Sample CMS-1500 Claim Form for Office Billing: RENFLEXIS[®] (infliximab-abda) for Injection, for Intravenous Use 100 mg

Before prescribing RENFLEXIS, please read the accompanying <u>Prescribing Information</u>, including the Boxed Warning about serious infections and malignancies. <u>The Medication Guide</u> also is available.

Note: See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/Part-B-Biosimilar-Biological-Product-Payment.html for additional guidance from CMS on billing for RENFLEXIS (infliximab-abda), including important information about differences between claims with dates of service on or after April 1, 2018 versus claims with dates of service before April 1, 2018. For questions on billing if a portion of a package is wasted, consult the applicable payer's policy regarding wastage. Record the amount of drug administered and the amount wasted in the patient's medical record. Medicare requires the use of the JW modifier on all claims that include wasted product.

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1. MEDICARE MEDIC/			1 a. INSURED'S I.D. NUMBER (For Progra	im in Item 1)
2. PATIENT'S NAME (Last Nar		3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No.,	Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
5. FATIENT 5 ADDRESS (NO.,	, Sileet)	Self Spouse Child Other	7. INSURED S ADDRESS (NU., SILEEL)	
CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Are	a Code)
				N N N N N N N N N N N N N N N N N N N
J. 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	<u> </u>
. OTHER INSURED'S POLIC	Y OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX	
		YES NO		
D. RESERVED FOR NUCC US	SE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	
. RESERVED FOR NUCC US	SE	c. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME	
		YES NO		ATTENT
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	<u>e</u>
Box 21		le la	YES NO <i>If yes</i> , complete items 9, 9a, 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
		ther information necessary payment of medical benefits to the undersigned physician or supplier for services described below.		or supplier for
Enter appropria	ate diagnosis code(s).			
14. DATE OF CURRENT ILLNI	ESS, IN URY, or PREGNANCY (LMP) 15.	OTHER DATE	SIGNED 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCC MM DD YY MM DD	
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