

Sample CMS-1500 Claim Form for Office Billing: LOQTORZI® (toripalimab-tpzi)



HEALTH INSURANCE CLAIM FORM

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

| | | | |
|---|--|--|--|
| PICA <input type="checkbox"/> | | PICA <input type="checkbox"/> | |
| 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"/> | |
| 5. PATIENT'S ADDRESS (No., Street) | | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | |
| 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) | | 8. RESERVED FOR NUCC USE | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| b. RESERVED FOR NUCC USE | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | |
| c. RESERVED FOR NUCC USE | | a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | b. OTHER CLAIM ID (Designated by NUCC) | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. | | c. INSURANCE PLAN NAME OR PROGRAM NAME | |
| SIGNED _____ | | 10d. CLAIM CODES (Designated by NUCC) | |
| 14. DATE OF CURRENT SERVICE MM DD YY | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i> | |
| 17. NAME OF REFERRING PHYSICIAN | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. | |
| 19. ADDITIONAL CLAIM INFORMATION | | SIGNED _____ | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____ | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | |
| A. <u>XXX.XX</u> B. _____ C. _____ D. _____ | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | |
| E. _____ F. _____ G. _____ H. _____ | | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____ | |
| I. _____ J. _____ K. _____ L. _____ | | 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | |
| N470114034004ML240 | | I. ID. QUAL. J. RENDERING PROVIDER ID. # | |
| MM DD YY MM DD YY J3263 [JZ] A 240 NPI | | | |
| [96413] A NPI | | | |
| 26. PATIENT INFORMATION | | 29. AMOUNT PAID \$ 30. Hs.vd. for NUCC Use | |
| 32. SERVICE INFORMATION | | INFO & PH# () | |
| (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | | |
| SIGNED _____ DATE _____ | | a. b. | |

Item 21 Diagnosis

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

Item 24E Diagnosis

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

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
 - 240mg/6 mL (40 mg/mL) vial
- Enter Date(s) of Service

Item 24D Description of procedures and services

- Indicate appropriate HCPCS code, CPT code and modifiers for product and services:
For example:
- Drug: J3263**
 - Modifier: To denote administration of a full vial (no discarded amounts), enter JZ (if applicable)**
 - Administration: Based on infusion time (96413,96415,96417)**

Item 24G Billable Units

Specify the billing units. Billable units for LOQTORZI are in 1 mg increments.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

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