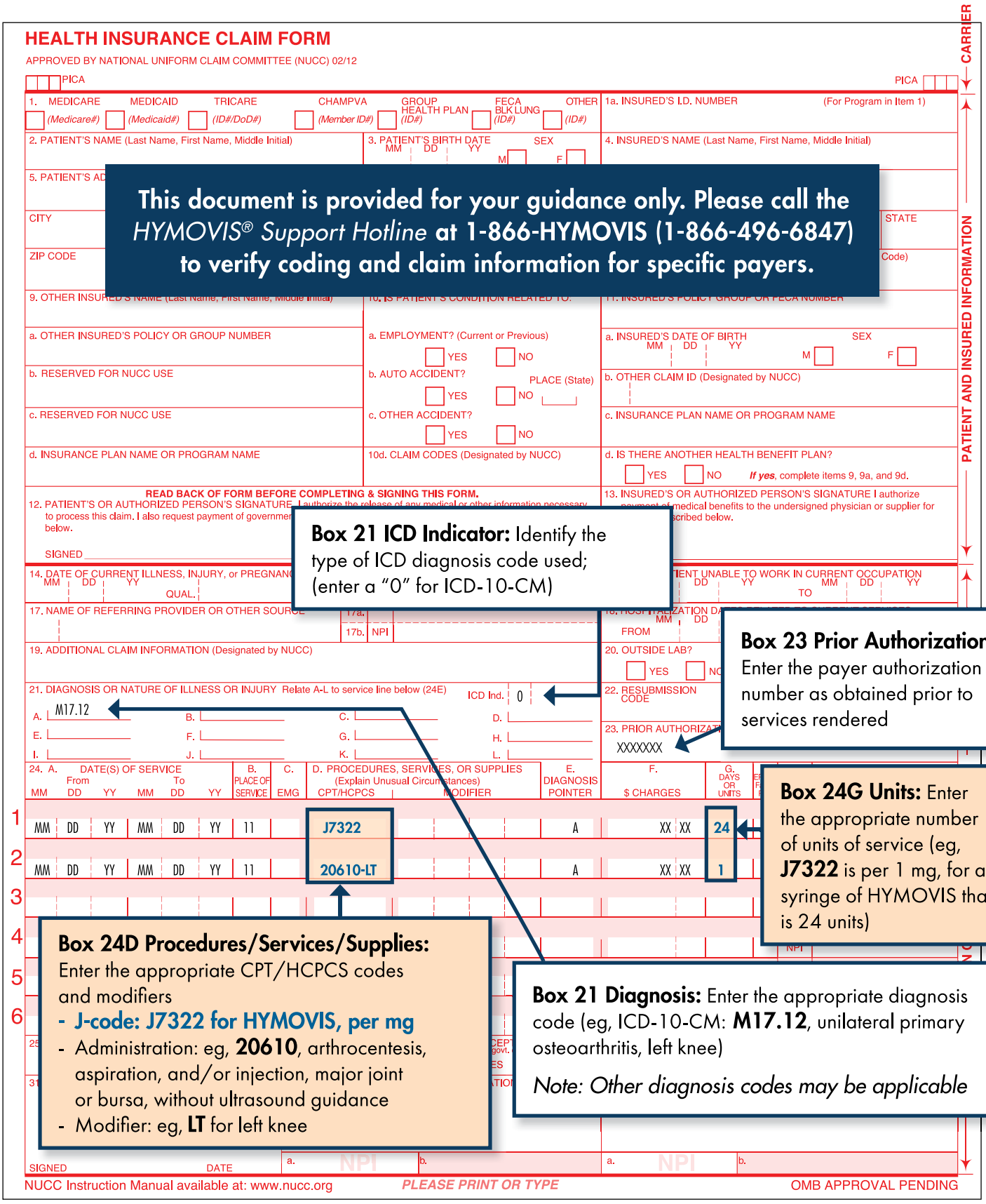
SAMPLE CMS-1500 CLAIM FORM FOR HYMOVIS®®

(HIGH MOLECULAR WEIGHT VISCOELASTIC HYALURONAN)



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 AD

CITY

STATE

ZIP CODE

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 governmen below.

SIGNED

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for scribed below.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANC MM DD YY QUAL.

TIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

HOSPITALIZATION DA MM DD FROM

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO

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 AUTHORIZATI XXXXXXX

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	
1	MM	DD	YY	MM	DD	YY	11		J7322	A	XX XX	24	
2	MM	DD	YY	MM	DD	YY	11		20610-LT	A	XX XX	1	
3													
4													
5													
6													

25.

31.

SIGNED DATE

a. NPI b.

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

OMB APPROVAL PENDING

CARRIER

PATIENT AND INSURED INFORMATION

This document is provided for your guidance only. Please call the *HYMOVIS® Support Hotline* at 1-866-HYMOVIS (1-866-496-6847) 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 (eg, **J7322** is per 1 mg, for a syringe of HYMOVIS that is 24 units)

Box 24D Procedures/Services/Supplies: Enter the appropriate CPT/HCPCS codes and modifiers

- **J-code: J7322 for HYMOVIS, per mg**
- Administration: eg, **20610**, arthrocentesis, aspiration, and/or injection, major joint or bursa, without ultrasound guidance
- Modifier: eg, **LT** for left knee

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

Note: Other diagnosis codes may be applicable