

Chapter 5

Claim Form Requirements



**This Page
Intentionally
Left Blank**



INTRODUCTION

Claims for services must be submitted to the AHCCCS Administration on the correct form for the type of service billed. This chapter outlines the requirements for completing the CMS 1500, UB-04 and ADA 2006 claim forms.

NOTE: This chapter applies to *paper* CMS 1500, UB-04, and ADA 2006 claims submitted to AHCCCS. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the AHCCCS Web site at www.ahcccs.state.az.us. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

CMS 1500 REQUIREMENTS

The CMS 1500 claim form is used to bill for:

- IHS and 638 tribal claims for individual practitioner services
- Emergency and non-emergency transportation
- Durable medical equipment

The following general billing rules apply:

- CPT and HCPCS procedure codes must be used to identify all services.
- ICD-9 diagnosis codes are required.
 - ✓ AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.

COMPLETING THE CMS 1500 CLAIM FORM

The following instructions explain how to complete the paper CMS 1500 claim form and whether a field is "Required," "Required if applicable," or "Not required."

1. Program Block

Required

Check the second box labeled "Medicaid."

MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
<input type="checkbox"/> (Medicare#)	<input checked="" type="checkbox"/> (Medicaid#)	<input type="checkbox"/> (Sponsor's SSN)	<input type="checkbox"/> (VA File #)	<input type="checkbox"/> (SSN or ID)	<input type="checkbox"/> (SSN)	<input type="checkbox"/> (ID)



1a. Insured's ID Number

Required

Enter the recipient's *AHCCCS ID number*. If you have questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. (See Chapter 2, Eligibility). Behavioral health providers must enter the client's AHCCCS ID number, *not* the client's BHS number.

1a. INSURED'S ID NUMBER	(FOR PROGRAM IN ITEM 1)
A12345678	

2. Patient's Name

Required

Enter recipient's last name, first name, and middle initial as shown on the AHCCCS ID card.

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Holliday, John H.

3. Patient's Date of Birth and Sex

Required

Enter the month, day, and year (MM/DD/YYYY format) of recipient's birth. Check the appropriate box to indicate the patient's gender.

3. PATIENT'S BIRTH DATE	SEX
MM DD YY	
08 14 1851	M <input checked="" type="checkbox"/> F <input type="checkbox"/>

4. Insured's Name

Not required

5. Patient Address

Not required

6. Patient Relationship to Insured

Not required

7. Insured's Address

Not required

8. Patient Status

Not required



- 9. Other Insured's Name** **Required if applicable**
If the recipient has no coverage other than AHCCCS, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the recipient, enter "Same."
- 9a. Other Insured's Policy or Group Number** **Required if applicable**
Enter the group number of the other insurance.
- 9b. Other Insured's Date of Birth and Sex** **Required if applicable**
If the other insured is not the AHCCCS recipient, enter the month, day, and year (MM/DD/YYYY) of the other insured's birth. Check the appropriate box to indicate gender.
- 9c. Employer's Name or School Name** **Required if applicable**
Enter the name of the organization, such as an employer or school, which makes the insurance available to the individual identified in Field 9.
- 9d. Insurance Plan Name or Program Name** **Required if applicable**
Enter name of insurance company or program name that provides the insurance coverage.
- 10. Is Patient's Condition Related to:** **Required**
Check "YES" or "NO" to indicate whether the patient's condition is related to employment, an auto accident, or other accident.

10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (CURRENT OR PREVIOUS)	
<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
b. AUTO ACCIDENT?	PLACE (State)
<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO <input type="text"/>
c. OTHER ACCIDENT?	
<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO

- 11. Insured's Group Policy or FECA Number** **Required if applicable**
- 11a. Insured's Date of Birth and Sex** **Required if applicable**



- 11b. Employer's Name or School Name** **Required if applicable**
- 11c. Insurance Plan Name or Program Name** **Required if applicable**
- 11d. Is There Another Health Benefit Plan** **Required if applicable**
- Check the appropriate box to indicate coverage other than AHCCCS. If "Yes" is checked, you must complete Fields 9a-d.
- 12. Patient or Authorized Person's Signature** **Not required**
- 13. Insured's or Authorized Person's Signature** **Not required**
- 14. Date of Illness or Injury** **Required if applicable**
- Enter the appropriate date in MM/DD/YYYY format.
- 15. Date of Same or Similar Illness** **Not required**
- 16. Dates Patient Unable to Work in Current Occupation** **Not required**
- 17. Name of Ordering/Referring Physician** **Required if applicable**
- 17a. ID Number of Ordering/Referring Physician**

