

Sample CMS-1500 Claim Form

Coding, coverage, and reimbursement may vary significantly by payer, plan, patient, and setting of care. Actual coverage and reimbursement decisions are made by individual payers following the receipt of claims. For additional information, customers should consult with their payers for all relevant coding, reimbursement, and coverage requirements. It is the sole responsibility of the provider to select the proper code and ensure the accuracy of documentation used in seeking coverage or reimbursement. All services must be medically appropriate and properly supported in the patient medical record.

Field 21 – Diagnosis Code(s)

Enter the appropriate diagnosis codes.

Examples:

- R11.2 Nausea with vomiting, unspecified
- R11.0 Nausea
- R11.10 Vomiting, unspecified
- R11.11 Vomiting without nausea
- R11.12 Projectile vomiting

Field 24D – Procedures, Services, or Supplies

Enter the appropriate HCPCS and CPT codes.

Examples:

- CPT code: 96367, intravenous infusion for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour
- HCPCS code: J1454, injection, fosnetupitant 235mg and palonosetron 0.25mg

Field 24G - Days or Units

Enter the appropriate number of units.

Example: Enter "1" for a single-dose vial of fosnetupitant 235 mg/palonosetron 0.25 mg

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

1. MEDICARE (Medicare) MEDICAID (Medicaid) TRICARE (TRICARE) CHAMPVA (Champva) GROUP HEALTH PLAN (Group Health Plan) FECA (FECA) OTHER (Other)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX (M/F)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)

7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO: (YES/NO)

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (with date)

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (with date)

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

15. OTHER DATE (MM/DD/YY) QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM/DD/YY TO MM/DD/YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (17a: NP, 17b: NP)

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LMP? (YES/NO) \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Retain A-L to service line below (24E) ICD 9th)

22. SUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE (From MM/DD/YY To MM/DD/YY) B. PLACE OF SERVICE (EMS) C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) (CPT/HCPCS) D. DIAGNOSIS MODIFIER E. DIAGNOSIS POINTER F. CHARGES G. SUPPLY UNITS H. ICD 9th I. D. QUAL. J. RENDERING PROVIDER ID. #

25. FEDERAL TAX ID. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (YES/NO)

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. Refill for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (including address or credentials)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ()

SIGNED DATE a. NPI b. NPI

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

Please see adjacent webpage for AKYNZEO Indication, Important Safety Information and the [full US Prescribing Information](#).

For more information, call 1-84HELSINN-U (1-844-357-4668, select prompt 2).