

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

Injections: Billing Example for CMS-1500

This section is to assist providers in completing the *CMS-1500* claim form for injections. For detailed policy information, refer to the following sections of this manual:

- *Injections: An Overview*
- *Injections: Drugs A–D Policy*
- *Injections: Drugs E–H Policy*
- *Injections: Drugs I–M Policy*
- *Injections: Drugs N–R Policy*
- *Injections: Drugs S–Z Policy*
- *Injections: Hydration*
- *Non-Injectable Drugs*

Refer to the *CMS-1500 Completion* section of this manual for instructions to complete claim fields not explained in the following example. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Billing Tips: When completing claims, do not enter the decimal points in ICD-9-CM codes or dollar amounts. If requested information does not fit neatly in the *Additional Claim Information* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Weekly Injections

Figure 1. Billing example for weekly injections.

This is a sample only. Please adapt to your billing situation.

In this example, the injection is administered once a week for two weeks. The first injection is administered on August 10, 2014 and the second injection is administered on August 17, 2014.

Claim Line 1: First Injection

Enter the date the first injection is administered on claim line 1 in the *Date(s) of Service* field (Box 24A under “From”) as “081014.”

Enter Place of Service code “11” (office) in Box 24B and the usual and customary charges in the *Charges* field (Box 24F). Enter a “180” in the *Days or Units* field (Box 24G).

Claim Line 2: Second Injection

Enter the date the second injection is administered on claim line 2 in the *Date(s) of Service* field (Box 24A under “From”) as “081714.”

Enter Place of Service code “11” (office) in Box 24B and the usual and customary charges in the *Charges* field (Box 24F). Enter a “180” in the *Days or Units* field (Box 24G).

The name of the drug and the dates administered are referenced in the *Additional Claim Information* field (Box 19) or on an attachment to the claim.

Physician-Administered Drug Requirements: Claim Lines 1 and 2

Because the injections are considered “physician-administered” drugs, providers must enter the two-character product qualifier and 11-digit National Drug Code (NDC). The NDC unit of measure qualifier and numeric quantity are entered in the shaded areas above Boxes 24A and 24D. Instructions to complete these fields are included in the *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions* section in this manual.

Note: Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial. Claims for vaccines do not require an NDC. Also, payment for bulk drugs is not allowed. Bulk drugs are Active Pharmaceutical Ingredients (APIs) that are represented for use in the drug and that when used in the manufacturing, processing or packaging of a drug, become an active ingredient of the drug product. APIs are distributed in a form (for example, a kilogram of powder) that does not meet the definition of a covered outpatient drug product by both the federal Food and Drug Administration according to the *Food, Drug, and Cosmetic Act*, Section 505, and Section 1927(k)(2) of the *Social Security Act*. (An example of such a bulk drug would be pharmaceutically active ingredients combined into a pharmaceutical product/formulation, whether the products are combined by the provider or ordered from a compounding pharmacy.)

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HEALTH INSURANCE CLAIM FORM										
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12										
PICA <input type="checkbox"/>					PICA <input type="checkbox"/>					
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9000000A95001					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE, JOHN					3. PATIENT'S BIRTH DATE MM DD YY 06 21 62 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street) 1234 MAIN STREET					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)			
CITY ANYTOWN		STATE CA			8. RESERVED FOR NUCC USE		CITY		STATE	
ZIP CODE 985235555		TELEPHONE (Include Area Code) (916) 555-5555			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) <input type="checkbox"/> YES <input type="checkbox"/> NO			b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)		b. OTHER CLAIM ID (Designated by NUCC)	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)			c. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>		c. INSURANCE PLAN NAME OR PROGRAM NAME	
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					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.					15. OTHER DATE MM DD YY QUAL.					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) INJECTION ADMINISTERED: 08/10/14 AND 08/17/14					17b. NPI		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.					22. RESUBMISSION CODE ORIGINAL REF. NO.					
A. _____ B. _____ C. _____ D. _____					23. PRIOR AUTHORIZATION NUMBER					
E. _____ F. _____ G. _____ H. _____					F. \$ CHARGES					
I. _____ J. _____ K. _____ L. _____					G. DAYS OR UNITS					
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	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 QUALIFIER + 11-DIGIT NDC		11		UNIT QUALIFIER + QUANTITY				9000	180	NPI
2 QUALIFIER + 11-DIGIT NDC		11		UNIT QUALIFIER + QUANTITY				9000	180	NPI
3										NPI
4										NPI
5										NPI
6										NPI
25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 18000	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.) <i>Jane Doe</i>					32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH # (916) 555-5555		
SIGNED					a. NPI			b.	a. 0123456789	b.
DATE 8/30/14										

Figure 1. "From-Through" Billing Example for Weekly Injections.