



PRIMARY

HIDALGO COUNTY SHERIFFS DEPT HCSD
711 E L CIBOLO RD
ATT ACCOUNTS PAYABLE
EDINBURG, TX 78542-0471

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE NUCC 02/11

CARRIER

1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SECA
 (Medicare #) (Medicaid #) (TRICARE #) (Medicaid #) (Group Health Plan #) (SECA #) X

2 PATIENT'S NAME (Last, First, Middle Initial) [REDACTED] SEX [REDACTED] AGE [REDACTED]

3 PATIENT'S ADDRESS (No. Street) [REDACTED] CITY [REDACTED] STATE [REDACTED] ZIP CODE [REDACTED] TELEPHONE (Area Code) [REDACTED]

4 OTHER INSURED'S NAME (Last, First, Middle Initial) [REDACTED] POLICY OR GROUP OR MEDICARE NUMBER [REDACTED]

5 OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]

6 INVOICE RECEIVED BY: Palenberg on 11/3/22

7 GOOD/SERVICES RECEIVED BY: Rodriguez on 8/29/22

8 PHONE NUMBER: 1100-42327-200-002-0-331

Please process this invoice/credit memo from this copy due to vendor not submitting original.

Hidalgo County Sheriff's Office

PATIENT AND INSURED INFORMATION

9 READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

10 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Include date and time of signature) [REDACTED]

11 NAME OF REFERRING PROVIDER OR OTHER REFERRER: DR SOBIA NASIR PHONE NUMBER: 300566001

12 ADDITIONAL CLAIM INFORMATION (Optional) [REDACTED]

13 DIAGNOSIS (ICD-9-CM) (ICD-10-CM) [REDACTED]

14 A	DATE OF SERVICE	ICD-9-CM	ICD-10-CM	ICD-9-CM PROCEDURE	ICD-10-CM PROCEDURE	UNIT	RATE	AMOUNT	REMARKS
1	08 29 22	09 09 22 11	33213		A		65.00	2.0	1740389712
2	08 29 22	09 29 22 11	81002		A		10.00	2.0	1740389712
3	08 29 22	09 29 22 11	80325		A		80.00	1.0	1740389712
4	08 29 22	09 29 22 11	86892		A		15.00	1.0	1740389712
5									
6									

PHYSICIAN OR SUPPLIER INFORMATION

15 FEDERAL TAX ID NUMBER: 454034067 GEN. INV. NO.: X PAYEE'S ACCOUNT NUMBER: 2994E33280 PAYEE'S ACCOUNT TYPE: X PAYEE'S ACCOUNT BALANCE: 140.00

16 SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degree and title) Sobia SOBIA NASIR MD PA 702 W UNIVERSITY DR EDINBURG TX 785393241

17 SIGNATURE OF PATIENT OR AUTHORIZED PERSON (Including name and title) SOBIA NASIR MD PA PO BOX 4290 EDINBURG TX 785404290

18 SIGNED: Sobia DATE: 10/11/2022 SIGNATURE OF PHYSICIAN OR SUPPLIER: 1043568935 SIGNATURE OF PATIENT OR AUTHORIZED PERSON: 1043568935



PRIMARY

HIDALGO COUNTY SHERIFFS DEPT HCSD
711 E L CIBOLO RD
ATTN ACCOUNTS PAYABLE
EDINBURG, TX 78642-0471

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/13

PCA

CARRIER

1 MEDICARE <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICARE	MEDICARE <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICARE	TRICARE <input type="checkbox"/> TRICARE <input type="checkbox"/> TRICARE <input type="checkbox"/> TRICARE	CHAMPVA <input type="checkbox"/> CHAMPVA <input type="checkbox"/> CHAMPVA <input type="checkbox"/> CHAMPVA	VA <input type="checkbox"/> VA <input type="checkbox"/> VA <input type="checkbox"/> VA	OTHER <input type="checkbox"/> OTHER <input type="checkbox"/> OTHER <input type="checkbox"/> OTHER	INSURANCE NUMBER 438449724	For Program Use Only
2 PATIENT'S NAME (Last, First, Middle Initial) [REDACTED]			3 PATIENT'S BIRTH DATE [REDACTED]		4 INSURER'S NAME (Last, First, Middle Initial) [REDACTED]		
5 PATIENT'S ADDRESS (No. Street) [REDACTED]			6 PATIENT'S CITY, STATE, ZIP [REDACTED]		7 INSURER'S ADDRESS (No. Street) [REDACTED]		
8 CITY [REDACTED]			9 STATE [REDACTED]		10 ZIP [REDACTED]		
11 PHONE [REDACTED]			12 TELEPHONE (Include Area Code) [REDACTED]		13 GROUP OR PLAN NUMBER [REDACTED]		
14 OTHER INSURANCE (Please check all that apply) P.O. #: 842099			15 EMPLOYER [REDACTED]		16 DATE OF BIRTH [REDACTED]		

Invoice Received By: P. Eilenberger on 11/3/22
 Good Services Received By: V. Rodriguez on 9/1/22
 2-1100-423-21-200-002-0-331

Please process this invoice/credit memo from this copy due to vendor not submitting original.
 Hidalgo County Sheriff's Office

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

17 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Print name)
[REDACTED]

18 SIGNATURE ON FILE
[REDACTED]

19 DATE OF SIGNATURE
[REDACTED]

20 WORK IN CURRENT OCCUPATION
[REDACTED]

21 NAME OF PROVIDER (Last, First, Middle Initial)
DR. SOBIA NASIR

22 DATE OF SERVICE
[REDACTED]

23 ADDITIONAL CLAIM INFORMATION
[REDACTED]

24 ORIGINAL PER NO.
[REDACTED]

25 PROVIDER IDENTIFICATION NUMBER
[REDACTED]

DATE	DESCRIPTION	AMOUNT	STATUS	REMARKS
09 01 22 09 01 22 01	98011	10.00	1.0	
09 01 22 09 01 22 01	80308	80.00	1.0	
09 01 22 09 01 22 01				
09 01 22 09 01 22 01				
09 01 22 09 01 22 01				
09 01 22 09 01 22 01				

26 PROVIDER TAX ID NUMBER
454034067

27 PROVIDER ID NUMBER
2306234202

28 PROVIDER SIGNATURE
SOBIA NASIR MD PA
702 W UNIVERSITY ST
EDINBURG TX 78642-0471

29 PROVIDER IDENTIFICATION NUMBER
1043589435

30 DATE
10/24/2022

31 SIGNATURE
[Signature]

32 INSURER'S SIGNATURE
[Signature]

33 DATE
[REDACTED]

PHYSICIAN OR SUPPLIER INFORMATION



PRIMARY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0011

HIDALGO COUNTY SHERIFFS OFFICE
ATTN BUDGET DEPARTMENT
PO BOX 1228
EDINBURG, TX 78541

CARRIER

1 MEDICARE MEDICAID TRICARE CHANGVA OTHER HEALTH PLAN FEBA
 Medicare # Medicaid # Tricare # CHANGVA # OTHER HEALTH PLAN # FEBA #

2 PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED] PATIENT'S BIRTH DATE [REDACTED] SEX [REDACTED]

3 PATIENT'S ADDRESS (No Street) [REDACTED] PATIENT'S RELATIONSHIP TO MEMBER [REDACTED]

CITY [REDACTED] STATE [REDACTED] ZIP CODE [REDACTED] TELEPHONE () [REDACTED]

4 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED] MEMBER'S SOCIAL SECURITY NUMBER [REDACTED]

5 OTHER INSURED'S P.O. # OF [REDACTED] INVOICE RECEIVED BY: [REDACTED] GOOD SERVICES RECEIVED BY: [REDACTED]

6 HEDERA [REDACTED] MEMBER'S GROUP OR PLAN NUMBER [REDACTED]

Please process this invoice/credit memo from this copy due to vendor submitting original

Hidalgo County Sheriff's Office

PATIENT AND INSURED INFORMATION

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE [REDACTED] DATE [REDACTED]

14 DATE OF CURRENT ILLNESS (MM/DD/YYYY) [REDACTED] FREQUENCY OF [REDACTED] OTHER DATE [REDACTED]

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED] PROVIDER'S IDENTIFICATION NUMBER [REDACTED]

19 ADDITIONAL CLAIM INFORMATION (Diagnosis, ICD-9) [REDACTED]

21 DIAGNOSIS OR NATURE OF INJURY OR ILLNESS (ICD-9) [REDACTED]

PHYSICIAN OR SUPPLIER INFORMATION

23 FEDERAL TAX ID NUMBER 454034067

24 PATIENT'S ACCOUNT NUMBER 2900E33929

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING ADDRESS & CREDENTIALS) [REDACTED] DATE 10/11/2022

26 SERVICE FACILITY (NAME, ADDRESS, CITY, STATE, ZIP) [REDACTED]

27 PHYSICIAN OR SUPPLIER IDENTIFICATION NUMBER (956) 383-0714

28 SIGNATURE OF PHYSICIAN OR SUPPLIER [REDACTED] IDENTIFICATION NUMBER 1043589435



PRIMARY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE NUCC 02/12

HIDALGO COUNTY SHERIFFS OFFICE
ATTN BUDGET DEPARTMENT
PO BOX 1228
EDINBURG, TX 78541

CARRIER

1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER PLAN

2 PATIENT'S NAME (Last, First, Middle Initial) [REDACTED]

3 PATIENT'S ADDRESS (No. Street) [REDACTED]

4 CITY [REDACTED] STATE [REDACTED] ZIP CODE [REDACTED] TELEPHONE (Area Code) [REDACTED]

5 OTHER INSURED'S NAME (Last, First, Middle Initial) [REDACTED]

6 INVOICE RECEIVED BY: P.O. # 844669
S. Eilenberg on 11/3/22
GOOD SERVICES RECEIVED BY: V. Rodriguez on 9/5/22
4193 493 0 233 000-0
2-1100-421-00-285-001-0-331

Please process this invoice/credit memo from this copy due to vendor not submitting original.
Hidalgo County Sheriff's Office

PATIENT AND INSURED INFORMATION

10 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Print name and date) [REDACTED]

11 DATE OF CURRENT ILLNESS (MM/DD/YY) [REDACTED]

12 NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED]

13 ADDITIONAL CLAIM INFORMATION (Diagnosis, ICD-9) [REDACTED]

14 DIAGNOSIS OF NATURE OF ILLNESS (ICD-9) [REDACTED]

15	16 A DATES OF SERVICE						17	18	19	20		
	From	To	MM	DD	YY	MM					DD	YY
1	09	05	22	09	05	22	11	99013	A	03.00	1.0	17101339712
2	09	05	22	09	05	22	11	91002	A	13.00	1.0	17101339712
3	09	05	22	09	05	22	11	90205	A	30.00	1.0	17101339712
4	09	05	22	09	05	22	11	96692	A	18.00	1.0	17101339712
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

21 FEDERAL TAX ID NUMBER 454034067

22 PATIENT ACCOUNT NUMBER 2899E33925

23 SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees and state) SOBIA NASIR MD PA 702 W UNIVERSITY DR EDINBURG TX 785333242

24 SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees and state) SOBIA NASIR MD PA 702 W UNIVERSITY DR EDINBURG TX 785404290



PRIMARY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) #13

HIDALGO COUNTY SHERIFFS OFFICE
ATTN BUDGET DEPARTMENT
PO BOX 1228
EDINBURG, TX 78541

CARRIER

Form with fields for 1. MEDICARE, 2. PATIENT'S NAME, 3. PATIENT'S ADDRESS, 4. OTHER INSURED'S NAME, 14. DATE OF CURRENT ILLNESS, 17. NAME OF REFERRING PROVIDER, 24. DATE OF SERVICE, 25. FEDERAL TAX ID NUMBER, 31. SIGNATURE OF PROVIDER.

SECURE CLAIM

FIRST AND MIDDLE NAME AND SURNAME

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

Please process this invoice/credit memo from this copy due to vendor not submitting original. Hidalgo County Sheriff's Office

Invoice Received By: Cilenbeign on 11/3/22
Good Services Received By: V Rodriguez on 9/14/22

Table with 6 rows and 4 columns: Line, Date of Service, Code, Amount. Contains service records for dates 09/14/22.



PRIMARY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/13

HIDALGO COUNTY SHERIFFS OFFICE
ATTN BUDGET DEPARTMENT
PO BOX 1229
EDINBURG, TX 78541

CARRIER

Form sections 1-11 including patient information, insurance details, and provider information. Includes handwritten notes like 'Invoice Received By: E. Ellerbe' and 'Good Services Received By: V. Rodriguez'.

Please process this invoice/credit memo from this copy due to vendor not submitting original. Hidalgo County Sheriff's Office

PATIENT AND INSURED INFORMATION

Form sections 12-19 including signature lines for patient and provider, and additional claim information.

Table with 6 rows and 4 columns detailing charges. Columns include dates, procedure codes (e.g., 39013, 81002, 80305, 86582), and amounts.

PHYSICIAN OR SUPPLIER INFORMATION

Form sections 20-23 including federal tax ID, patient account number, and provider signature/credentials.



PRIMARY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE IN 2001

HIDALGO COUNTY SHERIFFS OFFICE
ATTN: BUDGET DEPARTMENT
PO BOX 1223
EDINBURG, TX 78541

CARRIER

PICA

1 MED CARE MED CAC TRICARE
 2 PATIENT'S NAME (Last Name, First Name, Middle Initial)
 3 PATIENT'S ADDRESS (No. Street)
 CITY STATE RECEIVED FROM (Last Name, First Name, Middle Initial)
 ZIP CODE TELEPHONE (Area Code) (Number)
 4 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
 5 OTHER INSURED'S ADDRESS (No. Street)
 CITY STATE RECEIVED FROM (Last Name, First Name, Middle Initial)
 ZIP CODE TELEPHONE (Area Code) (Number)
 6 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
 SIGNED SIGNATURE ON FILE
 7 NAME OF REFERRING PHYSICIAN OR SUPPLIER
 8 ADDITIONAL CLAIM INFORMATION (Assigned by NUCC)
 9 DIAGNOSIS OR NATURE OF ILLNESS (ICD-9-CM)
 10 DATE OF CURRENT ILLNESS (MM, DD, YY)
 11 NAME OF REFERRING PHYSICIAN OR SUPPLIER
 12 ADDITIONAL CLAIM INFORMATION (Assigned by NUCC)

PATIENT AND INSURED INFORMATION

13	14	15	16	17	18	19	20	21	22	23	24
DATE OF CURRENT ILLNESS (MM, DD, YY)	DATE OF CURRENT ILLNESS (MM, DD, YY)	DATE OF CURRENT ILLNESS (MM, DD, YY)	DATE OF CURRENT ILLNESS (MM, DD, YY)	DATE OF CURRENT ILLNESS (MM, DD, YY)	DATE OF CURRENT ILLNESS (MM, DD, YY)	DATE OF CURRENT ILLNESS (MM, DD, YY)	DATE OF CURRENT ILLNESS (MM, DD, YY)	DATE OF CURRENT ILLNESS (MM, DD, YY)	DATE OF CURRENT ILLNESS (MM, DD, YY)	DATE OF CURRENT ILLNESS (MM, DD, YY)	DATE OF CURRENT ILLNESS (MM, DD, YY)
09 14 22	09 14 22	09 14 22	09 14 22	09 14 22	09 14 22	09 14 22	09 14 22	09 14 22	09 14 22	09 14 22	09 14 22
29113	29113	29113	29113	29113	29113	29113	29113	29113	29113	29113	29113
81002	81002	81002	81002	81002	81002	81002	81002	81002	81002	81002	81002
80305	80305	80305	80305	80305	80305	80305	80305	80305	80305	80305	80305
86892	86892	86892	86892	86892	86892	86892	86892	86892	86892	86892	86892

