

# 2011 CMS-1500 Sample Claim Form

**1. Note** ↻ Payers' policies regarding use of the 10-digit NDC format (57894-060-03) or the 11-digit format (57894-0060-03) may vary. Consult your payers or AccessOne® at (888) ACCESS-1 (222-3771) to obtain specific coding guidance.

**2. Item 19** ↻ Some payers may ask providers to specify name, dosage strength, NDC, and method of administration. Payer requirements vary. Note: Some payers require alternate product codes. Contact AccessOne® at (888) ACCESS-1 (222-3771) to confirm payer-specific coding requirements.

**3. Item 21** ↻ Indicate diagnosis using the appropriate ICD-9-CM code.

**4. Item 24D** ↻ Indicate appropriate CPT® and HCPCS codes and modifiers if required. Be sure to enter the correct CPT® codes by payer. The updated HCPCS J code, J3357, should be utilized for STELARA®, and should be considered equivalent to 1 mg. This code replaces J3590 and C9261. Consult your local payers for coding policy. Please contact AccessOne® at (888) ACCESS-1 (222-3771) to confirm payer requirements.

## How supplied

Dosage	NDC (item 19)	Units (item 24G)
STELARA® 45 mg prefilled syringe	57894-060-03	45
STELARA® 90 mg prefilled syringe	57894-061-03	90

**1500**  
**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE  MEDICAID  TRICARE  CHAMPVA  GROUP HEALTH PLAN  FECA BLK LUNG  OTHER   
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **Doe, John B.**

3. PATIENT'S BIRTH DATE **07 01 30** SEX  M  F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) **Doe, John B.**

5. PATIENT'S ADDRESS (No., Street) **3914 Spruce Street**

6. PATIENT RELATIONSHIP TO INSURED  Self  Spouse  Child  Other

7. INSURED'S ADDRESS (No., Street) **3914 Spruce Street**

8. PATIENT STATUS  Single  Married  Other

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

10. IS PATIENT'S CONDITION RELATED TO:  
a. EMPLOYMENT? (Current or Previous)  YES  NO  
b. AUTO ACCIDENT?  YES  NO PLACE (State)

11. INSURED'S POLICY GROUP OR FECA NUMBER

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.  
SIGNED **on file** 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

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) **MM DD YY**

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE **MM DD YY**

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE  
17a. **Dr. Jones**  
17b. NPI **123-456-7890** **8a**

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES **MM DD YY**

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB?  YES  NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)  
**1 XXX X**

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPST Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 02 11 01 02 11 11			96372	1	XXX XX 1				NPI 123-456-7890
2 01 02 11 01 02 11 11			J3357	1	XXX XX 45				NPI 123-456-7890
3									NPI
4									NPI
5									NPI
6									NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. claims, see back)  YES  NO

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. BALANCE DUE \$

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.) **8c**

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # **8d**

SIGNED DATE **123-456-7890** **123-456-7890**

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

**5. Item 24E** ↻ Refer to the diagnosis for this service (see Item 21).

**6. Item 24F** ↻ Indicate \$ charges. Note: When STELARA® is delivered to providers by specialty pharmacies or brought to the office by the patient, enter "\$00.00" or "\$00.01," with respect to J3357, depending upon payer claims processing system requirements.

**7. Item 24G** ↻ Use of the J3357 code to indicate a 1 mg unit of STELARA® may refer to either the 45 mg or 90 mg dosage, depending on the NDC. The proper coding for the 45 mg dose requires 45 1-mg units; the 90 mg dose requires coding that specifies 90 1-mg units. Consult your payers or AccessOne® at (888) ACCESS-1 (222-3771) to obtain specific coding guidance.

**8a–d. Items 17b, 24J, 32a, 33a** ↻ For proper use of the NPI, please refer to the CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing, Chapter 26; available at www.cms.hhs.gov/manuals.

Please click here to read the [Full Prescribing Information](#) and [Medication Guide](#) for STELARA®. Provide the Medication Guide to your patients and encourage discussion.



The information provided on this form is not a guarantee of reimbursement or coverage. The healthcare professional or prescribing physician is responsible for determining and recording the patient's accurate diagnosis and for providing health-related information.