ROSTER BILLING Job Aid

Introduction

Roster billing was developed as a simplified process to providers to perform mass vaccination programs.

Properly licensed individuals and groups conducting mass immunization programs may submit claims using the roster billing format to bill for vaccines if they agree to accept assignment for these claims. Providers that utilize roster billing must accept assignment and may not collect any “donation” or other cost sharing of any kind from the Medicare beneficiaries for these immunizations.

Provider Enrollment Criteria

Entities and individuals that want to provide mass immunization services but may not otherwise be able to qualify as a Medicare provider, may be eligible to enroll as a provider type “Mass Immunizer.” They must complete the CMS 855 form to enroll with the Medicare contractor. Once enrolled as a Mass Immunizer they must roster bill and accept assignment. No other services may be billed to Medicare by these providers except the vaccine(s) and their administrations. Visit our Provider Enrollment (https://www.cgsmedicare.com/partb/enrollment/index.html) Web page for additional information.

Completing the CMS 1500 and the Roster Form

Providers must complete a CMS-1500 claim form for each completed roster submitted. Only one vaccine may be submitted per claim and roster form.

NOTE: If other services were furnished to a beneficiary along with the vaccine, the provider must submit claims using normal billing procedures (filing the CMS-1500 or electronic billing for each patient).

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Each of the following fields must be completed for roster billing:	
Item 1:	Place an "X" in the Medicare box
Item 2: (Patient's Name)	"See Attached Roster"
Item 11: (Insured's Policy Group or FECA Number)	"None"
Item 20: (Outside lab)	Place an "X" in the NO box
Item 21: (Diagnosis)	ICD-10 Z23 - Encounter for Immunization (Additional ICD-10 codes may apply.)
Item 24B (Place of Service)	Use the 2-digit place of service code “60” Note: POS code “60” must be used for roster billing
Item 24D: (Procedures, Services or Supplies)	Influenza Virus: Line 1 - Appropriate influenza virus vaccine CPT or HCPCS code Line 2 - G0008 (administration of the flu vaccine) **OR** PPV: Line 1 - Appropriate pneumococcal virus vaccine CPT or HCPCS code Line 2 - G0009 (administration of PPV)
Item 24E: (Diagnosis code pointer)	Lines 1 and 2: "1"
Item 24F: ($ Charges)	**The provider must enter the charge for each listed service.** If the provider is not charging for the vaccine or its administration, they should enter $0.00 or NC (no charge) on the appropriate line for that item.
Item 27: (Accepting Assignment)	Place an "X" in the YES box.
Item 29: (Amount Paid)	"$0.00"
Item 31: (Signature of Provider or Supplier)	The provider or a representative of the provider must sign.
Item 32: (Name and Address of the Facility)	Item 32 must be completed to report the name, address and ZIP code of the location where the service was provided.
Item 33: Provider's/ Supplier's Billing Name and Address)	Item 33 must be completed to report the name and address of the billing provider.
Item 33A: Provider's/ Supplier's NPI	The NPI of the billing provider should be reported in this field.

Completing the Attached Roster Form

Qualified billers must attach a roster (https://www.cgsmedicare.com/pdf/j15/j15_roster_billing_form.pdf) that contains the claims information for supplier of the service and the individual beneficiaries. Provider’s may make their own roster form, but at the minimum, the roster must contain:

- Provider name and NPI
- Control No. This is a CMS requirement for the form. Providers/Suppliers should NOT enter any information in this field.
- Date of service (Note: Although providers who provide immunizations may roster bill if they vaccinate fewer than five beneficiaries per day, they must include the individual date of service for each beneficiary’s vaccination on the roster form.)
- Patient’s Medicare MBI
- Patient’s name
- Patient’s address
- Date of birth
- Patient’s gender (M or F)
- Beneficiary’s signature or stamped “Signature on File”

MAILING ADDRESS:
J15 — Part B/HHH Claims
CGS Administrators, LLC
PO Box 20019
Nashville, TN 37202

The Centers for Medicare & Medicaid Services has a dedicated Web page for the influenza season. Visit the CMS website (https://www.cms.gov/medicare/payment/all-fee-service-providers/medicare-part-b-drug-average-sales-price/vaccine-pricing) to get the most up to date list of billing codes, effective dates, and payment allowances.

Additional CMS Resources

- Roster Billing for Mass Immunizers: https://www.cms.gov/roster-billing
- Medicare Preventive Services Chart: https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html
- National Uniform Claim Committee (CMS-1500): https://nucc.org/index.php/1500-claim-form-mainmenu-35

Originated October 16, 2020 | Revised March 15, 2024 |

ROSTER BILLING

Job Aid

Sample CMS 1500 form shown at right, and at:

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500.pdf

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) MEDICAID (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)

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)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

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? YES NO PLACE (State)

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 TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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										NPI	
2										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 $

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 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

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