The ordering provider is required for
 Laboratory
 Radiology
 Medical and Surgical Supplies
 Respiratory DME
 Enteral and Parenteral Therapy
 Durable Medical Equipment
 Drugs (J-codes)
 Temporary K codes
 Orthotics
 Prosthetics
 Temporary Q codes
 Vision codes (V-codes)
 97001-97546

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



- 18. **Hospitalization Dates Related to Current Services** **Not required**
- 19. **Reserved for Local Use** **Not required**
- 20. **Outside Lab** **Not required**
- 21. **Diagnosis Codes** **Required**

You must enter at least one *ICD-9 diagnosis code* describing the recipient's condition. Behavioral health providers must **not** use DSM-4 diagnosis codes. You may enter up to four diagnosis codes in priority order (primary condition, secondary condition, etc.).

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)			
1. <u>250</u> . <u>52</u>		3. _____ . _____	
2. _____ . _____		4. _____ . _____	

- 22. **Medicaid Resubmission Code** **Required if applicable**

Enter the appropriate code ("A" or "V") to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the AHCCCS Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled "Original Reference No."

See Chapter 4, General Billing Rules, for information on resubmissions, adjustments, and voids.

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
A	040010004321

- 23. **Prior Authorization Number** **Not required**

The AHCCCS claims system automatically searches for the appropriate authorization for services that require authorization. See Chapter 6, Authorizations/Referrals, for information on prior authorization.

- 24A. **Date(s) of Service and NDC (effective 7/1/12)** **Required/NDC if applicable**

In Field 24A of the CMS-1500 Form in the shaded area, enter the NDC Qualifier of N4 in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then a space and the NDC

Units of Measure Qualifier, followed by the NDC Quantity. All should be left justified in the pink shaded area above the Date of Service.



The billed units in column G (Days or Units) should reflect the HCPCS units and not the NDC units. Billing should not be based off the units of the NDC. Billing based on the NDC units may result in underpayment to the provider.

24. A						B	C	D	
DATE(S) OF SERVICE						Place of Service	EMG	PROCEDURE, SERVICES, OR SUPPLIES	
From			To					(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER	
N400074115278 ML10									
07	01	12	07	01	12	11	J1642		

The beginning and ending service dates must be entered in the non-shaded area

24B. Place of Service

Required

Enter the two-digit code that describes the place of service.

24B. Place of Service

Required

Enter the two-digit code that describes the place of service.

- | | | |
|---------------------------------------|---|---|
| 03 School | 22 Outpatient Hospital | 54 ICF/Mentally Retarded |
| 04 Homeless shelter | 23 ER - Hospital | 55 Residential Substance Abuse Treatment Facility |
| 05 IHS Free-standing Facility | 24 ASC | 56 Psych Residential Treatment Center |
| 06 IHS Provider-based Facility | 25 Birthing Center | 57 Non-residential Substance Abuse Treatment Facility |
| 07 Tribal 638 Free-standing Facility | 26 Military Treatment Facility | 60 Mass Immunization Center |
| 08 Tribal 638 Provider-based Facility | 31 Skilled Nursing Facility | 61 Comprehensive Inpatient Rehabilitation Facility |
| 11 Office | 32 Nursing Facility | 62 Comprehensive Outpatient Rehabilitation Facility |
| 12 Home | 33 Custodial Care Facility | 65 ESRD Treatment Facility |
| 13 Assisted Living Facility | 34 Hospice | 71 Public Health Clinic |
| 14 Group Home | 41 Ambulance – Land | 72 Rural Health Clinic |
| 15 Mobile Unit | 42 Ambulance – Air or Water | 81 Independent Laboratory |
| 20 Urgent Care Facility | 49 Independent Clinic | 99 Other Place of Service |
| 21 Inpatient Hospital | 50 FQHC | |
| | 51 Inpatient Psych Facility | |
| | 52 Psych Facility - Partial Hospitalization | |
| | 53 Community Mental Health Center | |

24. A						B	C	D	
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURE, SERVICES, OR SUPPLIES	
From			To					(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER	
						05			



24C. EMG – Emergency Indicator

Required if applicable

Mark this box with a “✓,” an “X,” or a “Y” if the service was an emergency service, regardless of where it was provided.

