

0.18 mg

YUTIQ
(fluocinolone acetonide
intravitreal implant) 0.18 mg

Sample UB-04 Paper Claim Form

Form locator 4: Enter the 4-digit code that specifies place of service and submission type. For example, for HOPD, the first 3 digits are 013. The final digit is usually a "1," meaning one claim for the event

Enter all applicable patient information

Form locator 17: Enter Patient Status

Form locator 47: Enter price for YUTIQ from price schedule, including all applicable markups

Form locator 42*: Enter the Revenue Code

Form locator 44: Enter the unique Billing Code for YUTIQ

Form locator 44*: Enter the Procedure Code(s)

Form locator 46: Enter the number of Units. For YUTIQ, 1 unit=0.01 mg. Should be billed with 18 units per injection

Form locator 50A: If Medicare is the primary payer, enter "Medicare" on line A

Form locator 66: Enter the primary Diagnosis Code

Form locator 80: This is where NDC number should be placed if NOC code required or if Medicaid for 340B rebate requirement

1 Hospital Name 123 Street Road Anytown, NJ 01234		2 Hospital Name 123 Street Road Anytown, NJ 01234		3a PAT. CAT. 19 1111	3b MED. REC. # 22222	4 TYPE OF BILL 0131
8 PATIENT NAME a Smith, Jane		9 PATIENT ADDRESS a 1 Pine Street		c NJ 01234		
10 BIRTHDATE 01 31 1950	11 SEX F	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR
17 STAT 01		18		19		20
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE
35 CODE		36 CODE		37 CODE		38 CODE
39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42 VALUE CODES AMOUNT
38 Jane Smith 1 Pine Street Anytown, NJ 01234		39		40		41
42 REV. CD. XXX XXX	43 DESCRIPTION Refer to payer contract for code Intravitreal injection		44 HCPCS / RATE / HPPS CODE J7314 67028	45 SERV. DATE	46 SERV. UNITS 18	47 TOTAL CHARGES XXX : XX
PAGE 1 OF 1		CREATION DATE		TOTALS		
50 PAYER NAME Medicare		51 HEALTH PLAN ID		52 BILL INFO Y	53 PRIOR PAYMENTS Y	54 EST. AMOUNT DUE
55 NPI 1111111111		56 OTHER PRV ID		57		
58 INSURED'S NAME Jane Smith		59 P. REL. 18	60 INSURED'S UNIQUE ID XYZ0987654321		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		
65 EMPLOYER NAME		66		67		
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69 ADMIT DX XXXX		70 PATIENT REASON DX		71 PPS CODE		72
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80 REMARKS NDC# 71879-0136-01		81CC		82		83
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