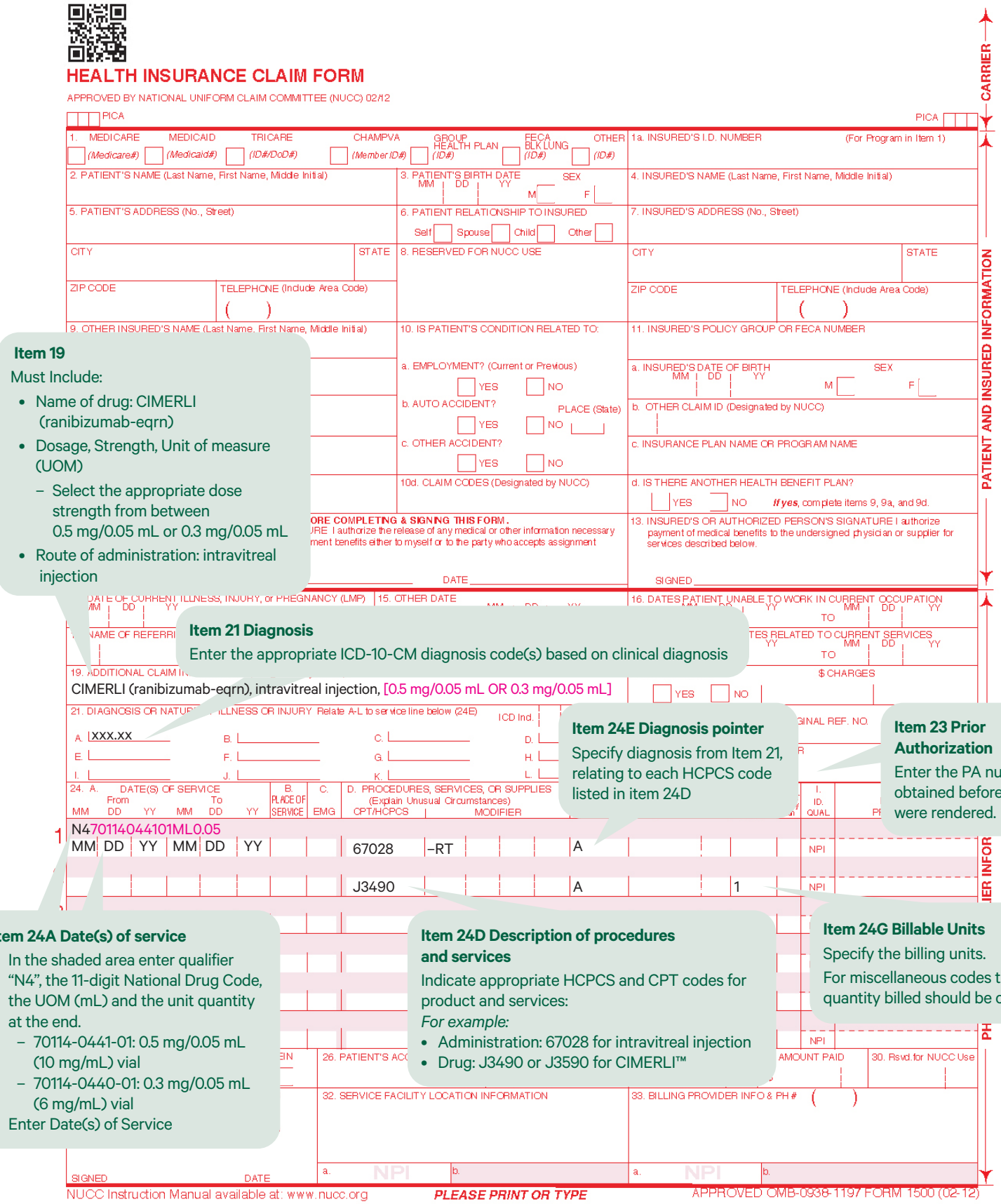
Sample CMS-1500 Claim Form for Physician Office Billing: CIMERLI™ (ranibizumab-eqrn) Injection Miscellaneous J-code



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. EMPLOYMENT? (Current or Previous) YES NO

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

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. OTHER ACCIDENT? YES NO

c. 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.

ORE COMPLETING & SIGNING THIS FORM.
URE I authorize the release of any medical or other information necessary
ment benefits either to myself or to the party who accepts assignment

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

DATE

SIGNED

DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY

15. OTHER DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY TO MM DD YY

NAME OF REFERRI

TES RELATED TO CURRENT SERVICES MM DD YY TO

19. ADDITIONAL CLAIM I

CIMERLI (ranibizumab-eqrn), intravitreal injection, [0.5 mg/0.05 mL OR 0.3 mg/0.05 mL]

$ CHARGES

YES NO

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

A. xxx.xx B. C. D.

E. F. G. H.

I. J. K. L.

GINAL REF. NO.

R

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 N470114044101ML0.05

MM DD YY MM DD YY | 67028 | -RT | A | NPI

J3490 | A | 1 | NPI

NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S AC

AMOUNT PAID

30. Rsvd.for NUCC Use

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

a. NPI b.

SIGNED DATE

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PH

IER INFOR

Item 19

Must Include:

- Name of drug: CIMERLI (ranibizumab-eqrn)
- Dosage, Strength, Unit of measure (UOM)
  - Select the appropriate dose strength from between 0.5 mg/0.05 mL or 0.3 mg/0.05 mL
- Route of administration: intravitreal injection

Item 21 Diagnosis

Enter the appropriate ICD-10-CM diagnosis code(s) based on clinical diagnosis

Item 24E Diagnosis pointer

Specify diagnosis from Item 21, relating to each HCPCS code listed in item 24D

Item 23 Prior Authorization

Enter the PA number as obtained before services were rendered.

Item 24A Date(s) of service

- In the shaded area enter qualifier "N4", the 11-digit National Drug Code, the UOM (mL) and the unit quantity at the end.
  - 70114-0441-01: 0.5 mg/0.05 mL (10 mg/mL) vial
  - 70114-0440-01: 0.3 mg/0.05 mL (6 mg/mL) vial
- Enter Date(s) of Service

Item 24D Description of procedures and services

Indicate appropriate HCPCS and CPT codes for product and services:

For example:

- Administration: 67028 for intravitreal injection
- Drug: J3490 or J3590 for CIMERLI™

Item 24G Billable Units

Specify the billing units.

For miscellaneous codes the quantity billed should be one (1).

This sample claims form is for informational purposes only and does not replace a medical provider's professional judgment. Before initiating CIMERLI™ 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. Coherus BioSciences does not guarantee CIMERLI™ coverage or reimbursement.

CIMERLI™ (ranibizumab-eqrn) injection