AHCCCS ON-LINE CLAIM SUBMISSION MANUAL

Section 4.a:

Professional (1500)

Updated 10/04/2013

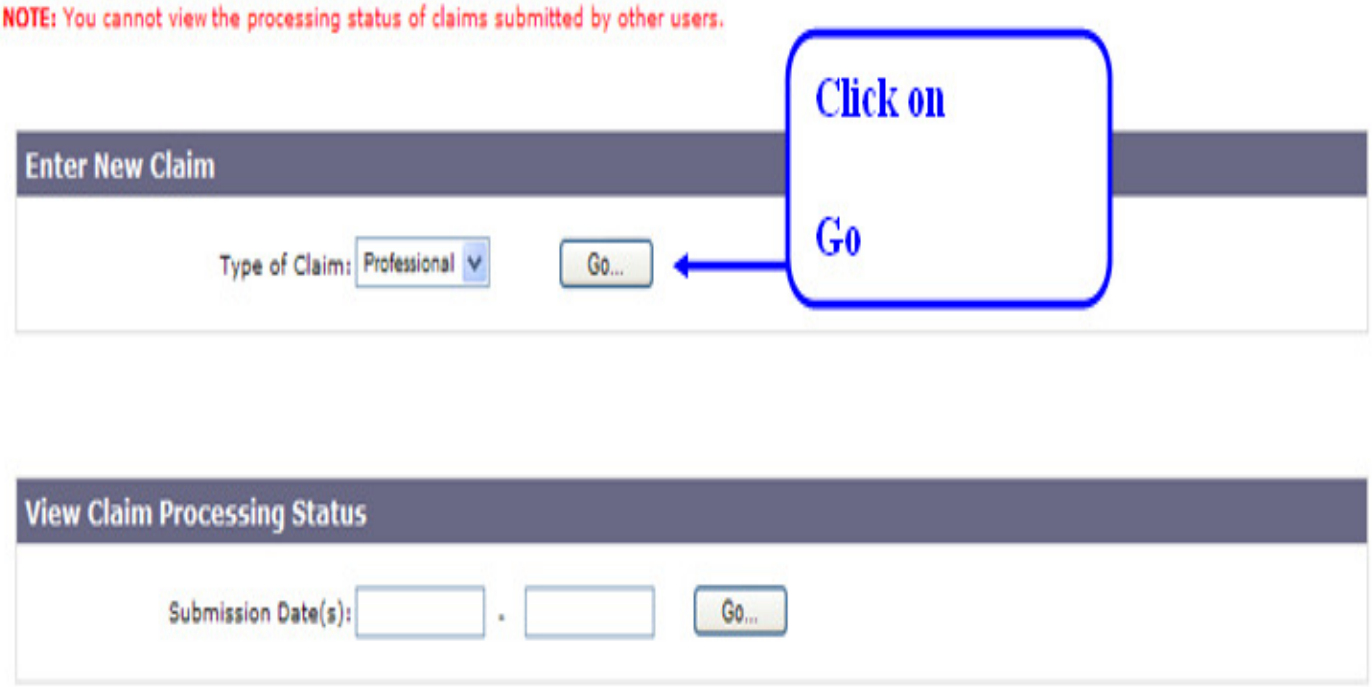

Main Menu
Member Verfication
Eligibility And Enrollment Status
Provider Information
Claim Status
Prior Authorization Inquiry
Newborn Notification
Provider Verification
Prior Authorization Submission
Claim Status 5010
Claims Submission 5010
Claim Submission
Provider Verification_New
Support and Manuals
AHCCCS Online User Manuals
Account Information
User Name: Test05
User ID: 0116631
Type: Master
IP: 170.68.41.245
AHCCCS Provider ID: 231725
Admin
For security purposes, your session will be logged out after 15 minutes of inactivity.
Claim Status allows providers to check the status of Fee-For-Service claims. If the recipient is enrolled in a capitated Health Plan, please contact the Health Plan for claim inquiries. For a listing of the Health Plan contact information, please click on Health Plan Listing.
Claim Submission allows providers to submit Fee-For-Service claims to AHCCCS for nightly processing.
Prof
cepted.
Prior
verify the status of previously submitted Prior Authorization
reque
Click on
Claim Submission 5010
Memb
verify an AHCCCS recipient's eligibility and their enrollment in a
Health
her third party coverage information for a recipient.
Newborn Notification allows providers to submit newborn information to AHCCCS during the hours when the COM Center is not available.
HealthPlan Address Changes allows health plans to send address changes from members via the web.
Prior Authorization Submission allows providers to submit prior authorizations via the web.
Provider Verification allows providers to update their correspondence addresses. Providers may also view (but not update) their Service and Pay-To Addresses, Group Affiliations and Authorized Signatures. For further information, please click on AHCCCS Provider Registration.
The AHCCCS mainframe systems will have scheduled downtimes that occur on a weekly basis. During these downtimes (usually weekends), the web site will be unavailable. During system downtimes, please contact the AHCCCS COM Center at 602-417-7000 for immediate assistance regarding eligibility/enrollment. The Interactive Voice Response (IVR) System is also available for eligibility inquiries at 602-417-7200. For claim inquiries, please contact the AHCCCS Claims Customer Service at 602-417-7670. For a full list of contacts, please click on AHCCCS Contacts
Privacy Policy | Contact AHCCCS | © Copyright AHCCCS
AHCCCS, 801 E. Jefferson, Phoenix, AZ 85034, (602) 417-4000

Claim Submission

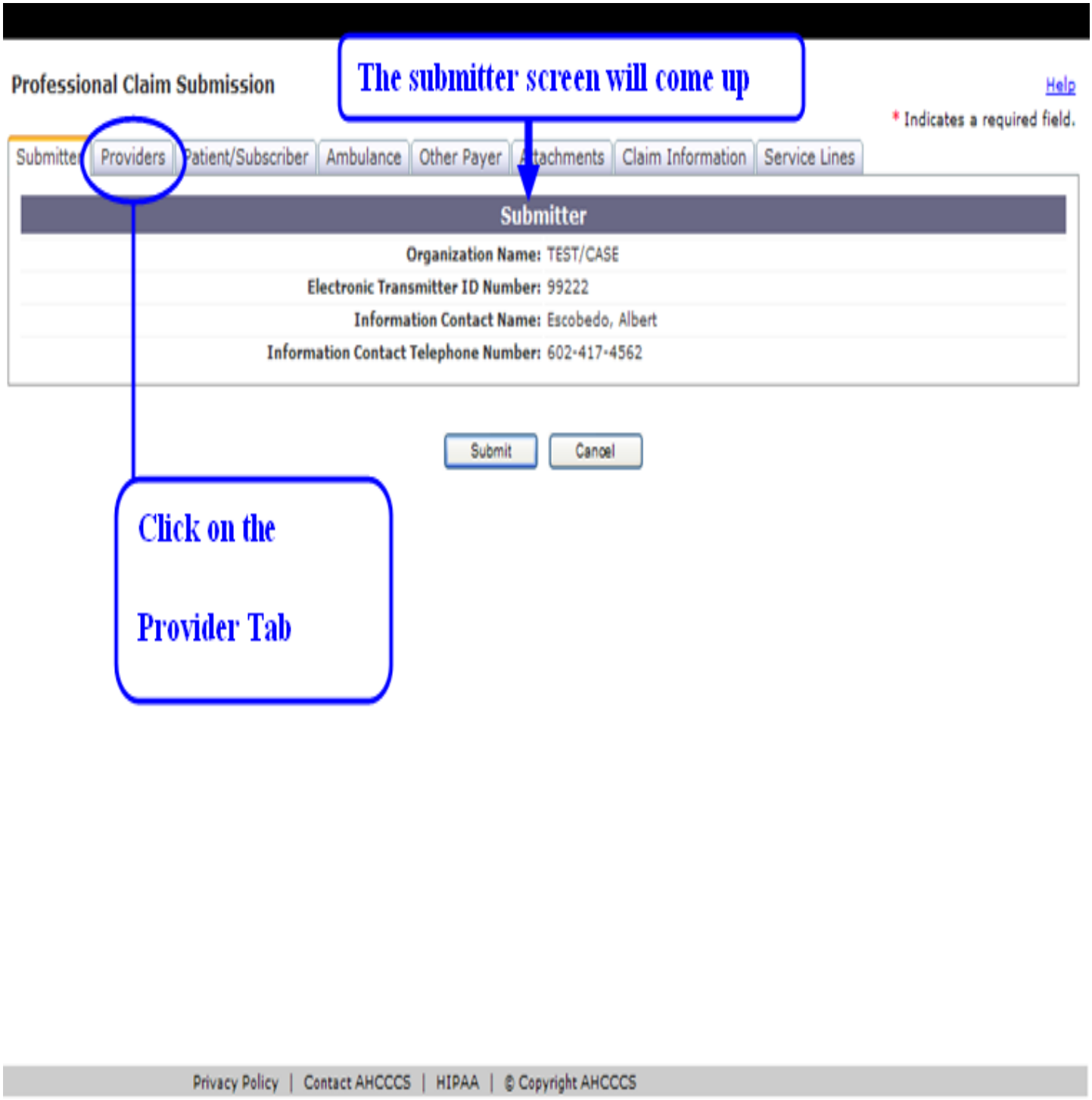
Claims submitted to AHCCCS prior to 4:00 PM will be processed within 24 to 48 hours. Once the claim has been sent for processing, it can no longer be modified via the web. After the processing deadline, corrections will need to be submitted as a **Replacement** or **Void**. The claim will not be accepted 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):

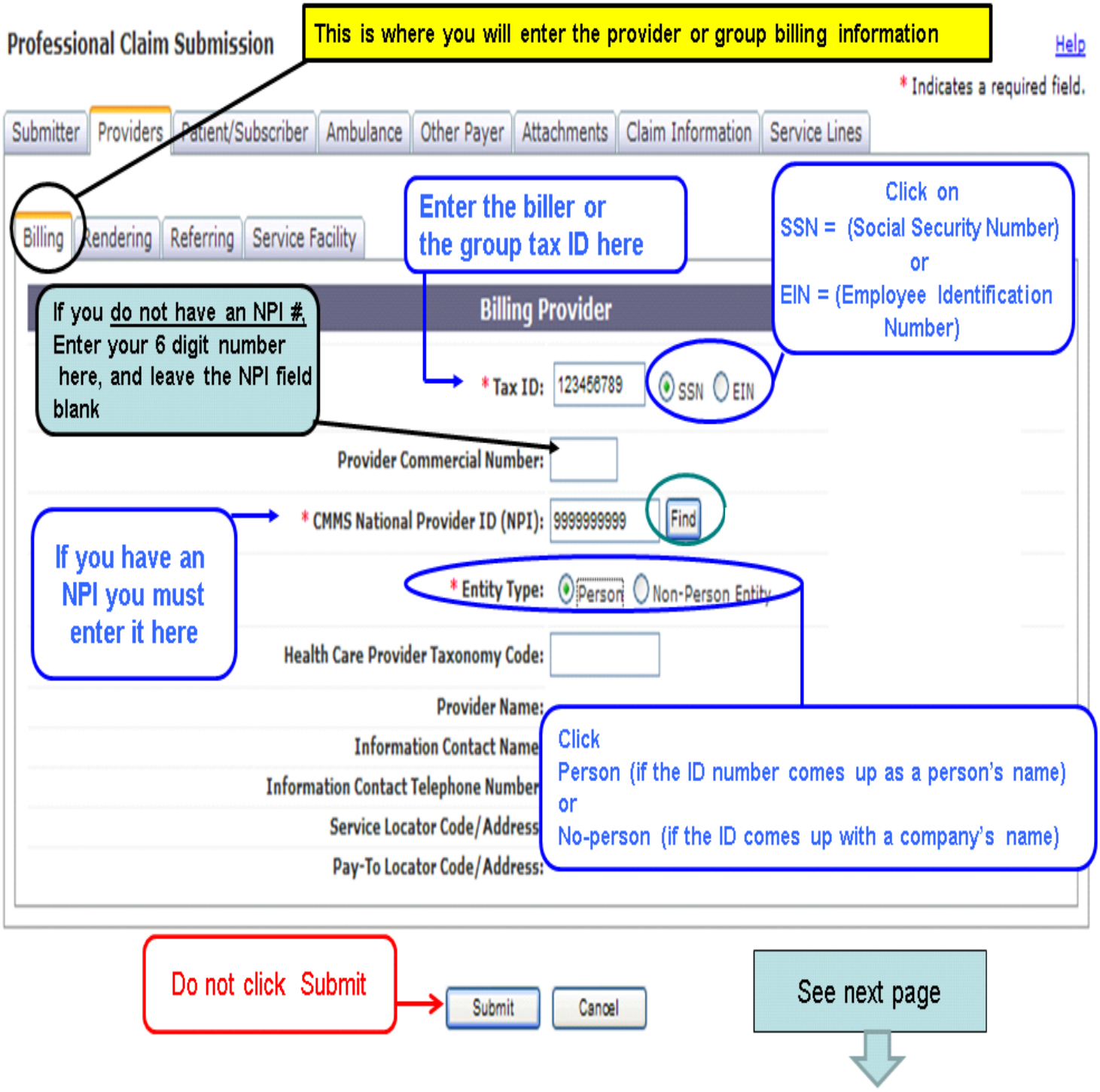
Payer/Receiver Electronic Transmitter Identification Number: 866004791

