Sample CMS-1500 Claim Form

Physician Office CMS-1500 Claim Form¹

				<u>↑</u>	
	RANCE CLAIM FORM UNIFORM CLAIM COMMITTEE (NUCC) 02/12	2		САВ	19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
1. MEDICARE MED		VA GROUP FECA OTHE HEALTH PLAN BLK LUNG (<i>ID#</i>) (<i>ID#</i>) (<i>ID#</i>) (<i>ID#</i>)	R 1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
	licaid#) (ID#/DoD#) (Member Name, First Name, Middle Initial)	ID#) (ID#) (ID#) (ID#) (ID#) (ID#)	4. INSURED'S NAME (Last Name, First Name, Middle Initial)		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)
5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)		B A B C	
Self Spouse Child Other					
CITY	STATE	8. RESERVED FOR NUCC USE	CITY STATE	3	1.
ZIP CODE	TELEPHONE (Include Area Code)	_	ZIP CODE TELEPHONE (Include Area Court		From To PLACE OF (Explain Unusual Circumsta OF DD MM DD YY MM DD YY SERVICE EMG CPT/HCPCS MM
9. OTHER INSURED'S NAM	ME (Last Name, First Name, Middle Initial)	10, IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECANT/MBER		
a. OTHER INSURED'S POL	LICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a, INSURED'S DATE OF PIRTH SEX		
b. RESERVED FOR NUCC	b. RESERVED FOR NUCC USE b. AUTO ACCIDENT?		M F		2
c. RESERVED FOR NUCC	C. RESERVED FOR NUCC USE		C. INSURANCE PLAN NAME OR PROGRAM NAME		
d. INSURANCE PLAN NAM	IE OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		4
R 12. PATIENT'S OR AUTHOR	READ BACK OF FORM BEFORE COMPLETIN RIZED PERSON'S SIGNATURE I authorize the	IG & SIGNING THIS FORM. e release of any medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Lauthorize payment of medical banefits to the undersigned physician or surplier for		
12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE 1 authorize the release of any medical or other information necessary to process this claim, I also request payment of government benefitis either to myself or to the party who accepts assignment below.			services described below.		5
SIGNED		DATE	SIGNED		6
	QUAL.	JAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD TO		0
17. NAME OF REFERRING		7a. 7b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		
19, ADDITIONAL CLAIM INI			20. OUTSIDE LAB? \$ CHARGES		
21. DIAGNOSIS OR NATUR	RE OF ILLNESS OR INJURY Relate A-L to set	rvice line below (24E) ICD Ind.	YES NO 22. RESUBMISSION ORIGINAL REF. NO.		A Item 19
A L B. L C. L D. L			23. PRIOR AUTHORIZATION NUMBER		Some payers may require drug name, total
				dosage, method of administration, and 11-digit	
24. A DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES E. From To PLACE OF (Explain Unusual Circumstances) DIAGNOSI: MM DD YY SERVICE LNG CPT/HOPCS MODIFIER POINTER		S CHARGES UNITS THE PROVIDER ID, #		NDC to be provided in Item 19. ²	
1			1 NPI		
2				B Item 21	
3			NPI		Enter appropriate site-specific ICD-10-CM
			NPI		diagnosis code(s) based on the patient's
4			NPI	HO N	documented medical record. ³
5			NPI		
6			NPI	NH4	C Item 24A and 24B
25. FEDERAL TAX LD. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? For gov. claims, see badd			28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use		Enter the date of service and the appropriate
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION			\$ \$ 33. BILLING PROVIDER INFO & PH # ()		place of service code. In the red shaded area,
INCLUDING DEGREES (I certify that the stateme apply to this bill and are	ents on the reverse				enter the NDC qualifier "N4" followed by the
					11-digit NDC, the quantity qualifier, and the
SIGNED	DATE a. N		a. NPI b.	<u> </u>	quantity administered. ³
NUCC Instruction Mar	nual available at: www.nucc.org	PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM 1500 (02-12	,	-

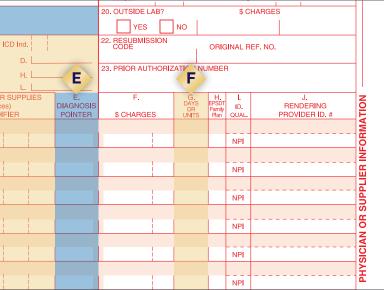
This sample form is provided for informational purposes only. The accurate completion of claims documentation is the responsibility of the healthcare provider. Astellas and Seagen do not guarantee reimbursement for any services or products.

References: 1. Centers for Medicare & Medicaid Services. CMS forms. https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf. Accessed 02-01-2021. 2. Centers for Medicare & Medicaid Services. Billing and coding guidelines for drugs and biologics (non-chemotherapy). https://downloads.csm.gov/ medicare-coverage-database/lcd_attachments/34741_55/BCG_L34741.pdf. Accessed 02-01-2021. 3. Centers for Medicare & Medicaid Services. Medicare claims processing manual chapter 26 - completing and processing form CMS-1500 data set. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/ downloads/clm104c26.pdf. Accessed 02-01-2021. 4. Centers for Medicare & Medicaid Services. Healthcare Common Procedure Coding System (HCPCS) Level II Coding Procedures. (09-16-2020). https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/2018-11-30-HCPCS-Level2-Coding-Procedure.pdf. Accessed 02-01-2021. 5. Centers for Medicare & Medicaid Services. Medicare claims processing manual chapter 17 – drugs and biologicals (08-28-2020). https:// www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf. Accessed 02-01-2021.

CPT® = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; ICD-10-CM = International Classification of Diseases, 10th Revision, Clinical Modification; NDC = National Drug Code.

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D Item 24D

Enter the appropriate HCPCS code for PADCEV® (enfortumab vedotin-ejfv): J9177.⁴ Enter the appropriate CPT[®] code^a for the administration service.³ If applicable, discarded product should be reported on a separate line with the HCPCS code and JW modifier.⁵



E Item 24E

Enter the diagnosis code reference letter or number from Item 21 that relates to the product or procedure listed in Item 24D.³



Item 24G

Report billing units here. 0.25 mg = 1 billing unit. Actual units reported will vary by dosage required for each individual patient.^{2,4}