Injections: Billing Example for CMS-1500

Page updated: March 2026

This section is to assist providers in completing the *CMS-1500* claim form for injections. ‹‹For detailed policy information, refer to the *List of Physician-Administered Drugs and HCPCS Codes* and *Injections: Hydration* sections of this manual.››

Refer to the *CMS-1500 Completion* section of this manual for instructions to complete claim fields not explained in the following example. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Billing Tips: When completing claims, do not enter the decimal points in ICD-10-CM codes or dollar amounts. If requested information does not fit neatly in the *Additional Claim Information* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Weekly Injections

Figure 1. Billing example for weekly injections.

This is a sample only. Please adapt to your billing situation.

In this example, the injection is administered once a week for two weeks. The first injection is administered on August 10, 2014, and the second injection is administered on August 17, 2014.

Claim Line 1: First Injection

Enter the date the first injection is administered on claim line 1 in the *Date(s) of Service* field (Box 24A under “From”) as “081014.”

Enter Place of Service code “11” (office) in Box 24B and the usual and customary charges in the *Charges* field (Box 24F). Enter a “180” in the *Days or Units* field (Box 24G).

Claim Line 2: Second Injection

Enter the date the second injection is administered on claim line 2 in the *Date(s) of Service* field (Box 24A under "From") as "081714."

Enter Place of Service code "11" (office) in Box 24B and the usual and customary charges in the *Charges* field (Box 24F). Enter a "180" in the *Days or Units* field (Box 24G).

The name of the drug and the dates administered are referenced in the *Additional Claim Information* field (Box 19) or on an attachment to the claim.

Physician-Administered Drug Requirements: Claim Lines 1 and 2

Because the injections are considered "physician-administered" drugs, providers must enter the two-character product qualifier and 11-digit National Drug Code (NDC). The NDC unit of measure qualifier and numeric quantity are entered in the shaded areas above Boxes 24A and 24D. Instructions to complete these fields are included in the *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions* section in this manual.

Note: Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial. Claims for vaccines do not require an NDC. Also, payment for bulk drugs is not allowed. Bulk drugs are Active Pharmaceutical Ingredients (APIs) that are represented for use in the drug and that when used in the manufacturing, processing or packaging of a drug, become an active ingredient of the drug product. APIs are distributed in a form (for example, a kilogram of powder) that does not meet the definition of a covered outpatient drug product by both the federal Food and Drug Administration according to the *Food, Drug, and Cosmetic Act,* Section 505, and Section 1927(k)(2) of the *Social Security Act*. (An example of such a bulk drug would be pharmaceutically active ingredients combined into a pharmaceutical product/formulation, whether the products are combined by the provider or ordered from a compounding pharmacy.)

Figure 1. **"From-Through" Billing Example for Weekly Injections**

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

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

3. PATIENT'S BIRTH DATE MM DD YY: 06 21 62 SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 985235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE: TELEPHONE (Include Area Code): ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

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 necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

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

SIGNED _____

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 MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): INJECTION ADMINISTERED: 08/10/14 AND 08/17/14

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

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

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 QUALIFIER + 11-DIGIT NDC 08 10 14		11		UNIT QUALIFIER + QUANTITY PROCEDURE CODE			9000	180		NPI	
2 QUALIFIER + 11-DIGIT NDC 08 17 14		11		UNIT QUALIFIER + QUANTITY PROCEDURE CODE			9000	180		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 18000

29. AMOUNT PAID $

30. Rsvd 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.)

SIGNED Jane Doe DATE 8/30/14

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 0123456789 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

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‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.