

Utilizing the CMS-1500 and UB-04 forms

We've identified portions of reimbursement forms where errors are likely to occur. Use this guide when completing these forms to ensure your patients receive the care they need

CMS-1500

ITEM 19

The following information is required if a miscellaneous code is used:

- Drug name
- Total dosage and strength
- Method of administration
- 11-digit NDC
- Basis of measurement

ITEM 24A

The following information is required:

- NDC information in the shaded area above the line on which a drug is reported in 24D

ITEM 24D

The following information is required:

- The specific HCPCS code
- Codes associated with recording waste

ITEM 24E

The following information is required:

- Enter the relevant diagnosis code reference letter or number from Box 21 that relates to the date of service and the services or procedures performed that are entered on that same line under 24D

ITEM 21

The following information is required:

- Site-specific ICD-10-CM codes in priority order

ITEM 24G

The following information is required:

- Billing units



HEALTH INSURANCE CLAIM FORM

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

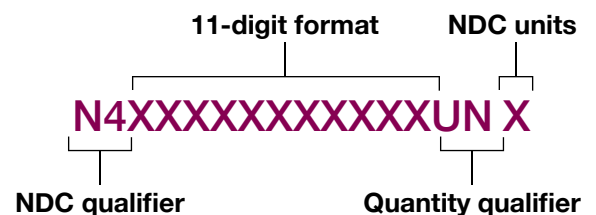
1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN (ID#) ☐ FECA BLK (LUNG) (ID#) ☐ OTHER (ID#) ☐		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE MM DD YY SEX ☐ M ☐ F		7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	
CITY STATE		CITY STATE	
ZIP CODE TELEPHONE (Include Area Code)		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. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? ☐ YES ☐ NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
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.		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 DATE		SIGNED DATE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) FROM MM DD YY TO MM DD YY QUAL.		15. OTHER DATE QUAL. MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI 17b. NPI	
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to services line below (24E) ICD-10 Ind.			
A. L. B. L. C. L. D. L. E. L. F. L. G. L. H. L. I. L. J. L. K. L. L. L.			
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS F. CHARGES G. CPT/HCPCS CODES H. ICD-10 CODES I. J. RENDERING PROVIDER ID. #			
1			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S SERVICE			

Claim NDC requirements (for filling out ITEM 19)

Reporting NDCs is required for Medicaid and Medicare/Medicaid claims. In general, NDC is reported for Healthcare Common Procedure Coding System (HCPCS) codes for physician-administered drugs to medicines and biologics. NDCs may also be reported to facilitate claims processing and may be required by payers. Accurate NDC reporting must include specific elements.

- NDC qualifier (N4)
- NDC unit of measure qualifier
- NDC (11-digit format)
- NDC units

NDC billing information must conform to the HIPAA 5010 standard and follows a specific format:



UB-04

ITEM 42

The following information is required:

- Revenue code corresponding to the code in item 44

ITEM 43

The following information is required:

- Name of product and the description of administrative service

ITEM 66

The following information is required:

- Diagnosis ICD-10-CM

ITEM 44

The following information is required:

- Appropriate HCPCS and/or CPT codes

ITEM 46

The following information is required:

- Appropriate number of units

ITEM 67A-67Q

The following information is required:

- The primary diagnosis code on line A, the secondary diagnosis code on line B, tertiary on line C, etc.

The image shows a UB-04 CMS-1450 form with several sections highlighted in yellow to indicate required information for specific items. Item 42 points to the Revenue Code field (42 REV CD). Item 43 points to the Description field (43 DESCRIPTION). Item 44 points to the HCPCS / RATE / HPCS CODE field (44 HCPCS / RATE / HPCS CODE). Item 46 points to the Units field (46 BERN UNITS). Item 67A-67Q points to the Diagnosis field (67A-67Q). The form also includes fields for Patient Name, Address, Birth Date, Sex, Admission Date, Type, SRC, DHR, STAT, Condition Codes, Occurrence Codes, Value Codes, Amount, Total Charges, Non-Covered Charges, Payer Name, Health Plan ID, Prior Payments, Est. Amount Due, NPI, Other ID, Insured's Name, Unique ID, Group Name, Insurance Group No., Treatment Authorization Codes, Document Control Number, Employer Name, Admit Date, Reason for Admit, Principal Procedure Code, Other Procedure Code, Date, PPS Code, Date, Attending, Operating, Other, and Remarks.

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