24. A						B	C	D	
DATE(S) OF SERVICE						Place of Service	EMG	PROCEDURE, SERVICES, OR SUPPLIES	
From			To					(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER	
							Y		

24D. Procedure and Procedure Modifier

Required

Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the *same date of service*, enter the procedure only once. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT manuals.

For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provided and avoid delay or denial of payment. If more than two modifiers are required to completely delineate the service provided, enter “99” as the first modifier, then list the modifiers being billed with the procedure code. Call Claims Customer Service to verify that a modifier is valid for a procedure code.

24. A						B	C	D	
DATE(S) OF SERVICE						Place of Service	EMG	PROCEDURE, SERVICES, OR SUPPLIES	
From			To					(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER	
							71010	26	

24E. Diagnosis

Required

Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the *number* of the appropriate diagnosis. Enter only the reference number from Field 21 (1, 2, 3, or 4), *not* the diagnosis code itself. If more than one number is entered, they should be in descending order of importance.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
CPT/HCPCS	MODIFIER				
		1			
		1, 2			



24F. Charges

Required

Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at \$50.00 and three units were provided, enter \$150.00 here and three units in Field 24G.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
CPT/HCPCS	MODIFIER				
			150.00		
			79.00		

24G. Units

Required

Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS manuals.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
CPT/HCPCS	MODIFIER				
				2	
				1	

24H. EPSDT/Family Planning

Not required

24I. ID Qualifier

Required if applicable

24J. (SHADED AREA) – Use for COB INFORMATION

Required if applicable

Use this SHADED field to report Medicare and/or other insurance information. For Medicare, enter the Coinsurance and Deductible amounts. If a recipient's Deductible has been met, enter zero (0) for the Deductible amount.

For recipients and service covered by a third party payer, enter only the amount *paid*.

Always attach a copy of the Medicare or other insurer's EOB to the claim.



If the recipient has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should “zero fill” Field 24J (Shaded area). Leaving this field blank will cause the claim to be denied.

See Chapter 9, Medicare/Other Insurance Liability, for details on billing claims with Medicare and other insurance.

24J. (NON SHADED AREA) – RENDERING PROVIDER ID # Required

Rendering Provider’s NPI is required for all providers that are mandated to maintain an NPI #.

For atypical provider types, the AHCCCS ID must be used.

E DIAGNOSIS POINTER	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID #
					COB Information
					NPI Rendering Provider NPI ID #

25. Federal Tax ID Required

Enter your tax ID number and check the box labeled “EIN.” If you do not have a tax ID, enter your Social Security Number and check the box labeled “SSN.”

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.
86-1234567	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

26. Patient Account Number Required if applicable

This is a number that you have assigned to uniquely identify this claim in your records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and your own accounting or tracking system.



27. **Accept Assignment** **Not required**

28. **Total Charge** **Required**

Enter the total for all charges for all lines on the claim.

27. ACCEPT ASSIGNMENT? (For govt claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 179 00	29. AMOUNT PAID \$	30. BALANCE DUE \$
---	---------------------------------	-----------------------	-----------------------

29. **Amount Paid** **Required if applicable**

Enter the total amount that you have been paid for this claim by all sources *other than AHCCCS*. Do *not* enter any amounts expected to be paid by AHCCCS.

30. **Balance Due** **Not required**

31. **Signature and Date** **Required**

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	
SIGNED John Doe	DATE 03/01/03

32. **Service Facility Location Information** **Required if applicable**

32a. **Service Facility NPI #** **Required if applicable**

32b. **Service Facility AHCCCS ID # (Shaded Area)** **Required if applicable**

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)	
Arizona Hospital 123 Main Street Scottsdale, AZ 85252	
a. NPI	b. AHCCCS ID



33. Provider Name, Address and Phone

Required

Enter your provider name, address, and phone number. If a group is billing, enter the group biller's name, address, and phone number.

