

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 VISUDYNE 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).

## Sample CMS-1500 Claim Form for Billing in the Physician Office and Non-institutional Ambulatory Surgery Center (ASC)

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA  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)  
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 M  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  Spouse  Child  Other

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

CITY Anytown STATE AS

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:  
a. EMPLOYMENT? (Current or Previous) YES  NO   
b. AUTO ACCIDENT? YES  NO  PLACE (State) \_\_\_\_\_  
c. OTHER ACCIDENT? YES  NO

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M  F

b. RESERVED FOR NUCC USE

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME  
Medicare

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  
 YES  NO If yes, complete items 9, 9a, and 9d.

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 \_\_\_\_\_ DATE \_\_\_\_\_

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL \_\_\_\_\_

15. OTHER DATE MM DD YY QUAL \_\_\_\_\_

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE  
Dr. Jones

17a. \_\_\_\_\_ 17b. NPI \_\_\_\_\_

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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. 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. EPST/ Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
01 02 21 01 02 21			CPTcode						
01 02 21 01 02 21			J3396					XXX	Amount of drug administered
01 02 21 01 02 21			J3396 JW					XXX	Amount of drug discarded after infusion
01 02 21 01 02 21									

22. RESUBMISSION CODE \_\_\_\_\_ ORIGINAL REF. NO. \_\_\_\_\_

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.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # (203) 987-6543  
Dr. Jones  
4231 Center Road  
Anytown, AS 01010

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

a. 123 456 7890 b. \_\_\_\_\_

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

**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(s) for the patient's diagnosis/condition. If using B39.4, B39.5, or B39.9, these codes must be listed first and followed by H32. H32 may not be listed alone<sup>1</sup>

**Box 24D**  
Enter the appropriate CPT<sup>®</sup> code. Enter CPT<sup>®</sup> modifiers for left side, right side, or bilateral, as appropriate<sup>2</sup>

**Box 24D**  
Use HCPCS code J3396 to represent VISUDYNE

**IMPORTANT:**  
If modifier JW is required in Box 24D, include amount of drug administered on the same line in Box 24G. On a separate line, include HCPCS code in Box 24D and the amount discarded in Box 24G<sup>3</sup> if there is drug waste

**Box 24G**  
J3396 has a unit description of 0.1 mg; report a total of 150 billing units for a 15 mg injection of VISUDYNE.<sup>4,5</sup> For example, if you administered 110 billing units, also enter 40 billing units on a separate line to indicate amount of drug discarded, for a total of 150 billing units

**For full Prescribing Information, [click here](#) or see accompanying full Prescribing Information. See reverse for Sample UB-04 Claim Form.**

**References:** 1. ICD-10 H32 Code Mapping. HIPAA Space website. Accessed February 10, 2022. [http://www.hipaaspace.com/medical\\_billing/crosswalk.services/icd-10.to.icd-9.mapping](http://www.hipaaspace.com/medical_billing/crosswalk.services/icd-10.to.icd-9.mapping) 2. American Medical Association. CPT<sup>®</sup> 2022 Professional Edition. United States; American Medical Association; 2021. 3. HCPCS Level II 2022 Expert. United States; Optum360, LLC; 2021. 4. VISUDYNE<sup>®</sup> Prescribing Information. Bausch & Lomb Incorporated; 2021. 5. January 2022 ASP NDC-HCPCS Crosswalk for Medicare Part B Drugs. Effective January 1, 2022 through March 31, 2022. CMS website. Accessed February 10, 2022. <https://www.cms.gov>

**NOTE:**

For Medicare, Medicaid, and government payers, use of the UB-04 claim form may be appropriate for treatment with VISUDYNE 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).

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

**Boxes 42 & 43**

Enter the appropriate AHA Revenue Code, along with description

**Box 44**

Enter the appropriate CPT® code. Enter CPT® modifiers for left side, right side, or bilateral, as appropriate<sup>2</sup>

**Box 44**

Use HCPCS code J3396 to represent VISUDYNE

**IMPORTANT:**

If modifier JW is required in Box 44, include amount of drug administered on the same line in Box 46. On a separate line, include HCPCS code in Box 44 and the amount discarded in Box 46<sup>3</sup> if there is drug waste

**Box 46**

J3396 has a unit description of 0.1 mg; report a total of 150 billing units for a 15 mg injection of VISUDYNE.<sup>4,5</sup> For example, if you administered 110 billing units, also enter 40 billing units on a separate line to indicate amount of drug discarded, for a total of 150 billing units

**Box 66**

Enter the appropriate ICD-10-CM code(s) for the patient's diagnosis/condition. If using B39.4, B39.5, or B39.9, these codes must be listed first and followed by H32. H32 may not be listed alone<sup>1</sup>

**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

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	4 TYPE OF BILL
3b MED. REC. # DOE 1234-56		5 FED. TAX NO. 010001010		6 STATEMENT COVERS PERIOD FROM THROUGH	
8 PATIENT NAME a Jim A. Smith		9 PATIENT ADDRESS 29 Maple Ave.			
10 BIRTHDATE 6/28/47		11 SEX		12 DATE	
13 ADM. 13 HR		14 TYPE		15 SRC	
16 DHR		17 STAT		18	
19		20		21	
22		23		24	
25		26		27	
28		29 ACCT STATE		30	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM THROUGH	
37		38		39 VALUE CODES AMOUNT	
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