PHYSICIAN OR SUPPLIER INFORMATION

25 FEDERAL TAX ID NUMBER
 26 SERVICE PROVIDER IDENTIFICATION NUMBER
 27 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIAL AND DATE
 28 SERVICE PROVIDER IDENTIFICATION NUMBER
 29 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIAL AND DATE



PRIMARY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02-13

HIDALGO COUNTY SHERIFFS OFFICE
ATTN: BUDGET DEPARTMENT
PO BOX 1226
EDINBURG, TX 78541

CARRIER

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE, 2. PATIENT'S NAME, 5. PATIENT'S ADDRESS, 9. OTHER INSURED'S NAME, 10. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE, 14. DATE OF CURRENT ILLNESS, 17. NAME OF APPEARING PROVIDER, 24. DATES OF SERVICE, 25. FEDERAL TAX ID NUMBER, 31. SIGNATURE OF PHYSICIAN OR SUPPLIER.

Please process this invoice/credit memo from this copy due to vendor not submitting original. Hidalgo County Sheriff's Office

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



PRIMARY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) #210

HIDALGO COUNTY SHERIFFS OFFICE
ATTN BUDGET DEPARTMENT
PO BOX 1228
EDINBURG, TX 78541

CARRIER

PICA FICA

1 MEDICAID MEDICAID TRICARE CHAMPVA... 2 PATIENT'S NAME... 3 PATIENT'S BIRTH DATE... 4 INSURED'S NAME... 5 PATIENT'S ADDRESS... 6 PATIENT RELATIONSHIP TO INSURED... 7 CITY... STATE... 8 ZIP CODE... TELEPHONE... 9 OTHER INSURED'S NAME...

10 OTHER INSURED'S POLICY OR IDENTIFICATION NUMBER... 11 EMPLOYMENT... 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE... 13 ADDITIONAL CLAIM INFORMATION... 14 DATE OF CURRENT ILLNESS... 15 OTHER DATE... 16 NAME OF REFERRING PROVIDER... 17 ADDITIONAL CLAIM INFORMATION... 18 DIAGNOSIS OR NATURE OF ILLNESS... 19 A B C D... 20 FEDERAL TAX ID NUMBER... 21 SIGNATURE OF PROVIDER OR SUPPLIER...

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. SIGNED SIGNATURE ON FILE DATE 10/11/22 SIGNED SIGNATURE ON FILE

Table with 4 columns: A, B, C, D. Rows 1-6 containing dates and numbers.

Table with 4 columns: A, B, C, D. Rows 1-6 containing dates and numbers.

25 FEDERAL TAX ID NUMBER 454034067... 26 FEDERAL TAX ID NUMBER 2919E34071... 27 SIGNATURE OF PROVIDER OR SUPPLIER SOBIA NASIR MD PA... 28 FEDERAL TAX ID NUMBER 1043589435



PRIMARY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 05/12

HIDALGO COUNTY SHERIFFS DEPT HCSD
711 E L CIBOLO RD
ATT ACCOUNTS PAYABLE
EDINBURG, TX 78542-0471

CARRIER

1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FEDERAL EMPLOYER HEALTH PLAN OTHER HEALTH PLAN (For Private Plans)

2 PATIENT'S NAME Last Name, First Name, Middle Initial

3 PATIENT'S BIRTH DATE SEX

4 PATIENT'S SOCIAL SECURITY NUMBER

5 PATIENT'S ADDRESS (No. Street)

6 PATIENT RELATIONSHIP TO INSURER

7 CITY STATE TX ZIP CODE TELEPHONE (House Area Code) () ()

8 RESERVED FOR FUTURE USE

9 OTHER INSURER'S NAME Last Name, First Name, Middle Initial

10 OTHER INSURER'S POLICY OR GROUP NUMBER

11 REFER. INVOICE RECEIVED BY: 842099

12 REFER. GOOD/SERVICES RECEIVED BY: Good/Services Received By: V Rodriguez on 9/15/22

13 SIGNATURE ON FILE

14 DATE OF CURRENT LOSS (MM DD) (YR) (MM DD) (YR)

15 NAME OF REFERRING PROVIDER OR OTHER SOURCE

16 ADDITIONAL CLAIM INFORMATION (Delayed, NUCC)

17 DIAGNOSIS OR NATURE OF LOSS (ICD-9-CM) (ICD-10-CM) (ICD-9-CM) (ICD-10-CM)

18 DATE OF SERVICE (MM DD) (YR) (MM DD) (YR)

19 PROCEDURE CODE (ICD-9-CM) (ICD-10-CM)

20 CHARGE

21 FEDERAL TAX ID NUMBER

22 SIGNATURE OF PHYSICIAN OR SUPPLIER

23 SERVICE PERIOD

24 SIGNATURE OF PHYSICIAN OR SUPPLIER

25 SERVICE PERIOD

Please process this invoice/credit memo from this copy due to vendor not submitting original

Hidalgo County Sheriff's Office

PATIENT AND INSURED INFORMATION

LINE	DATE OF SERVICE (MM DD) (YR)	ICD-9-CM	ICD-10-CM	ICD-9-CM	ICD-10-CM	CHARGE	UNIT	RENDERING PROVIDER ID #
1	09 15 22	09 15 22 11	99113	A	48.00	1.0	NP	1710139912
2	09 15 22	09 15 22 11	81002	A	12.00	1.0	NP	1710139912
3	09 15 22	09 15 22 11	80305	A	80.00	1.0	NP	1710139912
4	09 15 22	09 15 22 11	86330	A	18.00	1.0	NP	1710139912
5							NP	
6							NP	

PHYSICIAN OR SUPPLIER INFORMATION

26 FEDERAL TAX ID NUMBER

27 SIGNATURE OF PHYSICIAN OR SUPPLIER

28 SERVICE PERIOD

29 SIGNATURE OF PHYSICIAN OR SUPPLIER

30 SERVICE PERIOD

31 SIGNATURE OF PHYSICIAN OR SUPPLIER

32 SERVICE PERIOD

PRIMARY

HIDALGO COUNTY SHERIFFS DEPT HCSD
711 E L CIBOLO RD
ATT ACCOUNTS PAYABLE
EDINBURG, TX 78542-3471



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE, INC. (N.U.C.C.)

