

# 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

<input type="checkbox"/> PICA <span style="float: right;">PICA <input type="checkbox"/></span>											
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#) BK/LUNG <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) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )						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 ZIP CODE TELEPHONE (Include Area Code) ( )			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM   DD   YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>			
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 _____											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 19   10   01 QUAL _____						15. OTHER DATE MM   DD   YY QUAL _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM   DD   YY TO MM   DD   YY			
17a. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17b. NPI _____						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? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____											
22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____											
24. A. DATE(S) OF SERVICE From MM   DD   YY To MM   DD   YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DATES CR LIMITS H. POSITIVE I. ID, QUAL. J. RENDERING PROVIDER ID, #											
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. NPI a. NPI b.											

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

NDC - National Drug Code.

