Sample CMS-1500 Claim Form

UDENYCA® (pegfilgrastim-cbqv) Autoinjector and Prefilled Syringe

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (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 F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

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.

DATE

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

GNANCY (LMP) 15. OTHER DATE QUAL. MM DD YY 16. DATES PA MM FROM

SOURCE 17a. 17b. NPI 18. HOSPITAL MM FROM

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE L YES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER XXXXXXX

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 [N470114010101]									
1 MM DD YY MM DD YY			Q5111	A	xxx xx	12		NPI	
2 MM DD YY MM DD YY			96372	A	xxx xx	1		NPI	
3								NPI	
4									

SSN IGNMENT? (see back) NO 28. TOT $

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.)

SIGNED DATE

33. BILL a.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

CARRIER

PATIENT AND INSURED INFORMATION

SUPPLIER INFORMATION

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:** 96372 for subcutaneous injection

ITEM 24G

Specify the billing units. For example, **12 billing units** for administration of 1 syringe or 1 autoinjector 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.

UDENYCA® pegfilgrastim-cbqv

Injection 6 mg/0.6 mL

ABP-UDY-2500003 08/25