PICA

CARRIER

1. MEDICARE MEDICAID TRICARE CHAMPVA
 Medicare # Medicaid # TRICARE Code Medicare # X 648284909

2. PATIENT'S NAME (Last, first, middle, initial)
 [REDACTED] [REDACTED] [REDACTED] [REDACTED]

3. PATIENT'S ADDRESS (Street)
 [REDACTED] [REDACTED] [REDACTED] [REDACTED]

CITY [REDACTED] STATE [REDACTED] TX ZIP CODE [REDACTED] TELEPHONE (Area Code) [REDACTED] ([REDACTED]) [REDACTED]

9. OTHER INSURED (Name)
 P.O. #: 842099

7. INVOICE RECEIVED BY:
 [Signature] on: 11/3/22

8. GOOD/SERVICES RECEIVED BY:
 [Signature] on: 9/16/23
 2-1103-425-21-200-002-0-331

10. INSURANCE PLAN NAME OR PROGRAM NAME

Please process this invoice/credit memo from this copy due to vendor not submitting original

Hidalgo County Sheriff's Office

PATIENT AND INSURED INFORMATION

12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

13. PATIENT'S SIGNATURE (Print name)
 SIGNED: [Signature] ON FILE: [Signature]

14. DATE OF CURRENT BIRTHDAY (MM/YY)
 MM/YY

17. NAME OF REFERRING PHYSICIAN (Print name)
 DR SOBIA NASIR

18. ADDITIONAL CLAIM INFORMATION (Date of service)
 DATE OF SERVICE (MM/YY)

LINE	DATE OF SERVICE (MM/YY)	ICD-9-CM	ICD-10-CM	PROCEDURE CODE	UNIT	REVENUE	CONTRACT	REVENUE
1	09 16 22 09 16 22 11	99011						
2	09 16 22 09 16 22 11	99038						
3								
4								
5								
6								

PHYSICIAN OR SUPPLIER INFORMATION

19. FEDERAL TAX ID NUMBER
 454034067

20. SIGNATURE OF PHYSICIAN (Print name)
 SOBIA NASIR MD PA
 702 W UNIVERSITY DR
 EDINBURG TX 785393042

21. SIGNATURE OF PHYSICIAN (Print name)
 SOBIA NASIR MD PA
 PO BOX 4037
 EDINBURG TX 785404290

SIGNED: [Signature] DATE: 10/11/2022



PRIMARY

HEALTH INSURANCE CLAIM FORM

HIDALGO COUNTY SHERIFFS DEPT HCSD
711 E L CIBOLA RD
ATTN: ACCOUNTS PAYABLE
EDINBURG, TX 78542-0471

CARRIER

APPROVED BY NATIONAL LIAB FORM CLAIM COMMITTEE NAJCC 1-11

PICA

1 MEDICARE	MEDICAID	TRICARE	CHAMPVA	Other Health Plan	Other Program Name
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	000049184
PATIENT'S NAME (Last, First, Middle Initial)			PATIENT'S ADDRESS (No. Street)		
[REDACTED]			[REDACTED]		
CITY			STATE		
[REDACTED]			TX		
TELEPHONE (Include Area Code)			FEDERAL IDENTIFICATION NUMBER		
[REDACTED]			[REDACTED]		
OTHER INSURED'S NAME			GROUP OR PLAN NUMBER		
[REDACTED]			[REDACTED]		
OTHER INSURED'S POLICY			INSURANCE COMPANY		
P.O. #: 841669			[REDACTED]		
Invoice Received By: P. Eidenberger on 11/3/22			[REDACTED]		
Good/Services Received By: V. Rodriguez on 9/28/22			[REDACTED]		
4100 420 ST 200-000-0			[REDACTED]		
2-1100-421-00-280-001-0-331			[REDACTED]		
SIGNATURE IN FILE			SIGNATURE ON FILE		
[REDACTED]			[REDACTED]		

Please process this invoice/credit-memo from this copy due to vendor not submitting original.

Hidalgo County Sheriff's Office

PATIENT AND INSURED INFORMATION

LINE	DATE	DESCRIPTION	AMOUNT	STATUS	REMARKS
1	09 22 09 22	99111	20.00	PAID	
2	09 22 09 22	81308	81.00	PAID	
3				RFI	
4				RFI	
5				RFI	
6				RFI	

PHYSICIAN OR SUPPLIER INFORMATION

FEDERAL TAX ID NUMBER	454034057	STATE TAX ID NUMBER	2940E34323
SIGNATURE (PRINT NAME OF PHYSICIAN OR SUPPLIER)		SIGNATURE (PRINT NAME OF PHYSICIAN OR SUPPLIER)	
SOBIA NASIF MD		SOBIA NASIF MD PA	
10/24/2022		EDINBURG TX 785420471	
1043589435		1043589435	



PRIMARY

HIDALGO COUNTY SHERIFFS DEPT HCSD
711 S L CIBOLO RD
ATT ACCOUNTS PAYABLE
EDINBURG, TX 76542-2471

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 1/1/17

ICA

PCA

CARRIER

1. MEDICARE <input type="checkbox"/> MEDICARE #	MEDICARE <input type="checkbox"/> MEDICARE #	TRICARE <input type="checkbox"/> TRICARE #	CHAMPVA <input type="checkbox"/> MEMBER ID #	STATE HEALTH PLAN <input type="checkbox"/> HEALTH PLAN #	EMERGENCY <input checked="" type="checkbox"/> EMERGENCY	GROUP NUMBER 630587270	FOR PROGRAM IDENTIFICATION
2. PATIENT'S NAME (Last, First, Middle Initial) [REDACTED]			3. PATIENT'S DATE OF BIRTH [REDACTED]		4. INSURER'S NAME (Last, First, Middle Initial) [REDACTED]		
5. PATIENT'S ADDRESS (No. Street) [REDACTED]			6. PATIENT'S RELATIONSHIP TO INSURER [REDACTED]		7. INSURER'S ADDRESS (No. Street) [REDACTED]		
CITY [REDACTED]			STATE & POLICE DISTRICT TX		STATE TX		
ZIP CODE [REDACTED]			TELEPHONE (Area Code) No. () [REDACTED]		TELEPHONE (Area Code) No. () [REDACTED]		
8. EMPLOYER'S NAME (Last, First, Middle Initial) [REDACTED]			9. EMPLOYER'S ADDRESS [REDACTED]		10. EMPLOYER'S GROUP OR PCA NUMBER [REDACTED]		
11. OTHER INSURER'S POLICY OR GROUP NUMBER [REDACTED]			12. EMPLOYER'S BUSINESS [REDACTED]		13. EMPLOYER'S CITY [REDACTED]		

PATIENT AND INSURED INFORMATION

P.O. #: 841669
 Invoice Received By: Elendro on: 11/3/22
 Good Services Received By: Rodriguez on: 9/28/22
~~2-1103-423-00-005-0~~
~~2-1100-431-00-280-001-0-331~~



Please process this invoice/credit memo from this copy due to vendor not submitting original.

Hidalgo County Sheriff's Office

[Handwritten Signature]

14. DATE OF CURRENT ILLNESS (MM/DD/YYYY)	15. DATE OF CURRENT ILLNESS (MM/DD/YYYY)	16. DATE OF CURRENT ILLNESS (MM/DD/YYYY)	17. DATE OF CURRENT ILLNESS (MM/DD/YYYY)
18. NAME OF REFERRING PHYSICIAN OR OTHER HEALTH CARE PROVIDER DR. SOBIA NASIR	19. NAME OF REFERRING PHYSICIAN OR OTHER HEALTH CARE PROVIDER DR. SOBIA NASIR	20. NAME OF REFERRING PHYSICIAN OR OTHER HEALTH CARE PROVIDER DR. SOBIA NASIR	21. NAME OF REFERRING PHYSICIAN OR OTHER HEALTH CARE PROVIDER DR. SOBIA NASIR
22. ADDITIONAL CLAIM INFORMATION (Date, Description, etc.)	23. ADDITIONAL CLAIM INFORMATION (Date, Description, etc.)	24. ADDITIONAL CLAIM INFORMATION (Date, Description, etc.)	25. ADDITIONAL CLAIM INFORMATION (Date, Description, etc.)
26. DATE OF SERVICE (MM/DD/YYYY)	27. DATE OF SERVICE (MM/DD/YYYY)	28. DATE OF SERVICE (MM/DD/YYYY)	29. DATE OF SERVICE (MM/DD/YYYY)
30. ICD-10 CODE	31. ICD-10 CODE	32. ICD-10 CODE	33. ICD-10 CODE
34. CPT CODE	35. CPT CODE	36. CPT CODE	37. CPT CODE
38. RECEIPT #	39. RECEIPT #	40. RECEIPT #	41. RECEIPT #

