

Sample CMS-1500 Claim Form for Office Billing: KEYTRUDA® (pembrolizumab) Injection 100 mg

Note: Please visit CMS.gov and contact other payers to obtain guidance on billing and coding for single-use vials and packages and wastage, including the appropriate use of the JW and JZ modifiers. Record the amount of drug administered and the amount wasted in the patient's medical record.

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"/> 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"/>	
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)	
8. RESERVED FOR NUCC USE		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)	
11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE MM DD YY QUAL.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		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) ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. _____ B. _____ C. _____ D. _____		23. PRIOR AUTHORIZATION NUMBER	
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. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #			
1		NPI	
2		NPI	
3		NPI	
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$	
29. AMOUNT PAID \$		30. Rsvd. for NUCC Use	
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. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH # ()			
SIGNED DATE		a. NPI b. NPI	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BOX 19

- Some payers may require drug name, route of administration, NDC, and/or dosage to be provided in Box 19. Check with your payer to verify requirements

Box 21

- Enter appropriate diagnosis code(s)

Box 24 D

- Use J9271 to bill for KEYTRUDA® (pembrolizumab)
- The infusion time corresponds to CPT code 96413

Box 24 E

- Record the relevant diagnosis pointer from Box 21

BOX 24 G

- Enter the appropriate number of units used
- On a separate line, enter the appropriate number of units of waste (if applicable) using the JW or JZ modifiers as appropriate.
- For J9271, each unit corresponds to 1 mg of KEYTRUDA® (pembrolizumab)

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