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

PICA PICA

CARRIER

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

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)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

GROUP OR FECA NUMBER

BIRTH MM DD YY SEX M F

YES NO

b. AUTO ACCIDENT

c. OTHER ACCIDENT

10d. CLAIM CODES

YES NO *If yes*, complete items 9, 9a, and 9d.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize

ING & SIGNING THIS FORM. the release of any medical or other information necessary her to myself or to the party who accepts assignment

12. PA

SIGNED DATE

INSURED INFORMATION

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

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

15. OTHER DATE QUAL. MM DD YY

16.

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
NDC 00023-xxxx-xx

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. xxxxx B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION 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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
									NDC 00023-xxxx-xx							
1	MM	DD	YY	MM	DD	YY	xx		J0585		A	xxx xx	XXX		NPI	
2	MM	DD	YY	MM	DD	YY	xx		xxxxx		A	xxx xx	1		NPI	
3															NPI	
4																
5																
6																

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.

26. NT? 28. $

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. 33.

SIGNED DATE a. NPI b. a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

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

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.

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