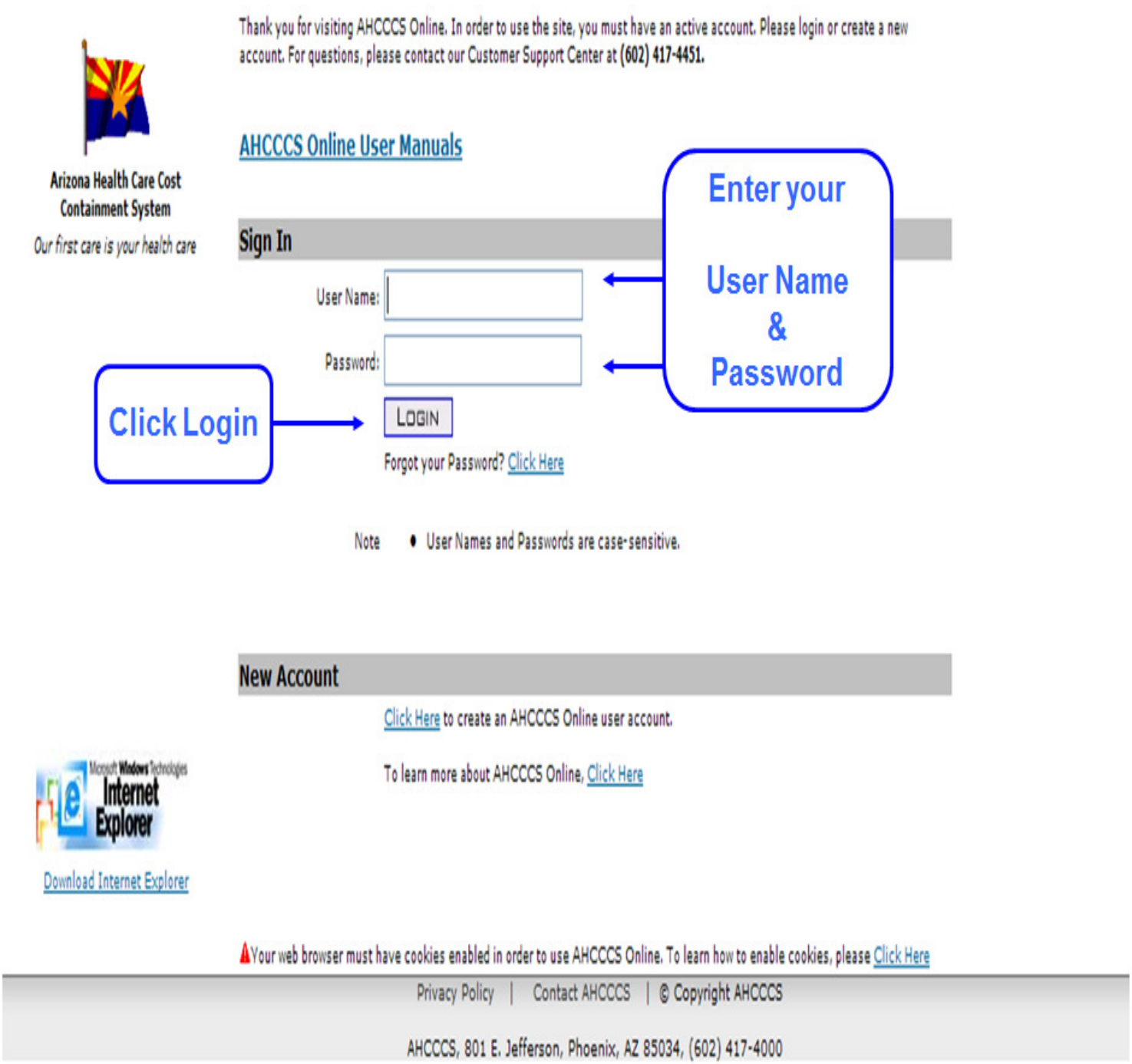
AHCCCS ON-LINE CLAIM SUBMISSION MANUAL

Section 4.b:

Institutional (UB)

Update 10/04/2013


Thank you for visiting AHCCCS Online. In order to use the site, you must have an active account. Please login or create a new account. For questions, please contact our Customer Support Center at (602) 417-4451.
Arizona Health Care Cost Containment System
Our first care is your health care
AHCCCS Online User Manuals
Enter your
User Name
&
Password
Sign In
User Name:
Password:
Click Login
LOGIN
Forgot your Password? Click Here
Note • User Names and Passwords are case-sensitive.
New Account
Click Here to create an AHCCCS Online user account.
To learn more about AHCCCS Online, Click Here
Download Internet Explorer
Your web browser must have cookies enabled in order to use AHCCCS Online. To learn how to enable cookies, please Click Here
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AHCCCS, 801 E. Jefferson, Phoenix, AZ 85034, (602) 417-4000


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.
For-Service claims to AHCCCS for nightly processing.
cepted.
verify the status of previously submitted Prior Authorization
verify an AHCCCS recipient's eligibility and their enrollment in a
her third party coverage information for a recipient.
Click on
Claim Submission 5010
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.

