

# Sample Revised CMS 1500 Form rev. (02-12)—Physician Office

**Note:** The information presented below is based on the paper claim format; **please adopt this information to electronic equivalent fields in your software systems.** The coding information discussed in this document and sample form is provided for informational purposes only, is subject to change, and should not be construed as legal advice. The codes listed below may not apply to all patients or to all health plans; providers should exercise independent clinical judgment when selecting codes and submitting claims to accurately reflect the services and products furnished to a specific patient.

### Box 21, Diagnosis Code

Enter the appropriate ICD-10-CM code for the patient's diagnosis/condition.

**Box 21, ICD Indicator:** enter 0 to indicate the ICD code set.

### Box 24D, Procedure Code

Enter the appropriate CPT\* code to denote intravitreal injection.

### Box 24D, Product Code

Enter HCPCS code J0178 to represent EYLEA® (afibercept) Injection.

Note: State Medicaid agencies, secondaries, and some private payers may require providers to report the EYLEA NDC (61755-0005-02) in addition to HCPCS code J0178; however, the NDC is not required for Medicare claims.

### Box 24G, Units Administration

J0178 has a unit descriptor of 1 mg; report 2 units of the code when billing for a 2 mg injection of EYLEA.

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE (Medicare)  MEDICAID (Medicaid)  TRICARE (TRICARE)  CHAMPVA (Member ID#)  GROUP HEALTH PLAN (ID#)  FECA (FECA)  BULK LUNG (BULK LUNG)  OTHER (OTHER)  PICA

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)

8. RESERVED FOR NUCC USE 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 (b) EMPLOYMENT? (Current or Previous) (c) RESERVED FOR NUCC USE

11. INSURED'S POLICY GROUP OR FECA NUMBER 12. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M) (F) 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY) QUAL. 15. OTHER DATE (MM DD YY) QUAL. 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (17a) (17b) (17c) 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) (NO) 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Retain A-C to service line below (24E)) (ICD Ind.) 22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

A	B	C	D	E	F	G	H	I	J
DATE(S) OF SERVICE (From MM DD YY To MM DD YY)	PLACE OF SERVICE (EMG)	PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS)	MODIFIER	DIAGNOSIS POINTER	\$ CHARGES	DAYS OF UNITS	UNIT PRICE	UNIT QTY	RENDERING PROVIDER ID.#
1 10 15 15 10 15 15		67028 RT							NPI
2 10 15 15 10 15 15		J0178						2	NPI
3									NPI
4									NPI
5									NPI
6									NPI

24. FEDERAL TAX I.D. NUMBER (SSN) (EIN) 25. PATIENT'S ACCOUNT NO. 26. ACCEPT ASSIGNMENT? (YES) (NO) 27. TOTAL CHARGE 28. AMOUNT PAID 29. BILLING PROVIDER INFO & PH #

30. 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.) 31. SERVICE FACILITY LOCATION INFORMATION 32. BILLING PROVIDER INFO & PH #

SIGNED DATE a. NPI b. NPI

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**EYLEA®**  
(afibercept) Injection

