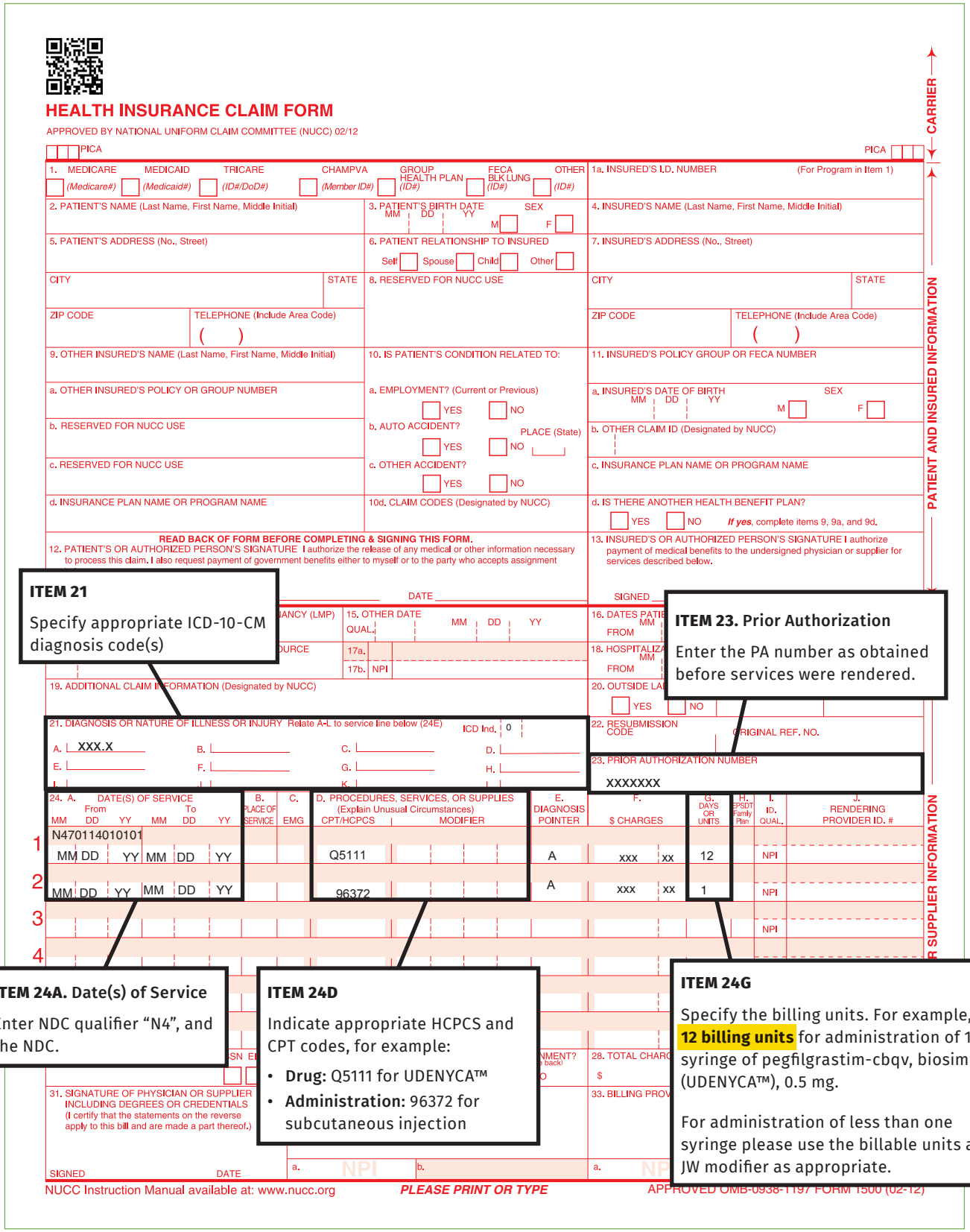
Sample CMS-1500 Claims Form



HEALTH INSURANCE CLAIM FORM

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

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. 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

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

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

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIE... MM FROM

17a.

17b. NPI

18. HOSPITALIZA... MM FROM

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LA... YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. XXX.X B. C. D.

E. F. G. H.

I. K.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER XXXXXXX

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 N470114010101 MM DD YY MM DD YY			Q5111		A	xxx xx	12		NPI	
2 MM DD YY MM DD YY			96372		A	xxx xx	1		NPI	
3									NPI	
4										

25. FEDERAL TAX I.D. NUMBER SSN EI

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)

28. TOTAL CHARG... $

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 PROV... a. NPI

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

ITEM 21

Specify appropriate ICD-10-CM diagnosis code(s)

ITEM 23. Prior Authorization

Enter the PA number as obtained before services were rendered.

ITEM 24A. Date(s) of Service

Enter NDC qualifier "N4", and the NDC.

ITEM 24D

Indicate appropriate HCPCS and CPT codes, for example:

- **Drug:** Q5111 for UDENYCA™
- **Administration:** 96372 for subcutaneous injection

ITEM 24G

Specify the billing units. For example, **12 billing units** for administration of 1 syringe of pegfilgrastim-cbqv, biosimilar, (UDENYCA™), 0.5 mg.

For administration of less than one syringe please use the billable units and JW modifier as appropriate.

This sample claims form is for informational purposes only and does not replace a medical provider's professional judgment. Before initiating UDENYCA™ treatment, the patient's health insurance provider should be contacted to confirm coverage, coding, and claims submission procedures. All claims should be reviewed for completeness, accuracy, and correct documentation from the patient's medical record. Coherus BioSciences does not guarantee UDENYCA™ coverage or reimbursement.

UDENYCA™ pegfilgrastim-cbqv