



C9088 SAMPLE CLAIM FORM CMS-1500

ASC (Medicare) and Physician Office

CMS requires ASCs to submit a CMS-1500 claim form when billing a Medicare Administrative Contractor (MAC). Physician office billing requires the submission of the CMS-1500 claim form for all plans.

Complete the information needed to bill for the procedure. **ZYNRELEF must be billed using a separate line.**

Field 24 (Shaded Area):

Include the required additional information (eg, product name and NDC).

Example:

- For 400 mg/12 mg (14 mL) kit: ZYNRELEF, 47426-0301-02
- For 200 mg/6 mg (7 mL) kit: ZYNRELEF, 47426-0303-01

Payer NDC requirements and placement may vary; confirm with payer or Heron Connect.

Field 24D:

Specify HCPCS Code for ZYNRELEF, **C9088**.

To indicate that the complete single-dose vial was administered, use the HCPCS modifier JZ.^a

If a portion of the single-use vial was discarded, document it on a separate line using the HCPCS modifier JW.

Additional modifiers may be required, please confirm with commercial plans.

Field 24G:

Specify the number of units administered. **The billable unit for C9088 is 1 mg/0.03 mg.** For example, 400 mg/12 mg (14 mL) corresponds to 400 billable units.

^aFor dates of service on or after July 1, 2023, the JZ modifier is required on claims for single-dose containers when no amount was discarded.



HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK/LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S ID. 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		7. INSURED'S ADDRESS (No., Street)	
STATE		8. RESERVED FOR NUCC USE	
ZIP CODE		CITY	
TELEPHONE (Include Area Code)		STATE	
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.		11. INSURED'S POLICY GROUP OR FECA NUMBER	
SIGNED _____ DATE _____		11. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.	
15. OTHER DATE MM DD YY		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		14. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17a. ICD 10		15. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17b. NPI		16. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		22. RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD 10d.		23. PRIOR AUTHORIZATION NUMBER	
A. _____ B. _____ C. _____ D. _____		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) EPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. PSPOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #	
E. _____ F. _____ G. _____ H. _____		1 MM DD YY MM DD YY XX XXXX A XXX XX 1 NPI XXXXXXXXXXXX	
I. _____ J. _____ K. _____ L. _____		2 ZYNRELEF, [NDC] MM DD YY MM DD YY XX C9088 JZ A XXX XX XXX NPI XXXXXXXXXXXX	
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) EPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. PSPOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #		3 _____ NPI	
25. FEDERAL TAX ID. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Rsvd for NUCC Use		4 _____ NPI	
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.)		5 _____ NPI	
32. SERVICE FACILITY LOCATION INFORMATION		6 _____ NPI	
33. BILLING PROVIDER INFO & PH # ()		7 _____ NPI	
SIGNED _____ DATE _____		8. NPI 9. NPI	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

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.

For more information, visit HeronConnect.com



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