

Sample CMS-1500 Claim Form for Office Billing: ONTRUZANT® (trastuzumab-dttb) for Injection, for Intravenous Use 21 mg/mL

Before prescribing ONTRUZANT, please read the accompanying [Prescribing Information](#), including the **Boxed Warning** about cardiomyopathy, infusion reactions (pulmonary toxicity), and embryo-fetal toxicity.

Note: For questions on billing if a portion of a package is wasted, consult the applicable payer's policy regarding wastage. Record the amount of drug administered and the amount wasted in the patient's medical record. Medicare requires the use of the JW modifier on all claims that include wasted product.

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"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)				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"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)																							
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)						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 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. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER CLAIM ID (Designated by NUCC) YES <input type="checkbox"/> NO <input type="checkbox"/> d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>				11. INSURED'S POLICY GROUP OR FECA NUMBER				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 MM DD YY												17. NAME OF REFERRING PROVIDER MM DD YY		19. ADDITIONAL CLAIM INFORMATION		21. DIAGNOSIS OR NATURE OF ILLNESS A. B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) PT/HPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS EMG Plan		H. QUAL		I. RENEWAL PERIOD	
25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. RES																					
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 a. NPI b.				33. BILLING PROVIDER INFO & PH # () a. NPI b.																											

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 E

- Record the relevant diagnosis pointer from Box 21.

BOX 24 D

- Use Q5112 to bill for ONTRUZANT (trastuzumab-dttb).
- The infusion time corresponds to CPT code 96413. (Some payers may prefer use of 96365. Check with the applicable payer.)

BOX 24 G

- Enter the number of units administered in this field.
- On a separate line, enter the appropriate number of units discarded (if applicable) using the JW modifier.
- Note that 1 unit equals 10 mg of ONTRUZANT (trastuzumab-dttb) for Q5112.

The suggestions contained on this form are compiled from sources believed to be accurate for the Medicare Part B program, but Organon makes no representation that the information is accurate or that it will comply with the requirements of any particular MAC or payer. You are solely responsible for determining the billing and coding requirements applicable to any payer or MAC. Diagnosis codes should be selected only by a health care professional. The information provided here is not intended to be conclusive or exhaustive, and is not intended to replace the guidance of a qualified professional advisor. Billing and coding requirements may vary or change over time, so it is important to regularly check these requirements with each payer or MAC. Organon and its agents make no warranties or guarantees, expressed or implied, concerning the accuracy or appropriateness of this information for your particular use and caution that changes in public and private payer billing requirements occur frequently. The use of this information does not guarantee payment or that any payment received will cover your costs.