SUSTOL® (granisetron) extended-release injection Sample CMS-1500 Claim Form

Item 19 or 24A shaded area*:
NDC Number(s):

- SUSTOL 10 mg/0.4 mL
- NDC 47426-0101-06 (single-dose kit), 10 mg granisetron/0.4 mL

*Requirements for coding may differ by Payer.

Item 21: Diagnosis or nature of illness or injury

Enter the appropriate ICD-10 diagnosis code as documented in the medical record.

Examples:

- R11.0 (nausea)
- R11.10 (vomiting, unspecified)
- R11.11 (vomiting without nausea)
- R11.12 (projectile vomiting)
- R11.13 (vomiting of fecal matter)
- R11.14 (bilious vomiting)
- R11.2 (nausea with vomiting, unspecified)
- T45.1X5* (adverse effects of antineoplastic and immunosuppressive drugs)
- Z41.9* (encounter for other procedures for purposes other than remedying health state)
- Z51.11*† (encounter for antineoplastic chemotherapy)

*Supplementary Classification Code

†Required when given within 48 hours of moderately or highly emetogenic chemotherapy

Item 24D: Procedures, Services or Supplies

Enter the appropriate HCPCS and CPT codes.

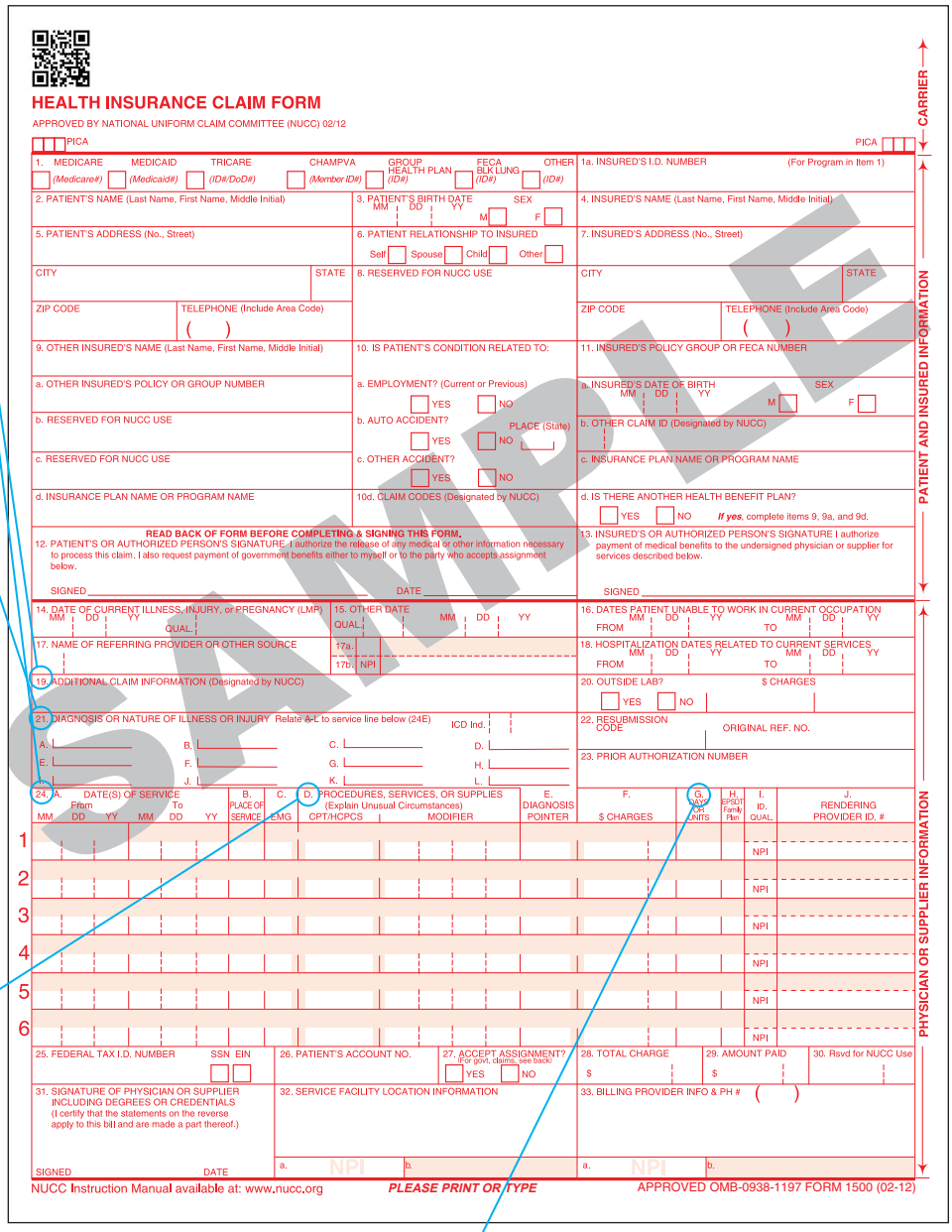
Examples:

- J1627 Injection, granisetron extended-release, 0.1 mg
- 96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

Other administration codes may be applicable.

Please use the appropriate HCPCS Modifier

Effective July 1, 2023, providers are **required** to report the JZ modifier on all claims that bill for drugs from single-dose containers that are separately payable **when there are no discarded amounts**. Providers may start using the modifier as of January 1, 2023, however, after July 1, 2023 use of the modifier is required.



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 ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

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 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 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

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 MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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.

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. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Item 24G: Days or units

Enter the appropriate number of units.

Example:

- Enter 100 units for one SUSTOL single-dose syringe, which contains 10 mg granisetron per 0.4 mL

Please ensure that appropriate HCPCS modifier is used based on units administered.

For example:

- **If 100 units are administered, the JZ modifier is required.**

This document is provided for your guidance only. Coding requirements may vary by payer; please consult the payer to determine which codes are required.

Please contact Heron Connect at **1-844-HERON11 (1-844-437-6611)** from 8 AM to 5 PM ET, Monday through Friday, to verify coding and claim information.

www.sustol.com

sustol® (granisetron) extended-release injection