PHYSICIAN OR SUPPLIER INFORMATION

1	09	28	22	09	28	22	11	33011	A	10.00	1.00	9.00	1000000000
2	09	28	22	09	28	22	11	80308	A	50.00	1.00	49.00	1000000000
3													
4													
5													
6													

42. FEDERAL TAX ID NUMBER 454034067	43. EMPLOYER'S TAX ID NUMBER [REDACTED]	44. PATIENT'S ID NUMBER 2938534321	45. PATIENT'S DATE OF BIRTH [REDACTED]	46. PATIENT'S SEX M	47. PATIENT'S RACE [REDACTED]	48. PATIENT'S ETHNICITY [REDACTED]	49. PATIENT'S RELIGION [REDACTED]	50. PATIENT'S MARITAL STATUS [REDACTED]	51. PATIENT'S OCCUPATION [REDACTED]	52. PATIENT'S SOCIAL SECURITY NUMBER [REDACTED]	53. PATIENT'S HOME PHONE (956) 353-0714
54. SIGNATURE OF PHYSICIAN OR SUPPLIER SOBIA NASIR MD PA		55. SIGNATURE OF PHYSICIAN OR SUPPLIER SOBIA NASIR MD PA		56. SIGNATURE OF PHYSICIAN OR SUPPLIER SOBIA NASIR MD PA		57. SIGNATURE OF PHYSICIAN OR SUPPLIER SOBIA NASIR MD PA		58. SIGNATURE OF PHYSICIAN OR SUPPLIER SOBIA NASIR MD PA		59. SIGNATURE OF PHYSICIAN OR SUPPLIER SOBIA NASIR MD PA	
60. DATE 10/24/2022		61. DATE 10/24/2022		62. DATE 10/24/2022		63. DATE 10/24/2022		64. DATE 10/24/2022		65. DATE 10/24/2022	



PRIMARY

HEALTH INSURANCE CLAIM FORM

HIDALGO COUNTY SHERIFFS DEPT HCSD
711 E L CIBOLA RD
ATT ACCOUNTS PAYABLE
EDINBURG, TX 78542-0471

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 10/2012

PICA For Program in Item 1

1 MEDICARE MEDICAID TRICARE CHAMPVA... 11 INSURER'S NUMBER (For Program in Item 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)
3 PATIENT'S ADDRESS (No. Street)
4 INSURER'S NAME (Last Name, First Name, Middle Initial)
5 INSURER'S ADDRESS (No. Street)
CITY STATE AND ZIP CODE TELEPHONE (Include Area Code)

6 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
7 OTHER INSURED'S P.O. #: 841669
8 INVOICE RECEIVED BY: P. Eilenberger on 11/3/22
9 GOOD SERVICES RECEIVED BY: Y. Rodriguez on 9/28/22
10 SIGNATURE ON FILE
11 NAME OF PROGRAM
12 SIGNATURE ON FILE

Please process this invoice/credit memo from this copy due to vendor not submitting original. Hidalgo County Sheriff's Office

13 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Print Name)
14 DATE OF CURRENT ILLNESS (MM DD) TO (MM DD)
15 NAME OF REFERRING PROVIDER OR OTHER SOURCE
16 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD) TO (MM DD)
17 ADDITIONAL CLAIM INFORMATION (Include Address, NCC)
18 PROVIDER'S SIGNATURE OF ADDRESS OF FILE
19 ORIGINAL REF NO
20 ORIGINAL LOCATION NUMBER

Table with 6 rows and 4 columns: ICD-9-CM, ICD-10, ICD-9-CM, ICD-10. Row 1: 09 28 22 09 28 20 11, 80300, A, 80.21 1.0. Row 2: 09 28 22 09 28 20 11, 80300, A, 80.21 1.0.

21 FEDERAL TAX ID NUMBER: 454034067
22 PATIENT'S COUNTY: 2937E34320
23 SIGNATURE OF PROVIDER: Sobia Nasir MD PA
24 DATE: 10/24/2022
25 PROVIDER ID: 10093569435



PRIMARY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 1/93

HIDALGO COUNTY SHERIFFS DEPT HCSD
711 E L BISCULO RD
ATT ACCOUNTS PAYABLE
EDINBURG, TX 78542-0471

PCA

CARRIER

1 MEDICARE <input type="checkbox"/> Medicare A <input type="checkbox"/> Medicare B <input type="checkbox"/> Medicare C	MEDICAID <input type="checkbox"/> Medicaid A <input type="checkbox"/> Medicaid B	TRICARE <input type="checkbox"/> TRICARE A <input type="checkbox"/> TRICARE B <input type="checkbox"/> TRICARE C	CHAMPVA <input type="checkbox"/> CHAMPVA A <input type="checkbox"/> CHAMPVA B	GROUP HEALTH INSURANCE <input type="checkbox"/> Group Health Insurance <input checked="" type="checkbox"/> Other	16 INSURED ID NUMBER (For Programs 1-5 only) 436744416
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]		3 PATIENT'S BIRTH DATE [REDACTED]	4 INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]		
5 PATIENT'S ADDRESS (No. Street) [REDACTED]		6 PATIENT'S HEALTH STATUS (Insured) [REDACTED]	7 INSURED'S OCCUPATION (Job) [REDACTED]		
CITY [REDACTED]		STATE & RESIDENCE STATE TX TX	STATE TX TX		
ZIP CODE [REDACTED]		TELEPHONE (Home Area Code) () [REDACTED]	TELEPHONE (Mobile Area Code) () [REDACTED]		
8 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]		9 IS PATIENT'S DOCT. RELATED? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	10 INSURED'S BIRTH DATE [REDACTED]		
Invoice Received By: <i>A. Eisenberger</i> on: <i>11/3/22</i>		Please process this invoice/credit memo from this copy due to vendor not submitting original.			
Good/Services Received By: <i>R. Rodriguez</i> on: <i>10/6/22</i>		Hidalgo County Sheriff's Office			
2-1100-0021-200-000-0-331					

Please process this invoice/credit memo from this copy due to vendor not submitting original.

Hidalgo County Sheriff's Office

PATIENT AND INSURED INFORMATION

11 READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Print name and title)
[REDACTED]

13 SIGNATURE ON FILE
[REDACTED]

14 DATE OF CURRENT CLAIM (Month, Day, Year)
MM DD YY

15 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
DR SOBIA NASIP

16 ADDITIONAL CLAIM INFORMATION (Date and description)
[REDACTED]

17 DATE OF SERVICE (Month, Day, Year)
MM DD YY

18 ICD-9-CM CODE
99011

19 REFERRING PROVIDER ID #
[REDACTED]

PHYSICIAN OR SUPPLIER INFORMATION

20	21	22	23	24	25	26	27	28	29
DATE OF SERVICE	ICD-9-CM CODE	REFERRING PROVIDER ID #	DATE OF SERVICE	ICD-9-CM CODE	REFERRING PROVIDER ID #	DATE OF SERVICE	ICD-9-CM CODE	REFERRING PROVIDER ID #	DATE OF SERVICE
10 06 22 10 06 22 11	99011	A	10 06 22 10 06 22 11	99011	A	10 06 22 10 06 22 11	99011	A	10 06 22 10 06 22 11
2									
3									
4									
5									
6									

30 FEDERAL TAX ID NUMBER
4540334067

31 SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials)
Sobia Nasip

32 SERVICE PROVIDER ID #
2750E34516

33 SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials)
Sobia Nasip MD PA

34 SERVICE PROVIDER ID #
1013569435

35 SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials)
Sobia Nasip MD PA

36 SERVICE PROVIDER ID #
1013569435



PRIMARY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL INFORM CLAIM COMMITTEE (NICC) 10/01/00

HIDALGO COUNTY SHERIFFS DEPT HOSD
711 E L CIBOLO RD
ATT ACCOUNTS PAYABLE
EDINBURG, TX 78542-0471

PLA

CARRIER

1 MEDICARE MEDICAID TRICARE CHAMPVA USVA HEALTH PLAN OTHER PLAN NUMBER 644803852

2 PATIENT'S NAME LAST FIRST MIDDLE INITIAL SEX DATE OF BIRTH 01/10/1982

3 PATIENT'S ADDRESS NO. STREET CITY STATE ZIP CODE TX

4 OTHER INSURED'S NAME LAST FIRST MIDDLE INITIAL SEX DATE OF BIRTH

5 OTHER INSURED'S POLICY NO. P.O.#: 842099

6 REFERENCE NO. DATE RECEIVED BY: Ederberger on 11/4/22

7 REFERENCE NO. DATE RECEIVED BY: Rodriguez on 10/10/22

8 INSURANCE PLAN NAME OF PROVIDER 2-1107-2321-230-C02-0-331

[Handwritten signature]

Please process this invoice/credit memo from this copy due to vendor not submitting original.

