

# Sample CMS-1500 Claim Form for Office Billing

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## HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA <span style="float: right;"><input type="checkbox"/> PICA</span>										
1. MEDICARE <input type="checkbox"/> (Medicare#)            MEDICAID <input type="checkbox"/> (Medicaid#)            TRICARE <input type="checkbox"/> (ID#/DoD#)            CHAMPVA <input type="checkbox"/> (Member ID#)            GROUP HEALTH PLAN <input type="checkbox"/> (ID#)            FECA BLK LUNG <input type="checkbox"/> (ID#)            OTHER <input type="checkbox"/> (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"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street)  CITY _____ STATE _____				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)  CITY _____ STATE _____				
ZIP CODE _____		TELEPHONE (Include Area Code) _____		8. RESERVED FOR NUCC USE		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) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>			
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? PLACE (State) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME			
10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY - MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. DATE OF REFERENCE <input type="checkbox"/> YES <input type="checkbox"/> NO			17b. NPI			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.			23. PRIOR AUTHORIZATION NUMBER			
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE _____ C. EMG <input type="checkbox"/> _____ D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS _____ MODIFIER _____ E. DIAGNOSIS POINTER _____ F. \$ CHARGES _____ G. DAYS OR UNITS _____ H. EPSTD Family Plan _____ I. ID. QUAL _____ J. RENDERING PROVIDER ID. # _____ NPI _____			30. Rsvd. for NUCC Use			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ _____		29. AMOUNT PAID \$ _____
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 _____				32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____			33. BILLING PROVIDER INFO & PH # ( ) a. NPI _____ b. _____			

**Box 19**

- SOME PAYERS MAY REQUIRE DRUG NAME, ROUTE OF ADMINISTRATION, NDC, AND/OR DOSAGE TO BE PROVIDED IN BOX 19. CHECK WITH YOUR PAYER TO VERIFY REQUIREMENTS

**Box 21**

- ENTER APPROPRIATE DIAGNOSIS CODE(S)

**Box 24 F**

- ENTER THE AMOUNT OF THE FACILITY'S ACTUAL CHARGES FOR THE PRODUCT/SERVICE

**Box 24 D**

- ENTER THE APPROPRIATE HCPCS OR CPT CODE
- ENTER THE APPROPRIATE J-CODE (J9317)

**Box 24 G**

- ENTER THE APPROPRIATE NUMBER OF UNITS USED

Immunomedics cannot guarantee payment of any claim. 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 all claims used in seeking reimbursement. All services must be medically appropriate and properly supported in the patient's medical record.

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