

# CINVANTI® (aprepitant) injectable emulsion

## Sample CMS-1500 Claim Form

### Form locator (FL) 19: NDC number(s)

- CINVANTI (aprepitant), NDC 47426-0201-01 (single-dose vial) 130 mg IV

### FL 21: Diagnosis or nature of illness or injury

Enter the appropriate ICD-10 diagnosis code as documented in the medical record.

#### Examples:

- R11.0 (nausea)
- R11.10 (vomiting, unspecified)
- R11.11 (vomiting without nausea)
- R11.12 (projectile vomiting)
- R11.13 (vomiting of fecal matter)
- R11.14 (bilious vomiting)
- R11.2 (nausea with vomiting, unspecified)
- T45.1X5\* (adverse effects of antineoplastic and immunosuppressive drugs)
- Z41.9\* (encounter for other procedures for purposes other than remedying health state)
- Z51.11\*† (encounter for antineoplastic chemotherapy)

\*Supplementary Classification Code

†Required when given within 48 hours of moderately or highly emetogenic chemotherapy

### FL 24D: Procedures, services, or supplies

Enter the appropriate HCPCS and CPT codes.

#### Examples:

- J0185 (Injection, aprepitant, 1 mg)
- 96367 (intravenous infusion, for therapy, prophylaxis, or diagnosis; additional sequential infusion of a new drug/substance, up to 1 hour)
- 96375 (Therapeutic, prophylactic or diagnostic IV push, new substance/ drug)

Other administration codes may be applicable.

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER  
(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

8. RESERVED FOR NUCC USE

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

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.)

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? \$ CHARGES YES NO

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

22. SUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) D. UNITS E. DIAGNOSIS POINTER F. \$ CHARGES G. \$ UNITS H. \$ UNITS I. \$ UNITS J. REFERRING PROVIDER ID #

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Rcvd 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 #

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

### FL 24G: Days or units

Enter the appropriate number of units.

#### Example:

- Enter 130 for a single-dose vial containing 130 mg/18 mL aprepitant injectable emulsion

This document is provided for your guidance only. Coding requirements may vary by payer; please consult the payer to determine which codes are required.

Please contact Heron Connect at **1-844-HERON11 (1-844-437-6611)** from 8 AM to 8 PM ET, Monday through Friday, to verify coding and claim information.