Hidalgo County Sheriff's Office

PATIENT AND INSURED INFORMATION

10 PATIENT'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE DATE 11/04/2022

11 DATE OF CURRENT CLAIM 11/04/2022

12 NAME OF REFERRING PHYSICIAN DR. SOBIA NASIR

13 ADDITIONAL CLAIM INFORMATION

14 DIAGNOSIS OR NATURE OF CLAIM

LINE	DATE	ICD-9	ICD-10	PROCEDURE	UNIT	RATE	TOTAL	REMARKS
1	10 10 22	10 10 22	10 10 22	99211	A	89.00	89.00	1710139710
2	10 10 22	10 10 22	10 10 22	91001	A	10.00	10.00	1710139710
3	10 10 22	10 10 22	10 10 22	80330	A	80.00	80.00	1710139710
4	10 10 22	10 10 22	10 10 22	86591	A	19.00	19.00	1710139710
5								
6								

PHYSICIAN OR SUPPLIER INFORMATION

15 FEDERAL TAX ID NUMBER 454034067 X 2951E34573 X 140.00

16 SIGNATURE OF PHYSICIAN SOBIA NASIR MD PA 702 W UNIVERSITY DR EDINBURG TX 785420470

17 SIGNATURE OF SUPPLIER SOBIA NASIR MD PA 702 W UNIVERSITY DR EDINBURG TX 785420470

18 DATE 11/04/2022

19 IDENTIFICATION NUMBER 1043589435



PRIMARY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 1/97

HIDALGO COUNTY SHERIFFS DEPT HCSD
711 E L CIBOLO RD
ATT ACCOUNTS PAYABLE
EDINBURG, TX 78542-0471

PICA

1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN
 (Medicare #) (Medicaid #) (TRICARE #) (CHAMPVA #) (GROUP HEALTH PLAN #) OTHER

2 PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED] PATIENT'S BIRTH DATE (MM/DD/YY) [REDACTED] PATIENT'S SEX (M/F) [REDACTED]

3 PATIENT'S ADDRESS (No. Street) [REDACTED] PATIENT'S RELATIONSHIP TO INSURED [REDACTED] INSURED'S ADDRESS (No. Street) [REDACTED]

CITY [REDACTED] STATE [REDACTED] ZIP CODE [REDACTED] CITY [REDACTED] STATE [REDACTED] ZIP CODE [REDACTED]

4 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED] OTHER INSURED'S BIRTH DATE (MM/DD/YY) [REDACTED] OTHER INSURED'S SEX (M/F) [REDACTED]

5 OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]

6 RESERVED FOR NUCC USE
 Invoice Received By: Eidenberger on: 11/3/22
 Good/Services Received By: Rodriguez on: 10/11/22
2-1103-428-27-200-002-0-331

Please process this invoice/credit memo [REDACTED] copy due to vendor not submitting original
 Hidalgo County Sheriff's Office

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Print name and address below) [REDACTED] SIGNED [REDACTED] SIGNATURE ON FILE [REDACTED]

13 DATE OF CURRENT CLAIM (MM/DD/YY) [REDACTED] OTHER DATE (MM/DD/YY) [REDACTED]

14 NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED] I.D. NO. [REDACTED]

15 ADDITIONAL CLAIM INFORMATION [REDACTED]

16 ADVISORY OF NATURE OF CLAIMS (If "A" for all, leave blank; if "B" for some, check appropriate box; if "C" for none, check appropriate box)

1	2	3	4	5

17 DATE OF SERVICE

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
10	11	22	10	11	00	11	93019		A	00.00	1.0	110139712																																																																																							
10	11	23	10	11	00	11	91002		A	00.00	1.0	110139712																																																																																							
10	11	22	10	11	00	11	90306		A	00.00	1.0	110139712																																																																																							
10	11	23	10	11	00	11	96592		A	00.00	1.0	110139712																																																																																							

25 FEDERAL TAXID NUMBER (SSN) [REDACTED] PATIENT'S SOCIAL SECURITY NUMBER [REDACTED] AMOUNT PAID [REDACTED] BALANCE DUE [REDACTED]

31 SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials if applicable) [REDACTED] SIGNED Sobia Nasir MD DATE 11/01/2022

32 PHYSICIAN OR SUPPLIER IDENTIFICATION NUMBER (956) 383-0714
 SOBIA NASIR MD PA
 702 W UNIVERSITY DR
 EDINBURG TX 785393242

33 PHYSICIAN OR SUPPLIER IDENTIFICATION NUMBER (956) 383-0714
 SOBIA NASIR MD PA
 PO BOX 4030
 EDINBURG TX 785404030



PRIMARY

HEALTH INSURANCE CLAIM FORM

HIDALGO COUNTY SHERIFFS DEPT HCSD
711 E L CIBOLO RD
ATT ACCOUNTS PAYABLE
EDINBURG, TX 78842-0471

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

PICA PICA

1 MEDICARE	MEDICARE	TRICARE	CHARITY	GROUP HEALTH PLAN	RENTAL PLAN	OTHER	INSURANCE NUMBER	INSURANCE PLAN
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	434588814	

2 PATIENT'S NAME (Last, First, Middle)	PATIENT'S DATE OF BIRTH	3 INSURED'S NAME (Last, First, Middle)	INSURED'S DATE OF BIRTH
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

5 PATIENT'S ADDRESS (No. Street)	CITY	STATE	ZIP
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

6 OTHER INSURED'S NAME (Last, First, Middle)	OTHER INSURED'S DATE OF BIRTH	OTHER INSURED'S ADDRESS (No. Street)	CITY	STATE	ZIP
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

7 OTHER INSURED'S POLICY OR CONTRACT NUMBER	8 OTHER INSURED'S GROUP OR PLAN NUMBER
[REDACTED]	[REDACTED]

9 OTHER INSURED'S POLICY OR CONTRACT NUMBER	10 OTHER INSURED'S GROUP OR PLAN NUMBER
[REDACTED]	[REDACTED]

11 INVOICE RECEIVED BY:	DATE
<i>Celenberger</i>	On: 11/4/22

12 GOODS/SERVICES RECEIVED BY:	DATE
<i>Rodriguez</i>	On: 10/15/22

13 PATIENT'S OR OTHER PERSON'S SIGNATURE	DATE
[REDACTED]	[REDACTED]

Please process this invoice/credit memo from this copy due to vendor not submitting original.

