Sample CMS-1500 Claim Form for Office Billing: GARDASIL®9 (Human Papillomavirus 9-valent Vaccine, Recombinant), 0.5 mL

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

PICA PICA

1. MEDICARE (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)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

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:

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. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

RE COMPLETING & SIGNING THIS FORM.

E I authorize the release of any medical or other information necessary ent benefits either to myself or to the party who accepts assignment

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 SIGNED

14. DATE OF CURRENT ILLNESS, IN MM DD YY QUAL.

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

17. NAME OF REFERRING PROVID

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

19. ADDITIONAL CLAIM INFORMATION

LAB? NO $ CHARGES

21. DIAGNOSIS OR NATURE

SION ORIGINAL REF. NO.

UTHORIZATION NUMBER

A. E. F. G. I. J. K. L.

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.

1 NPI
2 NPI
3 NPI
4 NPI
5 NPI
6 NPI

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED 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 # ( )

SIGNED DATE

a. NPI b. a. NPI b.

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

Box 19

Some payers may require drug names, NDC, or other information to be provided in Box 19. Check with your payer to verify requirements.

Box 21

- Enter the appropriate diagnosis code.

Box 24 E

- Record the relevant diagnosis pointer from Box 21.

Box 24 G

- Enter the number of units in this field.
- Note that 1 unit equals one 0.5-mL dose of GARDASIL 9.

The suggestions contained on this form are compiled from sources believed to be accurate for the Medicare Part B program, but Merck 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. Merck 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.

CMS=US Centers for Medicare & Medicaid Services; NDC=National Drug Code; MAC=Medicare Administrative Contractor.

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