The codes listed are for general information, are subject to change, and may not apply to all patients or all insurers. The information provided is not intended to suggest any manner in which you can increase or maximize reimbursement from any payer or efficacy of the product. Bausch + Lomb does not guarantee that the use of these codes will result in reimbursement.

Providers should use their clinical judgment when selecting codes and submitting claims to accurately reflect the services and products provided to a specific patient.

**NOTE:**
For Medicare, Medicaid, and government payers, use of the CMS-1500 claim form may be appropriate for treatment with RETISERT in a non-institutional ASC. For commercial claims, please consult with the applicable third-party payer.

Payers may require use of the electronic version of the CMS-1500 (837P).

**Box 19**
Some payers may ask providers to specify the NDC code in addition to product brand and generic name, dose, and route of administration

**Box 21**
Enter the appropriate ICD-10-CM code for the patient's diagnosis/condition

**Box 24D**
Enter the CPT® code 67027. Enter CPT® modifiers 25, and LT or RT, as appropriate[1]

**Box 24D**
Use HCPCS code J7311 to represent RETISERT[2]

## Sample CMS-1500 Claim Form for Billing in a Non-institutional Ambulatory Surgery Center (ASC)

HEALTH INSURANCE CLAIM FORM

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

PICA　　　　　　　　　　　　　　　　　　　　　　　　　　PICA

CARRIER

1. MEDICARE [X] (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): 000-00-1234

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John B.

3. PATIENT'S BIRTH DATE MM DD YY: 07 01 45　SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, John B.

5. PATIENT'S ADDRESS (No., Street): 3914 Spruce Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 3914 Spruce Street

CITY: Anytown　STATE: AS

8. RESERVED FOR NUCC USE

CITY: Anytown　STATE: AS

ZIP CODE: 01010　TELEPHONE (Include Area Code): (203) 555-1234

ZIP CODE: 01010　TELEPHONE (Include Area Code): (203) 555-1234

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: Medicare

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 government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

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

SIGNED ______

PATIENT AND INSURED INFORMATION

SAMPLE

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　TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr. Jones　17a.　17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM　TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [ ] NO　$ CHARGES

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

A. ____ B. ____ C. ____ D. ____
E. ____ F. ____ G. ____ H. ____
I. ____ J. ____ K. ____ L. ____

22. RESUBMISSION CODE　ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 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 | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 01 02 21 | 01 02 21 | | | 67027 | | | | | | NPI | |
| 01 02 21 | 01 02 21 | | | J7311 | | | | 59 | | NPI | |
| 01 02 21 | 01 02 21 | | | | | | | | | NPI | |
| 01 02 21 | 01 02 21 | | | | | | | | | NPI | |
| | | | | | | | | | | NPI | |
| | | | | | | | | | | NPI | |

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER　SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd 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.)

SIGNED ______ DATE ______

32. SERVICE FACILITY LOCATION INFORMATION　a.　b.

33. BILLING PROVIDER INFO & PH #: (203) 987-6543
Dr. Jones
4231 Center Road
Anytown, AS 01010
a. 123 456 7890　b.

NUCC Instruction Manual available at: www.nucc.org　*PLEASE PRINT OR TYPE*　APPROVED OMB-0938-1197 FORM 1500 (02-12)

**Box 24G**
Each RETISERT implant should be billed as 59 units using J7311[3]

**For full Prescribing Information, click here or see accompanying full Prescribing Information.**

**See reverse for Sample UB-04 Claim Form.**


**References: 1.** *CPT® 2021 Professional Edition*. United States; American Medical Association; 2020. **2.** *HCPCS Level II 2021 Professional*. United States; American Medical Association; 2020. American Medical Association. **3.** July 2021 ASP NDC-HCPCS Crosswalk for Medicare Part B Drugs: Effective July 1, 2021–Sept. 30, 2021. Centers for Medicare & Medicaid Services. Accessed August 30, 2021. https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/2021-asp-drug-pricing-files

Retisert®
(fluocinolone acetonide intravitreal implant) 0.59 mg

# Sample CMS-1500 and UB-04 Claim Forms

## Sample UB-04 Claim Form for Billing in the Hospital Outpatient Department (HOPD) and Institutional Ambulatory Surgery Center (ASC)

**NOTE:**
For Medicare, Medicaid, and government payers, use of the UB-04 claim form may be appropriate for treatment with RETISERT in an institutional ASC. For commercial claims, please consult with the applicable third-party payer.

Payers may require use of the electronic version of the UB-04 (837I).

**Boxes 42 & 43**
Enter the appropriate AHA Revenue Code, along with description

**Box 44**
Enter the CPT® code 67027. Enter CPT® modifiers 25, and LT or RT, as appropriate[1]

**Box 44**
Use HCPCS code J7311 to represent RETISERT[2]

**Box 46**
Each RETISERT implant should be billed as 59 units using J7311[3]

**Box 66**
Enter the appropriate ICD-10-CM code for the patient's diagnosis/condition

**Box 80**
Some payers may ask providers to specify the NDC code in addition to product brand and generic name, dose, and route of administration

SAMPLE

1 Anytown Hospital
160 Main Street
Anytown, Anystate 01010

2 Pay-to-name
Pay-to-address
Pay-to-city/state

3a PAT. CNTL # XX-XXXX
b. MED. REC. # DOE 1234-56
4 TYPE OF BILL
5 FED. TAX NO. 010001010
6 STATEMENT COVERS PERIOD FROM THROUGH
7

8 PATIENT NAME a Jim A. Smith
b Jim A. Smith
9 PATIENT ADDRESS a 29 Maple Ave.
b Anytown c AS d 01234

10 BIRTHDATE 6/28/47
11 SEX
ADMISSION 12 DATE 13 HR 14 TYPE 15 SRC
16 DHR 17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE 30

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38
39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| 0000 | ??? | 67027 | 1-2-21 | | XXX XX | | |
| 0000 | ??? | | | | XXX XX | | |
| 0000 | ??? | J7311 | 1-2-21 | 59 | | | |
| | PAGE ___ OF ___ | CREATION DATE | | TOTALS | | | |

50 PAYER NAME: Medicare
51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | 57 OTHER PRV ID

58 INSURED'S NAME | 59 P.REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX 0 | 000.00 | 68

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL — LAST Jones FIRST John
77 OPERATING NPI QUAL — LAST FIRST
78 OTHER NPI QUAL — LAST FIRST
79 OTHER NPI QUAL — LAST FIRST

80 REMARKS 00000-0000-00
81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC™ National Uniform Billing Committee
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

**For full Prescribing Information, click here or see accompanying full Prescribing Information.**
**See reverse for Sample CMS-1500 Claim Form.**

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