SAMPLE UB-04/CMS-1450 Claim Form for BAVENCIO® (avelumab) Injection 20 mg/mL

CoverOne®

HOSPITAL OUTPATIENT DEPARTMENT

BOX 42
(837I electronic claim: Loop 2400, Segment type SV2)

List the appropriate revenue code for BAVENCIO.

Revenue code 0636 is required by Medicare. For payers other than Medicare, the revenue code may vary; although some private payers and Medicaid plans accept revenue code 0636, others may require other revenue codes, such as 0250.

Enter an appropriate revenue code for the administration service based on the cost center in which the service is performed.

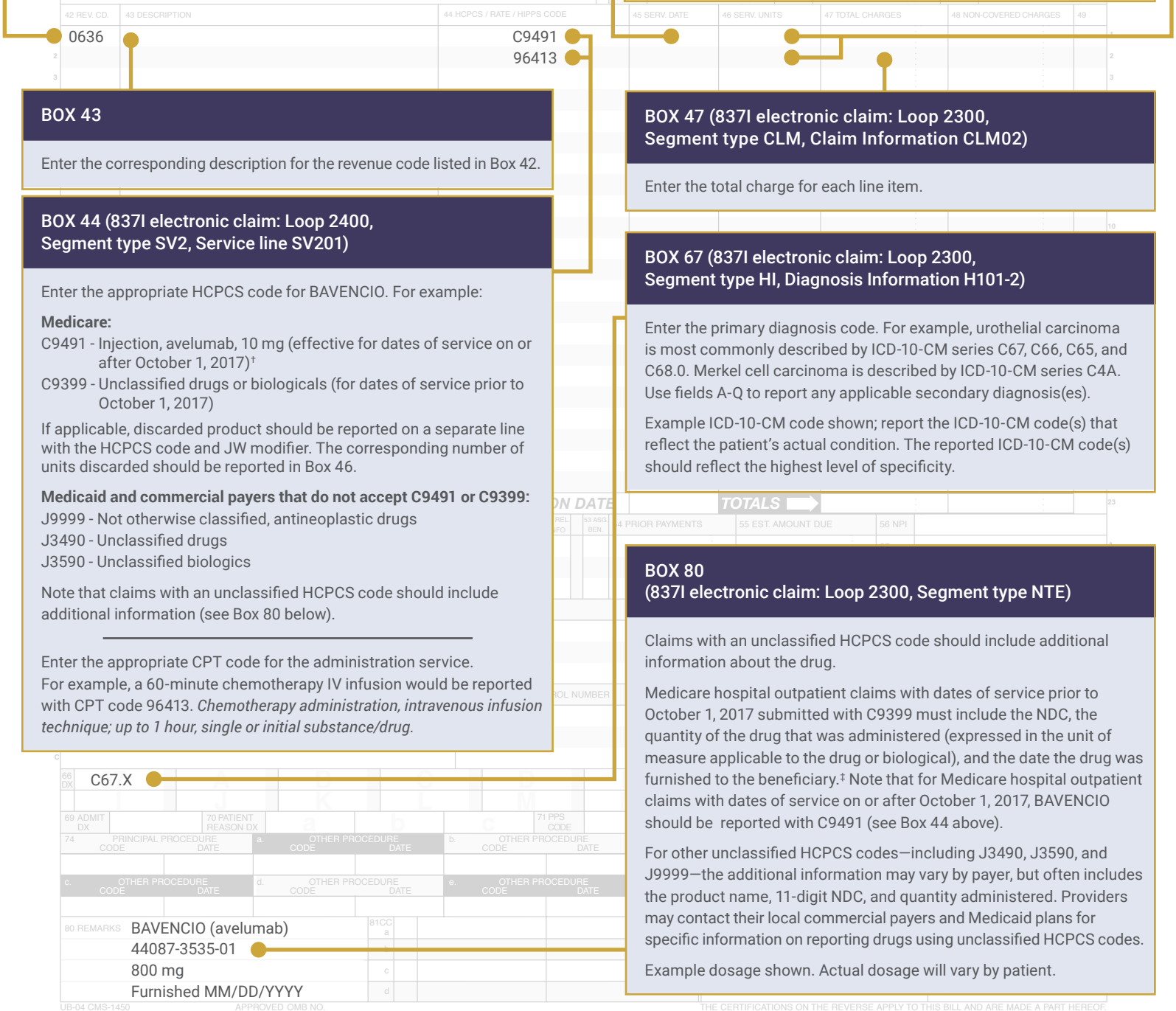
BOX 45
(837I electronic claim: Loop 2400, Segment type DTP)

Enter date of service.

