Blood and Blood Derivatives Billing Examples: CMS-1500

Page updated: September 2020

Examples in this section are to assist providers in billing for blood and blood derivatives on the *CMS-1500* claim form. Refer to the *Blood and Blood Derivatives* section of this manual for detailed policy information. Refer to the *CMS-1500 Completion* section of this manual for instructions to complete claim fields not explained in the following examples. 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-10-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.

Separate Manufacturers' AHF on One Claim Line

Figure 1, blood samples billed together on the same claim line, is a sample only. Please adapt to your billing situation.

In this example, six units (vials) of Factor VIII are billed on an inpatient basis. Enter J7190 (Factor VIII, antihemophilic factor, human, per IU) in the *Procedures, Services or Supplies* field (Box 24D).

The product qualifier (N4) and the National Drug Code (NDC) are required on the claim because antihemophilic factor (AHF) is a "physician-administered" drug. Providers enter the product qualifier/NDC number in the shaded area of Box 24A. The unit of measure and numeric quantity for the AHF is entered in the shaded area of Box 24D. (Refer to section *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions* for help.) Due to the large quantities of AHF dispensed, providers must include the number of international units or micrograms dispensed in the *Additional Claim Information* field (Box 19).

Notes:

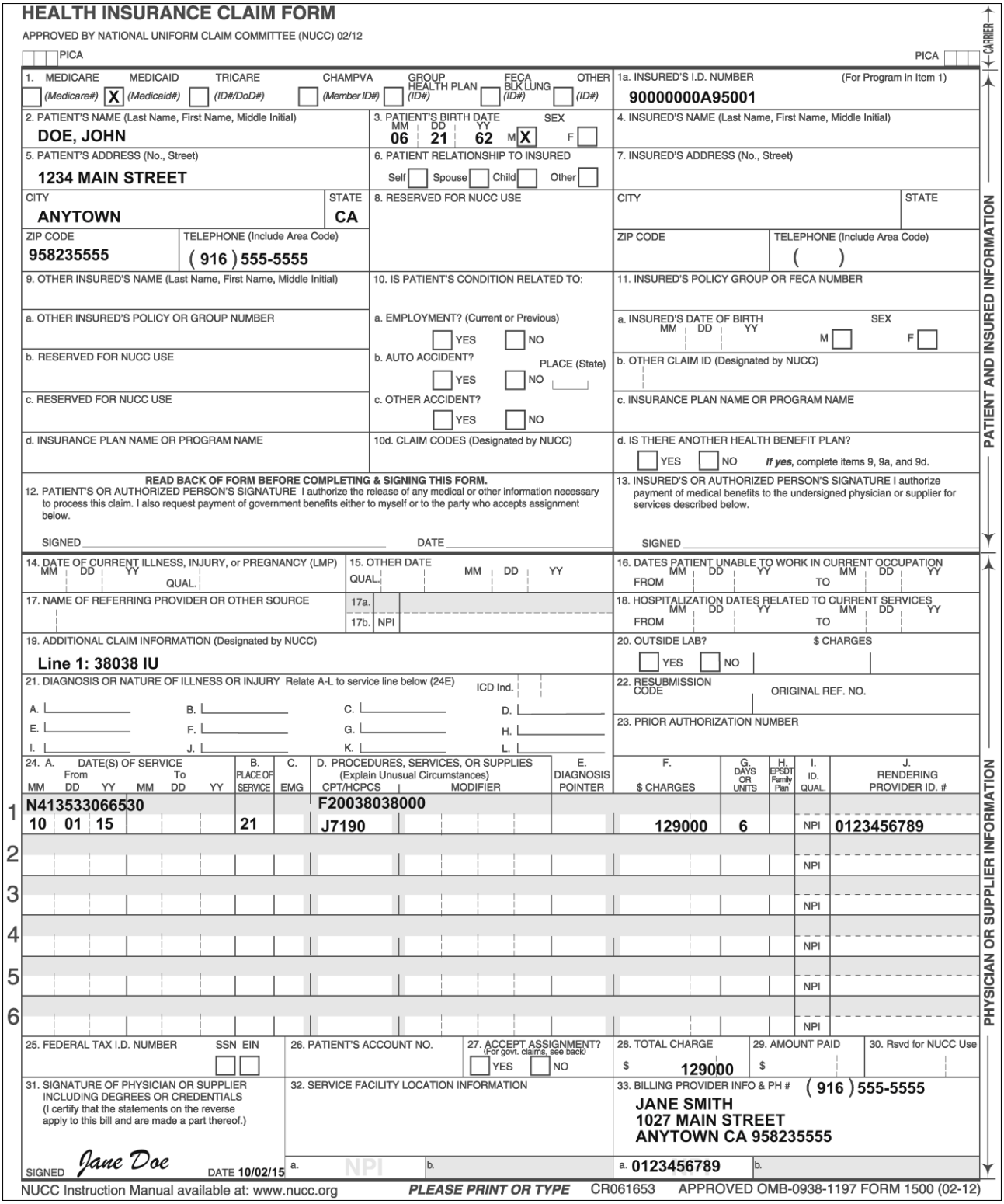
1. The unit of measure and numeric quantity in the shaded area of Box 24D are optional. Absence of these two elements will not result in claim denial.
2. Blood factor codes (HCPCS codes J7183, J7185, J7186, J7187, J7189, J7190, J7192 thru J7195, J7197 and J7198) are reimbursed using the lower of the manufacturer's Average Selling Price (ASP) plus 20 percent or the provider's usual and customary charge.
3. Providers participating as covered entities, and purchasing drugs through the Public Health Service (PHS) program, must not bill more than the actual acquisition cost, as charged by the manufacturer at a price consistent with the PHS program for covered outpatient drugs. Participants may also bill for a dispensing fee or markup, as allowed by Medi-Cal. Entities billing for PHS purchased factor must include the modifier UD in the modifier area (unshaded) of Box 24D.

