



# Claims submission using the AHCCCS Online portal.

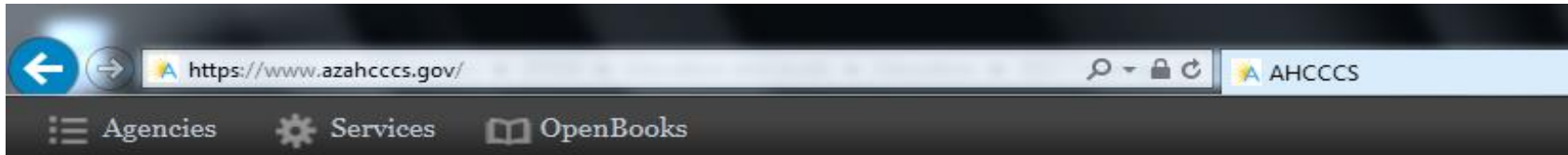
- Claim Type Professional (1500 Form)
- Claim Type Institutional (UB Form)
- Claim Type Dental (ADA Form)



# 5010 Online Claim Submission

## Claim Type Professional (1500 Form)





AHCCCS Online

Current Providers

<https://www.azahcccs.gov/>





Arizona Health Care Cost Containment System  
*Our first care is your health care*

#### New Account

Register for an AHCCCS Online account.

To learn more about AHCCCS Online,  
[Click Here](#)

#### Hospital Assessment

[View Hospital Assessment Invoice](#)

[Make a Hospital Assessment Payment](#)

#### Health Plan Links

[View Health Plan Links](#)

Thank you for visiting AHCCCS Online. In order to use the site, you must have an active account. Please login or register a new account. For questions, please contact our Customer Support Center at **(602) 417-4451**.

**\*\* ATTENTION - SHARING ACCOUNTS IS PROHIBITED! \*\***

Please remember that sharing account logins is prohibited and violates the AHCCCS User Acceptance Agreement. You should NOT share your user name and password with any other individuals. Each user must have their own web account. Access to the web site can be terminated if the User Acceptance Agreement is violated.

#### AHCCCS Online User Manuals

##### Sign In

Username

Password

Forgot your Password? [Click Here](#)

- Passwords are case-sensitive. After 3 failed attempts, within 15 minutes, your account will be locked out, and you will either need to contact your Master Account holder to unlock your account or use the Password Recovery feature.

1 Enter Username

2 Enter Password



Menu

- Claim Status
- Claims Submission
- EFT Enrollment
- Member Verification
- Newborn Notification
- Prior Authorization Inquiry
- Prior Authorization Submission
- Provider Verification
- Provider Re-Enrollment/Revalidation

Support and Manuals

- AHCCCS Online User Manuals
- AHCCCS Online Learn More
- Frequently Asked Questions

Account Information

Username: Training01  
User: Albert Escobedo  
Type: Master  
IP: 170.68.81.110  
Provider ID: 231725

Main Page

▲ For security purposes, your session will be logged out after 15 minutes of inactivity. ▲

**AHCCCS Online is an AHCCCS website designed for registered providers.  
It offers the convenience and efficiency of several online services.**

**CLAIM STATUS**

Claim Status allows providers to check the status of **Fee-For-Service** claims submitted to AHCCCS. If a recipient is enrolled in a capitated Health Plan, the Health Plan contact information is available. For a listing of the Health Plan contact information, please click on [Health Plan Listing](#).

**CLAIM SUBMISSION**

Claim Submission allows providers to submit Professional, Dental and Institutional claims to AHCCCS for nightly processing. Claims submitted prior to 4:00 PM night. Claims submitted after 4:00 PM Friday will be processed the following Monday. The status of the claims can be viewed online by searching for the claim ID. Processing time may take 24-72 hours, depending on the number of claims processed and the time of the submission.

**MEMBER VERIFICATION**

Eligibility and Enrollment Status allows providers to verify an AHCCCS recipient's eligibility and their enrollment in a Health Plan. Providers can also obtain Med party coverage information for a recipient.

**NEWBORN NOTIFICATION**

Newborn Notification allows providers to submit newborn information to AHCCCS during the hours when the COM Center is not available. Status of these submissions can be viewed on the web site within 48 business hours.

**PROVIDER VERIFICATION**

Provider Information allows providers to update their correspondence addresses. Providers may also view (but not update) their Service and Pay-To Addresses and Signatures.

For further information, please click on [AHCCCS Provider Registration](#).

**PROVIDER RE-ENROLLMENT/REVALIDATION**

Provider Re-Enrollment/Revalidation allows providers to submit their re-enrollment information electronically. Providers who were registered with AHCCCS prior to 1/1/10 must re-enroll by mail or e-mail when it is time to re-enroll. All data must be submitted by the indicated timeframe on the letter or the AHCCCS identification number will be terminated. Providers must wait to receive a re-enrollment notice. If documents are received prior to the re-enrollment notices being mailed out, the documents will be processed. Data may be submitted by authorized signers on file with AHCCCS. For further information, please click on [AHCCCS Provider Re-Enrollment](#).

**PRIOR AUTHORIZATION INQUIRY**

1 Select Claims Submission on the Menu

# Claim Submission

## Claim Submission

Claims submitted to AHCCCS prior to 4:00 PM, Monday through Friday, will be processed within 24 to 48 hours. Once the claim has been sent for processing, it can no longer be modified via the web. After the processing deadline, corrections will need to be submitted as a **Replacement** or **Void**. The claim will not be accepted if any required data elements are missing. The claim will also be rejected if the recipient is not eligible for coverage at the time the service is rendered. Claims will be processed under the following Identification Number (Non-Person Entity):

**Payer/Receiver Electronic Transmitter Identification Number:** 866004791

**NOTE:** You cannot view the processing status of claims submitted by other users.

### Enter New Claim

Type of Claim: Professional ▼

Go...

### View Claim Processing Status

Submission Date(s):

-

Go...

- 1 Select Professional in the ▼
- 2 Click GO...



**Menu**

- [Claim Status](#)
- [Claims Submission](#)
- [EFT Enrollment](#)
- [Member Verification](#)
- [Newborn Notification](#)
- [Prior Authorization Inquiry](#)
- [Prior Authorization Submission](#)
- [Provider Verification](#)
- [Provider Re-Enrollment/Revalidation](#)

**Support and Manuals**

- [AHCCCS Online User Manuals](#)
- [AHCCCS Online Learn More](#)
- [Frequently Asked Questions](#)

## Professional Claim Submission

[Help](#)  
\* Indicates a required field.

