) YES (X) 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 (X) 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: 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 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. W57.XXXA 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 02 06 2025	02 06 2025	11		99214		A	249 56	1		NPI	1710448691
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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

26. PATIENT'S ACCOUNT NO.: AB10002

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) (X) 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 09-11-2025 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