

# Sample CMS-1500 Claim Form for Office Billing: BILPREVDA® (denosumab-nxxp) injection 120 mg/1.7 mL

Before prescribing BILPREVDA, please read the [Prescribing Information](#).

## HEALTH INSURANCE CLAIM FORM

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

### Form Locator 19

- To report the use of BILPREVDA, include the NDC number and name of the drug (both brand and generic), strength of drug administered, and dose. Note: If using an electronic medical record (EMR), confirm that the appropriate information is entered in the Form Locator 19 equivalent and conforms to any plan-specific character limits.

### Form Locator 24 E

- Record the relevant diagnosis pointer from Form Locator 21.

### Form Locator 21

- Enter appropriate diagnosis code(s).

### Form Locator 24 G

- Enter the number of units administered in this field.
- Note that 1 unit equals 1 mg of BILPREVDA for Q5162.

### Form Locator 24

- The NDC information is required in the shaded area above the line on which a drug is reported in 24 D. The NDC is preceded by the qualifier N4 and followed by the quantity qualifier (UN) and the quantity administered (eg, N49999999999UN1).

### Form Locator 24 D

Please note that different payers may have different coding requirements for BILPREVDA. Check with the payer for information on billing and coding if you have questions. The guidance below applies to Medicare Part B claims. Check with the payer for information on billing and coding for commercial claims. For dates of service on or after April 1, 2026, use Q5162 to bill for BILPREVDA. For dates of service prior to April 1, 2026, use J3590/J9999 to bill for BILPREVDA.

- To record waste: Enter the HCPCS code with a JW modifier (eg, Q5162-JW) on the next line to record waste.
- For no wastage: Enter the HCPCS code with a JZ modifier (eg, Q5162-JZ) to attest that there were no discarded amounts.

For the administration procedure:

- Possible corresponding CPT® codes include 96372 and 96401.
- Health care providers should check with the payer or Medicare to determine the appropriate code for administration. It is the provider's responsibility to ensure that codes used reflect the service performed.

The suggestions contained on this form are compiled from sources believed to be accurate for the Medicare Part B program, but Organon makes no representation that the information is accurate or that it will comply with the requirements of any particular MAC or payer. You are solely responsible for determining the billing and coding requirements applicable to any payer or MAC. Diagnosis codes should be selected only by a health care professional. The information provided here is not intended to be conclusive or exhaustive, and is not intended to replace the guidance of a qualified professional advisor. Billing and coding requirements may vary or change over time, so it is important to regularly check these requirements with each payer or MAC. Organon and its agents make no warranties or guarantees, expressed or implied, concerning the accuracy or appropriateness of this information for your particular use and caution that changes in public and private payer billing requirements occur frequently. The use of this information does not guarantee payment or that any payment received will cover your costs.

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