

April 2026

EDI Solutions Upload Attachment Process

When using the AHCCCS Claim Reference Number (CRN) as your document attachment number or Payer Claim Control Number, enter only the first 12-digits of the CRN.

It is important to exclude the service line number, such as 001 or 002, as this information is not part of the claim number and will result in documents not linked to the associated claim.

Prior Authorization Search Tool

Easily determine if a service requires prior authorization, with our [FFS Prior Authorization Search Tool](#). Search by Current Procedural Terminology (CPT) codes, HCPCS, or Dental Codes

Assignment Of AHCCCS Claim Reference Numbers (CRNS)

Data that passes validation is translated and moved to the mainframe to be loaded for processing. Each claim/encounter record once received by AHCCCS adjudication system is assigned a unique Claim Reference Number (CRN) when loaded into the adjudication system. Rejected claims are never assigned a claim reference number.

AHCCCS subsequently uses the CRN to identify the encounter record and determine the encounter receipt date for timeliness calculations.

A CRN is derived from the following information:

- Julian Date (26) (030) 0000056 (001) (digits 1 - 5) (26 = year and 030 = day of the year 1-365). This date reflects the date the claim was received by AHCCCS.
- Batch Number (digits 6-9) (Sequence 0001-9999)
- Document Number (digits 10-12) (Sequence 001-999)
- Line Number (digits 13-15) (Sequence 001-999): This number applies to detail lines entered on the claim. The line numbers are not part of the AHCCCS 12-digit claim number.

The [DFSM Claims Clues](#) is a monthly newsletter that provides information about changes to the program, system changes/updates, billing and FFS policies.

Report an Incident, Accident, and/or Death in the AHCCCS QM Portal FFS providers are required to report any Quality of Care (QOC) Concerns and Incidents, Accidents, and Deaths (IADs) as soon as they are aware, and no later than 24 hours after discovering the issue. Reports should be submitted through the QM portal.

Claims, Prior Authorization and Provider Enrollment inquires: The Division of Member and Provider Services (DMPS) manages the service calls for AHCCCS Fee-for-Service. DMPS can assist providers with prior authorizations, claim inquires and status and provider registration (APEP) questions and processes.

The hours of operation are Monday – Friday, 8:00am-5:00pm (602-417-7670).

AHCCCS Provider Enrollment Portal (APEP): Questions regarding provider-related enrollment, policy, or APEP user issues email APEPTrainingQuestions@azahcccs.gov. Your email will automatically create a service ticket to Provider Enrollment for assistance.

AHCCCS Warrants - For questions about Warrants, paper EOBs or Electronic Fund Transfers (EFT), contact the Division of Business & Finance (DBF) at (602) 417-5500.

835 Electronic Remittance Payment Sign Up (Remittance Advice Sign Up/835) Contact: ServiceDesk@azahcccs.gov or call (602) 417-4451

To upload documents to the new EDI Solutions portal [ServiceNow](#), users will need to have access. If you do not have an account, please follow the instructions outlined in the [EDI Portal Provider Signup and Login Guide](#).

Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the [DFSM Provider Training Web Page](#).

For provider training questions please outreach the Provider Training Team via email at ServiceDesk@azahcccs.gov

COVID FAQ: [FAQ COVID Fact Sheet](#)

Compliance Reminders! Participating Provider Qualifier Codes Reporting Requirements

As a reminder, to all new and existing providers types; Integrated Care Clinic (PT IC), Clinic (PT 05), Behavioral Health Outpatient Clinic (PT 77) and Federally Qualified Health Centers (C2) are required to report the participating provider information on every claim submission.

AHCCCS Fee-for-Service recognizes two participating provider qualifier codes (XXNPI) and (9999999999). Additional information and examples on proper qualifier code formatting are provided below.

Participating Provider Qualifier Codes
XXNPI - Provider type who is registered with AHCCCS and has a valid NPI.
9999999999 - Practitioner who does not meet the criteria to be registered with AHCCCS under their own individual NPI.

Definitions:

- **Billing Provider** - This is the NPI of organization or person who receives payment for the AHCCCS covered service.
- **Servicing/Rendering Provider** -This is the NPI of the licensed individual or facility authorized to perform the service. When the actual service is performed by a non-licensed individual (e.g., a BHT, BHPP), the NPI of the licensed facility the BHT, BHPP is employed with is entered in the service/rendering provider field.
- **Participating Provider** - The individual provider(s) who provided the service(s) to the member, and is legally authorized to do so by the State in which they deliver the service(s), as specified in 42 CFR 457.10 and 42 CFR 438.2. This is the first and last name of the individual who performed the service billed on a claim.
- **Supervising Physicians** or physicians who sign off on services shall not be listed as the participating provider when services are performed by another provider or practitioner.

Formatting Requirement - Participating Provider with a NPI Number

- When the participating provider has a license and NPI, the provider must be reported by using this format: XXNPI Last Name, First Name. ***Provider credentials, (e.g., LPC, LCSW), may be included after the last name.***
- **XXNPIDoe LCSW, John**

The following examples meet participating provider configuration requirements.

- XX1234567890Brown LCSW, John
- XX1122334455Smith LPC, Tom

Formatting Requirement - Participating Provider Who Do Not Qualify for an NPI Number

- When the individual does not have a license, the participating provider must be reported as 9999999999 Last Name, First Name. ***Provider credentials, (e.g., BHT, BHPP, or PRSS, etc;) may be included after the last name.***
 - XXXXXXXXXXXDoe BHT, John
 - XXXXXXXXXXXJones BHPP, Tom
- Any individual/practitioner reported with the 9999999999 qualifier code, will be presumed by Division of

Compliance Reminders! Participating Provider Qualifier Codes Reporting Requirements Continued

Fee-for-Service Management (DFSM) to be

- Unlicensed, and
- Performing a service that does not require a professional license.

