

Annotated Claim Form

CMS-1500 Claim Form for Physician Offices

The annotations on the CMS-1500 claim form below may help you as you complete your RYONCIL® (remestemcel-L-rknd) infusion claim submission.

Box 19

When using a miscellaneous code, include detailed information for proper processing*: *Drug name, strength, route of administration, dosage administered, amount wasted (if applicable), and NDC*

Box 21

Enter the appropriate ICD-10-CM diagnosis code¹

Box 23

Enter prior authorization referral number from the payer (if applicable)

Boxes 24A-B

Enter the date of service and the appropriate place of service code. When using a miscellaneous J-code, include the following in the shaded portion of Item 24A for each NDC*: *N4+11-digit NDC+ML+unit quantity (administered or discarded)*

Box 24D

Enter the appropriate HCPCS, modifier, and CPT® codes.^{2,3} For example¹:

- Drug: HCPCS code
- Modifier - JW (Discarded product from single-dose containers should be reported on a separate line with the JW modifier. If no wastage occurs, include the JZ modifier inline with the HCPCS code.)
- Administration: CPT code

Box 24E

Refer to the diagnosis (Box 21), relating to the drug or procedure listed in Box 24D

Box 24G

Enter the number of units for each line item. With miscellaneous codes, "1" is typically used, as these codes do not have a specific unit value, but payer requirements may vary

HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA <input type="checkbox"/> PICA											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BENEFIT <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare) (Medicaid) (DoD) (Member ID#) (ID#) (ID#)</small>				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"/>				4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
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"/>				7. INSURED'S ADDRESS (No., Street)			
CITY STATE				8. RESERVED FOR NUCC USE				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) <input type="checkbox"/> YES <input type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>			
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <small># yes, complete items 9, 9a, and 9d.</small>			
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 _____						SIGNED _____					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.											
15. OTHER DATE MM DD YY											
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											
17a. ICD-10-CM ICD-10-PCS NPI											
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? <input type="checkbox"/> YES <input type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD-10-CM ICD-10-PCS											
22. SUBMISSION 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 EMG C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) D. DIAGNOSIS POINTER E. DAYS OR UNITS F. CHARGES G. H. I. J. RENDERING PROVIDER ID. #											
Line 1											
Line 2											
Line 3											
Line 4											
Line 5											
Line 6											
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> 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 #											
SIGNED _____ DATE _____				a. NPI b.				a. NPI b.			



*Always refer to specific payer policies, as billing requirements for miscellaneous codes may vary by payer.
 †Please refer to payer policies, as other miscellaneous codes may be required.

If you have any questions or want to request a meeting with a Key Account Manager, please visit www.ryoncil.com or contact us at keyaccountmanager@mesoblast.com.

For Medicare, Medicaid, and other government payers, the use of the CMS-1500 claim form may be appropriate for treatment with RYONCIL® in a physician's office. For commercial claims, please consult with the applicable third-party payer. Note that payers may require use of the electronic version of the CMS-1500 claim form; we suggest adapting this information to the electronic equivalent fields in your software systems.

Mesoblast provides this information for educational purposes only and cannot guarantee insurance coverage or reimbursement, which may vary significantly by payer, plan, patient, and site of care. It is the healthcare provider's sole responsibility to select proper codes and ensure statement accuracy for coverage and reimbursement.

CPT, Current Procedural Terminology; HCPCS, Healthcare Common Procedure Coding System; ICD-10-CM, ICD-10 Clinical Modification; NDC, National Drug Code.

References: 1. AAPC. Codify. Accessed January 22, 2025. <https://www.aapc.com/codes/> 2. AAPC. Codify. Accessed January 22, 2025. <https://www.aapc.com/codes/hcpcs-codes> 3. Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug). FindACode.com. Accessed January 22, 2025. <https://www.findacode.com/code-set.php?set=CPT&i=37339>