

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**.

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

<input type="checkbox"/> PICA 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#)				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 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) a. OTHER INSURED'S POLICY OR GROUP NUMBER				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ b. OTHER CLAIM ID (Designated by NUCC) _____ c. INSURANCE PLAN NAME OR PROGRAM NAME _____ 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 a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) _____ c. INSURANCE PLAN NAME OR PROGRAM NAME _____ 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>			
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 _____											
19. ADDITIONAL CLAIM INFORMATION _____											
21. DIAGNOSIS OR NATURE OF ILLNESS (Indicate pointer to Box 21) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____											
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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. PLAN I. QUAL J. REN											
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 33. BILLING PROVIDER INFO & PH # ()											
SIGNED _____ DATE _____ a. NPI b. NPI a. NPI b. NPI											

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.

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