The Additional Claim Information field **shall not** include the facility name, nickname, initials or title.

The following examples do not meet participating provider configuration requirements. Claims that are not properly formatted will deny and a correction claim will be denied.

- 999999999Nurse 2 Peoria
- 999999999JT
- 999999999Jason

Replacement Claims and Medical/Clinical Documentation Submission

Claims that are not properly formatted will be denied, and a correction claim will be required for processing.

Replacement claims must still follow timely filing guidelines. If a claim is originally received within the 6-month time frame, the provider has up to **12 months from the date of service** to correctly resubmit the claim in order to achieve clean claim status or to adjust a previously processed claim.

When submitting a correction claim, follow these guidelines:

- The provider must reference the claim number that it is replacing.
- If the initial claim required corresponding medical or clinical documentation, the originally submitted medical records must also be uploaded with the new replacement claim.
- Failure to submit required documentation with a replacement claim will result in a claim denial.

Electronic Transaction Tools for Providers

Although AHCCCS accepts faxes for various documents, submitting required documents through the **AHCCCS EDI Solutions** portal is faster and can reduce time spent on routine administrative tasks.

Reminders: Documentation Behavioral Health Residential Facility

The following is feedback which can help prevent avoidable delays in the review of prior authorization (PA) requests.

When the CON and RON documents are complete, accurate, and accompanied by the required documentation on the initial submission, it facilitates a timelier review of your request and reduces overall processing times.

- The fields on the CON/RON form should be filled out completely and include all of the applicable signatures and provider's credentials.
- Ensure the author of clinical documents is signing the document and including their credentials with their signature,
- Submit CON/RON documents during the required timeframes. CON covers initial 30 calendar days of BHRF treatment and the RON is due upon expiration of the CON/previous RON and covers the next 60 calendar days of treatment, and
- Correct your PA dates of service as needed to reflect the member's actual date of admission and ensure the admission date is documented in your clinical documentation.

Key Steps for Obtaining an Outpatient Dialysis Extended Services Authorization Case for Federal Emergency Services (FESP) Members

When dialysis services are needed for the first time, the provider must submit an “Initial Dialysis Case Creation” form to DFSM PA Team. These forms can be found on the [Fee-for-Service Prior Authorization Forms](#) webpage. Extended services authorizations are not approved under a specific provider NPI number, because the members can receive dialysis services from any AHCCCS registered dialysis clinic.

Forms that are required with the initial ESRD Case Request:

Prior Authorization Medical Documentation Form: the Medical Documentation Form is required with the initial Extended Services authorization request for ESRD services for FES members. **This form must be included with the initial prior authorization request but is not required with the submission of the claim.**

Initial Dialysis Case Creation Form: AHCCCS registered providers must complete the Initial dialysis Case Creation Form to establish a (FESP) member on the Extended Service Program. **This form must be completed in its entirety, signed by the physician and must include the start date of services and faxed with the ESRD PA request, but is not required with the claim submission.**

Monthly Certification Form: Outpatient dialysis services are covered as an emergency service when a member’s physician, nurse practitioner, or physician assistant signs the Monthly Certification form confirming the member requires dialysis at least three times per week. **This form is not required with the initial ESRD authorization request, or with the claim submission.**

ESRD Forms

- [Initial Dialysis Case Creation Form](#)
- [Monthly Certification of Emergency Medical Condition](#)

Intensive Modulated Radiation Therapy (IMRT) Prior Authorization and Claims Billing

Prior authorization for IMRT services is required as part of IMRT planning. Radiation treatment delivery codes are reported once per treatment session; therefore, the prior authorization request must be submitted as a separate sequence for each individual authorized service date.

SEQ	TYPE	AUTHORIZED DATES
01	OP	02/12/2025 - 02/12/2025
02	OP	02/13/2025 - 02/13/2025
03	OP	02/14/2025 - 02/14/2025
04	OP	02/17/2025 - 02/17/2025
05	OP	02/18/2025 - 02/18/2025

Claims Submission: IMRT services provided in an outpatient hospital setting; each date of service must be billed on a separate UB-04 claim form.

Submitting a single claim with multiple dates in the “Service Covered Date” field, will result in denial reason code H220.3, “prior authorization mismatch.”

The facility must submit a correction claim for processing if the above claim submission guidelines are not adhered to.

Peer/Recovery Support Specialist Credentialing

Per [AHCCCS Medical Policy 963 Peer Support Services](#), to receive Medicaid reimbursement for peer support services, the individual providing the service shall possess a PRSS credential from an AHCCCS-recognized PSETP and receive supervision as specified in the AHCCCS Covered Behavioral Health Services Guide (CBHSG). Refer to AMPM Policy 310-B and the AHCCCS Fee-For-Service Provider Billing Manual for further details on billing limitations.

Peer Support Services can only be delivered by a Peer and Recovery Support Specialist (PRSS). A PRSS is someone with lived experience of behavioral health and/or substance use recovery who has received specialized training on how to use their experience to help others.

To be employed as a PRSS in Arizona, individuals must complete an AHCCCS-recognized training program and pass a competency exam. There are many training programs across the state, and while all trainings cover behavioral health and substance abuse, some trainings also focus on criminal justice involvement or other specialized topics such as Opioid Use Disorder.

Agencies with AHCCCS-recognized training programs are listed below. Visit their websites or contact them for training availability and enrollment requirements. AHCCCS members may contact their provider's employment specialist or AHCCCS Health Plan for assistance.