

# Sample ASC Medicare CMS-1500 paper claim form (version 02-12) for use of DURYSTA™ (bimatoprost intracameral implant) 10 mcg

**Box 24G: Units Administered**  
Report the number of billing units.  
The descriptor for HCPCS code J7351 is "Injection, bimatoprost, intracameral implant, 1 microgram."  
When using J7351 for DURYSTA™, bill 10 units.

**Box 24D:** Use a laterality modifier to report the associated eye.

**Box 24D: Procedure Code**  
Enter the procedure code.  
The intracameral administration of DURYSTA™ may be reported using Current Procedural Terminology (CPT®) code 66030.

**Box 21: Diagnosis Code(s)**  
Enter the appropriate ICD-10-CM code(s). Report diagnosis code(s) to the highest level of specificity for the date of service.

**Box 24B: Place of Service**  
Enter the appropriate place-of-service code:  
24 - Ambulatory surgical center  
This is for facilities that bill as ASCs—not hospital outpatient surgery departments that bill under the Outpatient Prospective Payment System.

**Box 24D: Medication Information**  
Enter the HCPCS code for DURYSTA™ on a separate line from the line in which the CPT® code 66030 is reported in Box 24D.  
DURYSTA™ may be reported using HCPCS code J7351 "Injection, bimatoprost, intracameral implant, 1 microgram." Bill 10 units.



## HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER		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"/>	
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"/>	
CITY STATE ZIP CODE TELEPHONE (Include Area Code)		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		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)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
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.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
14. DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE MM DD YY QUAL.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate X-1 to service line below (24E) ICD-10-CM A. XXX.XXXX B. C. D. E. F. G. H. I. J. K. L.		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) D. DIAGNOSIS POINTER E. \$ CHARGES F. G. DAYS OF UNITS H. EPISODE Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #		22. RE-SUBMISSION CODE ORIGINAL REF. NO.	
1 MM DD YY MM DD YY 24		2 MM DD YY MM DD YY 24	
66030 -RT		J7351	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For gov. claim, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		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.)		32. SERVICE FACILITY LOCATION INFORMATION	
SIGNED DATE		a. NPI b.	

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

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)



CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION