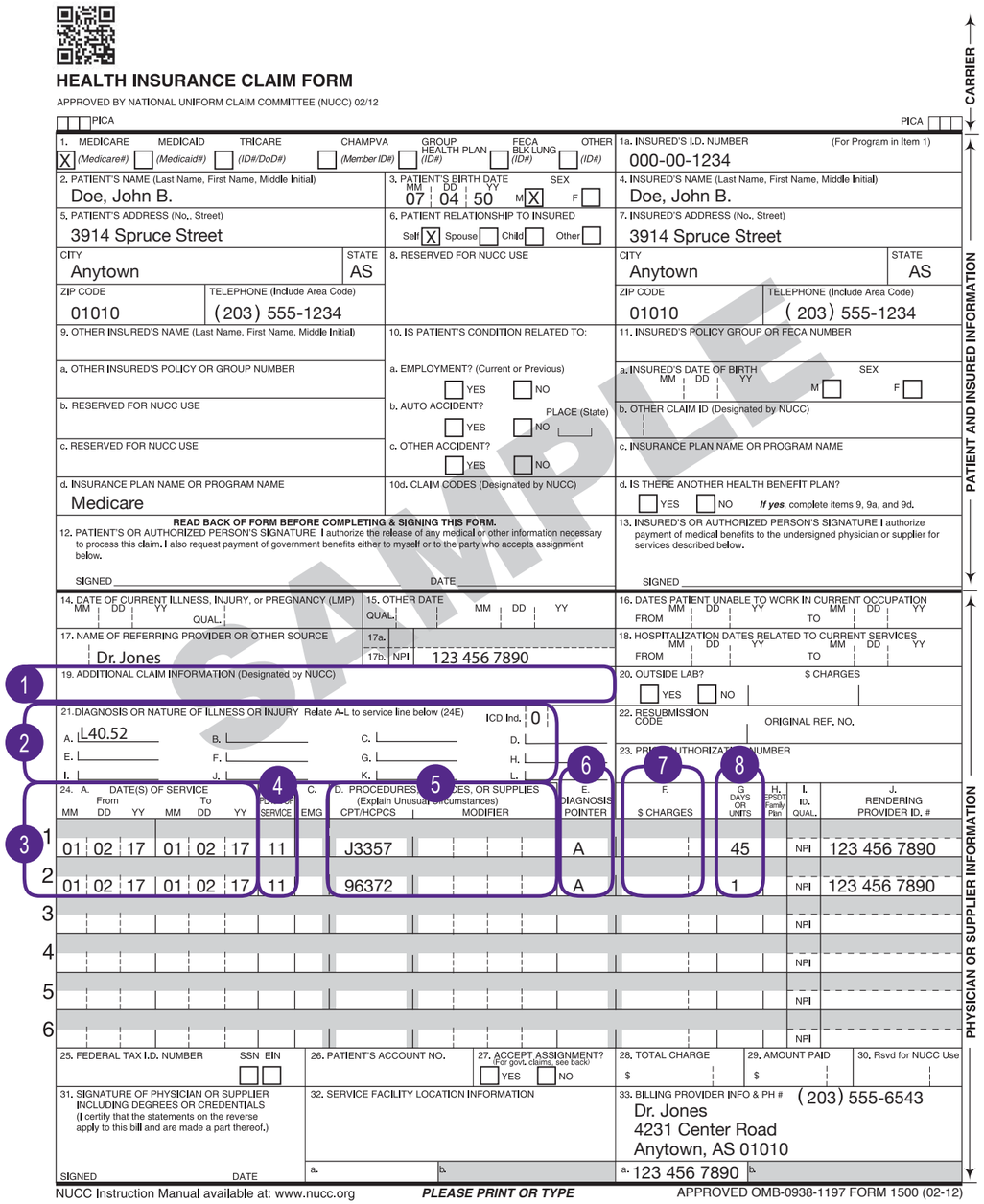
STELARA® (ustekinumab) CMS 1500 Sample Claim Form (SubQ USE)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

CARRIER

1. MEDICARE [X] (Medicare#)	MEDICAID [ ] (Medicaid#)	TRICARE [ ] (ID#/DoD#)	CHAMPVA [ ] (Member ID#)	GROUP HEALTH PLAN [ ] (ID#)	FECA BLK LUNG [ ] (ID#)	OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
000-00-1234	

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Doe, John B.	07 04 50	M [X] F [ ]	Doe, John B.

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
3914 Spruce Street	Self [X] Spouse [ ] Child [ ] Other [ ]	3914 Spruce Street

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
Anytown	AS		Anytown	AS

ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (Include Area Code)
01010	(203) 555-1234		01010	(203) 555-1234

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. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [ ] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME: Medicare	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, complete items 9, 9a, and 9d.

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 _____

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
Dr. Jones	17b. NPI 123 456 7890	

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0	22. RESUBMISSION CODE ORIGINAL REF. NO.
A. L40.52 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) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 02 17 01 02 17	11		J3357		A		45		NPI	123 456 7890
2 01 02 17 01 02 17	11		96372		A		1		NPI	123 456 7890
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER 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. Rsvd for NUCC Use

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 # (203) 555-6543
SIGNED DATE	a. b.	Dr. Jones 4231 Center Road Anytown, AS 01010 a. 123 456 7890 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

1. **Item 19** — Additional information is generally not required when reporting J3357 (ustekinumab, for subcutaneous injection, 1 mg). Payer requirements for information and codes may vary.*

2. **Item 21** — Indicate diagnosis using appropriate ICD-10-CM codes. Use diagnosis codes to the highest level of specificity for the date of service and enter the diagnoses in priority order. The "ICD Indicator" identifies the ICD code set being reported. For ICD-10-CM diagnoses, enter 0 (zero) as a single digit between the vertical, dotted lines.

3. **Item 24A** — If line item NDC information is required, it will be entered in the shaded portion of Item 24A. Payer requirements for NDC entries may vary.*

4. **Item 24B** — Indicate appropriate place of service (POS) code.
   - Physician office — 11
   - On-campus, outpatient, provider-based department of a hospital — 22
   - Off-campus, outpatient, provider-based department of a hospital — 19

5. **Item 24D** — Indicate appropriate CPT® and HCPCS codes and modifiers, if required.

   STELARA®

   HCPCS code J3357 (Ustekinumab, subcutaneous injection, 1 mg)

   Injection

   CPT® 96372 (Therapeutic, prophylactic, or diagnostic injection; subQ or intramuscular)

6. **Item 24E** — Refer to the diagnosis for this service (see box 21). Enter only one diagnosis pointer per line.

7. **Item 24F** — Indicate total charges.

8. **Items 24G** — Enter the amount of drug in HCPCS units:
   STELARA® 45 mg = 45 units
   STELARA® 90 mg = 90 units

Please click here to read the **full Prescribing Information** and **Medication Guide** for STELARA®. Provide the Medication Guide to your patients and encourage discussion.

The information provided on this form is not a guarantee of reimbursement or coverage. The healthcare professional or prescribing physician is responsible for determining and recording the patient's accurate diagnosis and for providing health-related information.

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* Contact your local payer or Janssen CarePath at 877-CarePath (877-227-3728) to confirm payer requirements.
For additional resources, visit Janssen CarePath online at: www.JanssenCarePath.com/hcp/stelara

Stelara® (ustekinumab)

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