PRIMARY

HEALTH INSURANCE CLAIM FORM

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

PICA

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

CARRIER

PICA

1 MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER		1a INSURED'S I.D. NUMBER (For Program in Item 1)
		471251174
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	3 PATIENT'S BIRTH DATE MM DD YY / SEX	4 INSURED'S NAME (Last Name, First Name, Middle Initial)
[redacted]	[redacted] M [X] F [ ]	[redacted]
5 PATIENT'S ADDRESS (No., Street)	6 PATIENT RELATIONSHIP TO INSURED	7 INSURED'S ADDRESS (No., Street)
[redacted]	Self [X] Spouse [ ] Child [ ] Other [ ]	[redacted]
CITY [redacted] STATE TX	8 RESERVED FOR NUCC USE	CITY [redacted] STATE TX
ZIP CODE [redacted] TELEPHONE (Include Area Code) ( )		ZIP CODE [redacted] TELEPHONE (Include Area Code) ( )
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 / SEX [redacted] M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) [ ] YES [X] NO	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. CLAIM CODES (Designated by NUCC)	d IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, complete items 9, 9a and 9d.

P.O. #:
Invoice Received By:
P Eilenberger on: 11/29/22
Good/Services Received By:
V Rodriguez on: 9/7/22
1100-423-21-280-002-0-331

SECOND FOLD

PATIENT AND INSURED INFORMATION

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 SIGNATURE ON FILE DATE 11/29/22

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 SIGNATURE ON FILE

14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	15 OTHER DATE QUAL MM DD YY	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 DN SOBIA NASIR	17a. OB 300666001 / 17b. NPI 1710139712	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 [X] NO $ CHARGES
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. 2021 B. C. D. E. F. G. H. I. J. K. L.		22 RESUBMISSION CODE ORIGINAL REF. NO 23 PRIOR AUTHORIZATION NUMBER

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV SS

PHYSICIAN OR SUPPLIER INFORMATION

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 07 22 09 07 22	11		99213		A	65.00	1.0		NPI	1710139712
2 09 07 22 09 07 22	11		81002		A	10.00	1.0		NPI	1710139712
3 09 07 22 09 07 22	11		80305		A	50.00	1.0		NPI	1710139712
4 09 07 22 09 07 22	11		86592		A	15.00	1.0		NPI	1710139712
5									NPI	
6									NPI	

25 FEDERAL TAX I.D. NUMBER SSN EIN	26 PATIENT'S ACCOUNT NO.	27 ACCEPT ASSIGNMENT? (For govt. claims, see back)	28 TOTAL CHARGE	29 AMOUNT PAID / 30 Rsvd for NUCC use
454034067 [ ] [X]	2931E34253	[X] YES [ ] NO	$ 140.00	$

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.)
SOBIA NASIR MD
SIGNED 11/29/2022 DATE

32 SERVICE FACILITY LOCATION INFORMATION
SOBIA NASIR MD PA
702 W UNIVERSITY DR
EDINBURG TX 785393242
a. 1043589435 b.

33 BILLING PROVIDER INFO & PH. # (956) 383-0714
SOBIA NASIR MD PA
PO BOX 4290
EDINBURG TX 785404290
a. 1043589435 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

PRIMARY

HEALTH INSURANCE CLAIM FORM

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

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ATTN BUDGET DEPARTMENT
PO BOX 1228
EDINBURG, TX 78541

CARRIER

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1 MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a INSURED'S I.D. NUMBER (For Program in Item 1)
X (ID#)	632707314
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]	3 PATIENT'S BIRTH DATE MM DD YY [redacted] SEX M / F X
5 PATIENT'S ADDRESS (No., Street) [redacted]	6 PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other
CITY [redacted] STATE TX	8 RESERVED FOR NUCC USE
ZIP CODE [redacted] TELEPHONE (Include Area Code) ( )	
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10 IS PATIENT'S CONDITION RELATED TO:
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Previous) YES X NO
b RESERVED FOR NUCC USE	b AUTO ACCIDENT? YES X NO PLACE (State)
c RESERVED FOR NUCC USE	c OTHER ACCIDENT? YES X NO
d INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM CODES (Designated by NUCC)

