

# Miscellaneous Coding & Billing Reference Guide

## Example CMS-1500 Claim Form - Physician Office Setting

This example form is provided for guidance and reference only.

ZYNYZ® (retifanlimab-dlwr) and the associated services provided in the physician's office are billed on the CMS-1500 Claim Form or its electronic equivalent. An example CMS-1500 Claim Form for billing ZYNYZ is provided below. It is always the provider's responsibility to determine the appropriate healthcare setting, and to submit true and correct claims for the products and services rendered. **Incyte cannot guarantee payment of any claim and providers should contact third-party payers for specific information on their coding, coverage, and payment policies as needed.**

### Box 19

Payers require drug name, route of administration, NDC, and total dosage

Check with your payer to verify specific requirements, including use of the 10-digit or 11-digit NDC

### Box 21

Enter appropriate diagnosis code(s)

### Box 24 A-B

Enter the date of service and the appropriate place of service code

### Box 24 D

Enter the appropriate drug and administration codes, for example:

- Drug - J9345 (Injection, retifanlimab-dlwr, 1 mg), effective 10/01/2023
- Administration - 96413

**Note:** Include the JZ modifier if no amount of drug was discarded

### Box 24 E

Specify the diagnosis, from Box 21, that relates to the drug or procedure listed in Box 24 D

### Box 24 G

Enter the number of service units for each line item

### HEALTH INSURANCE CLAIM FORM

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

|                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                                                                |  |                                                                                                                                                               |  |                                                                                  |  |                     |  |                    |  |                        |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|---------------------|--|--------------------|--|------------------------|--|
| PICA <input type="checkbox"/>                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  |  |  | PICA <input type="checkbox"/>                                                                                                                                  |  |                                                                                                                                                               |  |                                                                                  |  |                     |  |                    |  |                        |  |
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>                      |  |  |  |  |  |  |  |  |  |  |  | 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                                                                                                                               |  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)                                                                                                     |  |                                                                                  |  |                     |  |                    |  |                        |  |
| 5. PATIENT'S ADDRESS (No., Street)                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  |  |  | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> |  | 7. INSURED'S ADDRESS (No., Street)                                                                                                                            |  |                                                                                  |  |                     |  |                    |  |                        |  |
| CITY                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  |  |  | 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 <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  | a. INSURED'S DATE OF BIRTH MM DD YY                                                                                                                           |  | SEX M <input type="checkbox"/> F <input type="checkbox"/>                        |  |                     |  |                    |  |                        |  |
| b. RESERVED FOR NUCC USE                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |  |  | b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                     |  | b. OTHER CLAIM ID (Designated by NUCC)                                                                                                                        |  | c. INSURANCE PLAN NAME OR PROGRAM NAME                                           |  |                     |  |                    |  |                        |  |
| c. RESERVED FOR NUCC USE                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |  |  | c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                    |  | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                             |  | # yes, complete items 9, 9a, and 9d.                                             |  |                     |  |                    |  |                        |  |
| d. INSURANCE PLAN NAME OR PROGRAM NAME                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |  |  | 10d. CLAIM CODES (Designated by NUCC)                                                                                                                          |  | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. |  |                                                                                  |  |                     |  |                    |  |                        |  |
| 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.              |  |  |  |  |  |  |  |  |  |  |  | 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL. MM DD YY                                                                                         |  | 15. OTHER DATE QUAL. MM DD YY                                                                                                                                 |  | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY |  |                     |  |                    |  |                        |  |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  |  |  | 17a. NPI                                                                                                                                                       |  | 17b. NPI                                                                                                                                                      |  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY  |  |                     |  |                    |  |                        |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD-10-CM                                                                                                                                                                         |  |  |  |  |  |  |  |  |  |  |  | 22. RESUBMISSION CODE                                                                                                                                          |  | 23. PRIOR AUTHORIZATION                                                                                                                                       |  | 24 G. ORIGINAL REF. NO.                                                          |  |                     |  |                    |  |                        |  |
| 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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DATES OF SERVICE H. CHARGE UNITS I. NO. OF UNITS J. RENDERING PROVIDER ID # |  |  |  |  |  |  |  |  |  |  |  | 25. FEDERAL TAX I.D. NUMBER SSN EIN                                                                                                                            |  | 26. PATIENT'S ACCOUNT NO.                                                                                                                                     |  | 27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 28. TOTAL CHARGE \$ |  | 29. AMOUNT PAID \$ |  | 30. Rev'd 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 #                                                                                                                              |  |                                                                                  |  |                     |  |                    |  |                        |  |
| SIGNED DATE                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  |  |  | a. NPI                                                                                                                                                         |  | b. NPI                                                                                                                                                        |  | a. NPI                                                                           |  | b. NPI              |  |                    |  |                        |  |

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

NDC - National Drug Code.

**ZYNYZ**<sup>®</sup>  
retifanlimab-dlwr  
Injection 500 mg



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