



Robert C. Davis
RD 954483
1975-11-08
321 Pine Avenue

PICA ☐ ☐ ☐

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐		GROUP HEALTH PLAN ☐ FECA BOX (UNG) ☐ OTHER ☐		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) TX		3. PATIENT'S BIRTH DATE MM DD YY 733 01 8765 M ☐ F ☒		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Robert C Davis	
5. PATIENT'S ADDRESS (No., Street) PLN2025LMN		6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐		7. INSURED'S ADDRESS (No., Street) 1975-1-08	
CITY 301 Pine Avenue		STATE Austin		CITY TX	
ZIP CODE (902) 555-0234		TELEPHONE (Include Area Code) (Male) Self		ZIP CODE 456-78-9012	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) CIGTX-44556677		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) ☒ YES ☐ NO b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State) c. OTHER ACCIDENT? ☐ YES ☒ NO		11. INSURED'S POLICY GROUP OR FECA NUMBER Signature on File	
a. OTHER INSURED'S POLICY OR GROUP NUMBER N/A		10d. CLAIM CODES (Designated by NUCC) M255		a. INSURED'S DATE OF BIRTH MM DD YY None M ☒ F ☐	
b. RESERVED FOR NUCC USE WC-2025-888				b. OTHER CLAIM ID (Designated by NUCC) N/A N/A	
c. RESERVED FOR NUCC USE E11				c. INSURANCE PLAN NAME OR PROGRAM NAME F222	
d. INSURANCE PLAN NAME OR PROGRAM NAME Cigna				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, complete items 9, 9a, and 9d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED <u>Roe</u> DATE <u>2/3</u>					
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 <u>E669</u>					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY K580 11/19/90 10 QUAL <u>Dr Sarah Kim</u>		15. OTHER DATE QUAL <u>13344556677</u> MM DD YY <u>Austin Medical Center</u>		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY TO MM DD YY <u>7330813344556677</u>	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <u>Antonia M. Williams, M.D., Suite 400</u>		17a. <u>3344556677</u>		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY <u>7330813344556677</u>	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 7330813344556677		17b. NPI <u>Austin</u>		20. OUTSIDE LAB? ☒ YES ☐ NO \$ CHARGES 50.00	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A.L. to service line below #24E) A. 75.00 B. 50.00 C. 200.00 D. 125.00 E. 80.00 F. 40.00 G. 70.00 H. 99.00 I. 50.00 J. 65.00 K. 87.00 L. 72.00		ICD Ind		22. RESUBMISSION CODE 455 95.00 ORIGINAL REF. NO	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPICOT FEEBY Plan I. ID. QUAL J. RENDERING PROVIDER ID #					
25. FEDERAL TAX I.D. NUMBER 25.00		26. PATIENT'S ACCOUNT NO. 5.00		27. ACCEPT ASSIGNMENT? (For group claims, see back) ☐ YES ☒ NO	
28. TOTAL CHARGE \$ 10.00		29. AMOUNT PAID \$ 20.00		30. Paid 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		32. SERVICE FACILITY LOCATION INFORMATION E3M D225 E3M D227 E3M D228 E3M D229		33. BILLING PROVIDER INFO & PH # E3M D225 E3M D226 E3M D227 E3M D228 E3M D229	
SIGNED _____ DATE _____		a. FAC-IL-2026		b. FAC-IL-2027	
FAC-IL-2025		a. FAC-IL-2026		b. FAC-IL-2027	

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