



A Guide for Completing the CMS-1500 Form

The CMS-1500 is the standardized billing form for professional services. Longevity Health Plan offers this guide to assist you in completing the CMS-1500 form for your patients with Longevity Health Plan coverage.

Please remember to submit your professional claims electronically. Submission of a paper CMS-1500 should be an exception. Contact your Provider Network Representative if you have questions about submitting claims electronically.

For information on the CMS-1500 billing form, or to obtain an Official CMS-1500 Data Specifications Manual, visit the National Uniform Billing Committee (NUBC) Web site at www.nubc.org.

Thank you for helping us process your claims efficiently and accurately.

While Longevity Health Plan prefers electronic submission of claims, both electronic and paper claims are accepted. If interested in submitting claims electronically, contact your local Longevity Health Plan Provider Services Department at:

State	Call Center	EDI Payer ID
Colorado	1-888-332-5941	LCO01
Florida	1-888-332-5941	LFL01
Illinois	1-888-332-5941	LIL01
Massachusetts	1-888-332-5941	LMA01
Michigan	1-888-332-5941	LMI01
New Jersey	1-888-332-5941	LNJ01
New York	1-888-332-5941	LNJ01
North Carolina	1-888-332-5941	LNC01

MAIL CLAIMS TO:

Longevity Health Plan
PO Box 23428
Tampa, FL 33623

Key

- R** - REQUIRED IN FILING A LONGEVITY HEALTH PLAN CLAIM
- S** - SITUATIONAL—ONLY IF APPROPRIATE TO THIS CLAIM
- NR** - NOT REQUIRED/NOT USED

HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE (Medicare) ☐ TRICARE (TRICARE) ☐ CHAMPVA (CHAMPVA) ☐ GROUP HEALTH PLAN (RDE) ☐ FECA (FECA) ☐ OTHER (OTHER) ☐										2. INSURANCE NUMBER (For Program in Item 1)									
3. PATIENT NAME (Last Name, First Name, Middle Initial)										4. INSURER NAME (Last Name, First Name, Middle Initial)									
5. PATIENT ADDRESS (No. Street)										6. INSURER ADDRESS (No. Street)									
7. CITY										8. CITY									
9. STATE										10. STATE									
11. ZIP CODE										12. ZIP CODE									
13. TELEPHONE (Include Area Code)										14. TELEPHONE (Include Area Code)									
15. PATIENT'S CONDITION RELATED TO:										16. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
17. EMPLOYER (Current or Previous)										18. INSURANCE TYPE (M/F)									
19. AUTO ACCIDENT?										20. OTHER ACCIDENT?									
21. PLAN PROGRAM NAME										22. PLAN PROGRAM NAME									
23. IS THERE ANOTHER HEALTH BENEFIT PLAN?										24. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
25. READ BACK OF FORM BEFORE CO-SIGNED										26. READ BACK OF FORM BEFORE CO-SIGNED									
27. AUTHORIZED PERSON'S SIGNATURE										28. AUTHORIZED PERSON'S SIGNATURE									
29. SIGNED										30. SIGNED									
31. DATE										32. DATE									
33. NAME										34. NAME									
35. ADDRESS										36. ADDRESS									
37. NATURE OF ILLNESS										38. NATURE OF ILLNESS									
39. RELATIVE TO SERVICE (Line 24E)										40. RELATIVE TO SERVICE (Line 24E)									
41. A. DATE										42. A. DATE									
43. B. PLACE OF SERVICE										44. B. PLACE OF SERVICE									
45. C. EMG										46. C. EMG									
47. D. PROCEDURES, SERVICES, OR SUPPLIES										48. D. PROCEDURES, SERVICES, OR SUPPLIES									
49. E. DIAGNOSIS										50. E. DIAGNOSIS									
51. F. CHARGES										52. F. CHARGES									
53. G. DAYS ON UNITS										54. G. DAYS ON UNITS									
55. H. SPOT TREATMENT										56. H. SPOT TREATMENT									
57. I. BILLING PROVIDER										58. I. BILLING PROVIDER									
59. J. BILLING PROVIDER										60. J. BILLING PROVIDER									
61. TAX ID NUMBER										62. TAX ID NUMBER									
63. SSN (EIN)										64. SSN (EIN)									
65. ACCOUNT NO.										66. ACCOUNT NO.									
67. ASSIGNMENT?										68. ASSIGNMENT?									
69. TO										70. TO									
71. FROM										72. FROM									
73. BILLING PROVIDER INFO & PH #										74. BILLING PROVIDER INFO & PH #									
75. SIGNATURE OF PHYSICIAN OR SUPPLIER										76. SIGNATURE OF PHYSICIAN OR SUPPLIER									
77. DEGREES OR CREDENTIALS										78. DEGREES OR CREDENTIALS									
79. SERVICE FACILITY LOCATION INFORMATION										80. SERVICE FACILITY LOCATION INFORMATION									
81. SIGNED										82. SIGNED									
83. DATE										84. DATE									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OM 1197 FORM 1500 (02-12)

Key

- R** - REQUIRED IN FILING A LONGEVITY HEALTH PLAN CLAIM
- S** - SITUATIONAL—ONLY IF APPROPRIATE TO THIS CLAIM
- NR** - NOT REQUIRED/NOT USED

1	R	TYPE OF HEALTH INSURANCE COVERAGE - Select "Other" to indicate that you are submitting a Longevity claim.
1a	R	INSURED ID NUMBER - Enter the subscriber's identification number from their Longevity Health ID card
2	R	PATIENT'S NAME - Last name, First name, Middle initial. Enter the patient's last name, first name and middle initial.
3	R	PATIENT'S BIRTH DATE/SEX - Enter the patient's date of birth using the eight-digit date format (MM/DD/CCYY). Next, select the patient's gender.
4	R	INSURED'S NAME - Last name, First name, Middle initial. Enter the insured's last name, first name and middle initial.
5	R	PATIENT'S ADDRESS/TELEPHONE NUMBER - Enter the patient's permanent mailing address and telephone number.
6	R	PATIENT'S RELATIONSHIP TO THE INSURED - Select the appropriate box for patient's relationship to the insured person.
7	S	INSURED'S ADDRESS/TELEPHONE NUMBER - Enter the insured person's permanent mailing address (complete if different from the patient's address)
8	NR	RESERVED FOR NUCC USE
9	S	OTHER INSURED'S NAME - Enter the other insured person's last name, first name and middle initial. When the patient has other insurance coverage, you will need to complete fields 9a through 9d. This information is necessary to coordinate benefits with other insurance companies.
9a	S	OTHER INSURED'S POLICY OR GROUP NUMBER - Enter the other insured person's policy or group number.
9b	NR	RESERVED FOR NUCC USE - Enter the other insured person's date of birth in an eight-digit date format (MM/DD/CCYY).
9c	NR	RESERVED FOR NUCC USE - Enter the other insured person's employer or school name.
9d	S	INSURANCE PLAN NAME OR PROGRAM NAME - Enter the name of the other insured person's insurance plan or program name.
10 a-d		IS PATIENT'S CONDITION RELATED TO: For 10a – 10d, required status is contingent upon a definitive "Yes" or "No" answer. If you are unsure, leave blank.
10a	S	Select whether the patient's condition is related to employment.
10b	S	Select whether the patient's condition is related to an auto accident and enter the state in which the accident occurred. Use two-character abbreviation, i.e. NM.
10c	S	Select whether the patient's condition is related to any other type of accident.
10d	NR	CLAIM CODES (DESIGNATED BY NUCC)
11	R	INSURED'S POLICY GROUP OR FECA NUMBER - Enter the subscriber's group number from their Longevity Health ID card.
11a	R	INSURED'S DATE OF BIRTH, SEX - Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCYY) and select the subscriber's gender.
11b	NR	OTHER CLAIM ID (DESIGNATED BY NUCC) - Enter the subscriber's employer or school name.
11c	R	INSURANCE PLAN NAME OR PROGRAM NAME - Enter the subscriber's insurance plan name, include name of state.
11d	R	IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN - Select whether there is another health insurance plan. Remember, if there is another health insurance plan, you will need to complete fields 9, 9a, and 9d. This information is necessary to coordinate benefits with other insurance companies.
12	NR	PATIENT OR AUTHORIZED PERSON'S SIGNATURE - Not required in filing Longevity Health claims.
13	NR	INSURED OR AUTHORIZED PERSON'S SIGNATURE - Not required in filing Longevity Health claims.
14	R	DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) - Enter the date using an eight-digit date format (MM/DD/CCYY).
15	S	OTHER DATE - Enter the date using an eight-digit date format (MM/DD/CCYY).
16	S	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION - Enter the date using an eight-digit date format (MM/DD/CCYY).

17	S	NAME OF REFERRING PROVIDER OR OTHER SOURCE - Enter the referring, ordering or supervising provider's first name, middle initial, last name and credentials. This field is required only if there is a referring, ordering or supervising provider.
17a	S	OTHER ID# - Reserved for taxonomy code (preceded by "ZZ" qualifier).
17b	S	NPI # - Enter the 10-digit NPI number of the referring, ordering or supervising provider.
18	S	HOSPITAL DATES RELATED TO CURRENT SERVICES - Enter the hospital dates using an eight-digit date format (MM/DD/CCYY).
19	NR	ADDITIONAL CLAIM INFORMATION (DESIGNATED BY NUCC) - Not required in filing Longevity Health claims.
20	NR	OUTSIDE LAB/CHARGES - Select "Yes" or "No" to indicate if the claim includes charges for lab services performed outside of the physician's office. If "Yes," enter the total charges. NM does NOT allow pass through billing.
21	R	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY - Enter the ICD-9-CM codes. The primary diagnosis should be entered first, followed by other diagnoses if applicable. Up to three additional ICD-9-CM codes can be entered.
22	NR	RESUBMISSION - Not required in filing Longevity Health Claims.
23	NR	PRIOR AUTHORIZATION NUMBER - Not required in filing Longevity Health Claims.
24		SHADED AREA – SUPPLEMENTAL INFORMATION - The shaded area of field 24a - 24h was created to accommodate supplemental information, i.e., Anesthesia. For more information, see the National Uniform Claim Committee's website at www.nucc.org .
24a	R	DATE(S) OF SERVICE - Enter the dates of service using an eight-digit date format (MM/DD/CCYY).
24b	R	PLACE OF SERVICE - Enter the appropriate two-digit Place of Service code.
24c	S	EMG - If this service was an emergency, enter "Y" for "Yes," or leave blank if "No".
24d	R	PROCEDURES, SERVICES, OR SUPPLIES - Enter the CPT or HCPCS code for the procedures, services or supplies, and enter a modifier if applicable.
24e	R	DIAGNOSIS POINTER - Enter the appropriate ICD-9-CM diagnosis code or codes for each procedure performed. Enter one code per line of service.
24f	R	CHARGES - Enter the charge for each line of service. Do not include discounts.
24g	R	DAYS OR UNITS - Enter the number of days or units for each line of service.
24h	S	EPSDT/FAMILY PLAN - If applicable, enter the appropriate Early and Periodic Screening, Diagnosis and Treatment (EPSDT) code or family planning (FP) code.
24i	S	ID QUALIFIER - SHADED FIELD - Reserved for taxonomy code qualifier, "ZZ"; used for Medicaid claims.
24j	S	RENDERING PROVIDER ID. # - SHADED FIELD - Reserved for taxonomy code; used for Medicaid claims.
	R	NON-SHADED FIELD - Enter the performing provider's 10-digit NPI number in the non-shaded area.
25	R	FEDERAL TAX ID NUMBER - Enter the Federal Tax ID Number for the provider of service. Select the appropriate field for SSN or EIN.
26	S	PATIENT ACCOUNT NUMBER - Enter account number assigned to the patient, if applicable.
27	R	ACCEPT ASSIGNMENT - Select "Yes" if the provider should be <u>paid</u> , or select "No" if the patient should be paid.
28	R	TOTAL CHARGE - Enter the total charge for all services (total of all charges in 24f).
29	S	AMOUNT PAID - Enter any amount paid by the patient only. Do not enter any amount by Medicare or other insurance.
30	NR	RSVD FOR NUCC USE - Enter the difference, if any, between the total charge and the amount paid.
31	R	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDE DEGREES OR CREDENTIALS - The claim must be signed by the physician/supplier or an authorized representative. The form must also be dated, using an eight-digit date format (MM/DD/CCYY).
32	S	SERVICE FACILITY LOCATION INFORMATION - Enter the location where the services were rendered. The provider of service must identify the supplier's information when billing for purchased diagnostic tests. Note: Per NUCC Instruction Manual, Field 32 is required if Field 20 is checked "yes." For more info, see the NUCC's website at www.nucc.org .
32a	S	NPI - Enter the 10-digit NPI number of the service facility location.
32b	S	OTHER ID# - Reserved for taxonomy code; used for Medicaid claims. (preceded by "ZZ" qualifier).
33	R	BILLING PROVIDER INFO AND PH# - Enter the information of the billing provider or supplier to be paid for services.
33a	R	NPI - Enter the 10-digit NPI number of the billing provider.
33b	S	OTHER ID # - Reserved for taxonomy code; used for Medicaid claims. (preceded by "ZZ" qualifier).