P.O. #:
Invoice Received By:
Edinburg on: 11/29/22
Good/Services Received By:
VRodriguez on: 9/7/22
1100-423-21-230-002-0-339

1a INSURED'S I.D. NUMBER (For Program in Item 1)
632707314
4 INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted]
7 INSURED'S ADDRESS (No., Street) [redacted]
CITY [redacted] STATE TX
ZIP CODE [redacted] TELEPHONE (Include Area Code) ( )
11 INSURED'S POLICY GROUP OR FECA NUMBER
a INSURED'S DATE OF BIRTH MM DD YY [redacted] SEX M / F X
b OTHER CLAIM ID (Designated by NUCC)
c INSURANCE PLAN NAME OR PROGRAM NAME
d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a and 9d

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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.
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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 07 22 09 07 22	11		99213		A	65.00	1.0		NPI	1710139712
2 09 07 22 09 07 22	11		81002		A	10.00	1.0		NPI	1710139712
3 09 07 22 09 07 22	11		80305		A	50.00	1.0		NPI	1710139712
4 09 07 22 09 07 22	11		86592		A	15.00	1.0		NPI	1710139712
5									NPI	
6									NPI	

25 FEDERAL TAX I.D. NUMBER SSN EIN	26 PATIENT'S ACCOUNT NO.	27 ACCEPT ASSIGNMENT? (For govt. claims, see back)	28 TOTAL CHARGE	29 AMOUNT PAID	30 Rsvd for NUCC use
454034067 X	2932E34258	X YES NO	$ 140.00	$	

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.)	32 SERVICE FACILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH #
SOBIA NASIR MD SIGNED 11/29/2022 DATE	SOBIA NASIR MD PA 702 W UNIVERSITY DR EDINBURG TX 785393242 a 1043589435 b	SOBIA NASIR MD PA PO BOX 4290 EDINBURG TX 785404290 (956) 383-0714 a 1043589435 b

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WMCI 10 ENV WMCI 10 ENV 55

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PLEASE PRINT OR TYPE

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WCMS-1500CS-12

PRIMARY

HEALTH INSURANCE CLAIM FORM

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

PICA

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

CARRIER

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 635343019

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
[redacted]	[redacted]	M (X) F ( )	[redacted]

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
[redacted]	Self (X) Spouse ( ) Child ( ) Other ( )	[redacted]

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
[redacted]	TX		[redacted]	TX

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
[redacted]	( )	[redacted]	( )

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 [redacted] YY SEX M (X) F ( )
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. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ( ) YES (X) NO If yes, complete items 9, 9a and 9d.

P.O. #:
Invoice Received By:
P Rodriguez on: 11/29/22
Good/Services Received By:
V Rodriguez on: 9/6/22
2-1100-423-21-230-002-0-331

SECOND FOLD

PATIENT AND INSURED INFORMATION

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 SIGNATURE ON FILE DATE 11/29/22

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SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	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: DN SOBIA NASIR	17a. OB 300666001 / 17b. NPI 1710139712	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 (X) NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE ORIGINAL REF. NO
A. Z021 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

FIRST FOLD WHCF-10-ENV WHCF-10-ENV SS

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 06 22 09 06 22	11		99213		A	65.00	1.0		NPI	1710139712
2 09 06 22 09 06 22	11		81002		A	10.00	1.0		NPI	1710139712
3 09 06 22 09 06 22	11		80305		A	50.00	1.0		NPI	1710139712
4 09 06 22 09 06 22	11		86592		A	15.00	1.0		NPI	1710139712
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC use
454034067	( ) (X)	2929E34233	(X) YES ( ) NO	$ 140.00	$	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SOBIA NASIR MD SIGNED 11/29/2022 DATE	SOBIA NASIR MD PA 702 W UNIVERSITY DR EDINBURG TX 785393242 a. 1043589435 b.	SOBIA NASIR MD PA PO BOX 4290 EDINBURG TX 785404290 (956) 383-0714 a. 1043589435 b.