Enter the *service* provider's six-digit *AHCCCS provider ID number* and *two-digit locator code* next to "PIN #." Do not enter more than two digits for locator code. Behavioral health providers must **not** enter their BHS provider ID number.

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		
Doc Holliday 123 OK Corral Drive Tombstone, AZ 85999		
PIN # 123456	01	GRP #

** Note – NPI is required for all providers that are mandated to maintain an NPI number.

For atypical provider types, box 33b must be completed.

UB-04 REQUIREMENTS

The UB-04 claim form is used to bill for:

- All IHS and 638 tribal facility inpatient and outpatient claims for Title XIX (Medicaid) and Title XXI (KidsCare) recipients
- Nursing facility services
- Residential treatment center services
- Dialysis facility services

The following general billing rules apply:

- Revenue codes are used to bill line-item services provided in a facility.
- Revenue codes must be valid for the service provided.
- ICD-9 diagnosis codes are required.
 - ✓ AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.
- ICD-9 procedure codes must be used to identify surgical procedures billed on the UB-04.



COMPLETING THE UB-04 CLAIM FORM

The following instructions explain how to complete the UB-04 claim form and whether a field is “Required,” “Required if applicable,” or “Not required.” The instructions should be used to supplement the information in the *AHA Uniform Billing Manual for the UB-04*.

1. Provider Data **Required**

Enter the name, address, and phone number of the provider rendering service.

1 IHS/Tribal Hospital 123 Main Street Anywhere, AZ 85000
--

2. Unassigned **Not required**

3. Patient Control No. **Required if applicable**

This is a number that you have assigned to uniquely identify this claim in your records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS Claim Reference Number (CRN) and your own accounting or tracking system.

4. Bill Type **Required**

Facility type (1st digit), bill classification (2nd digit), and frequency (3rd digit). See *UB-04 Manual* for codes.

2.	3. PATIENT CONTROL NO.	4. TYPE OF BILL
		111

5. Fed Tax No. **Required**

Enter your facility’s federal tax identification number.

5. FED TAX NO.	6. STATEMENT COVERS PERIOD		7. COV D
86-1234567	FROM	THROUGH	

6. Statement Covers Period **Required**



Enter the beginning and ending dates of the billing period in MM/DD/YY or MM/DD/YYYY format.

5. FED TAX NO.	6. STATEMENT COVERS PERIOD FROM	THROUGH	7. COV D
	02/15/04	02/20/04	

or

	02/15/2004	02/20/2004	
--	------------	------------	--

- 7. **Covered Days** **Not required**
- 8. **Patient Name/Identifier** **Required**
 Enter the recipient's last name, first name, and middle initial as they appear on the AHCCCS ID card.
- 9. **Patient Address** **Required**
- 10. **Patient Birth Date** **Required**
- 11. **Patient Sex** **Required**
- 12. **Admission/Start of care date** **Required**

12 ADMISSION/START OF CARE	13 ADMISSION HOUR

- 13. **Admission hour** **Required if applicable**
- 14. **Priority (type) of Admission/Visit** **Required**

Required for all inpatient claims. An Admit Type of "1" is required for emergency inpatient and outpatient claims.

- 1 Emergency: Patient requires immediate medical intervention for severe, life threatening or potentially disabling conditions. Documentation must be attached to claim.
- 2 Urgent: Patient requires immediate attention. Claim marked as urgent will not qualify for emergency service consideration.
- 3 Elective: Patient's condition permits time to schedule services.
- 4 Newborn: Patient is newborn. Newborn source of admission code must be entered in Field 20.

- 5 Trauma Center: Visit to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.

15. Point of Origin for Admission or Visit **Required**

16. Discharge Hour **Required if applicable**

Enter the code which best indicates the recipient's time of discharge. Required for inpatient claims when the recipient has been discharged. See *UB-04 Manual* for code structure.