[Submitter](#) | [Providers](#) | [Patient/Subscriber](#) | [Ambulance](#) | [Other Payer](#) | [Attachments](#) | [Claim Information](#) | [Service Lines](#)

### Submitter

**Organization Name:** TEST/CASE  
**Electronic Transmitter ID Number:** 99222  
**Information Contact Name:** Escobedo, Albert  
**Information Contact Telephone Number:** 602-417-4562

1 This is the Submitter screen— verify the correct provider information (some providers may have more than 1 ID)

2 Select the Providers tab next



Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
Billing Provider	Rendering Provider	Referring Provider	Service Facility				

**Billing Provider**

**\* Tax ID:**   SSN  EIN

**Provider Commercial Number:**

**\* CMMS National Provider ID (NPI):**

**\* Entity Type:**  Person  Non-Person Entity

**Health Care Provider Taxonomy Code:**

**Provider Name:** TEST/CASE

**Information Contact Name:**

**Information Contact Telephone Number:** 6024174000

**Service Locator Code/Address:**  701 E. JEFFERSON  
PHOENIX, AZ 85004

**Pay-To Locator Code/Address:**  701 E. JEFFERSON  
PHOENIX, AZ 85004

- 1 This is the Billing Provider screen – fill out all the areas marked by red asterisks
- 2 Tax ID – enter biller or group tax ID
- 3 Provider Commercial Number – enter in the 6 digit AHCCCS ID here- if you do not have a valid NPI# leave that field blank
- 4 CMMS National Provider ID (NPI) – enter valid NPI#, leaving the Provider Commercial Number blank
- 5 Entity type – select “person” if the id number belongs to a person or “non-person” if a company is identified
- 6 Click “Find” – provider information should be displayed
- 7 Select the Rendering Provider tab next



## Professional Claim Submission

[Help](#)

\* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
Billing Provider	Rendering Provider	Referring Provider	Service Facility				

### Rendering Provider

Provider Commercial Number:

\* CMMS National Provider ID (NPI):

\* Entity Type:  Person  Non-Person Entity

Provider Name:

Performing Health Care Provider Taxonomy Code:

- 1 This is the Rendering Provider screen– fill out all areas marked with red asterisks, refer to previous slide since all definitions remain the same
- 2 CMMS National Provider ID (NPI) – Enter NPI
- 2 Click “Find” – the provider information should be displayed
- 3 Select the Referring Provider tab next, if there is a referring provider. Select the Patient/Subscriber tab next, if there is not a referring provider

# Referring Provider Tab – to be filled out only for specific providers PLEASE REFER TO THE LIST BELOW.

## Professional Claim Submission

[Help](#)  
\* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
Billing Provider	Rendering Provider	Referring Provider	Service Facility				

**Referring Provider (Person)**

Provider Commercial Number:

CMMS National Provider ID (NPI):

Provider Name:

1 The following services require submission of a Referring/Ordering provider:

- ✓ Laboratory, Radiology, Medical and Surgical Supplies, Respiratory DME, Enteral and Parenteral Therapy, Durable Medical Equipment, Drugs (J-Codes), Temporary K and Q codes, Orthotics, Prosthetics, Vision codes (V-codes), 97001-97546

2 Ordering providers must be M.D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Podiatrist, Psychologist or Certified Nurse Midwife.

Here is the link where you can find this information in the AHCCCS Provider Manual:

[https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS\\_Chap05.pdf](https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap05.pdf)

## Professional Claim Submission

[Help](#)

\* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
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### Insured or Subscriber

\* **Member ID Number/Date of Birth:**

**Person Name:** TEST, MEMBER  
**Gender:** M

**Residential Address:** 801 E JEFFERSON ST  
PHOENIX, AZ 85008

\* **Payer Responsibility:**

NOTE: AHCCCS no longer accepts ADOC claims.

- 1 This is the Patient/Subscriber screen– fill out all areas marked with red asterisks
- 2 Member ID Number/Date of Birth - Enter the members AHCCCS information (ID and Date of Birth)
- 3 Payer Responsibility- Enter the Payer Responsibility information by selecting P-Primary
- 4 Click “Find”- member information should be displayed
- 5 To send an attachment, select the Attachments tab. If you do not have an attachment, select the Claim Information tab. *For today’s training, we will be choosing to send an attachment.*

\* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
<b>Claim Attachments</b>							
	<b>Report Type **</b>	<b>Report Transmission **</b>	<b>Control Number **</b>				
1	B4 - Referral Form ▼	EL - Electronically Only ▼	A98734947021617				
2	▼	▼					
3	▼	▼					
4	▼	▼					
<b>Attachments (1-10):</b>	5	▼	▼				
	6	▼	▼				
	7	▼	▼				
	8	▼	▼				
	9	▼	▼				
	10	▼	▼				

\*\* Required ONLY if Attachment information is submitted.

- 1 This is the Claim Attachments screen
- 2 Report Type - Click the ▼ and select B4 – Referral Form
- 3 Report Transmission - Click the ▼ and select EL – Electronically Only
- 4 Control Number - Enter the PWK number. We recommend you use the members AHCCCS ID followed by the Date of Service, making sure the “A” in the ID is capitalized (see the next screen for additional information)
- 5 Select the Claim Information tab

## Example of a PWK number using a member's AHCCCS ID and the Date of Service

AHCCCS ID (9-character AHCCCS ID) The A in AHCCCSID must be a capital letter	A12345678
Date of Service	08/05/15
PWK for Claim 1, Document 1	A12345678080515

## Different AHCCCS ID member with the Same Date of Services

AHCCCS ID (9-character AHCCCS ID) The A in AHCCCSID must be a capital letter	A87654321
Date of Service	08/05/15
PWK for Claim 2, Document 2	A87654321080515

The combination of the member's AHCCCS ID and the Date of Service is what makes the PWK number unique to each claim.

**PWK?** The PWK is a number that you will create for each document you want to submit, this number will allow the system to link the attachment to the appropriate claim. Ensure there are no spaces and you use a capital letter.



Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
<b>Claim Information</b>							
<b>Original Reference Number:</b>		<input type="text"/>	<input type="radio"/> Replacement <input type="radio"/> Void				
<b>Prior Authorization Number:</b>		<input type="text"/>					
<b>* Patient Control Number:</b>		<input type="text" value="A98734947"/>					
<b>Medical Record ID Number:</b>		<input type="text"/>					
<b>Initial Treatment Date:</b>		<input type="text"/>					
<b>Date of Current Injury:</b>		<input type="text"/>	(Accident)				
<b>** Patient's Condition Related To:</b>		<input checked="" type="checkbox"/> Employment <input type="checkbox"/> Other Accident <input type="checkbox"/> Auto Accident					
<b>*** Place in which accident occurred:</b>		<input type="text" value="State"/>					
<b>Special Program Indicator:</b>		<input type="text"/>					
<b>* Provider Signature on File:</b>		<input checked="" type="radio"/> Yes <input type="radio"/> No					
<b>* Provider Accept Assignment:</b>		<input checked="" type="radio"/> Assigned <input type="radio"/> Accepted on Clinical Lab Services Only <input type="radio"/> Not Assigned					
<b>* Benefit Assignment:</b>		<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> Not Applicable					
<b>* Release of Information Consent:</b>		<input checked="" type="radio"/> Informed Consent <input type="radio"/> Yes					
<b>EPSTD Screening Referral:</b>		<input type="radio"/> Yes <input type="radio"/> No (Mutually Defined)					

- 1 This is the Claim Information screen– fill out all the areas marked by red asterisks
- 2 Patient Control Number - Enter the members AHCCCS ID or Patient Acct Number
- 3 Provider Signature on File– select “yes” since you are a billing agency & you have the provider’s signature on file
- 4 Provider Accept Assignment – select “Assigned” if you are accepting payment from AHCCCS
- 5 Benefit Assignment – select “Not Applicable”
- 6 Release of Information Consent – select “Informed Consent”, if a signed consent by the patient to release medical data is on file
- 7 Select the Service Lines tab

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
<b>Diagnosis or Nature of Illness or Injury (Relate Items 1 - 12 by line to the Diagnosis Code Pointer)</b>							
* Standard: <input type="radio"/> ICD-9 <input checked="" type="radio"/> ICD-10		* Diagnosis Codes: 1 R8889 2 3 4 5 6 7 8 9 10 11 12					
<b>Service Line</b>							
* Diagnosis Code Pointers: 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/>							
* Service Dates: 01/01/2017 - 01/01/2017		* Place of Service Code (POS): 99 - OTHER UNLISTED FACILITY					
* Line Charges: \$ 14.54		* Quantity: 2 <input type="radio"/> Minutes <input checked="" type="radio"/> Units					
* HCPCS Code: A0120		* Modifier Codes: 1 TN 2 3 4					
National Drug Code:		Prescription Date:					
**NDC Quantity/Measure:		**Prescription #/Identifier:					
Immunization Batch Number:		Taxonomy Code: (Performing HC Provider)					
Indicators: Emergency <input type="checkbox"/> EPSDT <input type="checkbox"/>		Patient Count:					
Provider Control Number:		* Other Payer: Primary ID Paid Amount \$ Units Procedure Code/Qualifier					
**Medicare: Paid Amount \$ Units Procedure Code/Qualifier							

