

Sample Medicare CMS-1500 paper claim form (version 02-12) for use of BOTOX® (onabotulinumtoxinA) injection



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> <input type="checkbox"/> PICA										<input type="checkbox"/> <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)										3. PATIENT'S BIRTH DATE MM DD YY					SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street) CITY STATE										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) CITY STATE					8. RESERVED FOR NUCC USE																																							
10. PROVIDER OR OTHER SOURCE Area Code Middle Initial										10a. PROVIDER'S BIRTH DATE MM DD YY					SEX M <input type="checkbox"/> F <input type="checkbox"/>					10b. AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO																																							
10c. OTHER ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO										10d. CLAIM CODE					10e. GROUP OR FECA NUMBER					13. SIGNING & SIGNING THIS FORM. I certify that the release of any medical or other information necessary for the release of this form is for the use of the information necessary for the release of this form.																																							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.					16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO MM DD YY MM DD YY					17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) NDC 00023-xxxx-xx										20. ICD INDICATOR Enter the ICD indicator as a single digit between the vertical, dotted lines: 0 - ICD-10-CM diagnosis					21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. ICD Ind. B. ICD Ind. C. ICD Ind. D. ICD Ind. E. ICD Ind. F. ICD Ind. G. ICD Ind. H. ICD Ind. I. ICD Ind. J. ICD Ind.					22. MODIFIER Enter a modifier to indicate how the service has been altered For example, Modifier -50 may be used to indicate bilateral procedures that are performed at the same session																																							
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSON Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #										24A. DATE(S) OF SERVICE From To MM DD YY MM DD YY					24B. PLACE OF SERVICE xx					24C. EMG 					24D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER NDC 00023-xxxx-xx J0585					24E. DIAGNOSIS POINTER A					24F. \$ CHARGES xxx xx					24G. DAYS OR UNITS XXX					24H. EPSON Family Plan NPI					24I. ID. QUAL. NPI					24J. RENDERING PROVIDER ID. # NPI				
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.)										32. NPI					33. NPI					34. NPI					35. NPI																																		

Box 17: Name of rendering provider or other source
Enter the appropriate provider to the left side of the dotted line:
DK - Ordering provider
DQ - Supervising provider
DN - Referring provider

Box 17b: National Provider Identifier (NPI)
Enter the referring provider's NPI number.

Box 19: Comment field or Box 24D in gray area above HCPCS code
Enter the appropriate drug identifying information - For example, National Drug Code (NDC), as required by payer. Use:
NDC 00023-1145-01 for the 100-Unit vial
NDC 00023-3921-02 for the 200-Unit vial

Box 21: Diagnosis code(s)
Enter appropriate ICD-10-CM diagnosis code(s) that reflect(s) the particular patient's condition. Note that both principal and secondary diagnoses may be entered in boxes A through L. Do not insert a period in the ICD-10-CM code.

Box 21: ICD indicator
Enter the ICD indicator as a single digit between the vertical, dotted lines:
0 - ICD-10-CM diagnosis

Box 24D: Modifier
Enter a modifier to indicate how the service has been altered
For example, Modifier -50 may be used to indicate bilateral procedures that are performed at the same session

Box 24B: Place of service
Enter the appropriate site of service code:
11 - Physician Office
19 - Off Campus-Outpatient Hospital
22 - On Campus-Outpatient Hospital
24 - Ambulatory Surgical Center

Box 24D: CPT® or HCPCS codes
Product
Bill for BOTOX® (onabotulinumtoxinA) with HCPCS code J0585.
Administration procedure
Enter the CPT® code that accurately describes the administration service performed.

Box 24G: Days or service Units
Product
Note the amount of BOTOX® used by reporting J0585 per Unit.
Administration procedure
Enter the appropriate number of Units for the administration CPT® code.

The coding information contained herein is gathered from various resources and is subject to change. This document is intended for reference only. Nothing in this document is intended to serve as reimbursement advice, a guarantee of coverage, or a guarantee of payment for BOTOX®. Third-party payment for medical products and services is affected by numerous factors. The decision about which code to report must be made by the provider/physician considering the clinical facts, circumstances, and applicable coding rules, including the requirement to code to the highest level of specificity. Please refer to your Medicare policy/other payer policies for specific guidance.

Please see full [prescribing information](#), including boxed warning.