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PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

PRIMARY

HEALTH INSURANCE CLAIM FORM

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

PICA

CARRIER

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

PICA

1 MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a INSURED'S I.D. NUMBER (For Program in Item 1)
OTHER (ID#) X	629508566
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]	3. PATIENT'S BIRTH DATE [redacted] SEX M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted]	
5. PATIENT'S ADDRESS (No., Street) [redacted]	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street) [redacted]	
CITY [redacted] STATE TX	8. RESERVED FOR NUCC USE
CITY [redacted] STATE TX	
ZIP CODE [redacted] TELEPHONE (Include Area Code) ( )	
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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 P.O. #:_____	a. EMPLOYMENT? (Current or Previous) YES X NO
a. INSURED'S DATE OF BIRTH [redacted] SEX M X F	
b. RESERVED FOR NUCC USE Invoice Received By: P Edinburgh on: 11/29/22	b. AUTO ACCIDENT? YES X NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE Good/Services Received By: KAdriguez on: 9/7/22	c. OTHER ACCIDENT? YES X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME 2-1100-423-21-200-002-0-331	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a and 9d.	

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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A 2021 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 09 07 22	09 07 22	11		99213		A	65.00	1.0		NPI	1710139712
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5										NPI	
6										NPI	

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454034067 X	2933E34260	X YES NO	$ 140.00	$	

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SOBIA NASIR MD SIGNED 11/29/2022 DATE	SOBIA NASIR MD PA 702 W UNIVERSITY DR EDINBURG TX 785393242 a. 1043589435 b.	SOBIA NASIR MD PA PO BOX 4290 EDINBURG TX 785404290 (956) 383-0714 a. 1043589435 b.

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WCMS-1500CS-12

SECOND FOLD

FIRST FOLD WMCF 10 ENV WMCF 10 ENV 58

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PRIMARY

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

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[ ] (Medicare #) [ ] (Medicaid #) [ ] (ID#/DoD#) [ ] (Member ID#) [ ] (ID#) [ ] (ID#) [X] (ID#)	628821247
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]	3. PATIENT'S BIRTH DATE [redacted] SEX M [X] F [ ]
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a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO
a. INSURED'S DATE OF BIRTH [redacted] SEX M [X] F [ ]	
b. RESERVED FOR NUCC USE P.O. #:	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE Invoice Received By: P.Edinburger on: 11/29/22	c. OTHER ACCIDENT? [ ] YES [X] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME Good/Services Received By: P.Rodriguez on: 9/5/22 2-1100-423-21-230-002-0-331	10d. CLAIM CODES (Designated by NUCC)
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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 [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A 2021 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 09 05 22 09 05 22	11		99213		A	65.00	1.0		NPI	1710139712
2 09 05 22 09 05 22	11		81002		A	10.00	1.0		NPI	1710139712
3 09 05 22 09 05 22	11		80305		A	50.00	1.0		NPI	1710139712
4 09 05 22 09 05 22	11		86592		A	15.00	1.0		NPI	1710139712
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC use
454034067 [ ] [X]	2901E34751	[X] YES [ ] NO	$ 140.00	$	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SOBIA NASIR MD SIGNED 11/29/2022 DATE	SOBIA NASIR MD PA 702 W UNIVERSITY DR EDINBURG TX 785393242 a. 1043589435 b.	SOBIA NASIR MD PA PO BOX 4290 EDINBURG TX 785404290 (956) 383-0714 a. 1043589435 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF ID ENV WMCF ID ENV SS

PRIMARY

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

HEALTH INSURANCE CLAIM FORM

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

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): 6942868738

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

7. INSURED'S ADDRESS (No., Street): [redacted]

CITY: [redacted] STATE: TX

8. RESERVED FOR NUCC USE

CITY: [redacted] STATE: TX

ZIP CODE: [redacted] TELEPHONE (Include Area Code) ( )

ZIP CODE: [redacted] TELEPHONE (Include Area Code) ( )