17. Patient discharge status **Required**

Required for all inpatient claims. Enter the code that best describes the recipient's status for this billing period

- 01 Discharged to home or self-care (routine discharge)
- 02 Discharged/Transferred to a short-term general hospital for inpatient care
- 03 Discharge/Transferred to SNF with Medicare Certification in anticipation of skilled care
- 04 Discharge/Transferred to a facility that provides custodial or supportive care
- 05 Discharge/Transferred to a designated cancer center or children's hospital
- 06 Discharge/Transferred to home under care of organized home health service organization in anticipation of covered skilled care
- 07 Left against medical advice or discontinued care
- 09 Admitted as an inpatient to this hospital
- 20 Expired
- 21 Discharged/Transferred to Court/Law Enforcement
- 30 Still a patient
- 40 Expired at home
- 41 Expired in a medical facility (e.g., hospital, SNF, or ICF or free-standing hospice)
- 42 Expired, place unknown (hospice only)
- 43 Discharged/Transferred to a federal health care facility
- 50 Discharged to Hospice - home
- 51 Discharged to Hospice - medical facility (certified) providing hospice level of care
- 61 Discharge/Transferred within this institution to a hospital-based Medicare-approved swing bed



- 62 Discharge/Transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
- 63 Discharge/Transferred to a Medicare-certified long term care hospital (LTCH)
- 64 Discharge/Transferred to a nursing facility certified under Medicaid but not certified under Medicare
- 65 Discharged/Transferred to a psychiatric hospital or psychiatric distinct part/unit of hospital
- 66 Discharges/Transfers to a Critical Access Hospital

- 70 Discharged/Transferred to another type of healthcare institution not defined elsewhere in this code list

18-28 Condition Codes

Required if applicable

Enter the appropriate condition codes that apply to this bill. See *UB-04 Manual* for codes.

In-state, non-IHS inpatient hospitals may request outlier consideration for a claim by entering “61” in any Condition Code field.

To bill for self-dialysis training, free-standing dialysis facilities approved to provide self-dialysis training must enter “73” in any Condition Code field and bill revenue code 841 (Continuous Ambulatory Peritoneal Dialysis, per day) or revenue code 851 (Continuous Cycling Peritoneal Dialysis, per day).

29. Accident State

Required if applicable

31-34 Occurrence Codes and Dates

Required if applicable

35-36. Occurrence Span codes and dates

Required if applicable

38. Responsible Party Name and Address

Required if applicable

39-41 Value Codes and Amounts

Required if applicable

42.Revenue Code

Required

Enter the appropriate revenue code(s) that describe the service(s) provided. See *UB-04 Manual* for revenue codes and abbreviations. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes. Accommodation days should not be billed on outpatient bill types.



	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	132		
2	251		
3	258		
4			

43. Revenue Code Description/NDC code (effective 7/1/12) Required/NDC if applicable

Enter the description of the revenue code billed in Field 42. See *UB-04 Manual* for description of revenue codes.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1		OB/3&4 BED	
2		DRUGS/GENERIC	
3		IV SOLUTIONS	
4			

To report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):

- The NDC Qualifier of N4 in the first 2 positions on the left side of the field.
- The NDC 11-digit numeric code, without hyphens.
- The NDC Unit of Measurement Qualifier (as listed above)
- The NDC quantity, administered amount, with up to three decimal places (i.e., 1234.456). Any unused spaces are left blank.

The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278 ML10	J1642	2.00
2				
3				



44. HCPCS/Rates

Required if applicable

Enter the inpatient (hospital or nursing facility) accommodation rate. Dialysis facilities must enter the appropriate CPT/HCPCS code for lab, radiology, and pharmacy revenue codes (See Chapter 15, Dialysis Services). Hospitals must enter the appropriate CPT/HCPCS codes and modifiers when billing for outpatient services (See Chapter 11, Hospital Services).

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1			1,088.00
2			85595
3			95900
4			

- Form Locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS code associated with the NDC.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278 ML10	J1642	2.00
2				
3				

45. Service Date

Required

The dates indicated outpatient service was provided on a series bill. The date of service should only be reported if the From and Through dates in Form Locator 6 are not equal to each other on the form. Enter the date in MM/DD/YY or MM/DD/YYYY format.

46. Service Units

Required

If accommodation days are billed, the number of units billed must be consistent with the patient status field (Field 22) and statement covers period (Field 6). If the recipient has been discharged, AHCCCS covers the admission date to, but not including, the discharge date. Accommodation days reported must reflect this. If the recipient expired or has not been discharged, AHCCCS covers the admission date through last date billed.

