HYALGAN® CMS-1500 SAMPLE CLAIM FORM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA — PICA — CARRIER

1. MEDICARE [X] (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123-45-6789A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 45 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, John

5. PATIENT'S ADDRESS (No., Street): 12345 Green Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 12345 Green Street

CITY: City Town STATE: XX

8. PATIENT STATUS: Single Married [X] Other

CITY: City Town STATE: XX

ZIP CODE: 10101 TELEPHONE (Include Area Code): (123) 444-5555

Employed Full-Time Student Part-Time Student

ZIP CODE: 10101 TELEPHONE (Include Area Code): (123) 444-5555

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'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.

SIGNED DATE

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

PATIENT AND INSURED INFORMATION

Box 21: Diagnosis Code
Enter appropriate ICD-10-CM diagnosis

Example:
M17.0—Bilateral primary osteoarthritis of knee

...rst symptom) OR ...cident) OR ...Y(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

...OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. M17.0

2.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Box 24D: HCPCS Code
Enter HCPCS code for HYALGAN® J7321—Hyaluronan or derivative, HYALGAN®, for intra-articular injection, per dose

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. ...CPCS MODIFIER | E. ...NOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #

Line	From MM	DD	YY	To MM	DD	YY	B. Place of Service	C. EMG	D. CPT/HCPCS	Modifier	E.	F. $ Charges		G. Days or Units	H.	I.	J.
1	MM	DD	11	MM	DD	11	11		J7321			XXX	XX	X		NPI	
2	MM	DD	11	MM	DD	11	11		20610	50		XXX	XX				
3																	
4																	
5																NPI	
6																NPI	

Box 24G: Days or Units
Enter number of HYALGAN® units administered

Example:
1 service unit for each dose

Box 24D: CPT Code
Enter appropriate CPT code and modifier

Example:
20610—Arthrocentesis, aspiration, and/or injection; major joint or bursa [eg, shoulder, hip, knee joint, subacromial bursa]

PHYSICIAN ... INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

DISCLAIMER: This HYALGAN® CMS-1500 Sample Claim Form is intended solely for use as a resource tool to assist physician office and hospital outpatient billing staff regarding reimbursement issues. Any determination about if and how to seek reimbursement should be made only by the appropriate members of the physician office or hospital outpatient staff in consultation with the physician and in consideration of the procedure performed or therapy provided to a specific patient. FIDIA FARMACEUTICI S.p.A/FIDIA PHARMA USA INC. do not recommend or endorse the use of any particular diagnosis or procedure code(s) and makes no determination if or how reimbursement may be available. Of important note, reimbursement codes and payment, as well as health policy/legislation are subject to continual change; information contained in this version of the HYALGAN® Reimbursement Guide is current as of March 2021.