

Sample CMS-1500 Claim Form for Physician Office Billing: CIMERLI® (ranibizumab-eqrn) Injection with Q-code (effective 4/1/23)



HEALTH INSURANCE CLAIM FORM

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

PICA		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)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED (Self Spouse Child Other)	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code)		CITY STATE	
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 (c. OTHER ACCIDENT? YES NO)	
		11. INSURED'S POLICY GROUP OR FECA NUMBER	
		12. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)	
		13. OTHER CLAIM ID (Designated by NUCC)	
		14. INSURANCE PLAN NAME OR PROGRAM NAME	
		15. OTHER DATE (MM DD YY) QUAL	
16. DATES PAID (FROM TO) (MM DD YY)		17. HOSPITALIZATION (FROM TO) (MM DD YY)	
18. HOSPITALIZATION (FROM TO) (MM DD YY)		19. OUTSIDE DELIVERY (YES NO)	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE DELIVERY (YES NO)	
CIMERLI (ranibizumab-eqrn), intravitreal injection, [0.5 mg/0.05 mL OR 0.3 mg/0.05 mL]			
21. DIAGNOSIS OR NAT. MODIFIERS (A. XXXX.XX E. I.)		22. ORIGINAL REF. NO. NUMBER	
23. PRIOR AUTHORIZATION (A. DATE(S) OF SERVICE (MM DD YY) (B. FROM (MM DD YY) (C. SERVICE) (D. EMG) (E. OPT/HCP) (F. CHARGES) (G. UNITS) (H. I.D. QUAL) (I. PH#)		24. PRIOR AUTHORIZATION (A. DATE(S) OF SERVICE (MM DD YY) (B. FROM (MM DD YY) (C. SERVICE) (D. EMG) (E. OPT/HCP) (F. CHARGES) (G. UNITS) (H. I.D. QUAL) (I. PH#)	
N470114044101ML0.05		67028 -RT A	
Q5128		JZ A 5	
25. PATIENT'S ACCOUNT NUMBER		26. PATIENT'S ACCOUNT NUMBER	
27. SERVICE FACILITY		28. SERVICE FACILITY	
29. SIGNATURE		30. SIGNATURE	
DATE		DATE	

Item 19

- 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

Modifiers
To denote site of administration, enter appropriate modifiers, -LT, -RT, or -50 for bilateral injection.
To denote administration of a full vial (no discarded amounts), enter JZ

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.
 - 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: Q5128 for CIMERLI®

Item 24G Billable Units
Specify the billing units. Billable units for CIMERLI® are in 0.1 mg increments.
For example
0.5 mg = 5 billable units
0.3 mg = 3 billable units

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.