Hidalgo County Sheriff's Office

14 PATIENT'S OR OTHER PERSON'S SIGNATURE	DATE
[REDACTED]	[REDACTED]

15 SIGNATURE ON FILE	DATE
[REDACTED]	[REDACTED]

16 DATE OF CURRENT CLAIM (MM/DD/YY)	DATE OF SERVICE (MM/DD/YY)
[REDACTED]	[REDACTED]

17 NAME OF REFERRING PHYSICIAN (Last, First, Middle)	DATE OF REFERRAL (MM/DD/YY)
DR. SOBIA NASIR	08/30/2022

18 ADDITIONAL CLAIM INFORMATION (e.g., ICD-9)	ICD-9 CODE
[REDACTED]	[REDACTED]

19 DATE OF SERVICE (MM/DD/YY)	DATE OF REFERRAL (MM/DD/YY)
[REDACTED]	[REDACTED]

20 DATE OF SERVICE (MM/DD/YY)	DATE OF REFERRAL (MM/DD/YY)
[REDACTED]	[REDACTED]

21 DATE OF SERVICE (MM/DD/YY)	DATE OF REFERRAL (MM/DD/YY)
[REDACTED]	[REDACTED]

22 DATE OF SERVICE (MM/DD/YY)	DATE OF REFERRAL (MM/DD/YY)
[REDACTED]	[REDACTED]

23 DATE OF SERVICE (MM/DD/YY)	DATE OF REFERRAL (MM/DD/YY)
[REDACTED]	[REDACTED]

24 DATE OF SERVICE (MM/DD/YY)	DATE OF REFERRAL (MM/DD/YY)
[REDACTED]	[REDACTED]

25 DATE OF SERVICE (MM/DD/YY)	DATE OF REFERRAL (MM/DD/YY)
[REDACTED]	[REDACTED]

26 DATE OF SERVICE (MM/DD/YY)	DATE OF REFERRAL (MM/DD/YY)
[REDACTED]	[REDACTED]

27 DATE OF SERVICE (MM/DD/YY)	DATE OF REFERRAL (MM/DD/YY)
[REDACTED]	[REDACTED]

28 DATE OF SERVICE (MM/DD/YY)	DATE OF REFERRAL (MM/DD/YY)
[REDACTED]	[REDACTED]

29 DATE OF SERVICE (MM/DD/YY)	DATE OF REFERRAL (MM/DD/YY)
[REDACTED]	[REDACTED]

30 DATE OF SERVICE (MM/DD/YY)	DATE OF REFERRAL (MM/DD/YY)
[REDACTED]	[REDACTED]

31 DATE OF SERVICE (MM/DD/YY)	DATE OF REFERRAL (MM/DD/YY)
[REDACTED]	[REDACTED]

32 DATE OF SERVICE (MM/DD/YY)	DATE OF REFERRAL (MM/DD/YY)
[REDACTED]	[REDACTED]



PRIMARY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE, NOVEMBER 2012

HIDALGO COUNTY SHERIFFS DEPT HCSD
711 E L CIBOLO RD
ATT ACCOUNTS PAYABLE
EDINBURG, TX 78542-0471

CARRIER

1 MEDICARE MEDICAID TRICARE CHAMPVA
 Medicare Medicaid Tricare CHAMPVA Other
 2 PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]
 3 PATIENT'S ADDRESS (No. Street) [REDACTED]
 4 CITY [REDACTED] STATE [REDACTED] ZIP [REDACTED]
 5 TELEPHONE (Area Code) [REDACTED] [REDACTED]
 6 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]
 7 OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]
 8 INVOICE RECEIVED BY: Colubera on 11/3/22
 9 GOOD SERVICES RECEIVED BY: V Rodriguez on 10/13/22
 10 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE [REDACTED]

Please process this invoice/credit memo from this copy due to vendor not submitting original.

Hidalgo County Sheriff's Office

PATIENT AND INSURED INFORMATION

11 DATE OF CURRENT ILLNESS [REDACTED]
 12 NAME OF REFERRING PHYSICIAN (Last Name, First Name, Middle Initial) DR SOBIA NASIF
 13 PHYSICIAN'S CLINICAL INFORMATION (Date, Time, Location) [REDACTED]
 14 ADDITIONAL CLINICAL INFORMATION (Date, Time, Location) [REDACTED]

PHYSICIAN OR SUPPLIER INFORMATION

LINE	DATE	FROM	TO	TIME	LOCATION	REASON FOR VISIT	AMOUNT	UNIT	RENDERING PROVIDER ID #
1	10/13/22	10/13/22	10/13/22	08:00	ED	90309	65.00	1.0	1710139712
2	10/13/22	10/13/22	10/13/22	08:00	ED	81002	10.00	1.0	1710139712
3	10/13/22	10/13/22	10/13/22	08:00	ED	80305	30.00	1.0	1710139712
4	10/13/22	10/13/22	10/13/22	08:00	ED	186592	15.00	1.0	1710139712
5									
6									

15 FEDERAL TAX ID NUMBER: 454034067 X 2953E34619 X 140.00
 16 SIGNATURE OF PHYSICIAN: Sobia SOBIA NASIF MD PA, 702 W UNIVERSITY DR, EDINBURG TX 785393242
 17 SIGNATURE OF SUPPLIER: SOBIA NASIF MD PA, PO BOX 4290, EDINBURG TX 785404290
 18 DATE: 11/01/2022
 19 IDENTIFICATION NUMBER: 1043589435



PRIMARY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 10/01/13

HIDALGO COUNTY SHERIFFS DEPT HOSD
711 E L CIBOLO RD
ATT ACCOUNTS PAYABLE
EDINBURG, TX 78542-3471

CARRIER

1 MEDICARE MEDICAD TRICARE CHAMPVA GROUP HEALTH PLAN FECA BY LUNA OTHER
 Medicare # Medicaid # ICDY CODE ICDY CODE ICDY CODE ICDY CODE X

2 PATIENT'S NAME (Last Name, First Name, Middle Initial) 3 PATIENT'S BIRTHDATE (MM/DD/YYYY) 4 INSURER'S NAME (Last Name, First Name, Middle Initial)
[REDACTED] [REDACTED] [REDACTED]

5 PATIENT'S ADDRESS (No. Street) 6 PATIENT'S RELATIONSHIP TO INSURER 7 INSURER'S ADDRESS (No. Street)
[REDACTED] [REDACTED] [REDACTED]

CITY 8 TELEPHONE (Area Code) 9 CITY 10 STATE TX TX
[REDACTED] [REDACTED] [REDACTED] TX TX

11 ZIP CODE 12 TELEPHONE (Area Code) 13 ZIP CODE 14 TELEPHONE (Area Code)
[REDACTED] [REDACTED] [REDACTED] [REDACTED]

15 OTHER INSURER'S NAME (Last Name, First Name, Middle Initial) 16 OTHER INSURER'S POLICY OR GROUP NUMBER
[REDACTED] [REDACTED]

17 OTHER INSURER'S POLICY OR GROUP NUMBER 18 DATE OF BIRTH (MM/DD/YYYY) 19 SEX
[REDACTED] [REDACTED] [REDACTED]

20 RESERVED FOR NUCC USE P.O. #: 842099 21 DATE RECEIVED
[REDACTED] [REDACTED]

22 INVOICE RECEIVED BY: P. Calhoun on: 11/4/22
23 GOOD/SERVICES RECEIVED BY: V. Rodriguez on: 10/14/22

24 PATIENT'S SIGNATURE (Print Name) 25 SIGNATURE OF PHYSICIAN (Print Name)
[REDACTED] [REDACTED]

26 DATE OF CURRENT ILLNESS (MM/DD/YYYY) 27 DATE OF CURRENT ILLNESS (MM/DD/YYYY) 28 DATE OF CURRENT ILLNESS (MM/DD/YYYY)
[REDACTED] [REDACTED] [REDACTED]

29 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 30 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
DR SOBIA NASIR [REDACTED]

31 ADDITIONAL CLAIM INFORMATION (Including Referral Code) 32 ADDITIONAL CLAIM INFORMATION (Including Referral Code)
[REDACTED] [REDACTED]

