

Sample CMS-1500 Claim Form for Physician Office Billing: UDENYCA (pegfilgrastim-cbqv) ONBODY®



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> <input type="checkbox"/> PICA										PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (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 MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
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.										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.									
15. OTHER DATE MM DD YY										16. DATES PAID FROM MM MM TO MM MM									
17a. SOURCE										17b. NPI									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE... YES <input type="checkbox"/> NO <input type="checkbox"/>									
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. <u> XXX.X </u> B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER XXXXXXXX									
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 QTY UNITS H. EPSDT (Family Plan) I. ID. QUAL. J. RENDERING PROVIDER ID. #										28. TOT. \$ 33. BILL									
[N470114010101] MM DD YY MM DD YY Q5111 A xxx xx 12 NPI										MM DD YY MM DD YY 96377 A xxx xx 1 NPI									
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.)										28. TOT. \$ 33. BILL									

ITEM 21
Specify appropriate ICD-10-CM diagnosis code(s).

ITEM 23. Prior Authorization
Enter the PA number as obtained before services were rendered.

ITEM 24A. Date(s) of Service
Enter NDC qualifier "N4", and the NDC.

ITEM 24D
Indicate appropriate HCPCS and CPT codes and modifiers, for example:
 • Drug: Q5111 for UDENYCA
 • Administration:* 96377: Application of on-body injector (includes cannula insertion) for timed subcutaneous injection

ITEM 24G
Specify the billing units. For example, **12 billing units** for use of 1 syringe of UDENYCA.
 Please use the appropriate HCPCS Modifier
 Effective July 1, 2023, providers are **required** to report the **JZ modifier** on all claims that bill for drugs from single-dose containers that are separately payable **when there are no discarded amounts**. The modifier may be used as of January 1, 2023; however, after July 1, 2023, use of the modifier is required.

This sample claim form is for informational purposes only and does not replace a medical provider's professional judgment. Before initiating UDENYCA treatment, the patient's health insurance provider should be contacted to confirm coverage, coding, and claims submission procedures. All claims should be reviewed for completeness, accuracy, and correct documentation from the patient's medical record. Accord BioPharma, Inc. does not guarantee UDENYCA coverage or reimbursement.

*Following an in-depth assessment by the American Medical Association, CPT Coding Advisors have determined that CPT code 96377 may be used to report the application of the UDENYCA on-body injector.

