

HYALGAN® CMS-1500 SAMPLE CLAIM FORM

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 type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BENEFIT <input type="checkbox"/> OTHER <input type="checkbox"/>					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 <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					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 STATE 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) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																																		
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)																																																																																		
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>																																																																																		
<p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>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.</p> <p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p>																																																																																									
DATE					SIGNED																																																																																				
15. OTHER DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																				
17a. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																				
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)																																																																																									
<p>Box 21: Diagnosis Code Enter appropriate ICD-10-CM diagnosis</p> <p>Example: M17.0—Bilateral primary osteoarthritis of knee</p>																																																																																									
<p>Box 24D: HCPCS Code Enter HCPCS code for HYALGAN J7321—Hyaluronan or derivative, HYALGAN®, for intra-articular injection, per dose</p>																																																																																									
<p>Box 24G: Days or Units Enter number of HYALGAN® units administered</p> <p>Example: 1 service unit for each dose</p>																																																																																									
22. RESUBMISSION CODE ORIGINAL REF. NO.																																																																																									
23. PRIOR AUTHORIZATION NUMBER																																																																																									
<table border="1"> <thead> <tr> <th>A.</th> <th>B.</th> <th>C.</th> <th>D.</th> <th>E.</th> <th>F.</th> <th>G.</th> <th>H.</th> <th>I.</th> <th>J.</th> </tr> <tr> <th>DATE(S) OF SERVICE</th> <th>PLACE OF SERVICE</th> <th>EMG</th> <th>HCPCS</th> <th>MODIFIER</th> <th>POINTER</th> <th>\$ CHARGES</th> <th>DAYS OFF UNFS</th> <th>H. EPSONI Family Plan</th> <th>RENDERING PROVIDER ID. #</th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> <td></td> <td>J7321</td> <td></td> <td></td> <td></td> <td>X</td> <td></td> <td>NPI</td> </tr> <tr> <td>2</td> <td></td> <td></td> <td>20610</td> <td>50</td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> <tr> <td>4</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> <tr> <td>5</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> <tr> <td>6</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> </tbody> </table>										A.	B.	C.	D.	E.	F.	G.	H.	I.	J.	DATE(S) OF SERVICE	PLACE OF SERVICE	EMG	HCPCS	MODIFIER	POINTER	\$ CHARGES	DAYS OFF UNFS	H. EPSONI Family Plan	RENDERING PROVIDER ID. #	1			J7321				X		NPI	2			20610	50					NPI	3									NPI	4									NPI	5									NPI	6									NPI
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25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For prior claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> 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.																																																																																			

DISCLAIMER: HYALGAN® Sample Claim Form CMS-1500 is intended solely for use as a resource tool to assist physician office and hospital outpatient billing staff regarding reimbursement issues. Any determination about if and how to seek reimbursement should be made only by the appropriate members of the physician office or hospital outpatient staff in consultation with the physician and in consideration of the procedure performed or therapy provided to a specific patient. FIDIA FARMACEUTICI S.P.A./FIDIA PHARMA USA INC. do not recommend or endorse the use of any particular diagnosis or procedure code(s) and makes no determination if or how reimbursement may be available. Of important note, reimbursement codes and payment, as well as health policy/legislation are subject to continual change; information contained in this version of the HYALGAN® Reimbursement Guide is current as of January 2020.