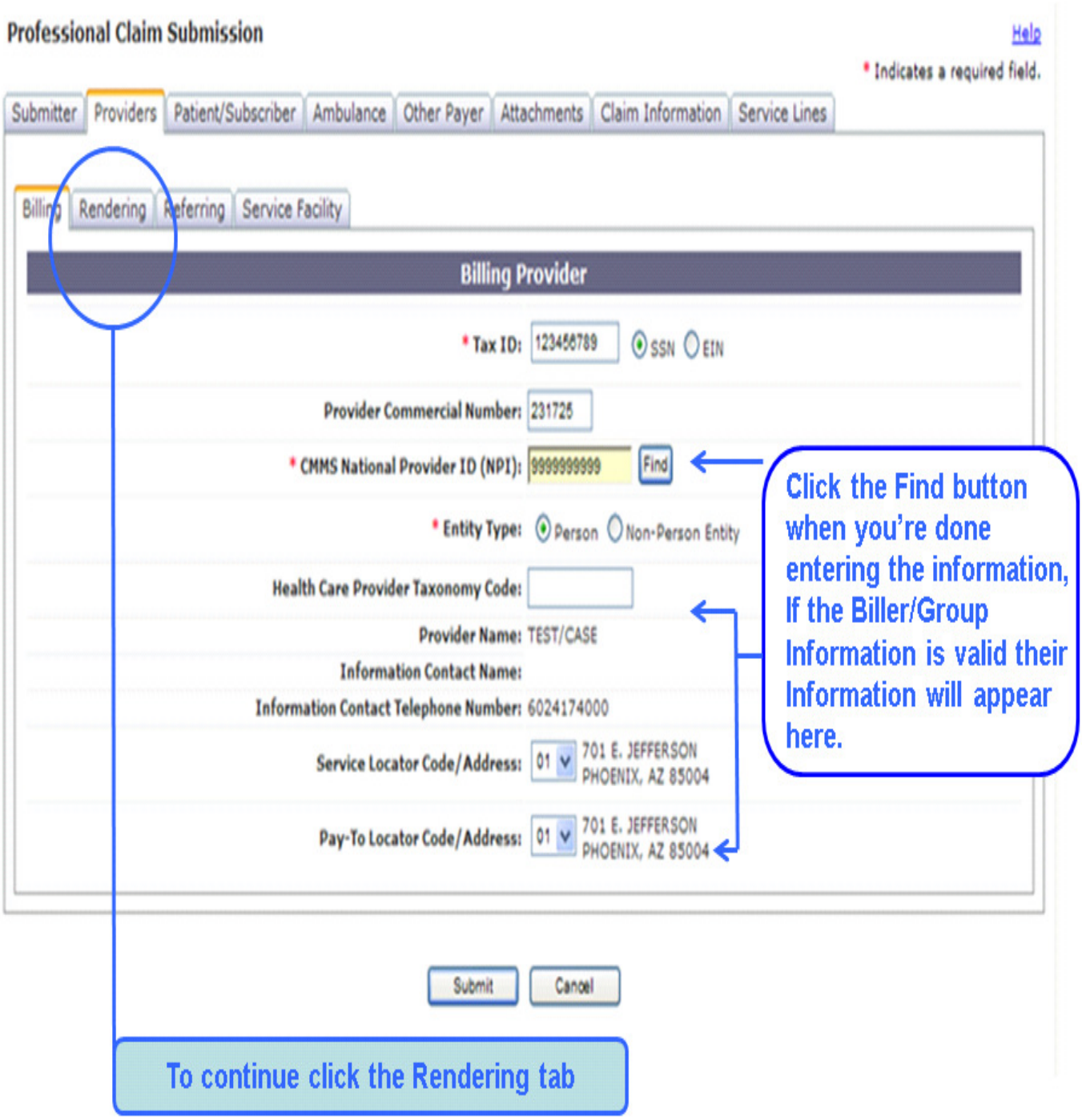
NOTE: You cannot view the processing status of claims submitted by other users.

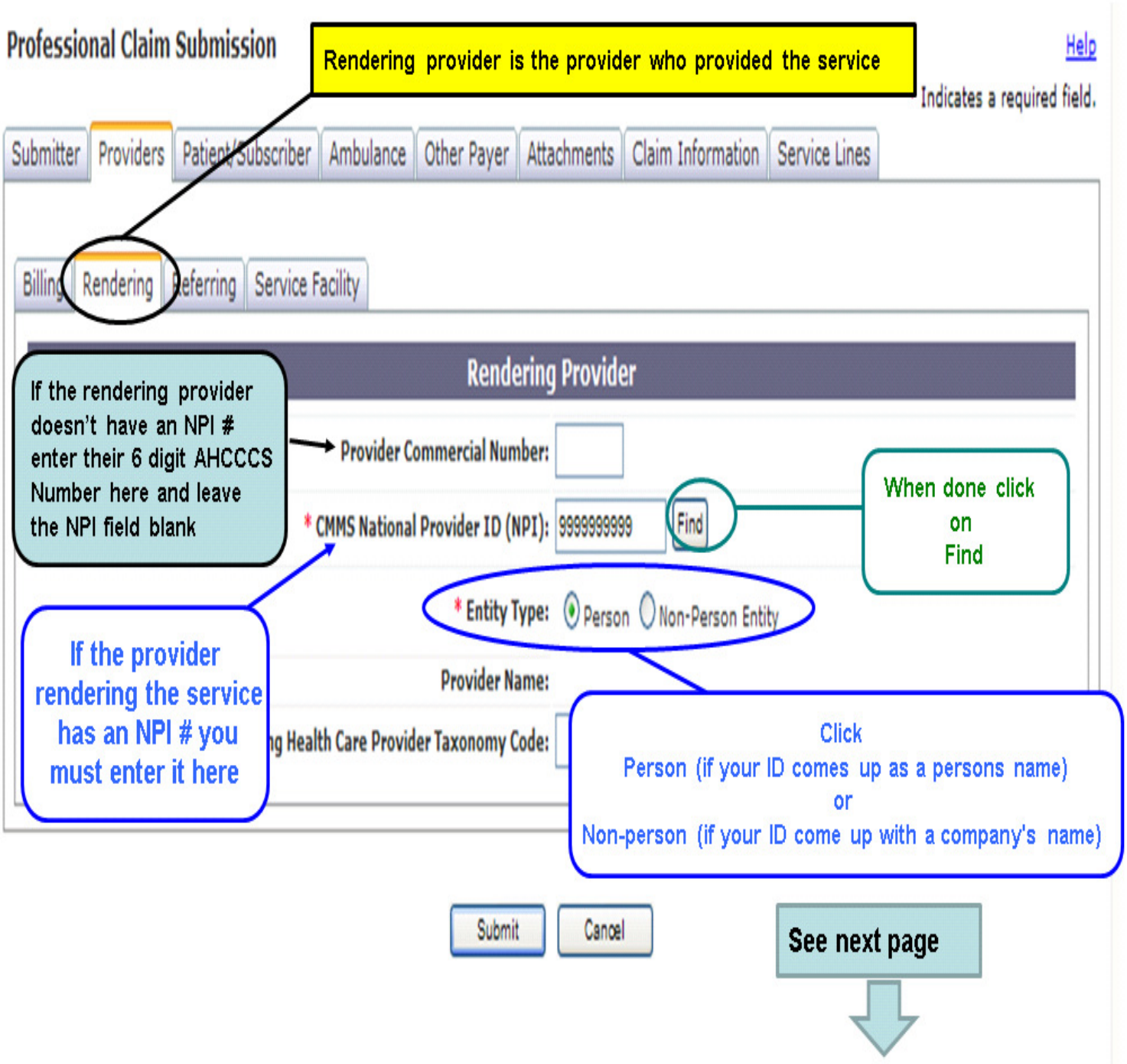


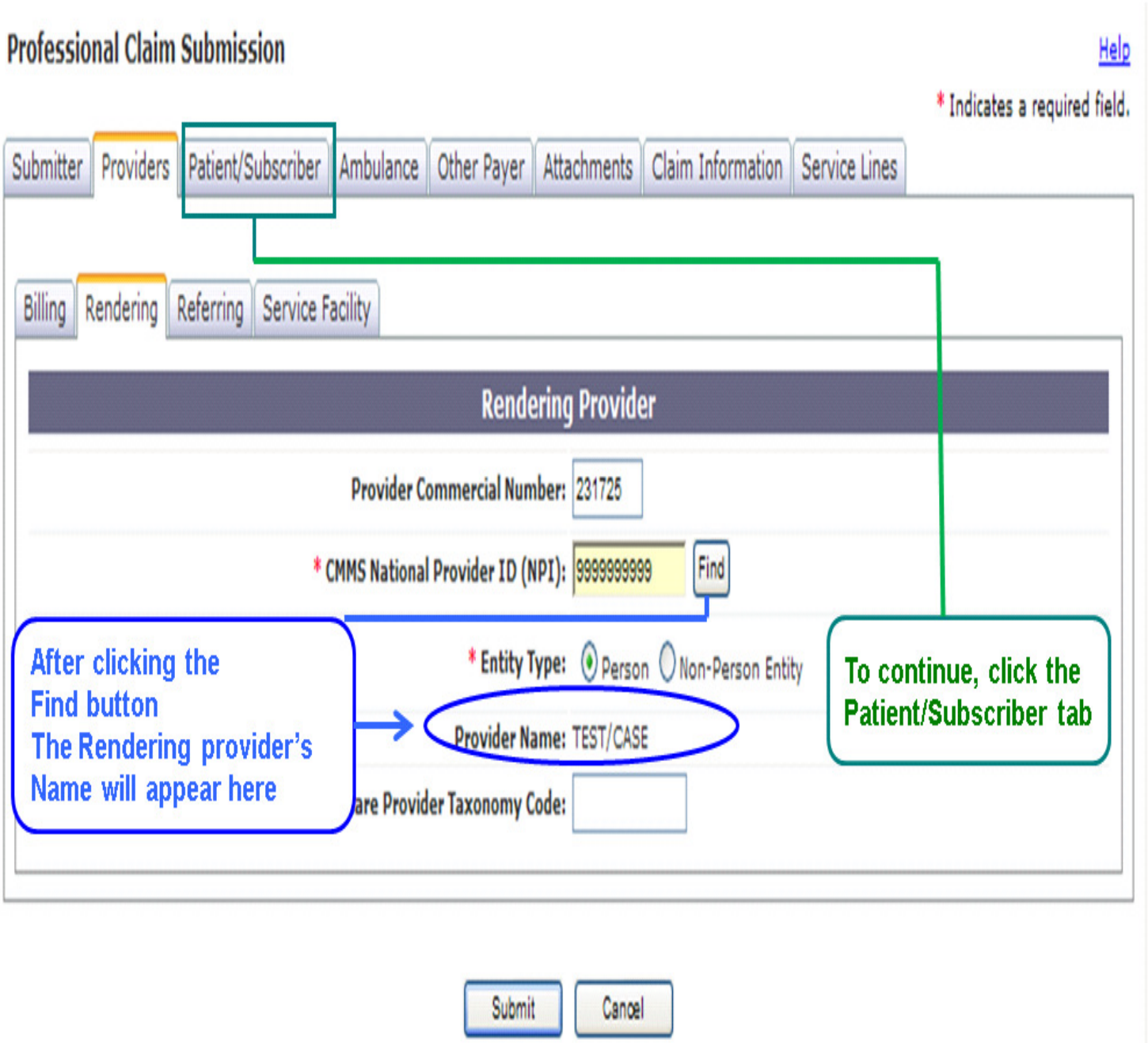
Privacy Policy | Contact AHCCCS | HIPAA | © Copyright AHCCCS

