Sample CMS-1500 Form

BOX 21

Enter the ICD-10-CM diagnosis code that reflects the patient's condition.

Example: B08.1 (molluscum contagiosum)

BOX 24A

In the non-shaded area, list the date of service. In the shaded area, give a detailed drug description (YCANTH cantharidin 0.7% single use applicator, 3.2 mg, N471349007001.).

BOX 24B

Enter the appropriate site of service code:

11 - Physician Office
19 - Off Campus, Outpatient Hospital
21 - Inpatient Hospital
22 - On Campus, Outpatient Hospital
49 - Independent Clinic

BOX 24D

Enter the appropriate HCPCS code for YCANTH:
J7354 - Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg) (effective for dates of service on or after April 1, 2024).

Enter the appropriate CPT code for YCANTH application based on the actual service performed.

Example:
CPT code 17110 for destruction of up to 14 lesions
CPT code 17111 for destruction of 15 or more lesions

BOX 24G

Bill for one or two YCANTH applicators based on the service provided.

Note: Depending on the service provided, provider should list 1 or 2 units of service in item 24G. The appropriate determination of the payment will be made by the insurance plan.

HEALTH INSURANCE CLAIM FORM

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

PICA — PICA — CARRIER

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)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT'S BIRTH DATE MM DD YY SEX M F | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) | 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other | 7. INSURED'S ADDRESS (No., Street)

CITY STATE | 8. RESERVED FOR NUCC USE | CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( ) | 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 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

PATIENT AND INSURED INFORMATION

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 FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. 17b. NPI | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

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. | 22. RESUBMISSION CODE ORIGINAL REF. NO.

A. B08.1 B. C. D.
E. F. G. H.
I. J. K. L.

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 YCANTH (cantharidin) topical solution 0.7%, one single-use applicator, 3.2 mg, N471349007001									
	11		J7354			1		NPI	
2 Destruction of up to 14 lesions									
	11		17110			1		NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

Y-Access SUPPORT SOLUTIONS

The information provided by Verrica regarding potential billing codes for YCANTH is for informational purposes only. It is not intended to constitute advice or be regarded as a substitute for advice. You should not rely upon the information as a basis for making any decisions and Verrica makes no representations or warranties about the completeness, accuracy, reliability, or suitability of the information.

Please see Important Safety Information and full Prescribing Information at www.YCANTHPro.com

Ycanth (cantharidin) TOPICAL SOLUTION 0.7%