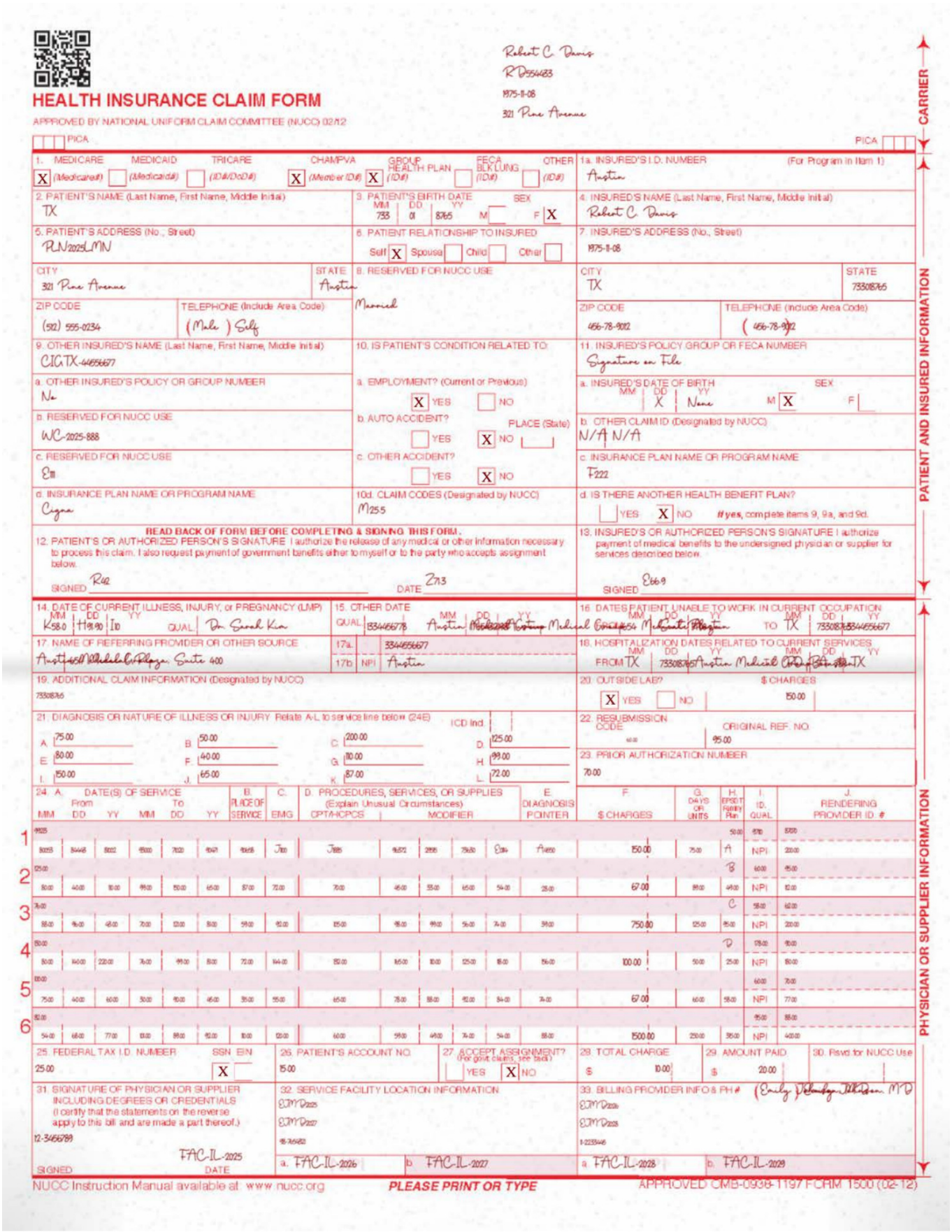

HEALTH INSURANCE CLAIM FORM

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

Robert C Davis
RD554433
1975-11-08
321 Pine Avenue

PICA

1. MEDICARE [X] (Medicare#) / MEDICAID [ ] (Medicaid#) / TRICARE [ ] (ID#/DoD#) / CHAMPVA [X] (Member ID#) / GROUP HEALTH PLAN [X] (ID#) / FECA BLK LUNG [ ] (ID#) / OTHER [ ] (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): Austin
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): TX	3. PATIENT'S BIRTH DATE: MM 733 DD 01 YY 8765 SEX: M [ ] F [X]
5. PATIENT'S ADDRESS (No., Street): PLN2025LMN	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
CITY: 321 Pine Avenue	STATE: Austin
ZIP CODE: (512) 555-0234	TELEPHONE (Include Area Code): (Male) Self
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): CIGTX-44656677	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER: Na	a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO
b. RESERVED FOR NUCC USE: WC-2025-888	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State) [ ]
c. RESERVED FOR NUCC USE: Em	c. OTHER ACCIDENT? [ ] YES [X] NO
d. INSURANCE PLAN NAME OR PROGRAM NAME: Cigna	10d. CLAIM CODES (Designated by NUCC): M255
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM K58.0 DD T19.90 YY I0 QUAL: Dr Sarah Kim	15. OTHER DATE QUAL: 334456778 MM Austin DD YY Medical Center Plaza
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Austin 456 Medical Center Plaza Suite 400	17a. 334455667 / 17b. NPI Austin
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): 7330876	

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: R42 DATE: Z713

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: E669

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY TO TX	7330876334455667
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TX 7330876 Austin Medical Center Plaza TX	
20. OUTSIDE LAB? [X] YES [ ] NO	$ CHARGES: 150.00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind.	
A 75.00 B 50.00 C 200.00 D 125.00	
E 80.00 F 40.00 G 80.00 H 99.00	
I 150.00 J 65.00 K 87.00 L 72.00	
22. RESUBMISSION CODE: 95.00	ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: 70.00	

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							150.00	75.00	A	NPI	
2							67.00		B	NPI	
3							750.00	125.00	C	NPI	
4							100.00	50.00	D	NPI	
5							67.00	60.00		NPI	
6							1500.00	250.00		NPI	

25. FEDERAL TAX I.D. NUMBER: 25.00 SSN [X] EIN [ ]	26. PATIENT'S ACCOUNT NO.: 15.00	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO	28. TOTAL CHARGE: $ 10.00	29. AMOUNT PAID: $ 20.00	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.)
12-3456789
SIGNED: FAC-IL-2025 DATE

32. SERVICE FACILITY LOCATION INFORMATION
FAC-IL-2025
FAC-IL-2027
45-76482
a. FAC-IL-2026 b. FAC-IL-2027

33. BILLING PROVIDER INFO & PH # (Emily Johnson MD)
FAC-IL-2028
FAC-IL-2029
1-2233446
a. FAC-IL-2028 b. FAC-IL-2029

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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