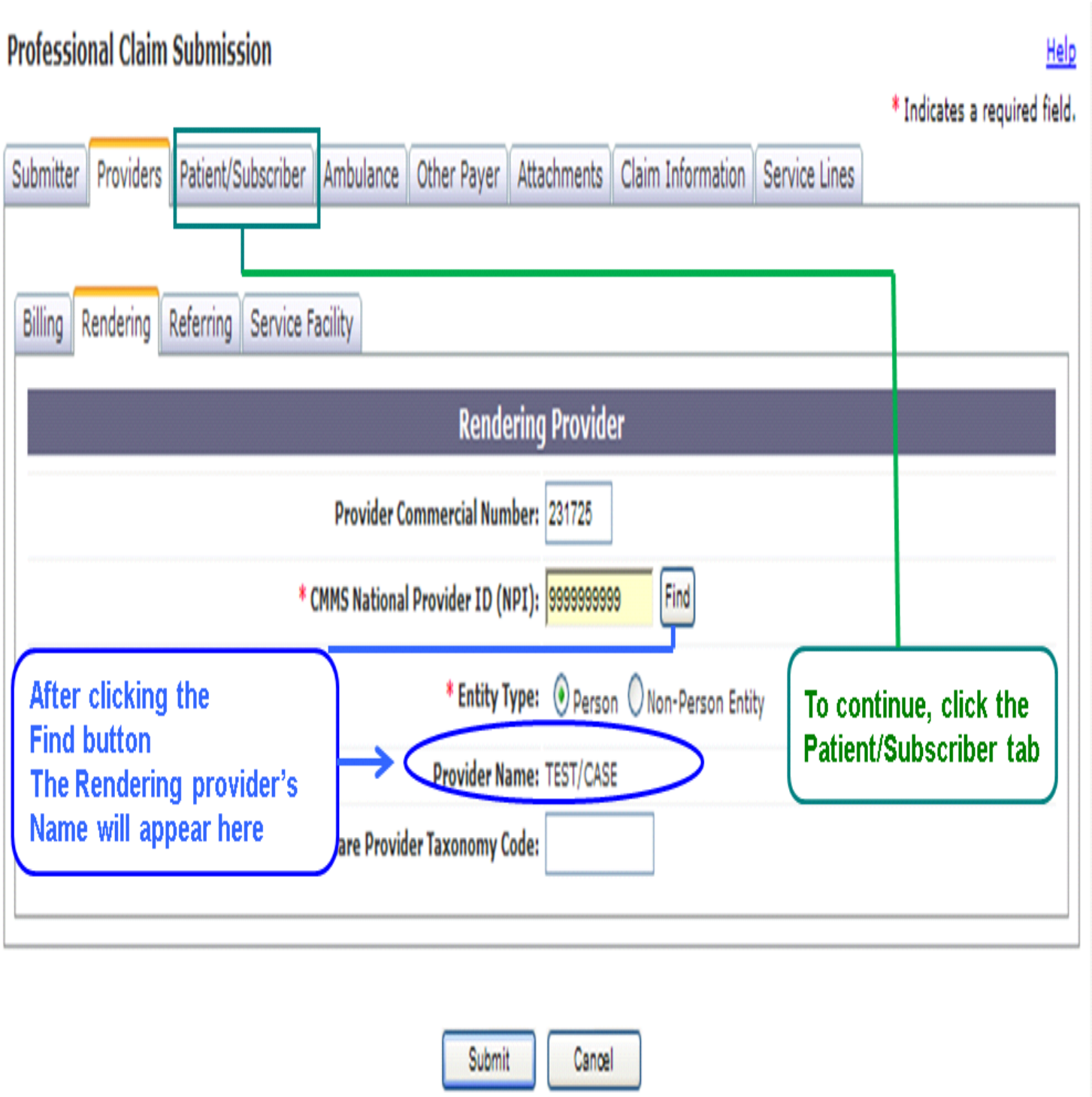

The submitter screen will come up
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Submitter
Organization Name: TEST/CASE
Electronic Transmitter ID Number: 99222
Information Contact Name: Escobedo, Albert
Information Contact Telephone Number: 602-417-4562
Submit
Cancel
Click on the
Provider Tab
Privacy Policy | Contact AHCCCS | HIPAA | © Copyright AHCCCS

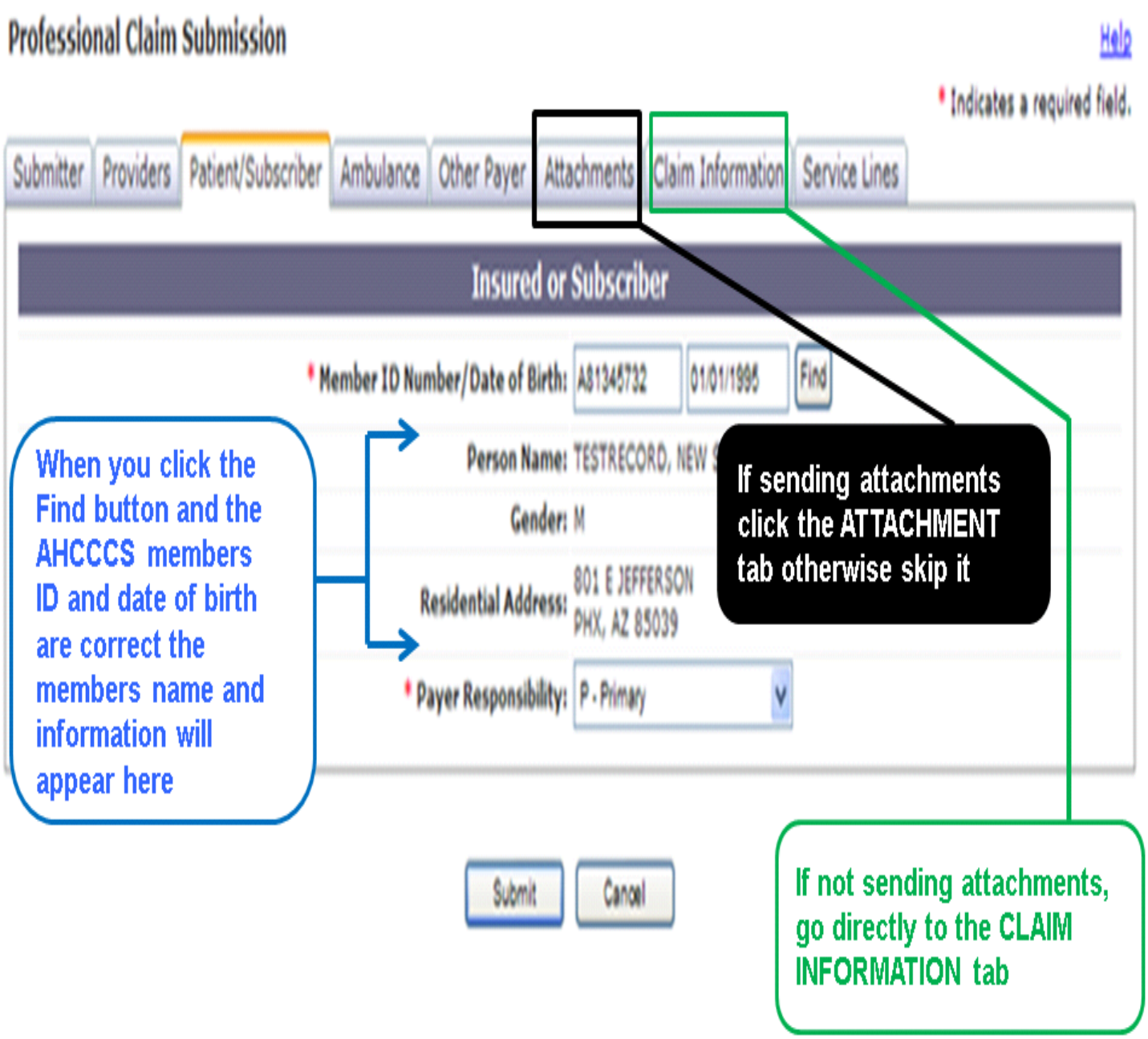

Professional Claim Submission
This is where you will enter the provider or group billing information
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Billing
Rendering
Referring
Service Facility
Enter the biller or the group tax ID here
Click on
SSN = (Social Security Number)
or
EIN = (Employee Identification Number)
If you do not have an NPI #, Enter your 6 digit number here, and leave the NPI field blank
Billing Provider
* Tax ID: 123456789
SSN
EIN
Provider Commercial Number:
* CMMS National Provider ID (NPI): 9999999999
Find
If you have an NPI you must enter it here
* 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:
Click
Person (if the ID number comes up as a person's name)
or
No-person (if the ID comes up with a company's name)
Do not click Submit
Submit
Cancel
See next page

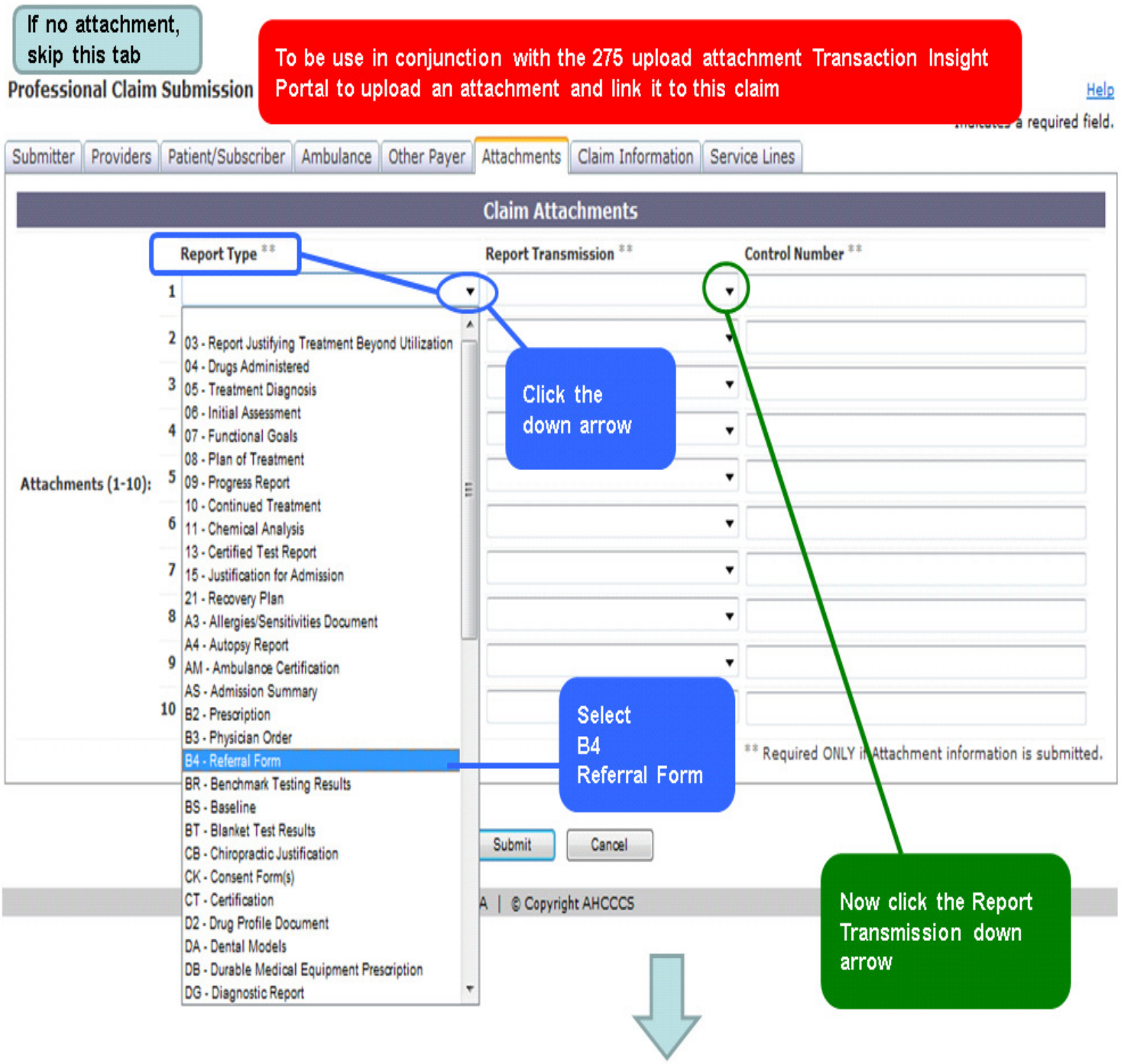

Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Billing
Rendering
Referring
Service Facility
Billing Provider
* Tax ID: 123456789 SSN EIN
Provider Commercial Number: 231725
* CMMS National Provider ID (NPI): 9999999999 Find
* 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: 01 701 E. JEFFERSON PHOENIX, AZ 85004
Pay-To Locator Code/Address: 01 701 E. JEFFERSON PHOENIX, AZ 85004
Click the Find button when you're done entering the information, If the Biller/Group Information is valid their Information will appear here.
Submit
Cancel
To continue click the Rendering tab