46. SERV. UNITS	47. TOTAL CHARGES	48. NON-COVERED CHARGES	49.
2.00			
3.00			
30.00			



- Form Locator 46 (Serv Units/HCPSCS Units): Enter the number of HCPCS units administered.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278 ML10	J1642	2.00
2				
3				

47. Total Charges Required

Total charges are obtained by multiplying the units of service by the unit charge for each service. Each line other than the sum of all charges may include charges up to \$999,999.99. Total charges are represented by revenue code 001 and must be the last entry in Field 47. Total charges on one claim cannot exceed \$999,999,999.99.

46. SERV. UNITS	47. TOTAL CHARGES	48. NON-COVERED CHARGES	49.
	2,176 00		
	104 26		
	529 92		

48. Non-covered Charges Required if applicable

Enter any charges that are not payable by AHCCCS. The last entry is total non-covered charges, represented by revenue code 001. Do not subtract this amount from total charges.

50. (A-C) Payer Required

Enter the name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the recipient and from which the provider might expect some reimbursement. If there are payers other than AHCCCS, AHCCCS should be the last entry. If there are no payers other than AHCCCS, AHCCCS will be the only entry.

	50. PAYER	51. PROVIDER NO.	52. REL INFO	53. ASG BEN
A	AHCCCS			
B				
C				

51.



(A–C) Provider No.

Required

Enter your facility’s ID number as assigned to you by the payer(s) listed in Fields 50 A, B, and/or C. Your six-digit *AHCCCS service provider ID number* should be listed last. Behavioral health providers must not enter their BHS provider ID number.

	50. PAYER	51. PROVIDER NO.	52. REL INFO		53. ASG BEN
A		654321			
B					
C					

52.

(A–C) Release of Information

Not required

53.

(A–C) Assignment of Benefits

Not required

54.

(A–C) Prior Payments

Required if applicable

Enter the amount received from Medicare Part B or any other insurance or payer *other than AHCCCS*, including the patient, listed in Field 50. If the recipient has other insurance but no payment was received, enter “Ø.” The "Ø" indicates that a reasonable attempt was made to determine available coverage and obtain payment. Enter only actual payments received. Do not enter any amounts expected from AHCCCS.

55.

(A–C) Amount due

Not required

56. Unassigned

Not required

57. Unassigned

Not required

58.

(A–C) Insured's Name

Required

Enter the name of insured (AHCCCS recipient) covered by the payer(s) in Field 50.



	58. INSURED'S NAME	59. P.REL.	60. CERT. - SSN - HIC. - ID NO.
A	Holliday, John H.		
B			
C			

59.
 (A-C) **Patient's Relationship To Insured** **Not required**

60.
 (A-C) **Patient CERT. - SSN - HIC - ID NO.** **Required**

Enter the recipient's AHCCCS ID number. If you have questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. (See Chapter 2, Eligibility). Behavioral health providers must be sure to enter the client's AHCCCS ID number, not the client's BHS number.

	58. INSURED'S NAME	59. P.REL.	60. CERT. -SSN - HIC. - ID NO.
A			A12345678
B			
C			

61.
 (A-C) **Group Name** **Required**

Enter "FFS."

60. CERT. -SSN - HIC. - ID NO.	61. GROUP NAME	62. INSURANCE GROUP NO.
	FFS	

62.
 (A-C) **Insurance Group Number** **Not required**

63.



(A–C) Treatment Authorization **Not required**

The AHCCCS claims system automatically searches for the appropriate authorization for services that require authorization. See Chapter 8, Authorizations, for information on prior authorization.

64. Document Control Number **Not required**

65. (A–C) Employer Name **Not required**

66. Diagnosis and Procedure Code Qualifier **Required**

67. Principal Diagnosis **Required**

Enter the principal *ICD-9 diagnosis code*. Behavioral health providers must **not** use DSM-4 diagnosis codes.

67. PRIN. DIAG CODE	OTHER DIAG. CODES							
	68. CODE	69. CODE	70. CODE	71. CODE	72. CODE	73. CODE	74. CODE	75. CODE
585.0								

69. Admitting Diagnosis **Required**

Required for inpatient bills. Enter the ICD-9 diagnosis code that represents the significant reason for admission.

70. Patient’s Reason for Visit **Not required**

72. E-Codes **Required if applicable**

Enter trauma diagnosis code, if applicable.