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: [redacted] SEX M X F

b. RESERVED FOR NUCC USE

P.O. #:________

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

Invoice Received By: P Eilenberger on: 11/29/22

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

Good/Services Received By: V Rodriguez on: 9/7/22

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes, complete items 9, 9a and 9d.*

1100-483-21-280-002-0-331

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 SIGNATURE ON FILE DATE 11/29/22

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 SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN SOBIA NASIR

17a. 0B 300666001

17b. NPI 1710139712

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind 0

A. Z021 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 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 07 22	09 07 22	11		99213		A	65.00	1.0		NPI	1710139712
2	09 07 22	09 07 22	11		81002		A	10.00	1.0		NPI	1710139712
3	09 07 22	09 07 22	11		80305		A	50.00	1.0		NPI	1710139712
4	09 07 22	09 07 22	11		86592		A	15.00	1.0		NPI	1710139712
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 454034067 X

26. PATIENT'S ACCOUNT NO.: 2934E34262

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

28. TOTAL CHARGE $ 140.00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SOBIA NASIR MD

SIGNED DATE 11/29/2022

32. SERVICE FACILITY LOCATION INFORMATION
SOBIA NASIR MD PA
702 W UNIVERSITY DR
EDINBURG TX 785393242

a. 1043589435 b.

33. BILLING PROVIDER INFO & PH # (956) 383-0714
SOBIA NASIR MD PA
PO BOX 4290
EDINBURG TX 785404290

a. 1043589435 b.

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

WCMS-1500CS-12

PATIENT AND INSURED INFORMATION | PHYSICIAN OR SUPPLIER INFORMATION

PRIMARY

HEALTH INSURANCE CLAIM FORM

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

PICA

CARRIER

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

PICA

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

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

2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	3 PATIENT'S BIRTH DATE / SEX	4 INSURED'S NAME (Last Name, First Name, Middle Initial)
[redacted]	[redacted] M X F	[redacted]
5 PATIENT'S ADDRESS (No., Street)	6 PATIENT RELATIONSHIP TO INSURED	7 INSURED'S ADDRESS (No., Street)
[redacted]	Self X Spouse Child Other	[redacted]
CITY [redacted] STATE TX	8 RESERVED FOR NUCC USE	CITY [redacted] STATE TX
ZIP CODE [redacted] TELEPHONE (Include Area Code) ( )		ZIP CODE [redacted] TELEPHONE (Include Area Code) ( )
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)	a INSURED'S DATE OF BIRTH / SEX
P.O. #:	YES X NO	[redacted] M X F
b RESERVED FOR NUCC USE	b AUTO ACCIDENT? PLACE (State)	b OTHER CLAIM ID (Designated by NUCC)
Invoice Received By:	YES X NO	
c RESERVED FOR NUCC USE	c OTHER ACCIDENT?	c INSURANCE PLAN NAME OR PROGRAM NAME
Invoice Received By: P Eisenberger on: 11/29/22	YES X NO	
d INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM CODES (Designated by NUCC)	d IS THERE ANOTHER HEALTH BENEFIT PLAN?
Good/Services Received By: [redacted] on: 9/6/22		YES X NO If yes, complete items 9, 9a and 9d.
2-1100-428-21-230-002-0-331		

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 SIGNATURE ON FILE DATE 11/29/22

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 SIGNATURE ON FILE

14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	15 OTHER DATE QUAL MM DD YY	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 OB 300666001	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
DN SOBIA NASIR	17b NPI 1710139712	
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20 OUTSIDE LAB? YES X NO $ CHARGES
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		22 RESUBMISSION CODE ORIGINAL REF. NO
A 2021 B C D		23 PRIOR AUTHORIZATION NUMBER
E F G H		
I J K L		

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 06 22 09 06 22	11		99213		A	65.00	1.0		NPI	1710139712
2 09 06 22 09 06 22	11		81002		A	10.00	1.0		NPI	1710139712
3 09 06 22 09 06 22	11		80305		A	50.00	1.0		NPI	1710139712
4 09 06 22 09 06 22	11		86592		A	15.00	1.0		NPI	1710139712
5									NPI	
6									NPI	