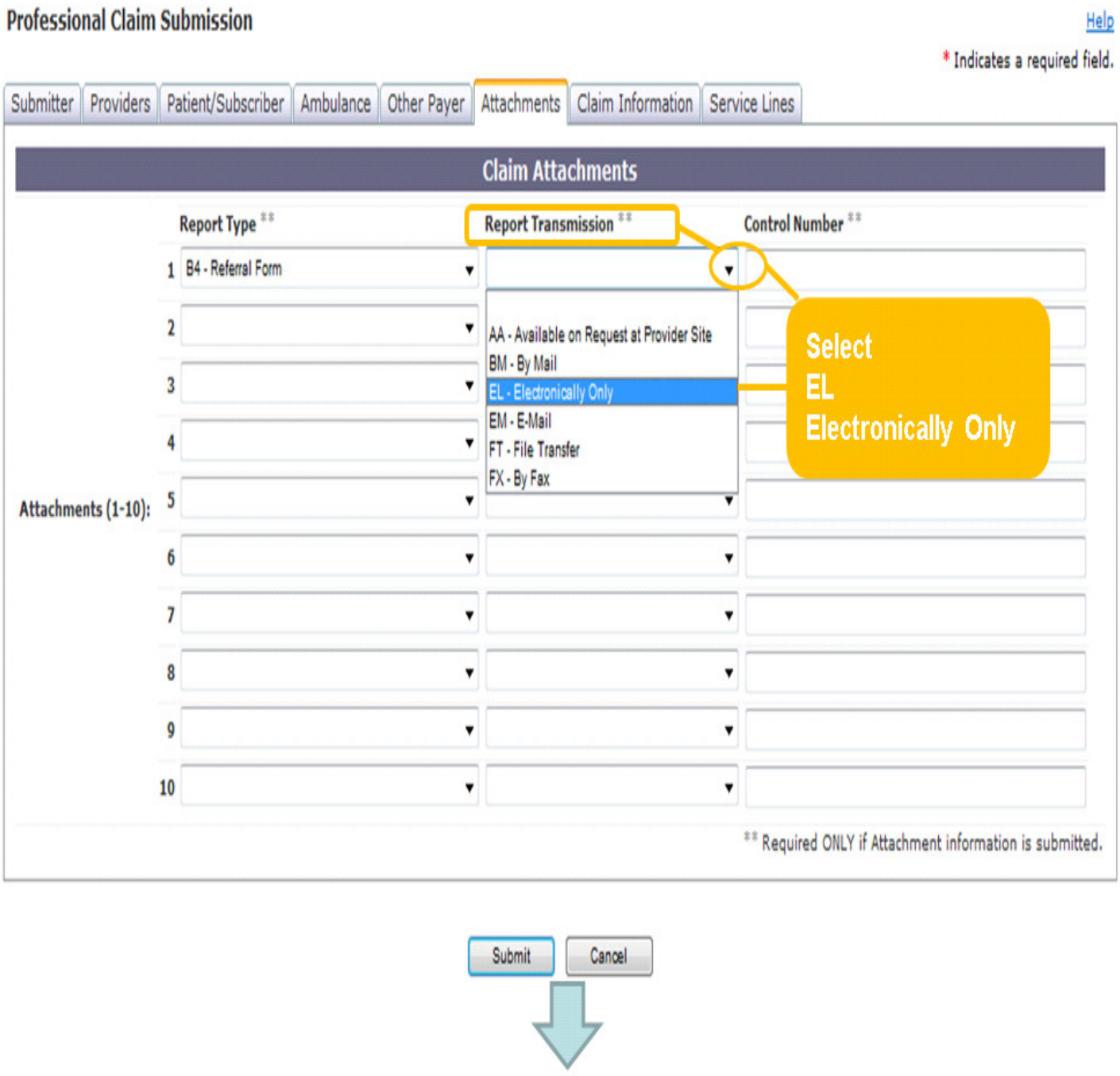

Professional Claim Submission
Rendering provider is the provider who provided the service
Help
Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Billing
Rendering
Referring
Service Facility
Rendering Provider
If the rendering provider doesn't have an NPI # enter their 6 digit AHCCCS Number here and leave the NPI field blank
Provider Commercial Number:
* CMMS National Provider ID (NPI):
9999999999
Find
When done click on Find
* Entity Type:
Person
Non-Person Entity
If the provider rendering the service has an NPI # you must enter it here
Provider Name:
Health Care Provider Taxonomy Code:
Click
Person (if your ID comes up as a persons name)
or
Non-person (if your ID come up with a company's name)
Submit
Cancel
See next page

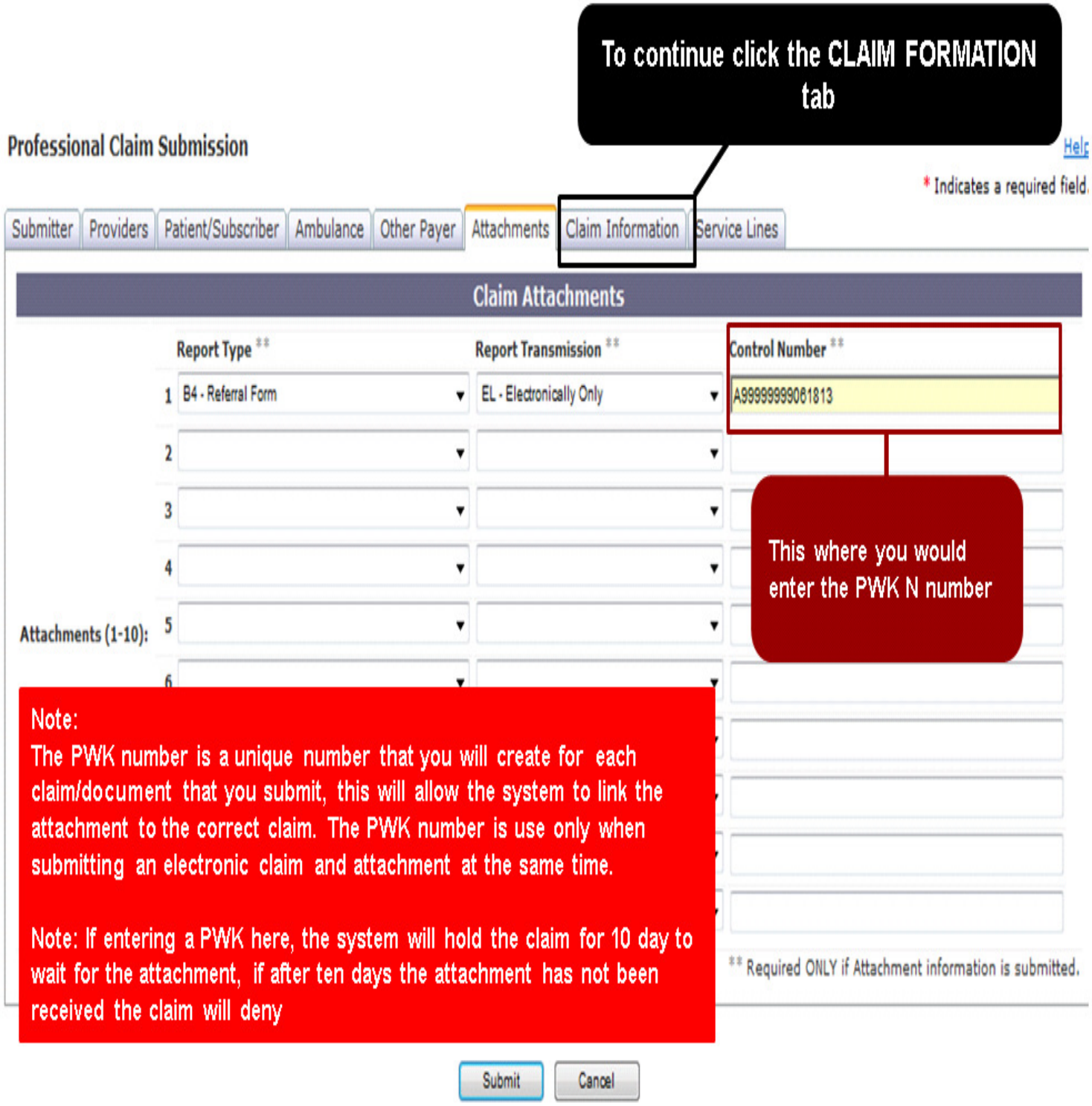

Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Billing
Rendering
Referring
Service Facility
Rendering Provider
Provider Commercial Number: 231725
* CMMS National Provider ID (NPI): 9999999999
Find
After clicking the Find button The Rendering provider's Name will appear here
* Entity Type: Person Non-Person Entity
Provider Name: TEST/CASE
are Provider Taxonomy Code:
To continue, click the Patient/Subscriber tab
Submit
Cancel