Enter the date of service, in the six-digit format, in the *Date(s) of Service* field (Box 24A). Enter Place of Service code 21 (inpatient) in Box 24B.

Enter the number of units (vials) of factor administered in the *Days or Units* field (Box 24G).

Reminder: The International units or micrograms represented by the vials dispensed must be entered in the *Additional Claim Information* field (Box 19).

Calculate the charges by multiplying the units per vial by the usual and customary charge (refer to the *Blood and Blood Derivatives* section of this manual). Enter the amount in the *Charges* field (Box 24F).



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) | MEDICAID [X] (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): 90000000A95001

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

3. PATIENT'S BIRTH DATE: 06 21 62 SEX: M [X] F

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 | Spouse | Child | Other

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

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

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 below.

SIGNED _____ 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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Line 1: 38038 IU

20. OUTSIDE LAB? YES | NO $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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 N413533066530 10 01 15	21		F20038038000 J7190			129000	6		NPI	0123456789
2									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) YES | NO

28. TOTAL CHARGE $ 129000

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.)

SIGNED Jane Doe DATE 10/02/15

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 0123456789 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Figure 1: Blood Factors Billed Together on the Same Claim Line.

Separate Manufacturers' Blood Factors Billed on Two Claim Lines

Figure 2 is a sample only. Please adapt to your billing situation.

In this example, the six units (vials) of Factor VIII are billed as two entries on the claim. Enter J7190 (Factor VIII, antihemophilic factor, human, per IU) on claim lines 1 and 2 in the *Procedures, Services or Supplies* field (Box 24D).

The product qualifier (N4) and the National Drug Code (NDC) are required on the claim because antihemophilic factor (AHF) is a "physician-administered" drug. Providers enter the product qualifier/NDC number in the shaded area of Box 24A. The unit of measure and numeric quantity for the AHF is entered in the shaded area of Box 24D. (Refer to section *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions* for help.) Due to the large quantities of AHF dispensed, providers must include the number of international units or micrograms dispensed in the *Additional Claim Information* field (Box 19).

Notes:

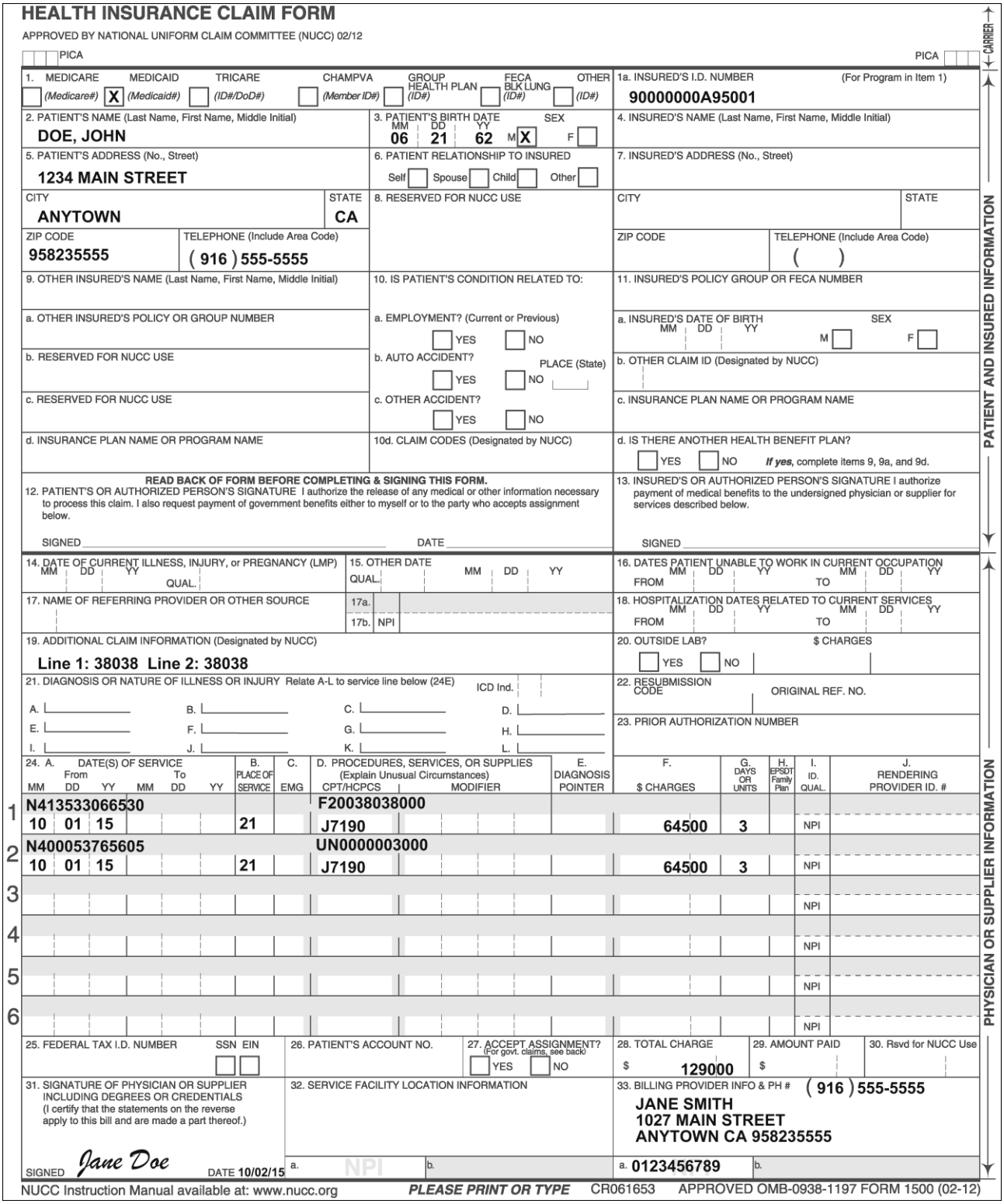
1. The unit of measure and numeric quantity are in the shaded area of Box 24D optional. Absence of these two elements will not result in claim denial.
2. Blood factor codes (HCPCS codes J7183, J7185, J7186, J7187, J7189, J7190, J7192 – J7195, J7197 and J7198) are reimbursed using the lower of the manufacturer's Average Selling Price (ASP) plus 20 percent or the provider's usual and customary charge.
3. Providers participating as covered entities, and purchasing drugs through the Public Health Service (PHS) program, must not bill more than the actual acquisition cost, as charged by the manufacturer at a price consistent with the PHS program for covered outpatient drugs. Participants may also bill for a dispensing fee or markup, as allowed by Medi-Cal. Entities billing for PHS purchased factor must include the modifier UD in the modifier area (unshaded) of Box 24D.

Enter the date of service, in the six-digit format, in the *Date(s) of Service* field (Box 24A). Enter Place of Service code 21 (inpatient) in Box 24B.

Enter the number of (vials) of factor administered in the *Days or Units* field (Box 24G).

Reminder: The International units or micrograms represented by the vials dispensed must be entered in the *Additional Claim Information* field (Box 19).

Calculate the charges by multiplying the units per vial by the provider's usual and customary charge (refer to the *Blood and Blood Derivatives* section of this manual). Enter the amount in the *Charges* field (Box 24F).



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (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): 90000000A95001

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 [X] F [ ]

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 [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

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 below.

SIGNED _____ 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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Line 1: 38038 Line 2: 38038

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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 N413533066530 10 01 15	21		F20038038000 J7190			64500	3		NPI	
2 N400053765605 10 01 15	21		UN0000003000 J7190			64500	3		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) YES [ ] NO [ ]

28. TOTAL CHARGE $ 129000

29. AMOUNT PAID $

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SIGNED Jane Doe DATE 10/02/15

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a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 0123456789 b.

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 2: Blood Factor Products Billed on Separate Claim Lines.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.