- 1 This is the Service Lines screen – fill out all areas marked with red asterisks
- 2 Diagnosis Code – Enter ICD-10 Diagnosis Codes, you can enter more than one code
- 3 Diagnosis Code Pointers – Select the number of diagnosis codes you have entered. In our example, we entered 1 diagnosis code and then selected 1 under the Diagnosis Code Pointer
- 4 Service Dates – enter the date service was provide
- 5 Line Charges– enter billing charges per line
- 6 Quantity – enter in units/days
- 7 HCPCS Code – enter the procedure code
- 8 Place of Service Code (POS) – click ▼ and choose from the list
- 9 Modifier Code – if applicable, you can enter up to 4 codes



Submitter    Providers    Patient/Subscriber    Ambulance    Other Payer    Attachments    Claim Information    Service Lines

**Diagnosis or Nature of Illness or Injury (Relate Items 1 - 12 by line to the Diagnosis Code Pointer)**

\* Standard:  ICD-9  ICD-10      \* Diagnosis Codes: 1 R8889 2 3 4 5 6 7 8 9 10 11 12

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**Service Line**

\* Diagnosis Code Pointers: 1 2 3 4 5 6 7 8 9 10 11 12

\* Service Dates: -

\* Line Charges: \$

\* Quantity:   Minutes  Units

\* HCPCS Code:

National Drug Code:

\*\*NDC Quantity/Measure:

Immunization Batch Number:

Indicators: Emergency  EPSDT

Provider Control Number:

\*\*Other Payer: Primary ID  Paid Amount \$  Units  Procedure Code/Qualifier

\*\*Medicare: Paid Amount \$  Units  Procedure Code/Qualifier

Other Adjustment(s): Medicare Deductible \$  Medicare Coinsurance \$  Medicare Copay \$

\*\*Durable Medical Equipment: HCPCS  Purchase Price \$  Rental Price \$  Length of Medical Necessity  (Days)

\*\*Ordering Physician: Plan ID  Last Name  First Name  City

\*\* All or none of the information is required for the line or group.

Line No.	Begin Date	End Date	POS	HCPCS	Mod 1	Mod 2	Mod 3	Mod 4	NDC Code	NDC Units	Diag 1	Diag 2	Diag 3	Diag 4	Diag 5	Diag 6	Diag 7	Diag 8	Diag 9	Diag 10	Diag 11	Diag 12	Min./Units	Type	Line Charges	Medicare Paid Amount	Units	Proc Code	D																						
1	1/1/2017	1/1/2017	99	A0120	TN					0	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	UN	14.54		0																								
																								<b>Totals: \$14.54</b>		<b>\$0.00</b>																									

- 1 Click Add - when you have entered all information under the Service Line section
- 2 At the bottom of the screen, the Service Line/s entered will populate, after which the Service Line section fields will clear allowing you to add another service line

Add


\*\* All or none of the information is required for the line or group.

Line No.	Begin Date	End Date	POS	HCPCS	Mod 1	Mod 2	Mod 3	Mod 4	NDC Code	NDC Units	Diag 1	Diag 2	Diag 3	Diag 4	Diag 5	Diag 6	Diag 7	Diag 8	Diag 9	Diag 10	Diag 11	Diag 12	Min./Units	Type	Line Charges	Medicare Paid Amount	Units	Pro Cod
1	1/1/2017	1/1/2017	99	A0120	TN	.	.	.	.	0.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2.000	UN	14.54	.	0.
2	1/31/2017	1/31/2017	99	S0215	TN	.	.	.	.	0.000	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	100.000	UN	150.00	.	0.000
<b>Totals: \$164.54</b>																									<b>\$0.00</b>			

Update

\*\* All or none of the information is required for the line or group.

Line No.	Begin Date	End Date	POS	HCPCS	Mod 1	Mod 2	Mod 3	Mod 4	NDC Code	NDC Units	Diag 1	Diag 2	Diag 3	Diag 4	Diag 5	Diag 6	Diag 7	Diag 8	Diag 9	Diag 10	Diag 11	Diag 12	Min./Units	Type	Line Charges	Medicare Paid Amount	Units	Pro Cod
1	01/01/2017	01/01/2017	99	A0120	TN	.	.	.	.	0.000	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2.000	UN	14.54	.	0.000
2	01/31/2017	01/31/2017	99	S0215	TN	.	.	.	.	0.000	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	100.000	UN	150.00	.	0.000
<b>Totals: \$164.54</b>																									<b>\$0.00</b>			

**Top screen**      The Service Line will allow you to continue to Add more lines unless you click the edit  or the remove button **X**

**Bottom screen**      When you have entered all Service Lines whether you edited or removed items, you will have the option to Update the changes

Submitter   Providers   Patient/Subscriber   Ambulance   Other Payer   Attachments   Claim Information   Service Lines

### Diagnosis or Nature of Illness or Injury (Relate Items 1 - 12 by line to the Diagnosis Code Pointer)

\* Standard:  ICD-9  ICD-10      \* Diagnosis Codes: 1 R8889   2   3   4   5   6  
7   8   9   10   11   12

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### Service Line

\* Diagnosis Code Pointers: 1  2  3  4  5  6  7  8  9  10  11  12

\* Service Dates: \_\_\_\_\_ - \_\_\_\_\_

\* Line Charges: \$ \_\_\_\_\_

\* Quantity: \_\_\_\_\_  Minutes  Units

\* HCPCS Code: \_\_\_\_\_

National Drug Code: \_\_\_\_\_

\*\*NDC Quantity/Measure: \_\_\_\_\_

Immunization Batch Number: \_\_\_\_\_

Indicators: Emergency     EPSDT

Provider Control Number: \_\_\_\_\_

\*\*Other Payer: Primary ID \_\_\_\_\_ Paid Amount \$ \_\_\_\_\_ Units \_\_\_\_\_ Procedure Code/Qualifier \_\_\_\_\_

\*\*Medicare: Paid Amount \$ \_\_\_\_\_ Units \_\_\_\_\_ Procedure Code/Qualifier \_\_\_\_\_

Other Adjustment(s): Medicare Deductible \$ \_\_\_\_\_ Medicare Coinsurance \$ \_\_\_\_\_ Medicare Copay \$ \_\_\_\_\_

\*\*Durable Medical Equipment: HCPCS \_\_\_\_\_ Purchase Price \$ \_\_\_\_\_ Rental Price \$ \_\_\_\_\_ Length of Medical Necessity \_\_\_\_\_ (Days)

\*\*Ordering Physician: Plan ID \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ City \_\_\_\_\_

\*\* All or none of the information is required for the line or group.