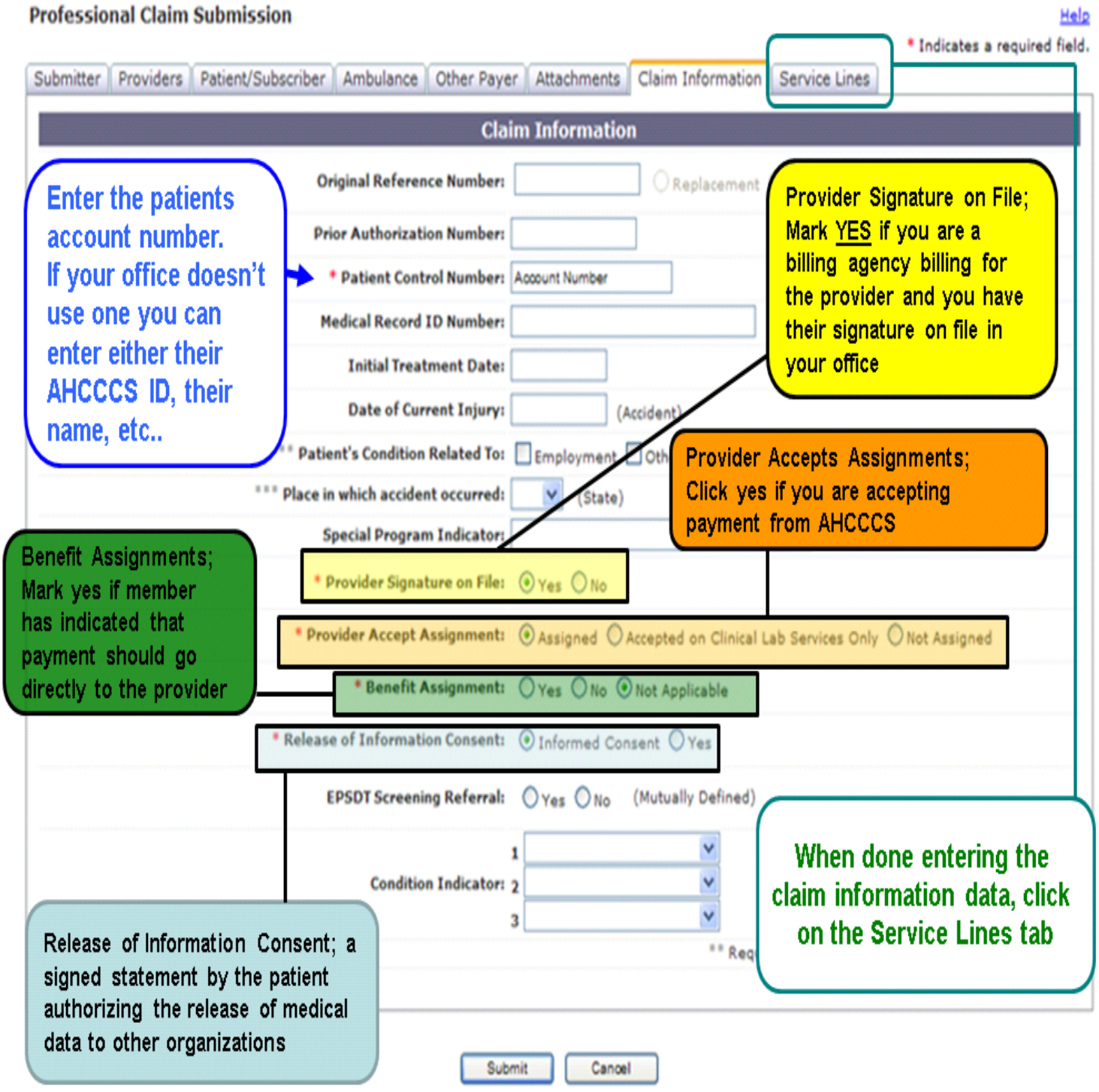

Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Billing
Rendering
Referring
Service Facility
Rendering Provider
Provider Commercial Number: 231725
* CMMS National Provider ID (NPI): 9999999999
Find
After clicking the Find button The Rendering provider's Name will appear here
* Entity Type: Person Non-Person Entity
Provider Name: TEST/CASE
are Provider Taxonomy Code:
To continue, click the Patient/Subscriber tab
Submit
Cancel

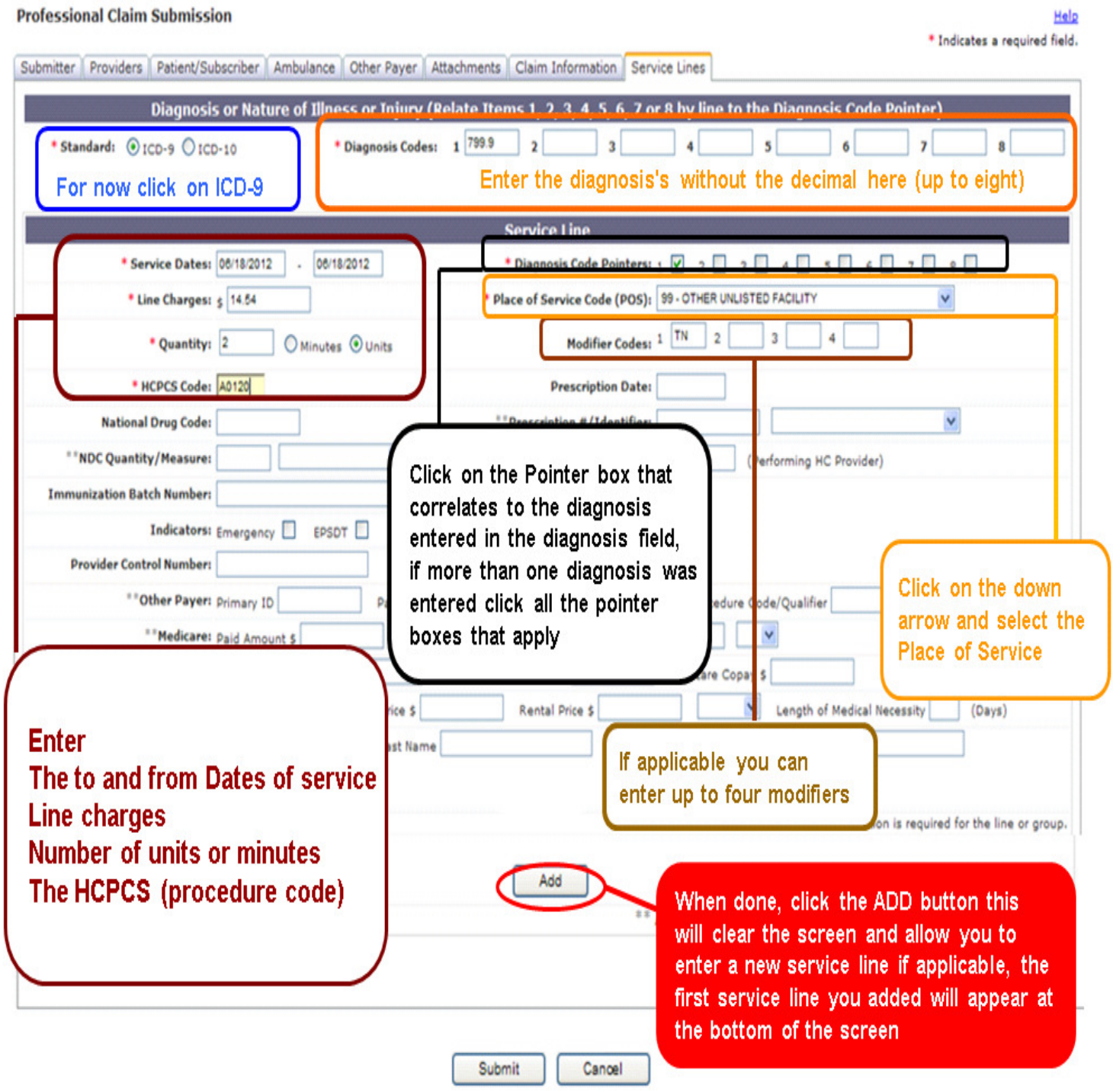

Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Insured or Subscriber
* Member ID Number/Date of Birth:
A81345732
01/01/1995
Find
Person Name: TESTRECORD, NEW
Gender: M
Residential Address:
801 E JEFFERSON
PHX, AZ 85039
* Payer Responsibility:
P - Primary
Submit
Cancel
When you click the Find button and the AHCCCS members ID and date of birth are correct the members name and information will appear here
If sending attachments click the ATTACHMENT tab otherwise skip it
If not sending attachments, go directly to the CLAIM INFORMATION tab


If no attachment, skip this tab
Professional Claim Submission
To be use in conjunction with the 275 upload attachment Transaction Insight Portal to upload an attachment and link it to this claim
Help
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Claim Attachments
Report Type **
Report Transmission **
Control Number **
Attachments (1-10):
03 - Report Justifying Treatment Beyond Utilization
04 - Drugs Administered
05 - Treatment Diagnosis
06 - Initial Assessment
07 - Functional Goals
08 - Plan of Treatment
09 - Progress Report
10 - Continued Treatment
11 - Chemical Analysis
13 - Certified Test Report
15 - Justification for Admission
21 - Recovery Plan
A3 - Allergies/Sensitivities Document
A4 - Autopsy Report
AM - Ambulance Certification
AS - Admission Summary
B2 - Prescription
B3 - Physician Order
B4 - Referral Form
BR - Benchmark Testing Results
BS - Baseline
BT - Blanket Test Results
CB - Chiropractic Justification
CK - Consent Form(s)
CT - Certification
D2 - Drug Profile Document
DA - Dental Models
DB - Durable Medical Equipment Prescription
DG - Diagnostic Report
Click the down arrow
Select B4 Referral Form
** Required ONLY if Attachment information is submitted.
Submit
Cancel
© Copyright AHCCCS
Now click the Report Transmission down arrow


Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Claim Attachments
Report Type **
Report Transmission **
Control Number **
1 B4 - Referral Form
2
3
4
5
6
7
8
9
10
Attachments (1-10):
AA - Available on Request at Provider Site
BM - By Mail
EL - Electronically Only
EM - E-Mail
FT - File Transfer
FX - By Fax
Select
EL
Electronically Only
** Required ONLY if Attachment information is submitted.
Submit
Cancel

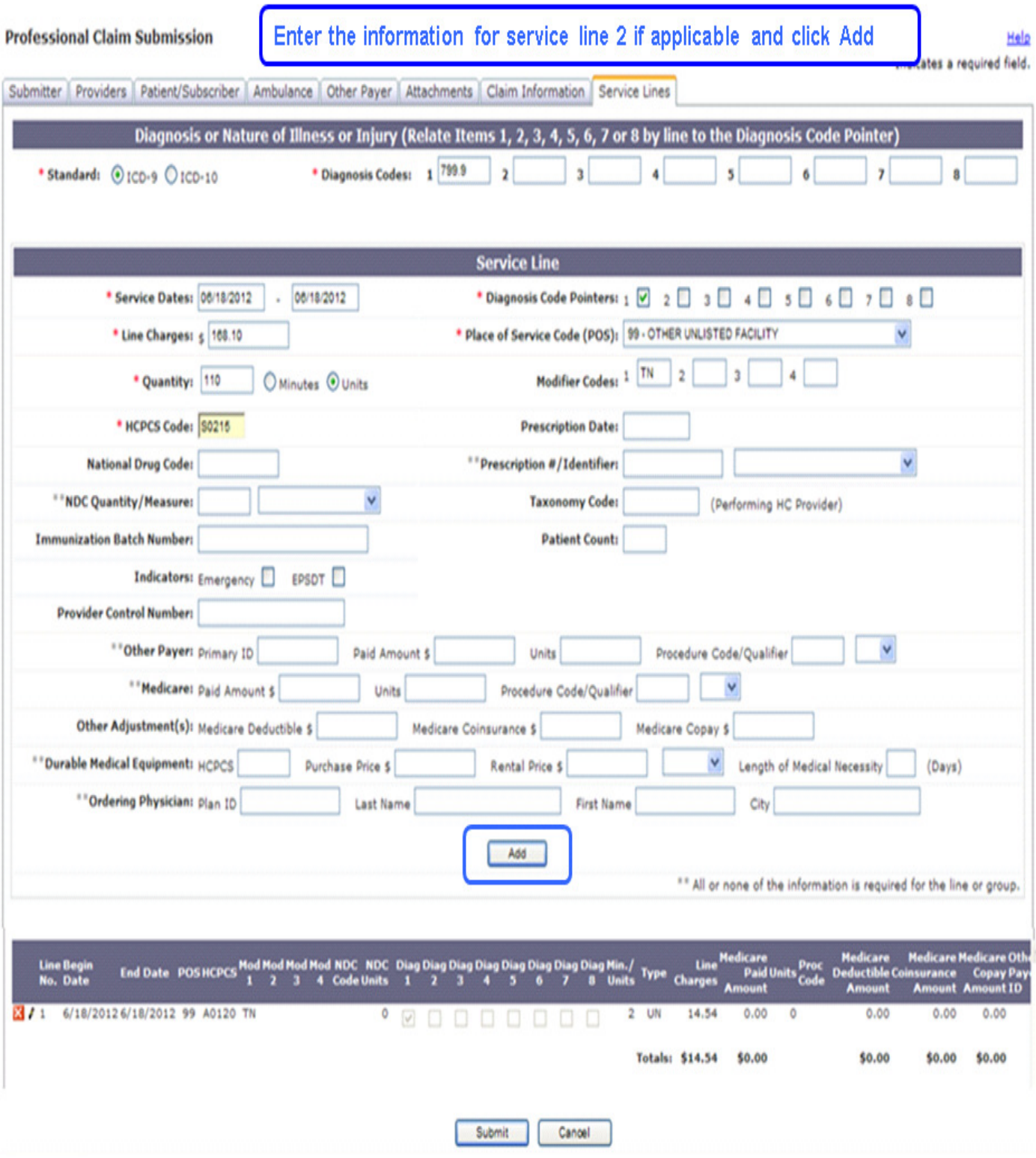

To continue click the CLAIM FORMATION tab
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Claim Attachments
Report Type **
Report Transmission **
Control Number **
1
B4 - Referral Form
EL - Electronically Only
A99999999061813
2
3
4
5
6
Attachments (1-10):
This where you would enter the PWK N number
Note:
The PWK number is a unique number that you will create for each claim/document that you submit, this will allow the system to link the attachment to the correct claim. The PWK number is use only when submitting an electronic claim and attachment at the same time.
Note: If entering a PWK here, the system will hold the claim for 10 day to wait for the attachment, if after ten days the attachment has not been received the claim will deny
** Required ONLY if Attachment information is submitted.
Submit
Cancel


Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Claim Information
Enter the patients account number. If your office doesn't use one you can enter either their AHCCCS ID, their name, etc..
Original Reference Number:
Replacement
Prior Authorization Number:
* Patient Control Number:
Account Number
Medical Record ID Number:
Initial Treatment Date:
Date of Current Injury:
(Accident)
** Patient's Condition Related To:
Employment
*** Place in which accident occurred:
(State)
Special Program Indicator:
Provider Signature on File; Mark YES if you are a billing agency billing for the provider and you have their signature on file in your office
Provider Accepts Assignments; Click yes if you are accepting payment from AHCCCS
Benefit Assignments; Mark yes if member has indicated that payment should go directly to the provider
* Provider Signature on File:
Yes
No
* Provider Accept Assignment:
Assigned
Accepted on Clinical Lab Services Only
Not Assigned
* Benefit Assignment:
Yes
No
Not Applicable
* Release of Information Consent:
Informed Consent
Yes
EPSDT Screening Referral:
Yes
No
(Mutually Defined)
Condition Indicator:
1
2
3
When done entering the claim information data, click on the Service Lines tab
Release of Information Consent; a signed statement by the patient authorizing the release of medical data to other organizations
Submit
Cancel

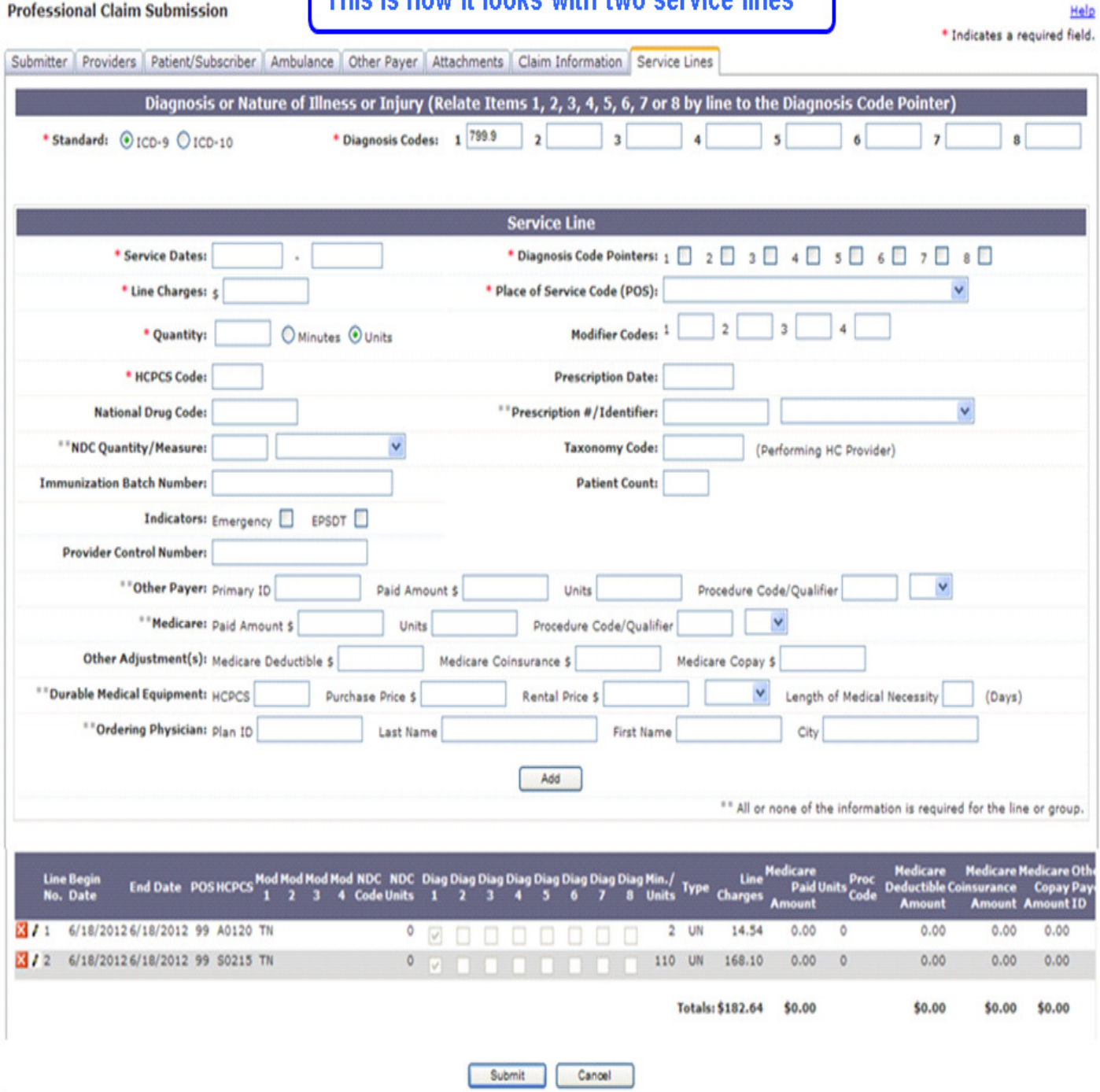

Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, 4, 5, 6, 7 or 8 by line to the Diagnosis Code Pointer)
* Standard: ICD-9 ICD-10
For now click on ICD-9
* Diagnosis Codes: 1 799.9 2 3 4 5 6 7 8
Enter the diagnosis's without the decimal here (up to eight)
Service Line
* Service Dates: 06/18/2012 - 06/18/2012
* Line Charges: $ 14.54
* Quantity: 2 Minutes Units
* HCPCS Code: A0120
* Diagnosis Code Pointers: 1
* Place of Service Code (POS): 99 - OTHER UNLISTED FACILITY
Modifier Codes: 1 TN 2 3 4
Prescription Date:
National Drug Code:
**NDC Quantity/Measure:
Immunization Batch Number:
Indicators: Emergency EPSDT
Provider Control Number:
**Other Payer: Primary ID
**Medicare: Paid Amount $
Rental Price $
Length of Medical Necessity (Days)
Add
Submit
Cancel
Click on the Pointer box that correlates to the diagnosis entered in the diagnosis field, if more than one diagnosis was entered click all the pointer boxes that apply
Click on the down arrow and select the Place of Service
If applicable you can enter up to four modifiers
Enter
The to and from Dates of service
Line charges
Number of units or minutes
The HCPCS (procedure code)
When done, click the ADD button this will clear the screen and allow you to enter a new service line if applicable, the first service line you added will appear at the bottom of the screen

When the Add button is click the first service line you entered will appear at the bottom of the screen and the screen will be blank for you to enter another line if applicable

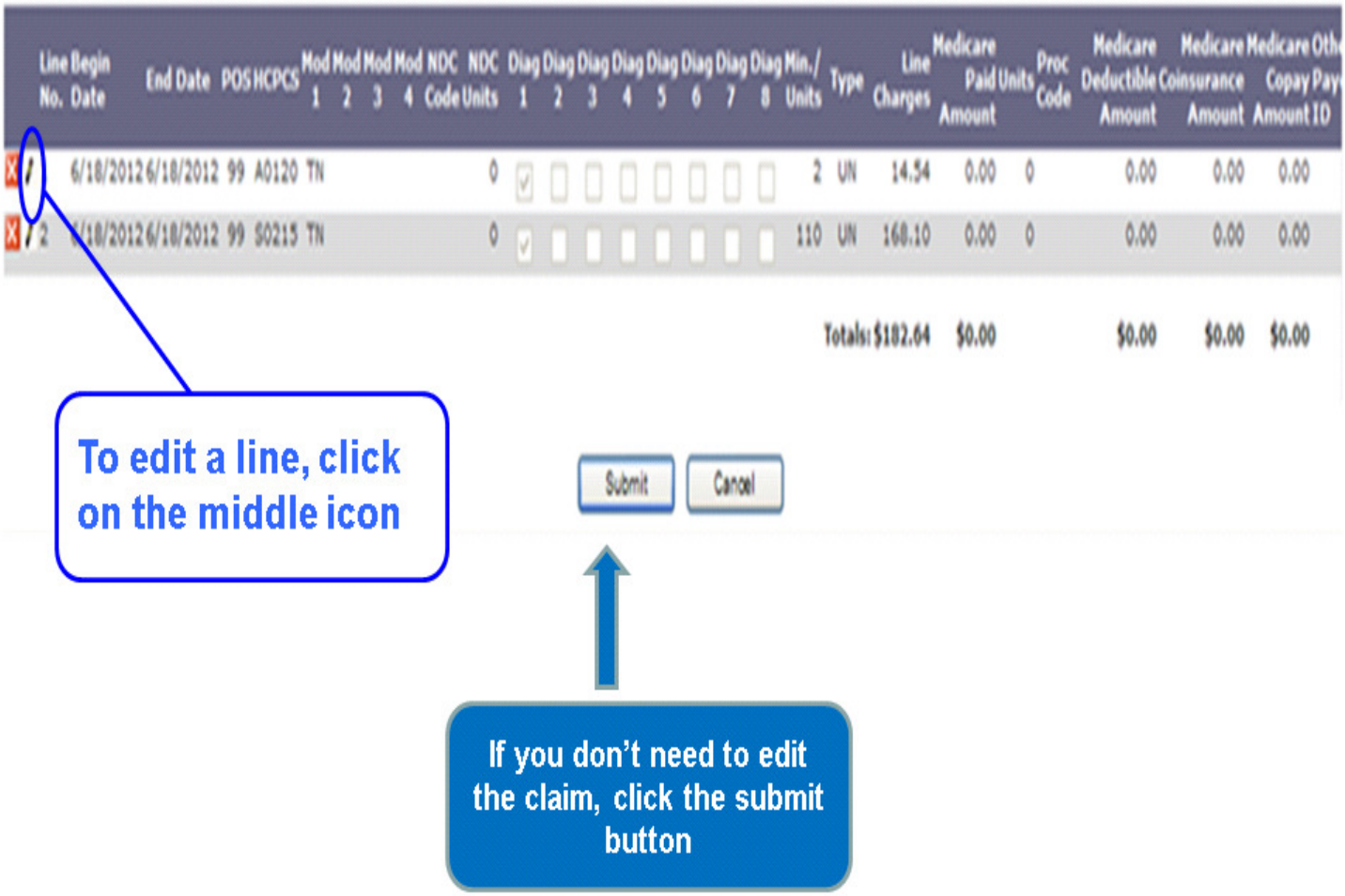
Note:
Must click the add button after every line that's entered (see next page for example)

