

Annotated CMS-1500¹

This annotated claims form may be used as a reference when billing for BRIUMVI and its administration

Field 17b:
Indicate the appropriate NPI number.

Field 21: Indicate the appropriate diagnosis code.

Field 24a: In the shaded area, list the N4 indicator, the 11-digit NDC (e.g., 73150015006), and the unit of measure qualifier (e.g., ML6, ML18). In the non-shaded area, list the date of service.

Field 24D: Enter the appropriate HCPCS code J2329 for BRIUMVI and/or CPT codes as required by the payer. NOTE: For BRIUMVI obtained through a specialty pharmacy, report the drug administration codes here. Check with the payer to identify how to report the drug that was administered if needed.

Field 23: If applicable, report the PA number here.

Field 24G: Include the appropriate number of units for J2329 (i.e., 150 for 150 mg, 450 for 450 mg) and/or CPT code required by the payer and administration duration.

The image shows a standard CMS-1500 Health Insurance Claim Form with several callout boxes. The callouts are:

- Field 17b:** Points to the NPI field in the provider information section.
- Field 21:** Points to the diagnosis code field (21).
- Field 24a:** Points to the shaded area for N4 indicator, NDC, and unit of measure, and the non-shaded area for date of service.
- Field 24D:** Points to the shaded area for HCPCS and CPT codes.
- Field 23:** Points to the prior authorization number field (23).
- Field 24G:** Points to the shaded area for units and CPT code.

 The form includes a QR code, a title 'HEALTH INSURANCE CLAIM FORM', and various fields for patient and insured information, dates, and charges. A vertical label on the right side of the form reads 'CARRIER' at the top, 'PATIENT AND INSURED INFORMATION' in the middle, and 'PHYSICIAN OR SUPPLIER INFORMATION' at the bottom.

The suggestions contained on this form are compiled from sources believed to be accurate for payers, including the Medicare Part B program, but TG makes no representation that the information is accurate or that it will comply with the requirements of any particular payer or MAC. You are solely responsible for determining the billing and coding requirements applicable to any particular 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. TG and its agents make no warranties or guarantees, expressed or implied, concerning the accuracy or appropriateness of this information for any party's 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, Centers for Medicare & Medicaid Services; CPT, Current Procedural Terminology; HCPCS, Healthcare Common Procedure Coding System; IV, Intravenous; MAC, Medicare Administrative Contractor; NOC, Not Otherwise Classified; NPI, National Provider Identification; PA, Prior Authorization.

REFERENCES

1. CMS Forms CMS-1500. CMS.gov. <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500.pdf>. Accessed June 8, 2023.

If you have questions about reimbursement support, contact an Access and Reimbursement Manager or BRIUMVI Patient Support by calling 1-833-BRIUMVI (1-833-274-8684), Monday-Friday 8 AM to 8 PM EST

