0.18 mg
YUTIQ®
(fluocinolone acetonide intravitreal implant) 0.18 mg

Sample CMS-1500 Paper Claim Form

Enter all applicable patient information

When using J-code for YUTIQ based on instruction from payer, please include NDC on line 19

Item 21: Enter "0" if using ICD-10-CM

Item 21: Enter the Diagnosis Code(s)

Item 24B: "11" indicates office

Item 23: Enter approval/ authorization number *(if applicable)*

Item 24D: Enter the applicable procedure code (eg, 67028 for intravitreal injection of a pharmacologic agent)

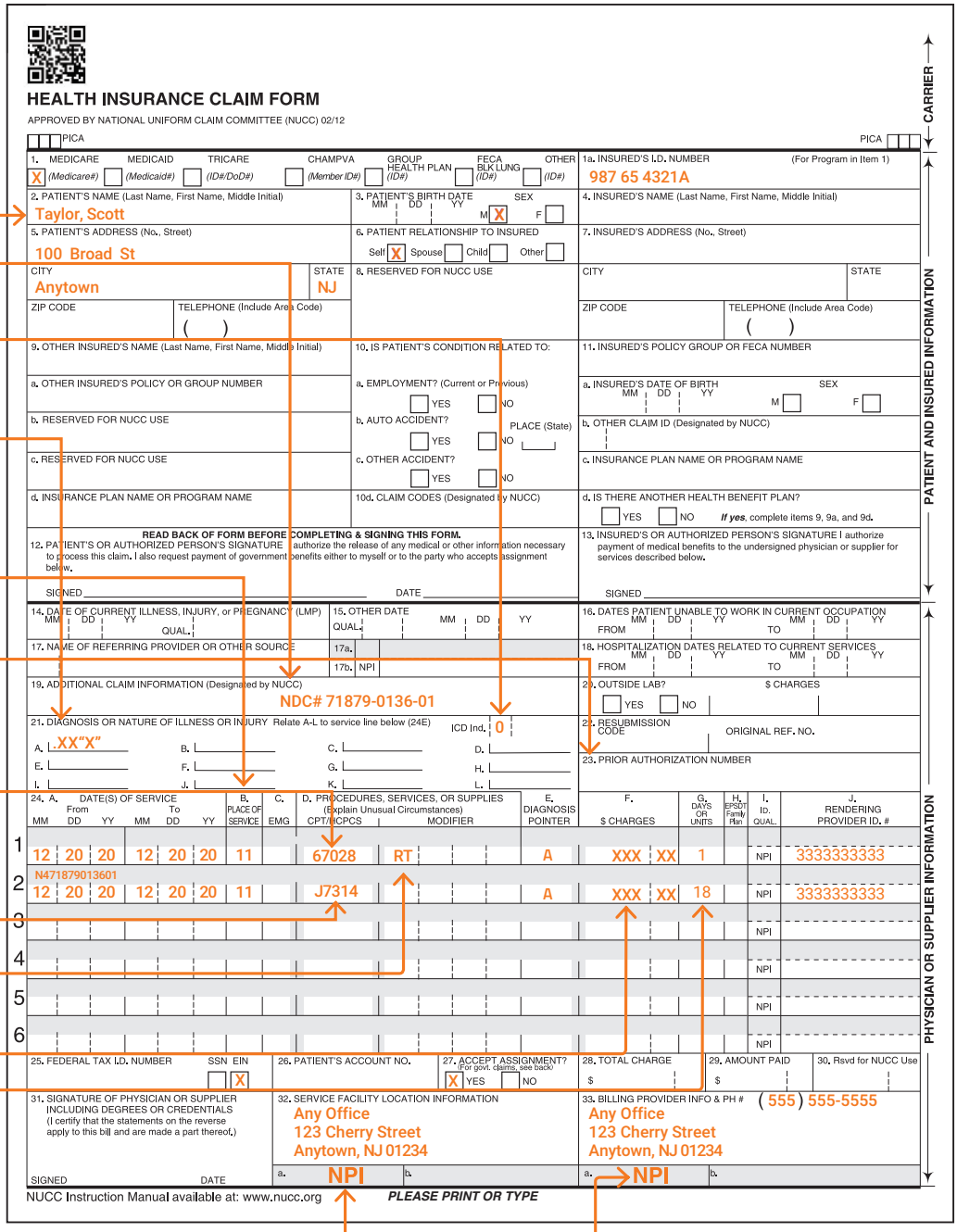
Item 24D: Enter the unique Billing Code for YUTIQ

Item 24D: Enter the Modifier for left eye (LT) or right eye (RT)

Item 24F: Enter price for YUTIQ from price schedule, including all applicable markups

Item 24G: Enter the number of Units. For YUTIQ, 1 unit= 0.01 mg. Should be billed with 18 units per injection

Items 32a and 33a: Entry of NPI Number is required



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [X] (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): 987 65 4321A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Taylor, Scott

3. PATIENT'S BIRTH DATE MM DD YY — SEX: M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 100 Broad St

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

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

CITY: Anytown — STATE: NJ

8. RESERVED FOR NUCC USE

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 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 — MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): NDC# 71879-0136-01

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. XX"X" 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	12	20	20	12	20	20	11		67028	RT	A	XXX	XX	1		NPI	3333333333
2	N471879013601 12	20	20	12	20	20	11		J7314		A	XXX	XX	18		NPI	3333333333
3																NPI	
4																NPI	
5																NPI	
6																NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] 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: Any Office, 123 Cherry Street, Anytown, NJ 01234

a. NPI b.

33. BILLING PROVIDER INFO & PH # (555) 555-5555: Any Office, 123 Cherry Street, Anytown, NJ 01234

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

For assistance with coverage, claims, appeals, and more, visit the Hub portal at YUTIQ.com/Reimbursement

Information contained herein is provided as a reference for obtaining appropriate and accurate reimbursement. This content is for informational purposes only. EyePoint does not guarantee that the use of the recommended codes will result in reimbursement. Providers should always contact the payer directly with reimbursement or billing questions. If you have any questions, please call EyePoint Assist℠ at **1-833-393-7646**.

ICD-10-CM=International Classification of Diseases, Tenth Revision, Clinical Modification; NDC=National Drug Code; NPI=National Provider Identifier.

EYEPOINT® PHARMACEUTICALS

480 Pleasant Street, Suite B300, Watertown, MA 02472

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