

Sample CMS-1500 Claim Form

The sample **CMS-1500** claim form below shows the fields to complete when using the recommended dose of BENLYSTA. In this scenario, the specific payer requires providers to report using J0490 for BENLYSTA in **Box 24D** and include additional information about BENLYSTA in **Box 19**.

Box 19

Per payer-specific requirements, enter BENLYSTA brand and generic names, NDC, and amount administered to the patient.

Box 21

Enter the appropriate diagnosis code(s).

Box 24B

Include the place of service code

Box 24D

Enter the appropriate HCPCS (J0490) and CPT® codes. Include any additional modifiers required by the payer.*

Enter the appropriate number of units of waste (if applicable) and include the JW modifier in Box 24D.

If no amount of drug was discarded, include the JZ modifier in Box 24D.

Include IV route of administration modifier JA in Box 24D.

Box 24E

Record the relevant diagnosis pointer from Box 21.

Box 24G

Document the number of billing units used for each line item.

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

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

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)

8. RESERVED FOR NUCC USE

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)
c. OTHER ACCIDENT? YES NO

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.

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

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE MM DD YY QUAL

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. ICD Ind. 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
N4 49401-0102-01 BENLYSTA/belumumab, 400 mg

20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 22. REU/REMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. PROCEDURE, SERVICE, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAVIS OR UNITS	H. PRIOR AUTH. NO.	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
01 01 26 01 01 26 11		J0490 JA		XX XX 88			NPI	
01 01 26 01 01 26 11		96365		XX XX 1			NPI	
							NPI	
							NPI	
							NPI	
							NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (per block) YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Rvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIAL(S) (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO (PH #)

SIGNED DATE a. NPI b. NPI

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)



Questions about CPT® or ICD coding?

Call your Access and Reimbursement Manager (ARM) or Together with BENLYSTA at 1-844-CALL-TwGSK (1-844-225-5894) Monday-Friday, 8AM-8PM ET

The suggestions contained on this form are compiled from sources believed to be accurate for the Medicare Part B program, but GSK makes no representation that the information is accurate or that it will comply with the requirements of any particular Medicare Administrative Contractor (MAC) or payer. You are solely responsible for determining the billing and coding requirements applicable to any payer or MAC.

*Different payers often have different billing and diagnosis code requirements. Please confirm requirements with individual payers or check with your ARM for additional information.

CMS=Centers for Medicare & Medicaid Services; CPT®=Current Procedural Terminology; HCPCS=Healthcare Common Procedure Coding System; ICD=International Classification of Diseases; NDC=National Drug Code.

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