Line No.	Begin Date	End Date	POS	HCPCS	Mod 1	Mod 2	Mod 3	Mod 4	NDC Code	NDC Units	Diag 1	Diag 2	Diag 3	Diag 4	Diag 5	Diag 6	Diag 7	Diag 8	Diag 9	Diag 10	Diag 11	Diag 12	Min./Units	Type	Line Charges	Medicare Paid Amount	Units	Proc Code
X 1	1/2/2017	1/2/2017	99	A0120	TN					0	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	UN	14.54		0	
X 2	1/2/2017	1/2/2017	99	S0215	TN	-	-	-	-	0	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	100	UN	150.00		0	
																							<b>Totals:</b>	<b>\$164.54</b>	<b>\$0.00</b>			

1 When you have completed entering all the relevant claim/s information, click Submit

### Claim Entry Confirmation

**Transmission Status:** Successful  
**Claim Type:** Professional  
**Patient Account Number:** A98734947  
**Confirmation Code:** P-269

**Error:**

**Attachments**

Beginning with services incurred on 7/1/2013, all NEMT claims must be submitted with the new AHCCCS standard Daily Trip Report. Effective with service dates 8/1/2013 and forward, any non-emergency transport claim that is submitted without the standard Daily Trip Report will be denied. It is the provider's responsibility to maintain all documentation that supports each transport service claimed. Please click [here](#) to submit an attachment.

View Claim

Enter New Claim

- 1 This is the Claim Entry Confirmation screen
- 2 The Transmission status will let you know the claim was submitted successfully
- 3 You have 2 options: View Claim to give you a summary of the claim that will be sent to AHCCCS or Enter New Claim
- 4 Select the "View Claim" button

## Arizona Health Care Cost Containment System Professional Claim Submission

Print Date: 6/19/2012 9:45:45 AM  
Confirmation Code: P-30

### Submitter

Organization Name: TEST/CASE  
Information Contact Name: Escobedo, Albert  
Information Contact Telephone #: 602-417-4562  
Electronic Transmitter ID: 99222

### Billing Provider

Tax ID: 122456789 (SY)  
National Provider ID (NPI):  
Provider Commercial Number/Name: 231725 (TEST/CASE)  
Provider Taxonomy Code:  
Entity Type: Person  
Information Contact Name:  
Information Contact Telephone #: 602-417-4000  
Service Address: 701 E. JEFFERSON  
PHOENIX, AZ 85004  
Pay-To Provider Address: 701 E. JEFFERSON  
PHOENIX, AZ 85004

### Rendering Provider

Provider Commercial Number/Name: 231725 (TEST/CASE)  
Entity Type: Person  
National Provider ID (NPI):  
Performing Provider Taxonomy Code:

### Service Facility

National Provider ID (NPI):  
Laboratory or Facility Name:  
Address:

### Referring Provider

National Provider ID (NPI):  
Provider Commercial Number/Name: ( )

### Patient/Insured

Member ID Number/Name: AB1345732 (TESTRECORD, NEW S)  
Date of Birth: 01/01/1995  
Gender: M  
Residential Address: 801 E JEFFERSON  
PHX, AZ 85039  
Payer Responsibility: Primary

### Ambulance Information

Pick-up Address:  
Drop-off Location Name:  
Drop-off Address:

### Attachments

Type	Transmission	Control Number
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

### Other Payer Information

Insured Identifier: ( )  
Insured/Subscriber Name: ( )  
Insured Address (City):  
Payer Primary ID:  
Payer Name:  
Payer Address (City):  
Responsibility:  
Insured Group or Policy Number:  
Insured Group Name:  
Individual Relationship:  
Insurance Type:  
Claim Filing Indicator:  
Benefit Assignment Certification:  
Release of Information:  
Payer Amount Paid:  
Date Claim Paid:

### Claim Detail

Original Reference Number:  
Prior Authorization Number:  
Patient's Control Number: ACCOUNT NUMBER  
Medical Record ID Number:  
Initial Treatment Date:  
Date of Current Injury:  
Patient's condition related to:  
Place in which accident occurred:  
Special Program Indicator:  
Provider Signature on File: Yes  
Provider Accept Assignment: Assigned  
Benefit Assignment: Not Applicable  
Release of Information Consent: Informed Consent  
EPSDT Screening Referral:

Condition Indicator(s)	1	2	3	4
Coding Standard: ICD-9				
Diagnosis Code(s)	1 799.9	2	3	4
	5	6	7	8

### Service Lines

#### Summary

Line No.	Begin Date	End Date	POS	HCPCS	Mod 1	Mod 2	Mod 3	Mod 4	NDC Code	NDC Units	Dias 1	Dias 2	Dias 3	Dias 4	Dias 5	Dias 6	Dias 7	Dias 8	Dias 9	Dias 0	Quantity	Line Charges	Medicare Paid Amount	Medicare Deductible Amount	Medicare Coinsurance Amount	Medicare Copay Amount	Other Payer Paid Amount	EMG	EPSDT	Cost							
1	06/18/2012	06/18/2012	99	A0120						0.000	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2.000	UN 14.34	0.00	0.00	0.00	0.00	0.00	<input type="checkbox"/>	<input type="checkbox"/>								
2	06/18/2012	06/18/2012	99	S0215						0.000	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	110.000	UN 168.30	0.00	0.00	0.00	0.00	0.00	<input type="checkbox"/>	<input type="checkbox"/>								
																							<b>Totals:</b>	<b>\$182.64</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>								

#### Details

1 The summary screen will be displayed and you can now review the entire information you entered for this claim

2 You have the option to edit the claim again or start a new claim

## Claim Submission

Claims submitted to AHCCCS prior to 4:00 PM, Monday through Friday, will be processed within 24 to 48 hours. Once the claim has been sent for processing, it can no longer be modified via the web. After the processing deadline, corrections will need to be submitted as a **Replacement** or **Void**. The claim will not be accepted if any required data elements are missing. The claim will also be rejected if the recipient is not eligible for coverage at the time the service is rendered. Claims will be processed under the following Identification Number (Non-Person Entity):

**Payer/Receiver Electronic Transmitter Identification Number:** 866004791

**NOTE:** You cannot view the processing status of claims submitted by other users.

### Enter New Claim

Type of Claim:

### View Claim Processing Status

Submission Date(s):  -

- 1 Enter New Claim – If you enter the “Type of Claim” and click “go” in this area, you will be re-directed back to the main screen
- 2 View Claim Processing Status – If you enter data here by either entering the day of service or by entering a span and click the “go” in this area, you can view the processing status for this claim

## Claim Submission Status

Claim Type	Creation Date/Time	Submission Date/Time	Patient Account #	Service Prov. NPI	Billing Prov. NPI	Date From	Date Thru	Status	Processing Date/Time	CRN Adjudication
Institutional	06/01/16 01:50 PM	06/01/16 01:50 PM	99999999			06/01/16	06/01/16	Processed	06/01/16 02:59 PM	
Institutional	12/30/16 03:12 PM	12/30/16 03:12 PM	A98155234			12/30/16	12/30/16	Processed	12/31/16 09:00 AM	
Professional	04/29/16 09:54 AM	04/29/16 09:54 AM	A95983554			04/29/16	04/29/16	Processed	04/29/16 12:00 PM	
Professional	05/26/16 09:25 AM	05/26/16 09:25 AM	A99999999			05/26/16	05/26/16	Processed	05/26/16 12:00 PM	
Professional	06/06/16 10:52 AM	06/06/16 10:52 AM	A99999999			06/01/16	06/04/16	Processed	06/06/16 12:00 PM	
Professional	06/13/16 02:15 PM	06/13/16 02:15 PM	A99999999			06/01/16	06/01/16	Processed	06/13/16 02:59 PM	
Professional	06/16/16 01:15 PM	06/16/16 01:15 PM	99999999			06/01/16	06/01/16	Processed	06/16/16 02:59 PM	
Professional	06/27/16 01:26 PM	06/27/16 01:26 PM	A99999999			06/01/16	06/01/16	Processed	06/27/16 02:59 PM	
Professional	06/29/16 01:52 PM	06/29/16 01:52 PM	A9999999	1366765190	1366765190	06/01/16	06/01/16	Processed	06/29/16 03:00 PM	
Professional	06/30/16 11:17 AM	06/30/16 11:17 AM	A9999999	1265880090	1265880090	06/20/16	06/27/16	Processed	06/30/16 12:00 PM	
Professional	07/08/16 10:33 AM	07/08/16 10:33 AM	A99999999			06/01/16	06/05/16	Processed	07/08/16 12:00 PM	
Professional	07/11/16 01:40 PM	07/11/16 01:40 PM	A999999999			06/01/16	06/01/16	Processed	07/11/16 03:00 PM	
Professional	11/16/16 10:34 AM	11/16/16 10:34 AM	A98155234			11/16/16	11/16/16	Processed	11/16/16 12:00 PM	
Professional	11/21/16 02:36 PM	11/21/16 02:36 PM	A98155234			11/21/16	11/21/16	Processed	11/21/16 03:00 PM	
Professional	11/22/16 09:59 AM	11/22/16 09:59 AM	A98155234			11/22/16	11/22/16	Processed	11/22/16 12:00 PM	
Professional	11/25/16 02:08 PM	11/25/16 02:08 PM	A98155234			11/22/16	11/22/16	Processed	11/25/16 03:00 PM	

