

# 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"/> PICA <span style="float: right;">PICA <input type="checkbox"/></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 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"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE 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 <input type="checkbox"/> NO <input type="checkbox"/>		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? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)				
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		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 <input type="checkbox"/> NO <input type="checkbox"/> <i>If yes, complete items 9, 9a, and 9d.</i>				
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.											
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 DATE						
14. PREGNANCY (LMP) SOURCE					15. OTHER DATE MM DD YY		16. DATES PA FROM MM MM				
17a. 17b. NPI					18. HOSPITAL FROM MM MM		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 Ad. to service line below (24E)						
A. XXX.X B. C. D. E. F. G. H. I. J. K. L.					22. RESUBMISSION CODE ORIGINAL REF. NO.						
23. PRIOR AUTHORIZATION NUMBER XXXXXXXX					24. PROCEDURE SERVICES OR SUPPLIES						
From MM DD YY To MM DD YY PLACE OF SERVICE EMG		(Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS POINTER		\$ CHARGES		DATES OF SERVICE (Family Plan) UNITS		ID. QUAL. RENDERING PROVIDER ID. #	
[N470114013001]		Q5111		A		xxx xx		12		NPI	
MM DD YY MM DD YY		96377		A		xxx xx		1		NPI	
MM DD YY MM DD YY		96377		A		xxx xx		1		NPI	
28. TOTAL BILL AMOUNT \$											
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						

**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, 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 claims 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. Coherus BioSciences 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.