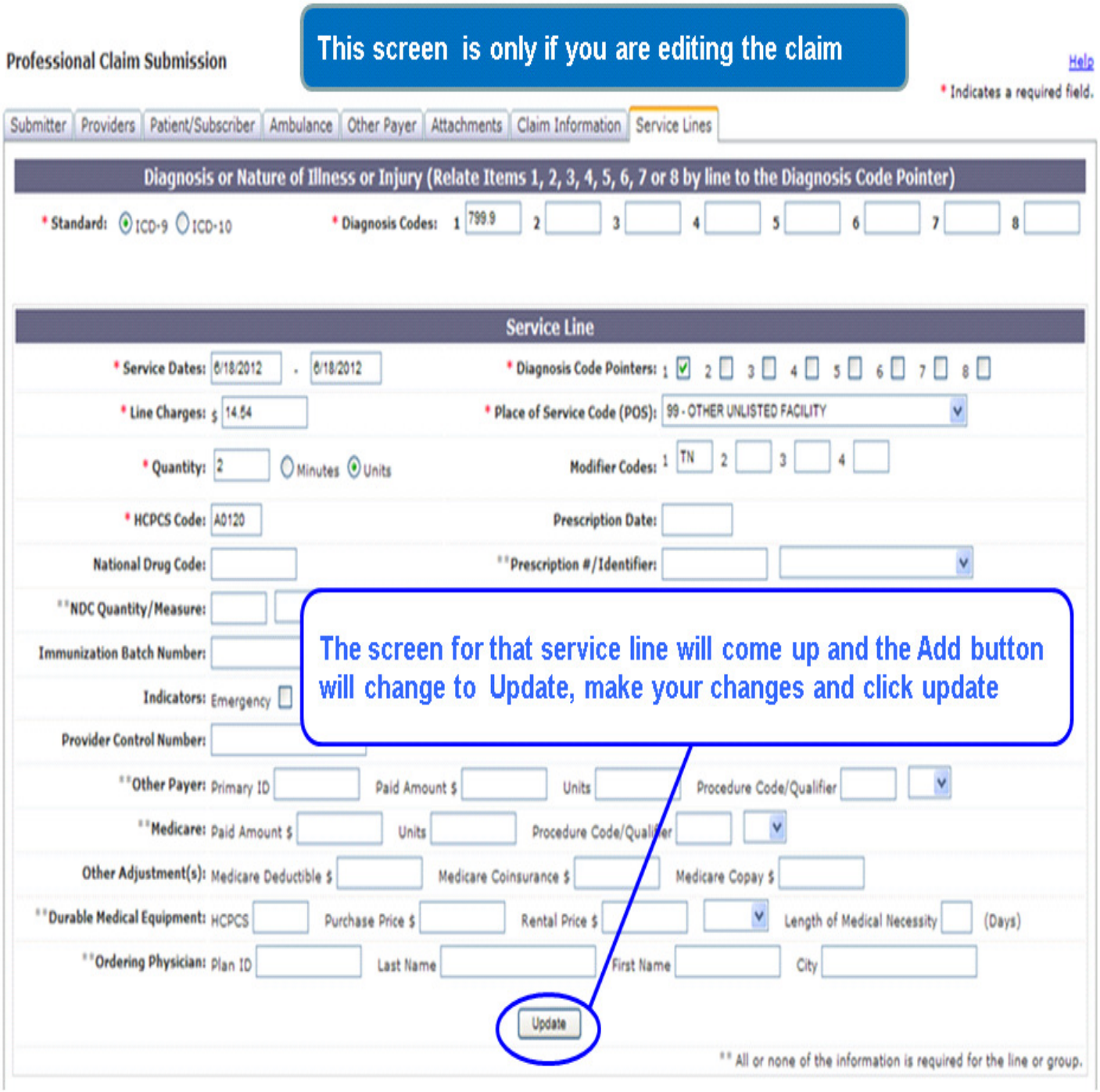

Professional Claim Submission
Enter the information for service line 2 if applicable and click Add
Help
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, 4, 5, 6, 7 or 8 by line to the Diagnosis Code Pointer)
Standard: ICD-9 ICD-10
Diagnosis Codes: 1 799.9 2 3 4 5 6 7 8
Service Line
Service Dates: 06/18/2012 - 06/18/2012
Diagnosis Code Pointers: 1 2 3 4 5 6 7 8
Line Charges: $ 168.10
Place of Service Code (POS): 99 - OTHER UNLISTED FACILITY
Quantity: 110 Minutes Units
Modifier Codes: 1 TN 2 3 4
HCPCS Code: S0215
Prescription Date:
National Drug Code:
Prescription #/Identifier:
NDC Quantity/Measure:
Taxonomy Code: (Performing HC Provider)
Immunization Batch Number:
Patient Count:
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
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 Min./ Units Type Line Charges Medicare Paid Amount Units Proc Code Medicare Deductible Amount Medicare Coinsurance Amount Medicare Other Copay Amount Payer ID
1 6/18/2012 6/18/2012 99 A0120 TN 0 2 UN 14.54 0.00 0 0.00 0.00 0.00
Totals: $14.54 $0.00 $0.00 $0.00 $0.00
Submit
Cancel

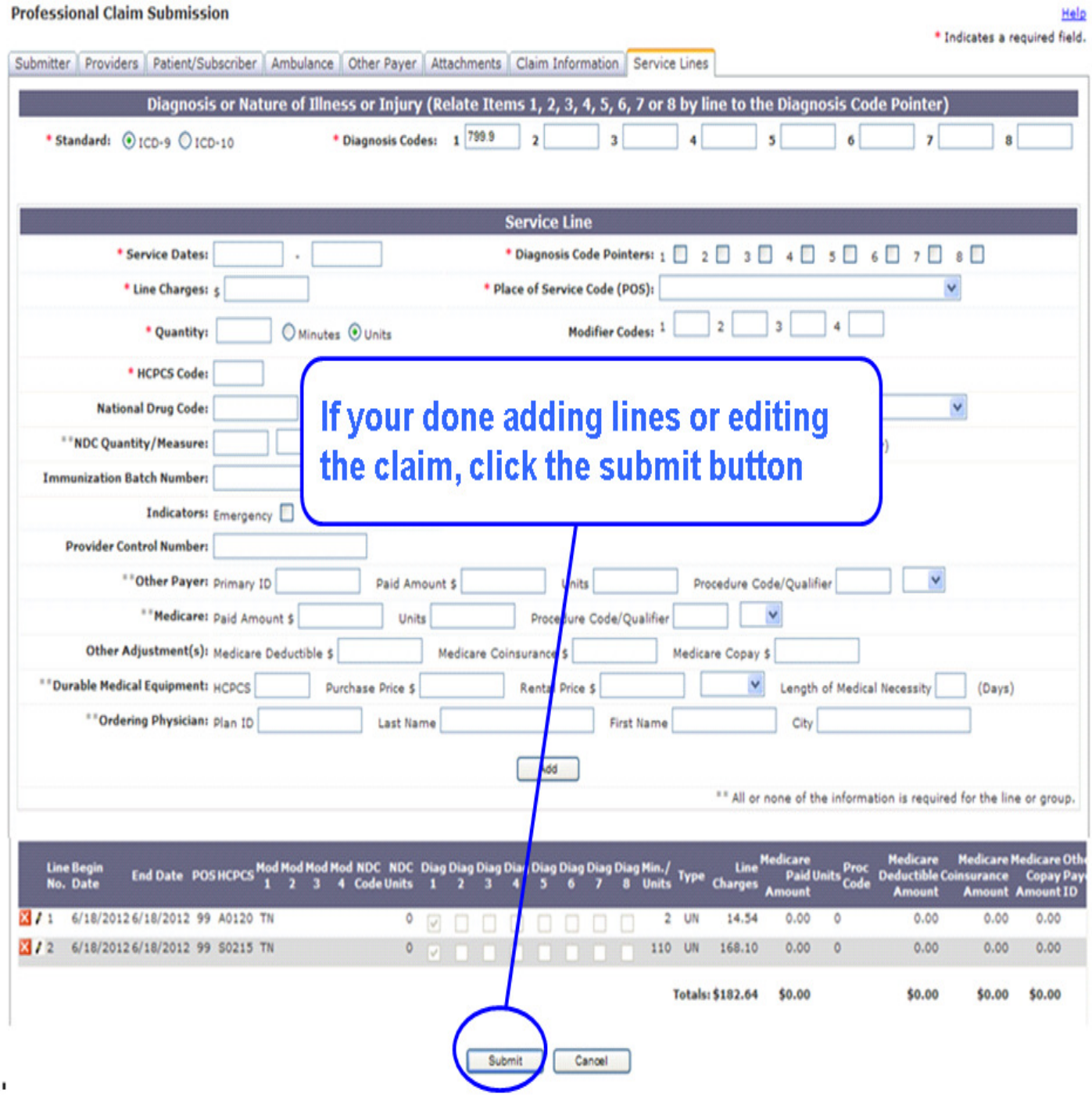
This is how it looks with two service lines

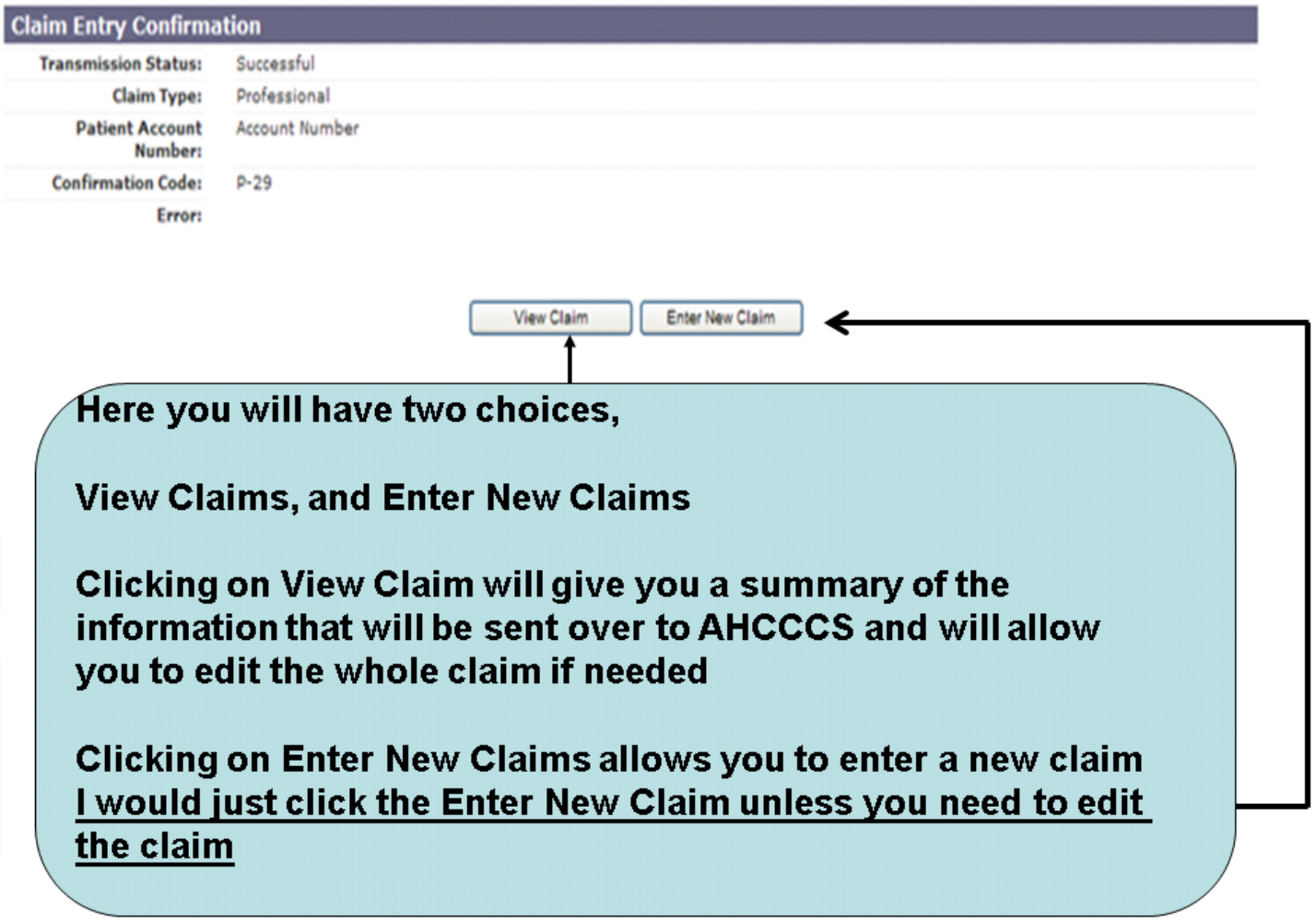


If you need to edit a line you've just entered you can do this by clicking on the pencil icon next to the line you want to edit (can only be done prior to clicking on the submit button)




This screen is only if you are editing the claim
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, 4, 5, 6, 7 or 8 by line to the Diagnosis Code Pointer)
* Standard: ICD-9 ICD-10
* Diagnosis Codes: 1 799.9 2 3 4 5 6 7 8
Service Line
* Service Dates: 6/18/2012 - 6/18/2012
* Diagnosis Code Pointers: 1 2 3 4 5 6 7 8
* Line Charges: $ 14.54
* Place of Service Code (POS): 99 - OTHER UNLISTED FACILITY
* Quantity: 2 Minutes Units
Modifier Codes: 1 TN 2 3 4
* HCPCS Code: A0120
Prescription Date:
National Drug Code:
**Prescription #/Identifier:
**NDC Quantity/Measure:
Immunization Batch Number:
Indicators: Emergency
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
Update
The screen for that service line will come up and the Add button will change to Update, make your changes and click update
** All or none of the information is required for the line or group.


Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, 4, 5, 6, 7 or 8 by line to the Diagnosis Code Pointer)
* Standard: ICD-9 ICD-10
* Diagnosis Codes: 1 799.9 2 3 4 5 6 7 8
Service Line
* Service Dates:
* Diagnosis Code Pointers: 1 2 3 4 5 6 7 8
* Line Charges: $
* Place of Service Code (POS):
* Quantity:
Minutes
Units
Modifier Codes: 1 2 3 4
* HCPCS Code:
National Drug Code:
**NDC Quantity/Measure:
Immunization Batch Number:
Indicators: Emergency
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
Add
** All or none of the information is required for the line or group.
If your done adding lines or editing the claim, click the submit button
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
Min./ Units
Type
Line Charges
Medicare Paid Amount
Units
Proc Code
Medicare Deductible Amount
Medicare Coinsurance Amount
Medicare Copay Amount
Oth Pay ID
1 6/18/2012 6/18/2012 99 A0120 TN 0 2 UN 14.54 0.00 0 0.00 0.00 0.00
2 6/18/2012 6/18/2012 99 S0215 TN 0 110 UN 168.10 0.00 0 0.00 0.00 0.00
Totals: $182.64 $0.00 $0.00 $0.00 $0.00
Submit
Cancel

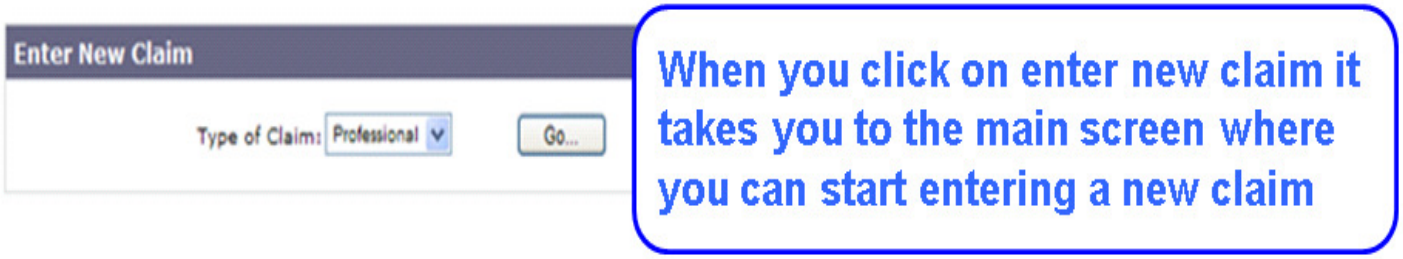

Claim Entry Confirmation
Transmission Status: Successful
Claim Type: Professional
Patient Account Number: Account Number
Confirmation Code: P-29
Error:
View Claim
Enter New Claim
Here you will have two choices,
View Claims, and Enter New Claims
Clicking on View Claim will give you a summary of the information that will be sent over to AHCCCS and will allow you to edit the whole claim if needed
Clicking on Enter New Claims allows you to enter a new claim
I would just click the Enter New Claim unless you need to edit the claim

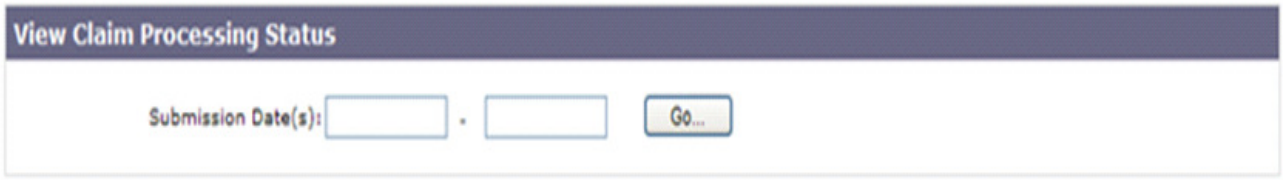
Claim Submission

Claims submitted to AHCCCS prior to 4:00 PM 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.



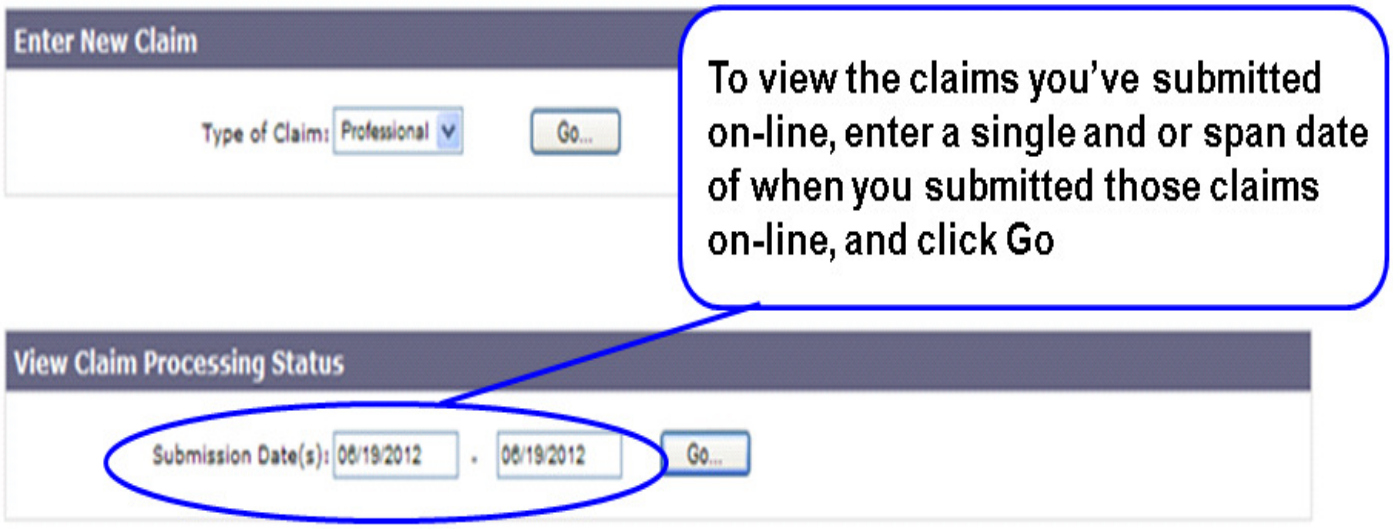


Claim Submission

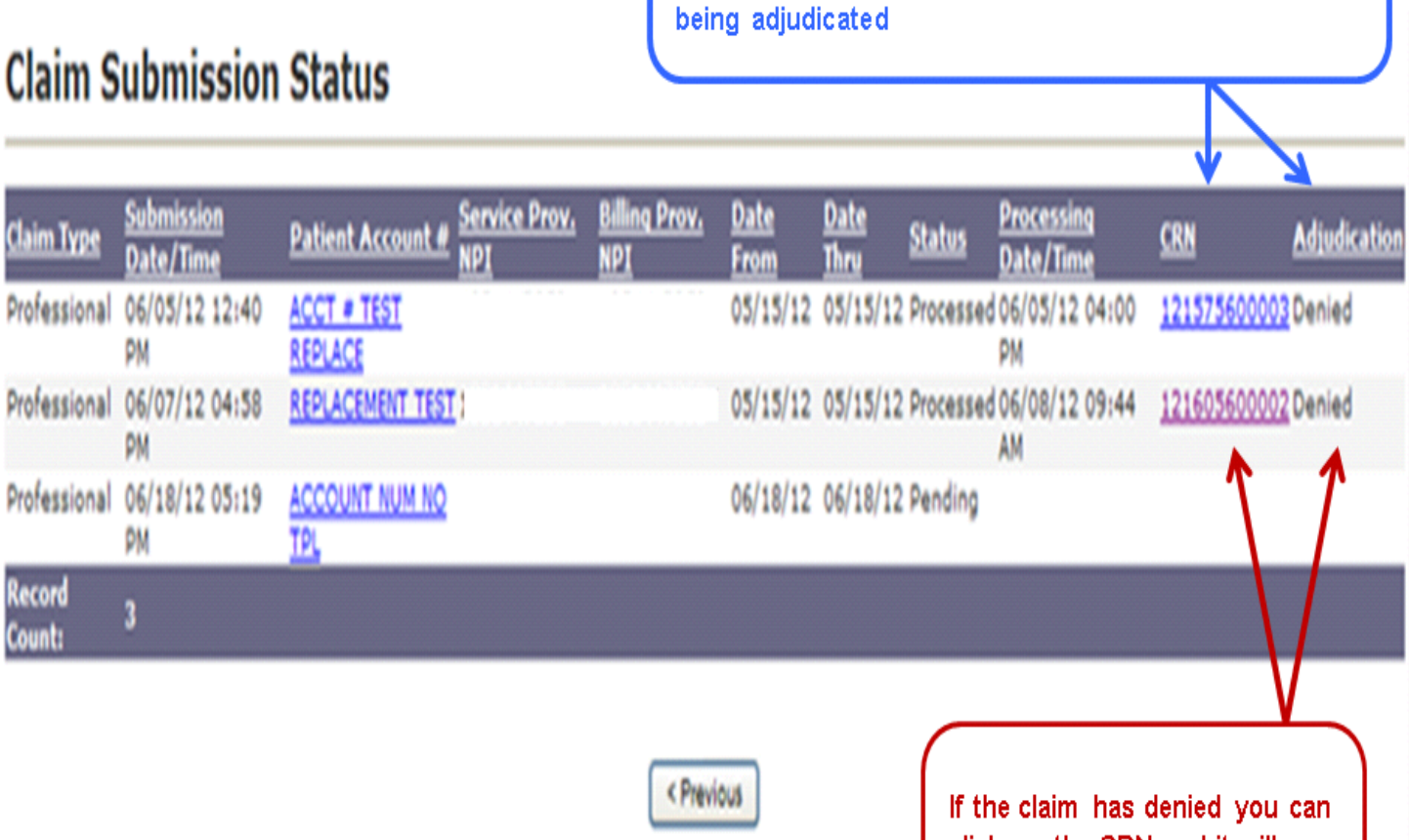
Claims submitted to AHCCCS prior to 4:00 PM will be processed within 24 to 48 hours. Once the claim has been sent for processing, it can no longer be modified via the web. After the processing deadline, corrections will need to be submitted as a **Replacement** or **Void**. The claim will not be accepted 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.



If the claim has been adjudicated it will show a CRN and a paid or denied status (note – claims with a status of un-adjudicated or in-process are in the process of being adjudicated



Claim Submission Status

Claim Type	Submission Date/Time	Patient Account #	Service Prov. NPI	Billing Prov. NPI	Date From	Date Thru	Status	Processing Date/Time	CRN	Adjudication
Professional	06/05/12 12:40 PM	ACCT # TEST REPLACE			05/15/12	05/15/12	Processed	06/05/12 04:00 PM	121575600003	Denied
Professional	06/07/12 04:58 PM	REPLACEMENT TEST			05/15/12	05/15/12	Processed	06/08/12 09:44 AM	121605600002	Denied
Professional	06/18/12 05:19 PM	ACCOUNT NUM NO TPL			06/18/12	06/18/12	Pending			
Record Count:	3									

< Previous

If the claim has denied you can click on the CRN and it will take you to the finance screen to see why it denied