Record Count: 16

< Previous

- 1 Entering a span of months allows you to see previous claims submitted. These are only SNAPSHOTS of the claims.
- 2 You have the option to view the Claim Processing Status by entering the day of service or enter a span



# Questions?





# 5010 Online Claim Submission

## Institutional (UB Form)

## Claim Submission

Claims submitted to AHCCCS prior to 4:00 PM, Monday through Friday, will be processed within 24 to 48 hours. Once the claim has been sent for processing, it can no longer be modified via the web. After the processing deadline, corrections will need to be submitted as a **Replacement** or **Void**. The claim will not be accepted if any required data elements are missing. The claim will also be rejected if the recipient is not eligible for coverage at the time the service is rendered. Claims will be processed under the following Identification Number (Non-Person Entity):

**Payer/Receiver Electronic Transmitter Identification Number:** 866004791

**NOTE:** You cannot view the processing status of claims submitted by other users.

### Enter New Claim

Type of Claim:

- Institutional
- Professional
- Institutional
- Dental

### View Claim Processing Status

Submission Date(s):  -

1 Enter New Claim – Select Institution on the ▼

2 Click on “Go” ...

## Institutional Claim Submission

[Help](#)

\* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Codes/Values	Attachments	Claim Information	Service Lines
<b>Submitter</b>							
Organization Name: TEST/CASE							
Electronic Transmitter ID Number: 99222							
Information Contact Name: AHCCCS							
Information Contact Telephone Number: 602-999-9999							

Save

Submit

Cancel

- 1 This is the Submitter screen– verify the correct provider information (some providers have more than 1 ID)
- 2 Select the Providers tab next

\* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Codes/Values	Attachments	Claim Information	Service Lines
Billing Provider	Referring Provider	Service Facility	Attending Provider	Operating Provider			

**Billing Provider**

\* Tax ID:   SSN  EIN

Provider Commercial Number:

\* CMMS National Provider ID (NPI):

\* Entity Type:  Person  Non-Person Entity

Health Care Provider Taxonomy Code:

Provider Name: \_\_\_\_\_

Information Contact Name: \_\_\_\_\_

Information Contact Telephone Number: \_\_\_\_\_

Service Locator Code/Address: \_\_\_\_\_

Pay-To Locator Code/Address: \_\_\_\_\_

- 1 This is the Billing screen – fill out all the areas marked by red asterisks
- 2 Tax ID – enter biller or group tax ID
- 3 CMMS National Provider ID (NPI) – enter valid NPI#, leaving the Provider Commercial Number blank (Hospital or facility can only bill using the NPI number)
- 4 Entity type – select “non-person”
- 5 Click Find – either hospital or facility information should be displayed
- 6 Select the Referring tab next

## Institutional Claim Submission

Submitter	Providers	Patient/Subscriber	Other Payer	Codes/Values	Attachments	Claim Information	Service Lines
Billing Provider	Referring Provider	Service Facility	Attending Provider	Operating Provider			

**Referring Provider (Person)**

**Provider Commercial Number:**

**CMMS National Provider ID (NPI):**

**Provider Name:**

- 1 This is the Referring Provider screen
- 2 CMMS National Provider ID– Enter NPI number
- 3 Click Find – the Referring Provider information should be displayed
- 4 Select the Attending Provider tab next

## Institutional Claim Submission

Submitter	Providers	Patient/Subscriber	Other Payer	Codes/Values	Attachments	Claim Information	Service Lines
Billing Provider	Referring Provider	Service Facility	Attending Provider	Operating Provider			

**Attending Physician**

**Provider Commercial Number:**

**National Provider ID (NPI):**

**Person Name:**

- 1 This is the Attending Provider screen – required for Institutional/UB
- 2 National Provider ID (NPI) - Enter NPI number
- 3 Click Find – the Attending Provider information should be displayed
- 4 Select the Patient/Subscriber tab next



## Institutional Claim Submission

[Help](#)

\* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Codes/Values	Attachments	Claim Information	Service Lines
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### Insured or Subscriber

\* **Member ID Number/Date of Birth:**

**Person Name:** TEST, MEMBER S  
**Gender:** F  
**Residential Address:** 701 E JEFFERSON  
PHX, AZ 85039

\* **Payer Responsibility:**  ▼

NOTE: AHCCCS no longer accepts ADOC claims.

- 1 This is the Patient/Subscriber screen – fill out all the areas marked by red asterisks
- 2 Member ID number/Date of Birth – Enter the members AHCCCS ID and date of birth
- 3 Payer Responsibility – select P-Primary
- 4 Click Find – member information should be displayed
- 5 Select the Codes/Values tab next

## Institutional Claim Submission

[Help](#)

\* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Codes/Values	Attachments	Claim Information	Service Lines
Procedure Codes	Diagnosis Codes	Condition Codes	Occurrence Codes	Value Codes			
Procedure Information							
** Principal Code/Date:		<input type="text"/>	<input type="text"/>				
	Code	Date **		Code	Date **		
	1	<input type="text"/>	<input type="text"/>	2	<input type="text"/>	<input type="text"/>	
	3	<input type="text"/>	<input type="text"/>	4	<input type="text"/>	<input type="text"/>	
Other Procedures (1-12):	5	<input type="text"/>	<input type="text"/>	6	<input type="text"/>	<input type="text"/>	
	7	<input type="text"/>	<input type="text"/>	8	<input type="text"/>	<input type="text"/>	
	9	<input type="text"/>	<input type="text"/>	10	<input type="text"/>	<input type="text"/>	
	11	<input type="text"/>	<input type="text"/>	12	<input type="text"/>	<input type="text"/>	

\*\* Required ONLY if Procedure Code is submitted.

