

together

**EXDENSUR**  
(depemokimab-ulaa)

# Sample CMS-1500 Claim Form

The sample **CMS-1500** claim form below shows the fields to complete when using the recommended dose of EXDENSUR. In this scenario, the specific payer requires providers to report using **J3490, J3590, C9399** for EXDENSUR in **Box 24D** and to include additional information about EXDENSUR in **Box 19**.

## Box 19

Per payer-specific requirements, enter EXDENSUR brand and generic names, NDC, and amount administered to the patient.

**Box 21**

Enter the appropriate diagnosis code(s).

**Box 24D**

Enter the appropriate HCPCS (J3490, J3590, C9399) and CPT® codes. Include any additional modifiers required by the payer.\*

If no amount of drug was discarded, include the JZ modifier in Box 24D.

**Box 24E**

Record the relevant diagnosis pointer from Box 21.

**Box 24G**

Document the number of billing units used for each line item.

HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12											
<input type="checkbox"/> PICA <span style="float: right;">PICA <input type="checkbox"/></span> <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <span style="float: right;">CARRIER <input type="checkbox"/></span> <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <span style="float: right;">(For Program in Item 1)</span>											
1. MEDICARE			MEDICAID			TRICARE			CHAMPVA		
<input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> (ID#) <input type="checkbox"/> BILK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#)			<input type="checkbox"/> BILK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#)			<input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> (ID#) <input type="checkbox"/> BILK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#)			<input type="checkbox"/> (ID#) <input type="checkbox"/> BILK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE			SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
			MM DD YY			<input type="checkbox"/> M <input type="checkbox"/> F					
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)					
			<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other								
CITY			STATE			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:											
a. OTHER INSURED'S POLICY OR GROUP NUMBER <input type="checkbox"/> YES <input type="checkbox"/> NO b. RESERVED FOR NUCC USE <input type="checkbox"/> YES <input type="checkbox"/> NO <span style="float: right;">PLACE (State)</span> c. RESERVED FOR NUCC USE <input type="checkbox"/> YES <input type="checkbox"/> NO d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC)											
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO											
11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY <span style="float: right;">SEX</span> <input type="checkbox"/> M <input type="checkbox"/> F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME											
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 _____											
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY <span style="float: right;">QUAL.</span>											
15. OTHER DATE QUAL. MM DD YY											
16. PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY <span style="float: right;">TO</span> MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 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? \$ CHARGES <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 Ind. _____											
22. RESUBMISSION CODE ORIGINAL REF. NO.											
23. PRIOR AUTHORIZATION NUMBER											
24. DATE(S) OF SERVICE From MM DD YY To MM DD YY PLACE OF SERVICE EMO (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS A. _____ B. _____ C. _____ D. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____											
F. \$ CHARGES G. DATES OR UNITS H. PAYOR/FAMILY PLAN I. ID. QUA. J. RENDERING PROVIDER ID. # XX:XX1 NPI											
1	01	01	25	01	01	25	JXXXX				
2	01	01	25	01	01	25	96372				
3											
4											
5											
6											
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <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. NPI c. NPI											



## Questions?

Call your Access and Reimbursement Manager (ARM) or Together with EXDENSUR at 1-844-CALL-TwGSK (1-844-225-5894) Monday-Friday, 8 AM to 8 PM ET.

**Payers may have different requirements regarding the use of billing and diagnosis codes. Please confirm requirements with individual payers or check with your ARM for additional information.**

The suggestions contained on this form are compiled from sources believed to be accurate for the Medicare Part B program, but GSK makes no representation that the information is accurate or that it will comply with the requirements of any particular Medicare Administrative Contractor (MAC) or payer. You are solely responsible for determining the billing and coding requirements applicable to any payer or MAC.

CPT®=Current Procedural Terminology; HCPCS=Healthcare Common Procedure Coding System; NDC=National Drug Code.

\*Different payers often have different billing and diagnosis code requirements. Please confirm requirements with individual payers or check with your ARM for additional information.

Trademarks are owned by or licensed to the GSK group of companies.

©2025 GSK or licensor.

NPUS-DEPELBND250003 December 2025

Produced in USA, 0002-0042-89

The GSK logo is displayed in a bold, orange, sans-serif font. The letters 'G', 'S', and 'K' are stacked vertically, with 'G' on top, 'S' in the middle, and 'K' on the bottom. The letters are outlined in white, and the fill is a bright orange color.