

Sample CMS-1500 Claim Form for Office Billing: RENFLXIS® (infliximab-abda) for Injection, for Intravenous Use 100 mg

Before prescribing RENFLXIS, please read the accompanying [Prescribing Information](#), including the **Boxed Warning**. [The Medication Guide](#) also is available.

Note: See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/Part-B-Biosimilar-Biological-Product-Payment.html> for additional guidance from CMS on billing for RENFLXIS (infliximab-abda), including important information about differences between claims with dates of service on or after April 1, 2018 versus claims with dates of service before April 1, 2018. 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)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				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? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.							
a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY				15. OTHER DATE QUAL MM DD YY				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.				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY TO MM DD YY LAB? <input type="checkbox"/> NO <input type="checkbox"/> CHARGES \$ _____							
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 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. I. J. RENDERING PHYSICIAN NPI	
1 2 3 4 5 6 25 31															

Box 21

- Enter appropriate diagnosis code(s).

Box 24 E

- Record the relevant diagnosis pointer from Box 21.

Box 24 D

Please note that different payers may have different coding requirements for RENFLXIS (infliximab-abda). Check with the payer for information on billing and coding if you have questions. The guidance below applies to Medicare Part B claims. Check with the payer for information on billing and coding for commercial claims.

For claims with dates of service on or after April 1, 2018:

- Use Q5104 to bill for RENFLXIS (infliximab-abda).

For infusion procedure:

- The infusion time corresponds to CPT® codes 96413 and 96415. (Some payers may prefer use of 96365 and 96366. Check with the applicable payer.)

Box 24 G

- Enter the number of units administered in this field.
- Note that 1 unit equals 10 mg of RENFLXIS for Q5104 (used to bill for RENFLXIS [infliximab-abda] for dates of service on or after April 1, 2018).

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.