Save

Submit

Cancel

1 This is the Codes/Values screen

2 Principal Code/Date – If billing for inpatient, enter procedure code/s and date

3 Select the Diagnosis Codes tab next

## Institutional Claim Submission

[Help](#)

\* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Codes/Values	Attachments	Claim Information	Service Lines
Procedure Codes	Diagnosis Codes	Condition Codes	Occurrence Codes	Value Codes			
Diagnosis Information							
* Principal Diagnosis Code:		<input type="text" value="R6889"/>	Present on Admission:		<input type="text"/>	<input type="text"/>	<input type="text"/>
Admitting Diagnosis Code:		<input type="text"/>					
External Cause of Injury Codes (1-12):		1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>
		7 <input type="text"/>	8 <input type="text"/>	9 <input type="text"/>	10 <input type="text"/>	11 <input type="text"/>	12 <input type="text"/>
		Code	Present on Admission	Code	Present on Admission		
		1 <input type="text"/>	<input type="text"/>	2 <input type="text"/>	<input type="text"/>		
		3 <input type="text"/>	<input type="text"/>	4 <input type="text"/>	<input type="text"/>		
Other Diagnosis (1-12):		5 <input type="text"/>	<input type="text"/>	6 <input type="text"/>	<input type="text"/>		

1 This is the Diagnosis Codes tab

2 Principal Diagnosis Code – Enter the Principal Diagnosis Code

3 For the rest of the fields on this screen, enter information if they apply to you

4 Select the Claim Information tab next

Submitter	Providers	Patient/Subscriber	Other Payer	Codes/Values	Attachments	Claim Information	Service Lines
<b>Claim Information</b>							
* <b>Provider Accept Assignment:</b> <input checked="" type="radio"/> Assigned <input type="radio"/> Accepted on Clinical Lab Services Only <input type="radio"/> Not Assigned				Admission Type: <input type="text"/>			
* <b>Benefit Assignment:</b> <input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> Not Applicable				* <b>Admission Date:</b> <input type="text"/>			
* <b>Release of Information:</b> <input checked="" type="radio"/> Informed Consent <input type="radio"/> Yes				Admission Time: <input type="text"/> (HHMM)			
* <b>Patient Control Number:</b> <input type="text" value="999999999"/>				Discharge Time: <input type="text"/> (HHMM)			
* <b>Patient Status:</b> <input type="text" value="30 - STILL PATIENT"/>				* <b>Statement From/To Date:</b> <input type="text"/> - <input type="text"/>			
Admission Source: <input type="text"/>				* <b>Claim Form Bill Type:</b> <input type="text"/>			
Delay Reason Code: <input type="text"/>				Medical Record ID #: <input type="text"/>			
* <b>Total Claim Charge Amount</b> \$ 4440 (Total for all service lines)				Original Reference #: <input type="text"/>			
* <b>Facility Type Code:</b> <input type="text" value="31 - SKILLED NURSING FACILITY"/>				Prior Authorization #: <input type="text"/>			
* <b>Standard:</b> <input type="radio"/> ICD-9 <input checked="" type="radio"/> ICD-10				Location: <input type="text"/> (Auto Accident State)			

- 1 This is the Claim information screen – fill out all the areas marked by red asterisks
- 2 Provider Accept Assignment – select “Assigned” if you are accepting payment from AHCCCS
- 3 Benefit Assignment – select “Not Applicable”
- 4 Release of Information Consent – select “Informed Consent” if a signed consent by the patient to release medical data is on file
- 5 Patient Control Number – Enter patients acct # or AHCCCS ID depending on your office
- 6 Patient Status – click the ▼ and choose from the list

Submitter	Providers	Patient/Subscriber	Other Payer	Codes/Values	Attachments	Claim Information	Service Lines
<b>Claim Information</b>							
* <b>Provider Accept Assignment:</b> <input checked="" type="radio"/> Assigned <input type="radio"/> Accepted on Clinical Lab Services Only <input type="radio"/> Not Assigned				<b>Admission Type:</b> <input type="text"/>			
* <b>Benefit Assignment:</b> <input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> Not Applicable				* <b>Admission Date:</b> 12/01/2016			
* <b>Release of Information:</b> <input checked="" type="radio"/> Informed Consent <input type="radio"/> Yes				<b>Admission Time:</b> <input type="text"/> (HHMM)			
* <b>Patient Control Number:</b> 99999999				<b>Discharge Time:</b> <input type="text"/> (HHMM)			
* <b>Patient Status:</b> 30 - STILL PATIENT				* <b>Statement From/To Date:</b> 01/01/2017 - 01/01/2017			
<b>Admission Source:</b> <input type="text"/>				* <b>Claim Form Bill Type:</b> 212 (Original)			
<b>Delay Reason Code:</b> <input type="text"/>				<b>Medical Record ID #:</b> <input type="text"/>			
* <b>Total Claim Charge Amount</b> \$ 44440 (Total for all service lines)				<b>Original Reference #:</b> <input type="text"/>			
* <b>Facility Type Code:</b> 31 - SKILLED NURSING FACILITY				<b>Prior Authorization #:</b> <input type="text"/>			
* <b>Standard:</b> <input type="radio"/> ICD-9 <input checked="" type="radio"/> ICD-10				<b>Location:</b> <input type="text"/> (Auto Accident State)			
<b>Patient's Reason(s) for Visit:</b>				<b>Additional Information:</b>			
1 <input type="text"/>							
2 <input type="text"/>							
3 <input type="text"/>							

## Continuation in the Claim information screen

- 7 Total Claim Charge Amount – Enter the total charges from the whole claim
- 8 Facility Type Code –click the ▼ and choose from the list
- 9 Standard – select ICD-10
- 10 If inpatient – Enter Admission type - click the ▼ and choose from the list
- 11 If inpatient – Enter Admission date – Enter the date the member was seen
- 12 If inpatient – Enter Admission/Discharge time
- 13 Statement From/To Date – Enter span date or single date
- 14 Select the Service Lines tab next

\* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Codes/Values	Attachments	Claim Information	Service Lines
<b>Service Line</b>							
* Service Dates: 01/01/2017 - 01/31/2017		* Service Unit Count: 31 <input type="radio"/> Days <input checked="" type="radio"/> Units		** Revenue Code: <input type="text"/>		* Line Item Charge Amount: \$ 4440.00	
** HCPCS: <input type="text"/>		Non-Covered Charge Amount: \$ <input type="text"/>		National Drug Code (5-4-2 Format): <input type="text"/>		Medicare Deductible/Quantity: \$ <input type="text"/> <input type="text"/>	
NDC Quantity/Measurement: <input type="text"/> <input type="text"/> ▼		Medicare Copayment/Quantity: \$ <input type="text"/> <input type="text"/>		Procedure Modifiers: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>		Medicare Coinsurance/Quantity: \$ <input type="text"/> <input type="text"/>	
Provider Control Number: <input type="text"/>		Date Claim Paid: <input type="text"/>		Prescription Number/Reference ID: <input type="text"/> <input type="text"/> ▼			
<input type="button" value="Add"/>							
** Either Revenue Code or HCPCS Code required for the service line.							

- 1 This is the Service Lines screen - fill out all the areas marked by red asterisks
- 2 Service Dates – Enter the date(s) of service
- 3 Revenue Code – Enter a Revenue Code
- 4 Service Unit Count – enter the unit or days you are billing
- 5 Line Item Charge Amount – Enter the dollar amount that will be charged to the line billed
- 6 Click Add to complete the entry - you can enter additional lines, if needed

Prescription Number/Reference ID:

Add

\*\* Either Revenue Code or HCPCS Code required for the service line.