25 FEDERAL TAX I.D. NUMBER SSN EIN	26 PATIENT'S ACCOUNT NO	27 ACCEPT ASSIGNMENT? (For govt. claims, see back)	28 TOTAL CHARGE	29 AMOUNT PAID	30 Rsvd for NUCC use
454034067 X	2930E34234	X YES NO	$ 140.00	$	

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.)	32 SERVICE FACILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH #
SOBIA NASIR MD	SOBIA NASIR MD PA	(956) 383-0714
SIGNED 11/29/2022 DATE	702 W UNIVERSITY DR	SOBIA NASIR MD PA
	EDINBURG TX 785393242	PO BOX 4290
	a 1043589435 b	EDINBURG TX 785404290
		a 1043589435 b

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF IB ENV WHCF IB ENV SS

PRIMARY

HEALTH INSURANCE CLAIM FORM

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

PICA

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

CARRIER

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) / (Medicaid #) / (ID# /DoD#) / (Member ID#) / (ID#) / (ID#) X (ID#)	637900727
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]	3. PATIENT'S BIRTH DATE [redacted] SEX X M / F
4. INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted]	
5. PATIENT'S ADDRESS (No., Street) [redacted]	6. PATIENT RELATIONSHIP TO INSURED: Self X / Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street) [redacted]	
CITY [redacted] STATE TX	8. RESERVED FOR NUCC USE
CITY [redacted] STATE TX	
ZIP CODE [redacted] TELEPHONE (Include Area Code) ( )	
ZIP CODE [redacted] TELEPHONE (Include Area Code) ( )	
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 [redacted] SEX M X / F	
b. RESERVED FOR NUCC USE P.O. #: [redacted] Invoice Received By: Edinburg on: 11/30/22 Good/Services Received By: Medicines on: 9/6/22	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. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / X NO If yes, complete items 9, 9a and 9d	

2-1100-423-21-230-C02-0-331

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 SIGNATURE ON FILE DATE 11/29/22

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 SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	15. OTHER DATE QUAL MM DD YY
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 DN SOBIA NASIR	17a. 0B 300666001 / 17b. NPI 1710139712
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 / X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A 2021 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 09 06 22 09 06 22	11		99213		A	65.00	1.0		NPI	1710139712
2 09 06 22 09 06 22	11		81002		A	10.00	1.0		NPI	1710139712
3 09 06 22 09 06 22	11		80305		A	50.00	1.0		NPI	1710139712
4 09 06 22 09 06 22	11		86592		A	15.00	1.0		NPI	1710139712
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC use
454034067 X	2928E34228	X YES / NO	$ 140.00	$	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SOBIA NASIR MD SIGNED 11/29/2022 DATE	SOBIA NASIR MD PA 702 W UNIVERSITY DR EDINBURG TX 785393242 a. 1043589435 b.	SOBIA NASIR MD PA PO BOX 4290 EDINBURG TX 785404290 (956) 383-0714 a. 1043589435 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

SECOND FOLD

FIRST FOLD WHCF ID ENV WHCF ID ENV SS

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PRIMARY

HEALTH INSURANCE CLAIM FORM

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

PICA

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

CARRIER

PICA

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): 640743939
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]		3. PATIENT'S BIRTH DATE MM DD YY: [redacted]	SEX: M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]			
5. PATIENT'S ADDRESS (No., Street): [redacted]		6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other		7. INSURED'S ADDRESS (No., Street): [redacted]			
CITY: [redacted]	STATE: TX	8. RESERVED FOR NUCC USE		CITY: [redacted]	STATE: TX		
ZIP CODE: [redacted]	TELEPHONE (Include Area Code): ( )			ZIP CODE: [redacted]	TELEPHONE (Include Area Code): ( )		
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: P.O. #:		a. EMPLOYMENT? (Current or Previous) YES NO X		a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] SEX: M X F			
b. RESERVED FOR NUCC USE: Invoice Received By: [redacted] on: 11/29/22		b. AUTO ACCIDENT? YES NO X PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE: Good/Services Received By: [redacted] on: 12/7/22		c. OTHER ACCIDENT? YES NO X		c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME: 2-1100-420-27-230-C02-0-331		10d. CLAIM CODES (Designated by NUCC)		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: SIGNATURE ON FILE DATE: 11/16/22

