

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



## HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'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"/>		7. INSURED'S ADDRESS (No., Street)	
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		CITY STATE	
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (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.		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		SIGNED	
14. DATE OF CURRENT SERVICE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Relate A-L to service line below (24E)		24E. ICD-10-CM CODE	
A. XXXX.XX B. C. D. E. F. G. H. I. J. K. L.		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPSCS MODIFIER	
N470114034004ML240		J3263 [JZ] A 240	
[96413]		A	
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.		29. AMOUNT PAID \$ 30. Rsvd. for NUCC Use	
32. SERVICE		33. NFO & PH #	
SIGNED DATE		SIGNED DATE	

NUCC Instruction Manual available at: [www.nucc.org](http://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.