Line No.	Rev. Code	HCPCS	NDC	NDC Quantity	Mod 1	Mod 2	Mod 3	Mod 4	Begin Date	End Date	Medicare Deductible Amount	Quantity	Medicare Coinsurance Amount	Quantity	Medicare Copayment Amount	Quantity	Line Item Charge Amount	Service Unit Count	Non Provider Covered Control Amount	Number
1	0192			0					06/01/16	06/30/16		0		0		0	4,440.00	30 UN		
<b>Totals:</b>											<b>\$0.00</b>		<b>\$0.00</b>		<b>\$0.00</b>		<b>\$4,440.00</b>		<b>\$0.00</b>	

Save Submit Cancel

1 All added lines will appear at the bottom of the screen

2 Click Submit if you are done



### Claim Entry Confirmation

**Transmission Status:** Successful

**Claim Type:** Institutional

**Patient Account Number:** 9999999999

**Confirmation Code:** I-90

**Error:**

**Attachments**

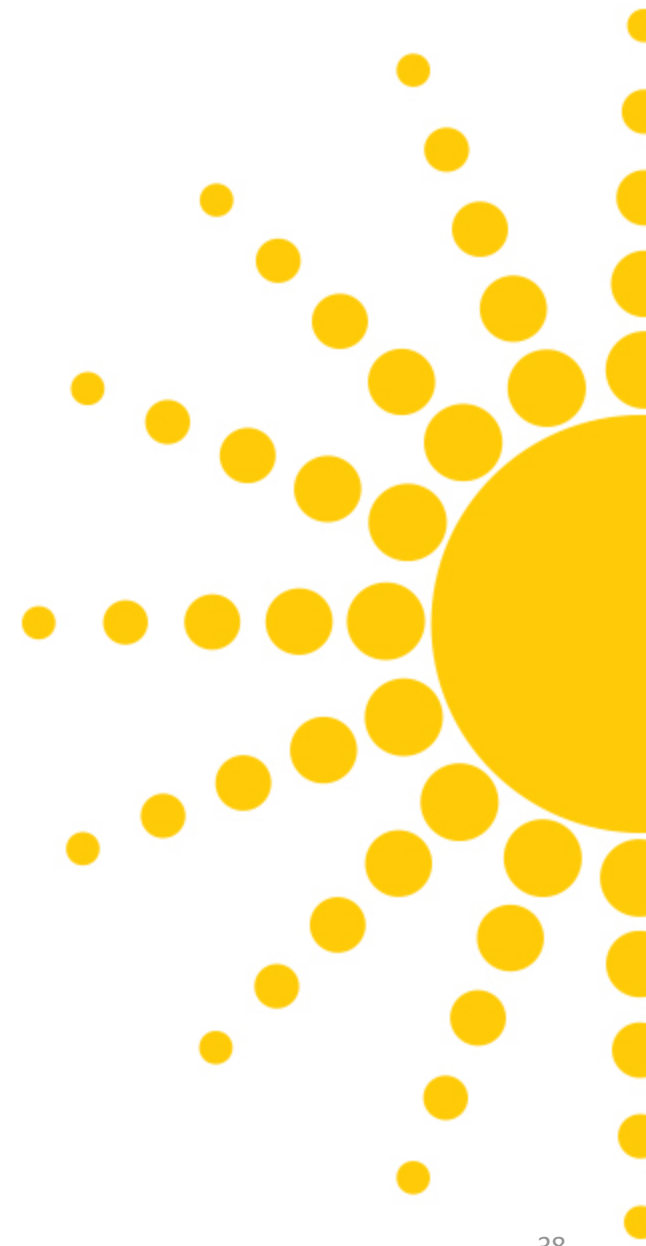
Beginning with services incurred on 7/1/2013, all NEMT claims must be submitted with the new AHCCCS standard Daily Trip Report. Effective with service dates 8/1/2013 and forward, any non-emergency transport claim that is submitted without the standard Daily Trip Report will be denied. It is the provider's responsibility to maintain all documentation that supports each transport service claimed. Please click [here](#) to submit an attachment.

[View Claim](#)

[Enter New Claim](#)

- 1 This is the Claim Entry Confirmation screen
- 2 The Transmission status will let you know the claim was submitted successfully
- 3 You have 2 options: View Claim to give you a summary of the claim that will be sent to AHCCCS or Enter a New Claim

# Questions?





# 5010 Online Claim Submission

## Claim Type Dental (ADA Form)

## Claim Submission

Claims submitted to AHCCCS prior to 4:00 PM, Monday through Friday, will be processed within 24 to 48 hours. Once the claim has been sent for processing, it can no longer be modified via the web. After the processing deadline, corrections will need to be submitted as a **Replacement** or **Void**. The claim will not be accepted if any required data elements are missing. The claim will also be rejected if the recipient is not eligible for coverage at the time the service is rendered. Claims will be processed under the following Identification Number (Non-Person Entity):

**Payer/Receiver Electronic Transmitter Identification Number:** 866004791

**NOTE:** You cannot view the processing status of claims submitted by other users.

### Enter New Claim

Type of Claim:

- Professional
- Institutional
- Dental

### View Claim Processing Status

Submission Date(s):  -

- 1 Enter New Claim – Select Dental in the ▼
- 2 Click on “GO” ...

## Dental Claim Submission

[Help](#)

\* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
-----------	-----------	--------------------	-------------	-------------	--------------	-------------------	---------------

**Submitter**

**Organization Name:** TEST/CASE

**Electronic Transmitter ID Number:** 99222

**Information Contact Name:** Escobedo, Albert

**Information Contact Telephone Number:** 602-417-4562

- 1 This is the Submitter screen– verify the correct provider information (some providers have more than 1 ID)
- 2 Select the Providers tab next

## Dental Claim Submission

Help

\* Indicates a required field

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
Billing Provider	Rendering Provider	Referring Provider	Service Facility				

### Billing Provider

\* Tax ID:   SSN  EIN

Provider Commercial Number:

\* CMMS National Provider ID (NPI):

\* Entity Type:  Person  Non-Person Entity

\*\* Health Care Provider Taxonomy Code:

Provider Name:

Information Contact Name:

- 1 This is the Billing Provider screen – fill out all the areas marked by red asterisks
- 2 Tax ID – enter biller or group tax ID
- 3 CMMS National Provider ID (NPI) – enter valid NPI#, leaving the Provider Commercial Number blank
- 4 Entity type – select “person” if the ID belongs to a person, or “non-person” if a company is identified
- 5 Health Care Provider Taxonomy Code (When/if required depending on service)  
[http://www.healthlink.com/tech\\_tip\\_taxonomy\\_code.asp](http://www.healthlink.com/tech_tip_taxonomy_code.asp)
- 6 Click Find – provider information should be displayed
- 7 Select the Patient/Subscriber tab next

ame.

12

## Dental Claim Submission

[Help](#)

\* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
-----------	-----------	--------------------	-------------	-------------	--------------	-------------------	---------------

### Insured or Subscriber

\* **Member ID Number/Date of Birth:**

**Person Name:** TEST, MEMBER  
**Gender:** M

**Residential Address:** 801 E JEFFERSON ST  
PHOENIX, AZ 85008

\* **Payer Responsibility:**  ▼

NOTE: AHCCCS no longer accepts ADOC claims.

- 1 This is the Patient/Subscriber screen – fill out all the areas marked by red asterisks
- 2 Member ID Number/Date of Birth – Enter members AHCCCS ID and Date of Birth
- 3 Payer Responsibility – Select a Payer Responsibility using the ▼ P - Primary
- 4 Select the Claim Information tab next

\* Patient Control Number:

\* Place of Service:

Date of Current Injury:  (Accident)

\*\* Patient's Condition Related To:  Employment  Other Accident  Auto Accident

\*\*\* Place in which Accident Occurred:  (State)

\* Provider Signature on File:  Yes  No

\* Provider Accept Assignment:  Assigned  Not Assigned

\* Benefit Assignment:  Yes  No  Not Applicable

\* Release of Information Consent:  Informed Consent  Yes

Special Program Code:

- 1 This is the Claim Information screen – fill out all the areas marked by red asterisks
- 2 Patient Control Number – Enter the members AHCCCS ID or Patient Acct Number
- 3 Place of Service –click the ▼ and choose from the list
- 4 Provider Signature – select “yes “ if you are a billing agency & you have the provider’s signature on file
- 5 Provider Accept Assignment – select “Assigned” if you are accepting payment from AHCCCS
- 6 Benefit Assignment – select “Not Applicable”
- 7 Release of Information Consent – select “Informed Consent” if a signed consent by the patient to release medical data is on file
- 8 Select the Service Lines tab



Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
<b>Diagnosis Codes (Relate Items Principal, 1, 2, or 3 by line to the Diagnosis Code Pointer)</b>							
*** Standard: <input type="radio"/> ICD-9 <input checked="" type="radio"/> ICD-10		Principal Diagnosis Code: R6889		Other Diagnosis Codes: 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/>			
<b>Universal National Tooth Designation System</b>							
<b>Service Line</b>							
* Service Date: 01/01/2017		*** Diagnosis Code Pointers: Principal <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>					
* Fee: \$ D2392		Place of Service: <input type="text"/>					
* ADA Procedure Code: <input type="text"/>		Line Item Control Number: <input type="text"/>					
ADA Modifier Codes: 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/>		Oral Cavity Designation Codes: 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/>					
Procedure Count: <input type="text"/>							
Tooth Number: <input type="text"/>							
Tooth Surface (1-5): 1 <input type="text"/> O - Occlusal <input type="text"/> 2 <input type="text"/> L - Lingual <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/>							
**Other Payer: Primary ID <input type="text"/>		Paid Amount \$ <input type="text"/>		Units <input type="text"/>		Procedure Code/Qualifier <input type="text"/>	
**Medicare: Paid Amount \$ <input type="text"/>		Units <input type="text"/>		Procedure Code/Qualifier <input type="text"/>			
Other Adjustment(s): Medicare Deductible \$ <input type="text"/>		Medicare Coinsurance \$ <input type="text"/>					
Date Claim Paid: Other Payer <input type="text"/>		Medicare <input type="text"/>		Other Adjustments <input type="text"/>			
**Rendering Provider: Taxonomy Code <input type="text"/>		Last/Organization Name <input type="text"/>				<input type="text"/>	
First Name <input type="text"/>		NPI <input type="text"/>		Commercial # <input type="text"/>			
<input type="button" value="Add"/>							
** All or none of the information is required for the line or group. *** Required ONLY if diagnosis codes are entered.							

- 1 This is the Service Lines screen – fill out all the areas marked by red asterisks and additional information required specifically for Dental Claims (i.e. Principal Diagnosis code, Diagnosis Code Pointer, tooth number, and tooth surface)
- 2 Principal Diagnosis Code – Enter Principal Diagnosis Code
- 3 Service Date – Enter Service Date
- 4 ADA Procedure Code – Enter ADA Procedure Code

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
<b>Diagnosis Codes(Relate Items Principal, 1, 2, or 3 by line to the Diagnosis Code Pointer)</b>							
*** Standard: <input type="radio"/> ICD-9 <input checked="" type="radio"/> ICD-10		Principal Diagnosis Code: R6889		Other Diagnosis Codes: 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/>			
<b>Universal National Tooth Designation System</b>							
<b>Service Line</b>							
* Service Date: 01/01/2017		*** Diagnosis Code Pointers: Principal <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>					
* Fee: \$ D2392		Place of Service: <input type="text"/>					
* ADA Procedure Code: <input type="text"/>		Line Item Control Number: <input type="text"/>					
ADA Modifier Codes: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>		Oral Cavity Designation Codes: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>					
Procedure Count: <input type="text"/>							
Tooth Number: <input type="text"/>							
Tooth Surface (1-5): 1 <input type="text"/> O - Occlusal <input type="text"/>		2 <input type="text"/> L - Lingual <input type="text"/>		3 <input type="text"/>		4 <input type="text"/> 5 <input type="text"/>	
**Other Payer: Primary ID <input type="text"/>		Paid Amount \$ <input type="text"/>		Units <input type="text"/>		Procedure Code/Qualifier <input type="text"/>	
**Medicare: Paid Amount \$ <input type="text"/>		Units <input type="text"/>		Procedure Code/Qualifier <input type="text"/>			
Other Adjustment(s): Medicare Deductible \$ <input type="text"/>		Medicare Coinsurance \$ <input type="text"/>					
Date Claim Paid: Other Payer <input type="text"/>		Medicare <input type="text"/>		Other Adjustments <input type="text"/>			
**Rendering Provider: Taxonomy Code <input type="text"/>		Last/Organization Name <input type="text"/>				<input type="text"/>	
First Name <input type="text"/>		NPI <input type="text"/>		Commercial # <input type="text"/>			
<input type="button" value="Add"/>							
** All or none of the information is required for the line or group. *** Required ONLY if diagnosis codes are entered.							

## Continuation in the Service Lines screen

- 5 Tooth Number – Enter Tooth Number
- 6 Tooth Surface – click the ▼ and choose from the list as needed for 1 through 5
- 7 Diagnosis Code Pointer – Select Principal
- 8 Click Add to complete the entry - you can enter additional lines, if needed

### Service Line

\* Service Date:

\* Fee: \$

\* ADA Procedure Code:

ADA Modifier Codes: 1  2  3  4

Procedure Count:

Tooth Number:

Tooth Surface (1-5): 1  2  3  4  5

\*\*Other Payer: Primary ID  Paid Amount \$  Units  Procedure Code/Qualifier

\*\*Medicare: Paid Amount \$  Units  Procedure Code/Qualifier

Other Adjustment(s): Medicare Deductible \$  Medicare Coinsurance \$

Date Claim Paid: Other Payer  Medicare  Other Adjustments

\*\*Rendering Provider: Taxonomy Code  Last/Organization Name

First Name  NPI  Commercial #

\*\* All or none of the information is required for the line or g  
 \*\*\* Required ONLY if diagnosis codes are ent

Line No.	Service Date	ADA Proc Code	Mod 1	Mod 2	Mod 3	Mod 4	Tooth #	Surface 1	Surface 2	Surface 3	Surface 4	Surface 5	Other Fee Payer ID	Payer Paid Amount	Procedure Code	Units	Medicare Paid Amount	Procedure Code	Units	Medicare Deductible Amount
1	01/01/17	D2392					E	O	L					208.00		0			0	
<b>Totals:</b>													<b>\$208.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>				

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- 1 Click "Add" when you have completed entering all information under the Service Line section
- 2 At the bottom of the screen, the Service Line/s entered will populate, after which the Service Line section fields will clear allowing you to add another service line.
- 3 When the claim is completed, click Submit

### Claim Entry Confirmation

**Transmission Status:** Successful  
**Claim Type:** Dental  
**Patient Account Number:** A98734947  
**Confirmation Code:** D-40

**Error:**

**Attachments**

Beginning with services incurred on 7/1/2013, all NEMT claims must be submitted with the new AHCCCS standard Daily Trip Report. Effective with service dates 8/1/2013 and forward, any non-emergency transport claim that is submitted without the standard Daily Trip Report will be denied. It is the provider's responsibility to maintain all documentation that supports each transport service claimed. Please click [here](#) to submit an attachment.

View Claim

Enter New Claim

- 1 This is the Claim Entry Confirmation screen
- 2 The Transmission status will let you know the claim was submitted successfully
- 3 You have 2 options: View Claim to give you a summary of the claim that will be sent to AHCCCS or Enter a New Claim

# Questions?



# Contact Information and Survey Link

[ProviderTrainingFFS@azahcccs.gov](mailto:ProviderTrainingFFS@azahcccs.gov)

Claim Customer Service 602-417-7670

Option 4 – Claims

Option 5 – Provider registration

Option 6 – Fee For Service

Please take a few minutes to complete a survey on today's training session. We appreciate your feedback.

Here is the survey link:

<https://www.surveymonkey.com/r/CLBKXF6>

# Thank You.