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: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	15. OTHER DATE QUAL MM DD YY	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: DN SOBIA NASIR	17a. 0B 300666001 17b. NPI 1710139712	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 X $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A Z021 B C D E F G H I J K		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	10 07 22	10 07 22	11		99213		A	65.00	1.0		NPI	1710139712
2	10 07 22	10 07 22	11		81002		A	10.00	1.0		NPI	1710139712
3	10 07 22	10 07 22	11		80305		A	50.00	1.0		NPI	1710139712
4	10 07 22	10 07 22	11		86592		A	15.00	1.0		NPI	1710139712
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 454034067 SSN EIN X	26. PATIENT'S ACCOUNT NO: 2949E34541	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE: $ 140.00	29. AMOUNT PAID: $	30. Rsvd for NUCC use

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.)
SOBIA NASIR MD
SIGNED 11/16/2022 DATE

32. SERVICE FACILITY LOCATION INFORMATION
SOBIA NASIR MD PA
702 W UNIVERSITY DR
EDINBURG TX 785393242
a. 1043589435 b.

33. BILLING PROVIDER INFO & PH. # (956) 383-0714
SOBIA NASIR MD PA
PO BOX 4290
EDINBURG TX 785404290
a. 1043589435 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WMCF 10 ENV WMCF 10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

PRIMARY

HEALTH INSURANCE CLAIM FORM

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

PICA

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

CARRIER

PICA

1 MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
X (ID#)	644704731
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]	3 PATIENT'S BIRTH DATE [redacted] SEX M [ ] F [X]
4 INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted]	
5 PATIENT'S ADDRESS (No., Street) [redacted]	6 PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]
7 INSURED'S ADDRESS (No., Street) [redacted]	
CITY [redacted] STATE TX	8 RESERVED FOR NUCC USE
CITY [redacted] STATE TX	
ZIP CODE [redacted] TELEPHONE (Include Area Code) ( )	
ZIP CODE [redacted] TELEPHONE (Include Area Code) ( )	
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 [redacted] SEX M [ ] F [X]	
b RESERVED FOR NUCC USE P.O. #:	b AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
b OTHER CLAIM ID (Designated by NUCC)	
c RESERVED Invoice Received By: DCalderon on: 11/30/22	c. OTHER ACCIDENT? [ ] YES [X] NO
c INSURANCE PLAN NAME OR PROGRAM NAME	
d INSURANCE Good/Services Received By: VRodriguez on: 10/17/22 1100-423-21-280-C02-0	10d CLAIM CODES (Designated by NUCC) 331
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 SIGNATURE ON FILE DATE 11/22/22

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 SIGNATURE ON FILE

14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	15. OTHER DATE QUAL MM DD YY	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 DN SOBIA NASIR	17a. OB 300666001 17b NPI 1710139712	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 [X] NO $ CHARGES
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. D A 2021 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 10 17 22 10 17 22	11		99213	A	65.00	1.0		NPI	~~1710139712~~
2 10 17 22 10 17 22	11		81002	A	10.00	1.0		NPI	~~1710139712~~
3 10 17 22 10 17 22	11		80305	A	50.00	1.0		NPI	~~1710139712~~
4 10 17 22 10 17 22	11		86592	A	15.00	1.0		NPI	~~1710139712~~
5								NPI	
6								NPI	

25 FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC use
454034067 [ ] [X]	2960E34712	[X] YES [ ] NO	$ 140.00	$	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SOBIA NASIR MD 11/22/2022 SIGNED DATE	SOBIA NASIR MD PA 702 W UNIVERSITY DR EDINBURG TX 785393242 a. 1043589435 b.	SOBIA NASIR MD PA PO BOX 4290 EDINBURG TX 785404290 (956) 383-0714 a. 1043589435 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WCS 10 DIV 10 INC 10 DIV 93

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12