74. Principal Procedure Code and Dates **Required if applicable**

Enter the principal ICD-9 procedure code and the date the procedure was performed during the inpatient stay or outpatient visit. Enter the date in MM/DD/YY or MM/DD/YYYY format. If more than one procedure is performed, the principal procedure should be the one that is related to the primary diagnosis, performed for definitive treatment of that condition, and which requires the highest skill level.

76. Attending Provider name and identifiers **Required if applicable**



- 77. **Operating Physician Name and Identifiers** **required if applicable**

- 78-79. **Other Physician** **Not required**

- 80. **Remarks** **Required if applicable**
Required on resubmissions, adjustments, and voids. Enter the CRN of the claim being resubmitted, adjusted, or voided. For resubmissions of denied claims, write "Resubmission" in this field.

- 81. **Other Procedure Codes** **Required if applicable**
Enter other procedure codes in descending order of importance



ADA 2006 CLAIM FORM

IHS and 638 tribal dental claims for title XXI (KidsCare) recipients for dates of service on and after January 1, 2004 must be billed on the ADA 2006 form. Claims billed on a CMS 1500 claim form for dates of service on and after January 1 will be denied.

COMPLETING THE ADA 2006 CLAIM FORM

The following instructions explain how to complete the ADA 2006 Claim Form and whether a field is “Required,” “Required if applicable,” or “Not required.”

1. **Type of Transaction** **Not required**

2. **Predetermination/Preauthorization Number** **Required if applicable**

Enter the appropriate code (“A” or “V”) to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the AHCCCS Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided.

See Chapter 4, General Billing Rules, for information on resubmissions, adjustments, and voids.

2. Predetermination/Preauthorization Number

040010004321

3. **Primary Payer Name and Address** **Required if applicable**

4. **Other Dental or Medical Coverage** **Required**

Check appropriate box to indicate whether recipient has third party coverage.

4. Other Dental or Medical Coverage? No (Skip 5-11) Yes (Complete 5-11)

5. **Subscriber Name** **Required if applicable**

6. **Date of Birth** **Required if applicable**

7. **Gender** **Required if applicable**



- 8. **Subscriber Identifier** **Required if applicable**
- 9. **Plan/Group Number** **Required if applicable**
- 10. **Relationship to Primary Subscriber** **Required if applicable**
- 11. **Other Carrier Name, Address** **Required if applicable**
- 12. **Primary Subscriber Name and Address** **Required**

Enter recipient's last name, first name, and middle initial as shown on the AHCCCS ID card.
Enter the recipient's address

12. NAME (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Earp, Wyatt H.
123 E. OK Corral Drive
Tombstone, AZ 85638

- 13. **Date of Birth** **Required**

Enter the recipient's date of birth.

13. Date of Birth

08/14/1851

- 14. **Gender** **Required**

Check the appropriate box to indicate the patient's gender.

14. Gender

M F

- 15. **Subscriber Identifier** **Required**

Enter the recipient's *AHCCCS ID number*. Contact the AHCCCS Verification Unit if there are questions about eligibility or the AHCCCS ID number. (See Chapter 2, Eligibility).

15. Subscriber Identifier (SSN or ID#)

A12345678



- 16. **Plan/Group Number** **Not required**
- 17. **Employer Name** **Not required**
- 18. **Relationship to Primary Subscriber** **Not required**
- 19. **Student Status** **Not required**
- 20. **Name** **Not required**
- 21. **Date of Birth** **Not required**
- 22. **Gender** **Not required**
- 23. **Patient ID/Account Number** **Required**

This is a number that you have assigned to uniquely identify this claim in your records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and your own accounting or tracking system.

23. Patient ID/Account # (Assigned by Dentist)
WEARP5678

- 24. **Procedure Date** **Required**

Enter the procedure date in MM/DD/YYYY format.

	24. Procedure Date (MM/DD/YYYY)	25. Area Of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)
1				
2				
3				

- 25. **Area of Oral Cavity** **Required**

Enter the code for the area of the oral cavity. Consult ANSI/ADA/ISO Specification No. 3950 *Designation System for Teeth and Areas of the Oral Cavity* for codes.

