Sample CMS-1500 Claim Form for Office Billing: KEYTRUDA QLEX™ (pembrolizumab and berahyaluronidase alfa-pmph) Injection 165 mg + 2,000 units/mL

Note: Please visit CMS.gov and contact other payers to obtain guidance on billing and coding for single-use vials and packages and wastage, including the appropriate use of the JW and JZ modifiers. Record the amount of drug administered and the amount wasted in the patient's medical record.

HEALTH INSURANCE CLAIM FORM

	VED BY NA	TIONAL U	NIFORM	CLAIM	COMMIT	TEE (N	UCC) 02	2/12																PICA		1
	EDICARE	MEDIO	_	_	CARE (DoD#)		_ `	MPVA	GRC HEA	LTH PL/	AN	FECA BLK LU (ID#)	JNG0		a. INS	URED'S I	.D. NU	MBEF	3			(For	Progran	n in Item	1)	<u></u>
Ш.	edicare#) IENT'S NAN	<u> </u>		<u>」` </u>		itial)	(wiem		(ID#)	'S BIRTI	H DATE	(IU#)	SEX	D#) 4	. INSU	IRED'S N	AME (L	ast N	ame,	First N	lame,	Middle	Initial)			-
									MM DD YY M F																	
5. PATI	5. PATIENT'S ADDRESS (No., Street)									6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other							7. INSURED'S ADDRESS (No., Street)									
CITY							STA		RESERV] Other		CITY									STATE		z
								rea Code)																	VT10	
	ZIP CODE TELEPHONE (Include Area Code) () O OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)								10. IS PATIENT'S CONDITION RELATED TO:							ZIP CODE TELEPHONE (Include Area C										AND INSURED INFORMATION
9. OTH	IER INSURE	D'S NAME	E (Last Na	ame, Fir	st Name,	Middle	Initial)	10.	IS PATIE	ENT'S C	ONDITIO	ON REI	LATED TO:	1	1. INS	URED'S F	POLICY	/ GRC	OUP C	R FE	CA NU	JMBER				Z
a. OTH	IER INSURE	D'S POLIC	CY OR GI	ROUP N	IUMBER			a.	EMPLOY	MENT?	•		vious)	a	ı. INSU	JRED'S DA	ATE OI	F BIR	TH Y		М		SEX	F]	SURE
b. RES	ERVED FO	R NUCC U	JSE					b	AUTO AC				PLACE (S	State) b	. OTH	IER CLAII	M ID (D	esign)	ated b	y NU	CC)					=
	EDVES = -								OT	YE		1	10	ı Ĺ												TAN
c. RES	ERVED FOR	NUCC U	SE					C.	OTHER A		NT? ES		10	C	. INSU	RANCE F	'LAN N	IAME	OR P	HOGF	RAM N	NAME				PATIENT
d. INSU	JRANCE PL	AN NAME	OR PRO	GRAM	NAME			100	d. CLAIM					c	I. IS TH	HERE AND	OTHER	RHEA	LTH E	BENER	FIT PL	AN?				PAT
																YES		NO	lf :	yes , o	omple	te items	9, 9a,	and 9d.		Ji.
to p	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 necessa to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											sary 1	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.													
SIG	NED	DENT II I	VECC IN	II IDV -	- DDEON	IANOV	(LMD)	45 OTI		ATE						GNED			F TO		(IN 0	UDDE!	IT 000	UDATIO		¥
MM	TE OF CUR	YY	QUAL.	JUNT, 0	" FREGIN	IANCY	(LIVIP)	QUAL.	ER DATE	-	MM !	DD	YY		6. DAT	TES PATII MM DM	DD	NABL	FYY	vvORI	K IN C	MM	DD	UPATIOI Y	Ϋ́	
17. NA	ME OF REF	ERRING F		R OR O	THER SO	DURCE		17a.						1		SPITALIZA MM ,	ATION DD	DATE	S RE	LATE			NT SEI	RVICES	Y	11
10. 40	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										FROM TO 20, OUTSIDE LAB? \$ CHARGES											-				
19. AD	UNAL C	LATIVI IINF	UNIVIA I IC	νιν (DeS	ignateu D	y NUCC	٠)							2	.0. 00	YES		NO			ş C	HARGE	.5			
21. DIA	AGNOSIS OI	R NATURE	E OF ILLN	IESS OI	R INJURY	/ Relat	e A-L to	service li	ne below	(24E)	ICD Ir	nd.		2	2. RES	SUBMISS				BIGIA	JAI P	EE NO				1
А. L			В.			_		с. L					D. L					ORIGINAL REF. NO.						4		
E. L	F. L.							G		_		н. 🗀		— ²	3. PRI	OR AUTH	IORIZA	TION	NUM	BER						
1. <u></u>) OF SER			B.		D. PR		RES, SER			L. L PLIES	E			F.		G.		H. PSDT	I.			J.		z
MM	From DD Y	′ MM	To DD	YY	PLACE OF SERVICE	EMG		Explain U HCPCS	nusual Ci		nces) DIFIER		DIAGN		\$ C	HARGES		DAY OR UNIT	S F	amily	ID. QUAL.			IDERING IDER ID.		SUPPLIER INFORMATION
																		4			NPI					Ö
		I														!	-			-						Ž
			i								<u> </u>							\dashv			NPI					Ë
																				-	 NPI					占
	,	T	,				1		1		,	,														œ
	-		-																		NPI					N O
																				+	 NPI					CIC
			!													1					 NPI					PHYSICIAN
25. FE	DERAL TAX	I.D. NUMI	BER	SSN	I EIN	26.	PATIEN	T'S ACC	I ON TNUC).		CEPT A govt. cla	ASSIGNMEI ims, see back		28. TO	TAL CHAF	RGE		29. A		NT PA	JD !	30. Rs	svd.for Nl	UCC Use	
INC (I c	GNATURE O CLUDING DE ertify that the ply to this bill	GREES C statemer	OR CRED nts on the	ENTIAL reverse	S	32.	SERVIC	E FACILI	TY LOCA	ATION IN	IFORMA	ATION		3	3. BILI	LING PRO	DVIDER	R INFO	O & PI	H#	()				1
						-		NIE.									-									41

The suggestions contained on this form are compiled from sources believed to be accurate for the Medicare Part B program, but Merck makes no representation that the information is accurate or that it will comply with the requirements of any particular Medicare Administrative Contractor (MAC) or payer. You are solely responsible for determining the billing and coding requirements applicable to any 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. Merck and its agents make no warranties or guarantees, expressed or implied, concerning the accuracy or appropriateness of this information for your 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.

PLEASE PRINT OR TYPE

US-PDS-00140 09/25

• Some payers may require drug name, route of administration, NDC, and/or dosage to be provided in Box 19. Check with your payer to verify requirements

BOX 21

BOX 24 D• Use J3590, J9999, J3490, or C9399

(pembrolizumab and berahyaluronidase

 These miscellaneous codes are for use until a unique HCPCS code is assigned

• The administration time corresponds to

• Enter appropriate diagnosis code(s)

to bill for KEYTRUDA QLEX™

to KEYTRUDA QLEX

CPT code 96401

alfa-pmph)

BOX 24 E

 Record the relevant diagnosis pointer from Box 21

BOX 24 G

- Enter the appropriate number of units used
- On a separate line, enter the appropriate number of units of waste (if applicable) using the JW or JZ modifiers as appropriate