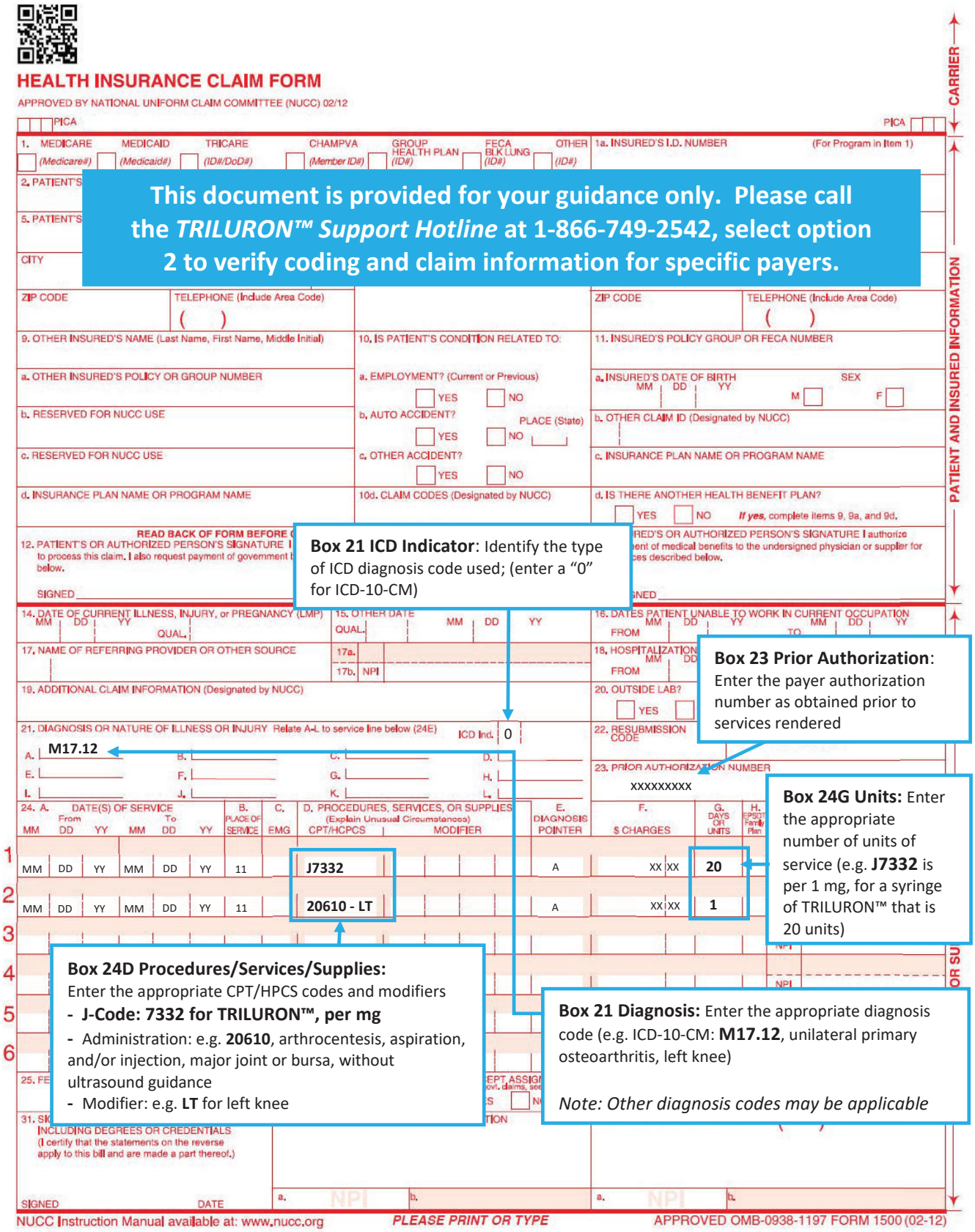
SAMPLE CMS-1500 CLAIM FORM FOR TRILURON™
(SODIUM HYALURONATE)



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

5. PATIENT'S

CITY

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

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE to process this claim. I also request payment of government below.

SIGNED

RED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize ent of medical benefits to the undersigned physician or supplier for ces 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 MM DD FROM

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M17.12 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER xxxxxxxxx

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
1 MM DD YY	MM DD YY	11		J7332		A	XX XX	20	
2 MM DD YY	MM DD YY	11		20610 - LT		A	XX XX	1	
3									
4									
5									
6									

25. FE EPT ASSIGN ovt. claims, see S N

31. SI INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) TION

SIGNED DATE

a. NPI b.

a. NPI b.

NPI

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

This document is provided for your guidance only. Please call the *TRILURON™ Support Hotline* at 1-866-749-2542, select option 2 to verify coding and claim information for specific payers.

Box 21 ICD Indicator: Identify the type of ICD diagnosis code used; (enter a "0" for ICD-10-CM)

Box 23 Prior Authorization: Enter the payer authorization number as obtained prior to services rendered

Box 24G Units: Enter the appropriate number of units of service (e.g. **J7332** is per 1 mg, for a syringe of TRILURON™ that is 20 units)

Box 24D Procedures/Services/Supplies:
Enter the appropriate CPT/HPCS codes and modifiers
- **J-Code: 7332 for TRILURON™, per mg**
- Administration: e.g. **20610**, arthrocentesis, aspiration, and/or injection, major joint or bursa, without ultrasound guidance
- Modifier: e.g. **LT** for left knee

Box 21 Diagnosis: Enter the appropriate diagnosis code (e.g. ICD-10-CM: **M17.12**, unilateral primary osteoarthritis, left knee)

Note: Other diagnosis codes may be applicable

TRILURON™
sodium hyaluronate