24. Procedure Date	25. Area	26.	27. Tooth Number(s)
--------------------	----------	-----	---------------------



	(MM/DD/YYYY)	Of Oral Cavity	Tooth System	or Letter(s)
1				
2				
3				

26. Tooth System

Required

Enter “JP” when designating teeth using the ADA’s Universal/National Tooth Designation system. Enter “JO” when using ANSI/ADA/ISO Specification No. 3950.

	24. Procedure Date (MM/DD/YYYY)	25. Area Of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)
1				
2				
3				

27. Tooth Number(s) or Letter(s)

Required

Enter the tooth number when the procedure directly involves a tooth. Use commas to separate individual tooth numbers. If a range of teeth is involved, use a hyphen to separate the first and last tooth in the range.

	24. Procedure Date (MM/DD/YYYY)	25. Area Of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)
1				
2				
3				

28. Tooth Surface

Required

Designate tooth surface(s) when the procedure directly involves one or more tooth surfaces.

28. Tooth Surface	29. Procedure Code	30. Description	31. Fee

29. Procedure Code

Required



Enter the appropriate procedure code from the *CDT-4 Manual*.

28. Tooth Surface	29. Procedure Code	30. Description	31. Fee	

30. Description

Required

Enter the description of the procedure code billed in Field 29.

28. Tooth Surface	29. Procedure Code	30. Description	31. Fee	

31. Fee

Required

Enter the fee for the procedure code billed in Field 29.

28. Tooth Surface	29. Procedure Code	30. Description	31. Fee	

32. Other Fees

Not required

33. Total Fee

Required

Enter the total of all fees in Field 31.

32. Other Fee(s)		
33. Total Fee		

34. Missing Teeth

Required



Mark all missing teeth.

MISSING TEETH INFORMATION	Permanent															
	34. (Place an 'X' on each missing tooth)	1	2	X	4	5	6	7	8	9	10	11	12	13	14	15
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

- 35. **Remarks** **Not required**
- 36. **Parent/Guardian Signature and Date** **Not required**
- 37. **Subscriber Signature and Date** **Not required**
- 38. **Place of Treatment** **Required**

Check the appropriate box.

38. Place of Treatment (Check applicable box)
<input checked="" type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other

- 39. **Number of Enclosures** **Required if applicable**
- 40. **Is Treatment for Orthodontics?** **Required**

Check the appropriate box. If "Yes" is checked, complete Fields 41 and 42.

40. Is Treatment for Orthodontics?
<input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)

- 41. **Date Appliance Placed** **Required if applicable**
- 42. **Months of Treatment Remaining** **Required if applicable**
- 43. **Replacement of Prosthesis** **Required**

Check the appropriate box. If "Yes" is checked, complete Field 44.

43. Replacement of Prosthesis?
<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)



44. Date of Prior Placement **Required if applicable**
If “Yes” is checked in Field 43, enter the date of prior placement in MM/DD/YYYY format.

45. Treatment Resulting From **Required if applicable**
Check the appropriate box, as applicable.

46. Date of Accident **Required if applicable**
Enter the date in MM/DD/YYYY format.

47. Auto Accident State **Required if applicable**
Enter the name of the state where the accident occurred.

48. Billing Dentist/Dental Entity Name and Address **Required**
Enter the name and address of the billing dentist or dental entity.

48. Name, Address, City, State, Zip Code Holliday, John H. 123 E. Main Street Scottsdale, AZ 85252
--

49. Provider ID (Group) **Required**
Enter the AHCCCS provider ID of the billing dentist or dental entity.

49. Provider ID 654321

50. License Number **Required**
Enter the license number of the billing dentist or dental entity.

50. License Number 987-654321

51. SSN or TIN **Required**
Enter the Social Security Number or tax ID number of the billing dentist or dental entity.



51. SSN or TIN

123-45-6789

52. Phone Number Not required

52a. Additional Provider ID Required if Applicable

53. Signature of Treating Dentist Required

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures

Signed (Treating Dentist) Date

54. NPI Required

Enter the NPI of the treating dentist.

49. Provider ID

654321

55. License Number Required

Enter the license number of the treating dentist.

50. License Number

987-654321

56. Address (Treating Dentist) Not required

57. Phone Number (Treating Dentist) Not required

58. Additional Provider ID Required if Applicable



This Page
Intentionally
Left Blank