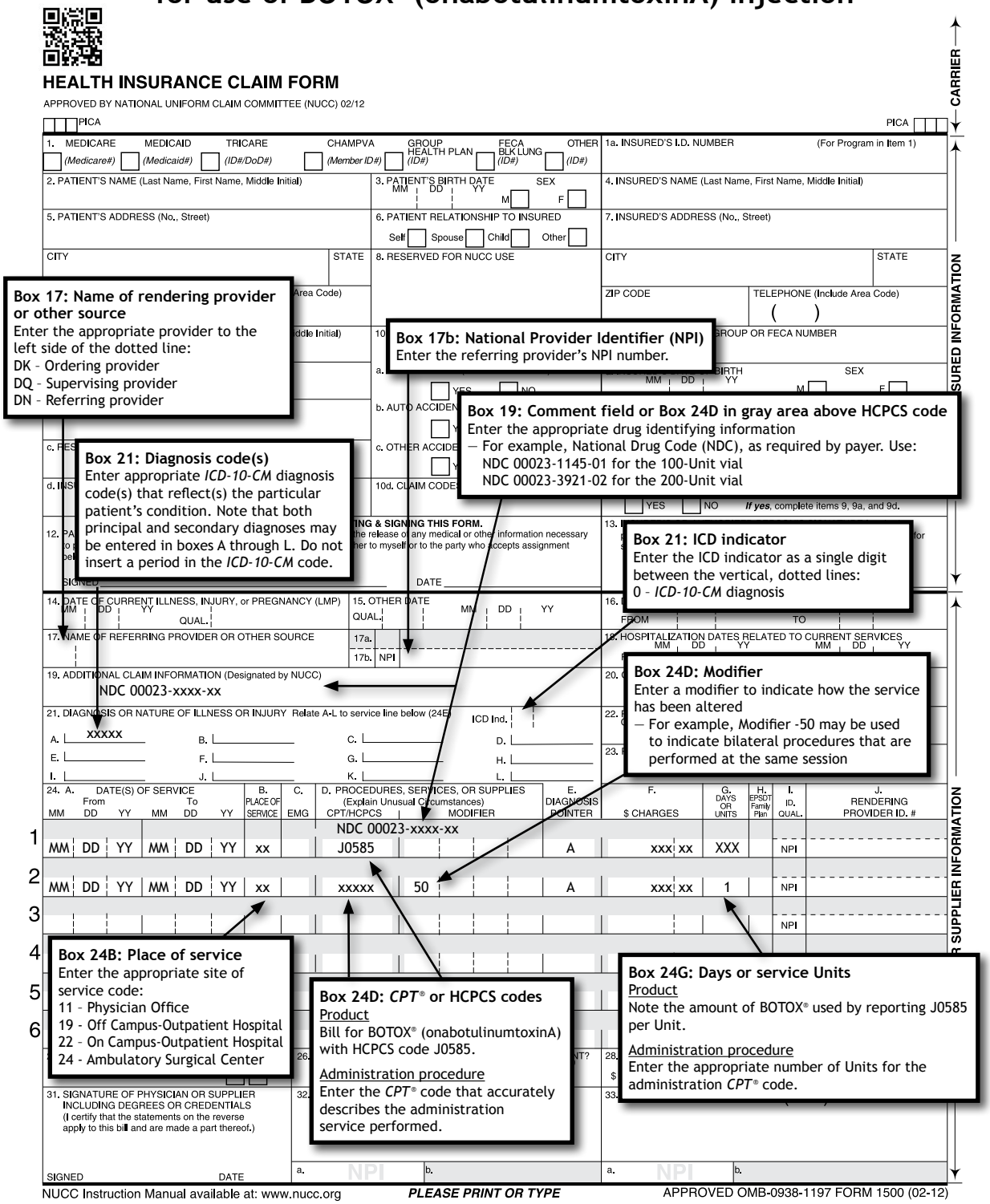
Sample Medicare CMS-1500 paper claim form (version 02-12) for use of BOTOX® (onabotulinumtoxinA) injection



Box 17: Name of rendering provider or other source
Enter the appropriate provider to the left side of the dotted line:
DK – Ordering provider
DQ – Supervising provider
DN – Referring provider

Box 17b: National Provider Identifier (NPI)
Enter the referring provider's NPI number.

Box 19: Comment field or Box 24D in gray area above HCPCS code
Enter the appropriate drug identifying information
– For example, National Drug Code (NDC), as required by payer. Use:
NDC 00023-1145-01 for the 100-Unit vial
NDC 00023-3921-02 for the 200-Unit vial

Box 21: Diagnosis code(s)
Enter appropriate *ICD-10-CM* diagnosis code(s) that reflect(s) the particular patient's condition. Note that both principal and secondary diagnoses may be entered in boxes A through L. Do not insert a period in the *ICD-10-CM* code.

Box 21: ICD indicator
Enter the ICD indicator as a single digit between the vertical, dotted lines:
0 – *ICD-10-CM* diagnosis

Box 24D: Modifier
Enter a modifier to indicate how the service has been altered
– For example, Modifier -50 may be used to indicate bilateral procedures that are performed at the same session

Box 24B: Place of service
Enter the appropriate site of service code:
11 – Physician Office
19 – Off Campus-Outpatient Hospital
22 – On Campus-Outpatient Hospital
24 – Ambulatory Surgical Center

Box 24D: *CPT*® or HCPCS codes
Product
Bill for BOTOX® (onabotulinumtoxinA) with HCPCS code J0585.
Administration procedure
Enter the *CPT*® code that accurately describes the administration service performed.

Box 24G: Days or service Units
Product
Note the amount of BOTOX® used by reporting J0585 per Unit.
Administration procedure
Enter the appropriate number of Units for the administration *CPT*® code.

The coding information contained herein is gathered from various resources and is subject to change. This document is intended for reference only. Nothing in this document is intended to serve as reimbursement advice, a guarantee of coverage, or a guarantee of payment for BOTOX® Third-party payment for medical products and services is affected by numerous factors. The decision about which code to report must be made by the provider/physician considering the clinical facts, circumstances, and applicable coding rules, including the requirement to code to the highest level of specificity. Please refer to your Medicare policy/other payer policies for specific guidance.

Please see full prescribing information, including boxed warning.

Allergan

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