

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 - J9999
- Administration - 96413

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

<input type="checkbox"/> PICA PICA <input type="checkbox"/>																				
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) BULKING <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>		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 STATE						8. RESERVED FOR NUCC USE		CITY STATE												
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"/>												
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>												
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		b. OTHER CLAIM ID (Designated by NUCC)												
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME												
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 _____						SIGNED _____ DATE _____														
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 19 QUAL						15. OTHER DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY												
17a. 17b. 17c. 17d.						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES \$																				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 24 A-B 24 D 24 E 24 G																				
22. RESUBMISSION CODE ORIGINAL REF. NO.																				
23. PRIOR AUTHORIZATION																				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE EMG			C. PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS) MODIFIER			D. DIAGNOSIS POINTER			E. CHARGES \$			F. DATE OF LIMITS			G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.		
25. FEDERAL TAX I.D. NUMBER SSN EIN																				
26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For print, circle on back) YES <input type="checkbox"/> NO <input type="checkbox"/>																				
28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Revid for NUCC Use																				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If 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.														

NUCC Instruction Manual available at: www.nucc.org

NDC - National Drug Code.



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