BOX 46 (837I electronic claim: Loop 2400, Segment type SV2, Service line SV205)

Enter the number of service units for each line item. For C9491, each unit corresponds to 10 mg of BAVENCIO. One 200 mg single-dose vial would be reported with 20 units. When billing an unclassified HCPCS code, report a unit of 1.*

For Medicare claims (if applicable), on a separate line, enter the number of units discarded and include the HCPCS code and JW modifier in Box 44.



BOX 43

Enter the corresponding description for the revenue code listed in Box 42.

BOX 44 (837I electronic claim: Loop 2400, Segment type SV2, Service line SV201)

Enter the appropriate HCPCS code for BAVENCIO. For example:

Medicare:

C9491 - Injection, avelumab, 10 mg (effective for dates of service on or after October 1, 2017)†

C9399 - Unclassified drugs or biologicals (for dates of service prior to October 1, 2017)

If applicable, discarded product should be reported on a separate line with the HCPCS code and JW modifier. The corresponding number of units discarded should be reported in Box 46.

Medicaid and commercial payers that do not accept C9491 or C9399:

J9999 - Not otherwise classified, antineoplastic drugs

J3490 - Unclassified drugs

J3590 - Unclassified biologics

Note that claims with an unclassified HCPCS code should include additional information (see Box 80 below).

Enter the appropriate CPT code for the administration service. For example, a 60-minute chemotherapy IV infusion would be reported with CPT code 96413. *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug.*

BOX 47 (837I electronic claim: Loop 2300, Segment type CLM, Claim Information CLM02)

Enter the total charge for each line item.

BOX 67 (837I electronic claim: Loop 2300, Segment type HI, Diagnosis Information H101-2)

Enter the primary diagnosis code. For example, urothelial carcinoma is most commonly described by ICD-10-CM series C67, C66, C65, and C68.0. Merkel cell carcinoma is described by ICD-10-CM series C4A. Use fields A-Q to report any applicable secondary diagnosis(es).

Example ICD-10-CM code shown; report the ICD-10-CM code(s) that reflect the patient's actual condition. The reported ICD-10-CM code(s) should reflect the highest level of specificity.

BOX 80
(837I electronic claim: Loop 2300, Segment type NTE)

Claims with an unclassified HCPCS code should include additional information about the drug.

Medicare hospital outpatient claims with dates of service prior to October 1, 2017 submitted with C9399 must include the NDC, the quantity of the drug that was administered (expressed in the unit of measure applicable to the drug or biological), and the date the drug was furnished to the beneficiary.‡ Note that for Medicare hospital outpatient claims with dates of service on or after October 1, 2017, BAVENCIO should be reported with C9491 (see Box 44 above).

For other unclassified HCPCS codes—including J3490, J3590, and J9999—the additional information may vary by payer, but often includes the product name, 11-digit NDC, and quantity administered. Providers may contact their local commercial payers and Medicaid plans for specific information on reporting drugs using unclassified HCPCS codes.

Example dosage shown. Actual dosage will vary by patient.

*Beginning January 1, 2017, Medicare claims require the use of the JW modifier (drug amount discarded/not administered to any patient) when applicable. (Source: Centers for Medicare and Medicaid Services. Transmittal R3538CP: JW Modifier—Drug amount discarded/not administered to any patient.) Other payers may have similar requirements.

†Centers for Medicare and Medicaid Services (CMS), October 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS), Transmittal 3853, August 25, 2017.

‡Source: Centers for Medicare and Medicaid Services. Claims Processing Manual Chapter 17, Section 90.3.

It is always the provider's responsibility to determine the appropriate healthcare setting and to submit true and correct claims for products and services rendered. EMD Serono, Inc. and Pfizer Inc do not guarantee coverage and/or reimbursement for BAVENCIO. Coverage, coding, and reimbursement policies vary significantly by payer, patient, and setting of care. Actual coverage and reimbursement decisions are made by individual payers following the receipt of claims. Patients and healthcare professionals should always verify coverage, coding, and reimbursement guidelines on a payer- and patient-specific basis.

Please contact CoverOne® at 1-844-8COVER1 (844-826-8371) for support with payer-specific BAVENCIO questions, or assistance verifying insurance benefits for a specific patient.

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