33 DATE OF SERVICE (MM/DD/YYYY) 34 DATE OF SERVICE (MM/DD/YYYY) 35 DATE OF SERVICE (MM/DD/YYYY)
[REDACTED] [REDACTED] [REDACTED]

36 DATE OF SERVICE (MM/DD/YYYY) 37 DATE OF SERVICE (MM/DD/YYYY) 38 DATE OF SERVICE (MM/DD/YYYY)
[REDACTED] [REDACTED] [REDACTED]

39 DATE OF SERVICE (MM/DD/YYYY) 40 DATE OF SERVICE (MM/DD/YYYY) 41 DATE OF SERVICE (MM/DD/YYYY)
[REDACTED] [REDACTED] [REDACTED]

42 DATE OF SERVICE (MM/DD/YYYY) 43 DATE OF SERVICE (MM/DD/YYYY) 44 DATE OF SERVICE (MM/DD/YYYY)
[REDACTED] [REDACTED] [REDACTED]

45 DATE OF SERVICE (MM/DD/YYYY) 46 DATE OF SERVICE (MM/DD/YYYY) 47 DATE OF SERVICE (MM/DD/YYYY)
[REDACTED] [REDACTED] [REDACTED]

48 DATE OF SERVICE (MM/DD/YYYY) 49 DATE OF SERVICE (MM/DD/YYYY) 50 DATE OF SERVICE (MM/DD/YYYY)
[REDACTED] [REDACTED] [REDACTED]

51 DATE OF SERVICE (MM/DD/YYYY) 52 DATE OF SERVICE (MM/DD/YYYY) 53 DATE OF SERVICE (MM/DD/YYYY)
[REDACTED] [REDACTED] [REDACTED]

54 DATE OF SERVICE (MM/DD/YYYY) 55 DATE OF SERVICE (MM/DD/YYYY) 56 DATE OF SERVICE (MM/DD/YYYY)
[REDACTED] [REDACTED] [REDACTED]

57 DATE OF SERVICE (MM/DD/YYYY) 58 DATE OF SERVICE (MM/DD/YYYY) 59 DATE OF SERVICE (MM/DD/YYYY)
[REDACTED] [REDACTED] [REDACTED]

60 DATE OF SERVICE (MM/DD/YYYY) 61 DATE OF SERVICE (MM/DD/YYYY) 62 DATE OF SERVICE (MM/DD/YYYY)
[REDACTED] [REDACTED] [REDACTED]

63 DATE OF SERVICE (MM/DD/YYYY) 64 DATE OF SERVICE (MM/DD/YYYY) 65 DATE OF SERVICE (MM/DD/YYYY)
[REDACTED] [REDACTED] [REDACTED]

66 DATE OF SERVICE (MM/DD/YYYY) 67 DATE OF SERVICE (MM/DD/YYYY) 68 DATE OF SERVICE (MM/DD/YYYY)
[REDACTED] [REDACTED] [REDACTED]

69 DATE OF SERVICE (MM/DD/YYYY) 70 DATE OF SERVICE (MM/DD/YYYY) 71 DATE OF SERVICE (MM/DD/YYYY)
[REDACTED] [REDACTED] [REDACTED]

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Please process this invoice/credit memo from this copy due to vendor not submitting original.
Hidalgo County Sheriff's Office

SIGNATURE OF PHYSICIAN (Print Name) 72 SIGNATURE OF PHYSICIAN (Print Name) 73 SIGNATURE OF PHYSICIAN (Print Name)
[REDACTED] [REDACTED] [REDACTED]

74 SIGNATURE OF PHYSICIAN (Print Name) 75 SIGNATURE OF PHYSICIAN (Print Name) 76 SIGNATURE OF PHYSICIAN (Print Name)
[REDACTED] [REDACTED] [REDACTED]



PRIMARY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) (2/1)

HIDALGO COUNTY SHERIFFS DEPT HCSD
711 E L CIBOLO RD
ATT ACCOUNTS PAYABLE
EDINBURG, TX 78542-0471

CARRIER

PICA PICA

1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER PLAN
 Medicare A Medicare B (ID# 0000) Medicare D Group ID# Other Other

2 PATIENT'S NAME (Last Name, First Name, Middle Initial) 3 PATIENT'S BIRTH DATE (MM/YY) SEX 4 INSURER'S NAME (Last Name, First Name, Middle Initial)

5 PATIENT'S ADDRESS (No. Street) 6 PATIENT RELATIONSHIP TO INSURED INSURED'S ADDRESS (No. Street)

CITY STATE 7 REFERRED FROM (Use) STATE TX TX

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

8 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) P.O. # 84669 9 EMPLOYMENT

10 RECEIVED BY (Name) 11 RECEIVED DATE (MM/YY) 12 RECEIVED TIME (MM/YY)

13 RECEIVED BY (Signature) 14 RECEIVED BY (Signature)

15 RECEIVED BY (Signature) 16 RECEIVED BY (Signature)

17 RECEIVED BY (Signature) 18 RECEIVED BY (Signature)

19 RECEIVED BY (Signature) 20 RECEIVED BY (Signature)

21 RECEIVED BY (Signature) 22 RECEIVED BY (Signature)

23 RECEIVED BY (Signature) 24 RECEIVED BY (Signature)

25 RECEIVED BY (Signature) 26 RECEIVED BY (Signature)

27 RECEIVED BY (Signature) 28 RECEIVED BY (Signature)

29 RECEIVED BY (Signature) 30 RECEIVED BY (Signature)

31 RECEIVED BY (Signature) 32 RECEIVED BY (Signature)

33 RECEIVED BY (Signature) 34 RECEIVED BY (Signature)

35 RECEIVED BY (Signature) 36 RECEIVED BY (Signature)

37 RECEIVED BY (Signature) 38 RECEIVED BY (Signature)

39 RECEIVED BY (Signature) 40 RECEIVED BY (Signature)

41 RECEIVED BY (Signature) 42 RECEIVED BY (Signature)

43 RECEIVED BY (Signature) 44 RECEIVED BY (Signature)

45 RECEIVED BY (Signature) 46 RECEIVED BY (Signature)

47 RECEIVED BY (Signature) 48 RECEIVED BY (Signature)

49 RECEIVED BY (Signature) 50 RECEIVED BY (Signature)

51 RECEIVED BY (Signature) 52 RECEIVED BY (Signature)

53 RECEIVED BY (Signature) 54 RECEIVED BY (Signature)

55 RECEIVED BY (Signature) 56 RECEIVED BY (Signature)

57 RECEIVED BY (Signature) 58 RECEIVED BY (Signature)

59 RECEIVED BY (Signature) 60 RECEIVED BY (Signature)

61 RECEIVED BY (Signature) 62 RECEIVED BY (Signature)

63 RECEIVED BY (Signature) 64 RECEIVED BY (Signature)

65 RECEIVED BY (Signature) 66 RECEIVED BY (Signature)

67 RECEIVED BY (Signature) 68 RECEIVED BY (Signature)

69 RECEIVED BY (Signature) 70 RECEIVED BY (Signature)

71 RECEIVED BY (Signature) 72 RECEIVED BY (Signature)

73 RECEIVED BY (Signature) 74 RECEIVED BY (Signature)

75 RECEIVED BY (Signature) 76 RECEIVED BY (Signature)

77 RECEIVED BY (Signature) 78 RECEIVED BY (Signature)

79 RECEIVED BY (Signature) 80 RECEIVED BY (Signature)

81 RECEIVED BY (Signature) 82 RECEIVED BY (Signature)

83 RECEIVED BY (Signature) 84 RECEIVED BY (Signature)

Please process this invoice/credit memo from this copy due to vendor not submitting original
Hidalgo County Sheriff's Office

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION