LONGEVITY
HEALTH PLAN

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.

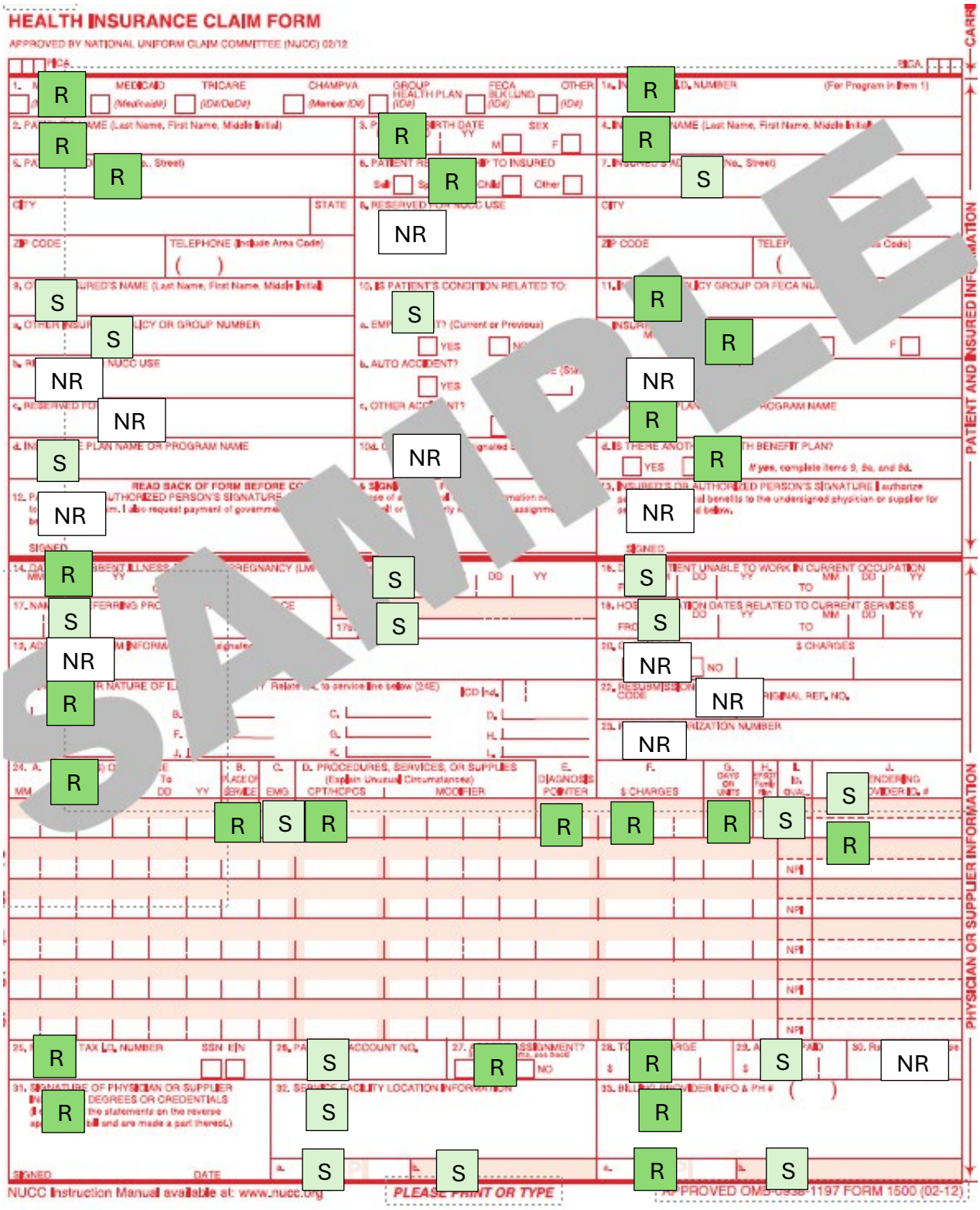
While Longevity Health Plan prefers electronic submission of claims, both electronic and paper claims are accepted. If interested in submitting claims electronically, contact your local Longevity Health Plan Provider Services Department at:

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	LNY01
North Carolina	1-888-332-5941	LNC01

MAIL CLAIMS TO:

Longevity Health Plan – Claims
PO Box 20688
Tampa, FL 33622

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



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	R	- REQUIRED IN FILING A LONGEVITY HEALTH PLAN CLAIM
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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 paid, 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).