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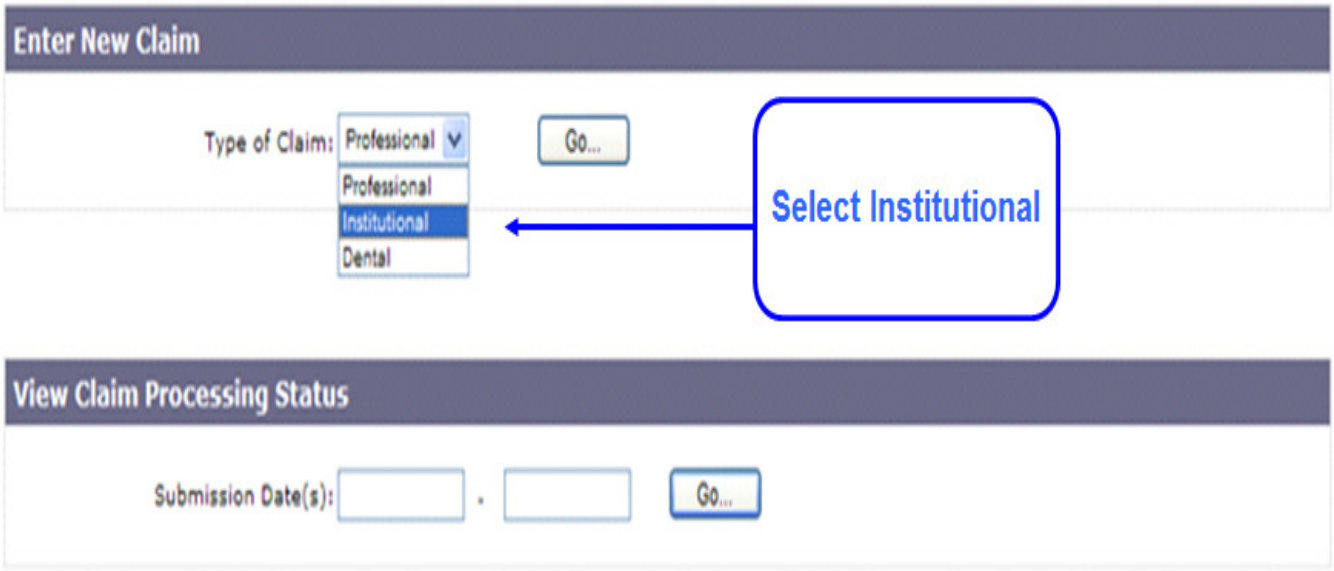

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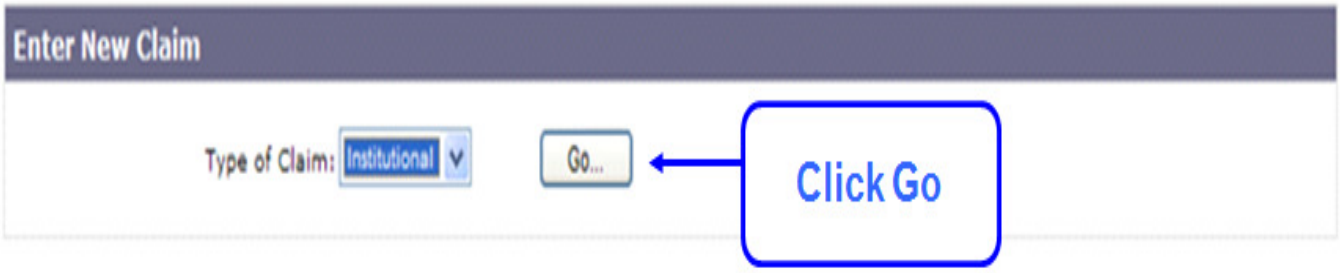
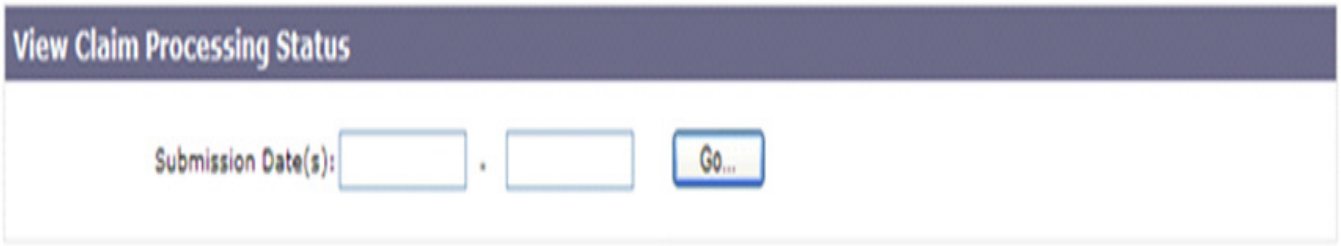
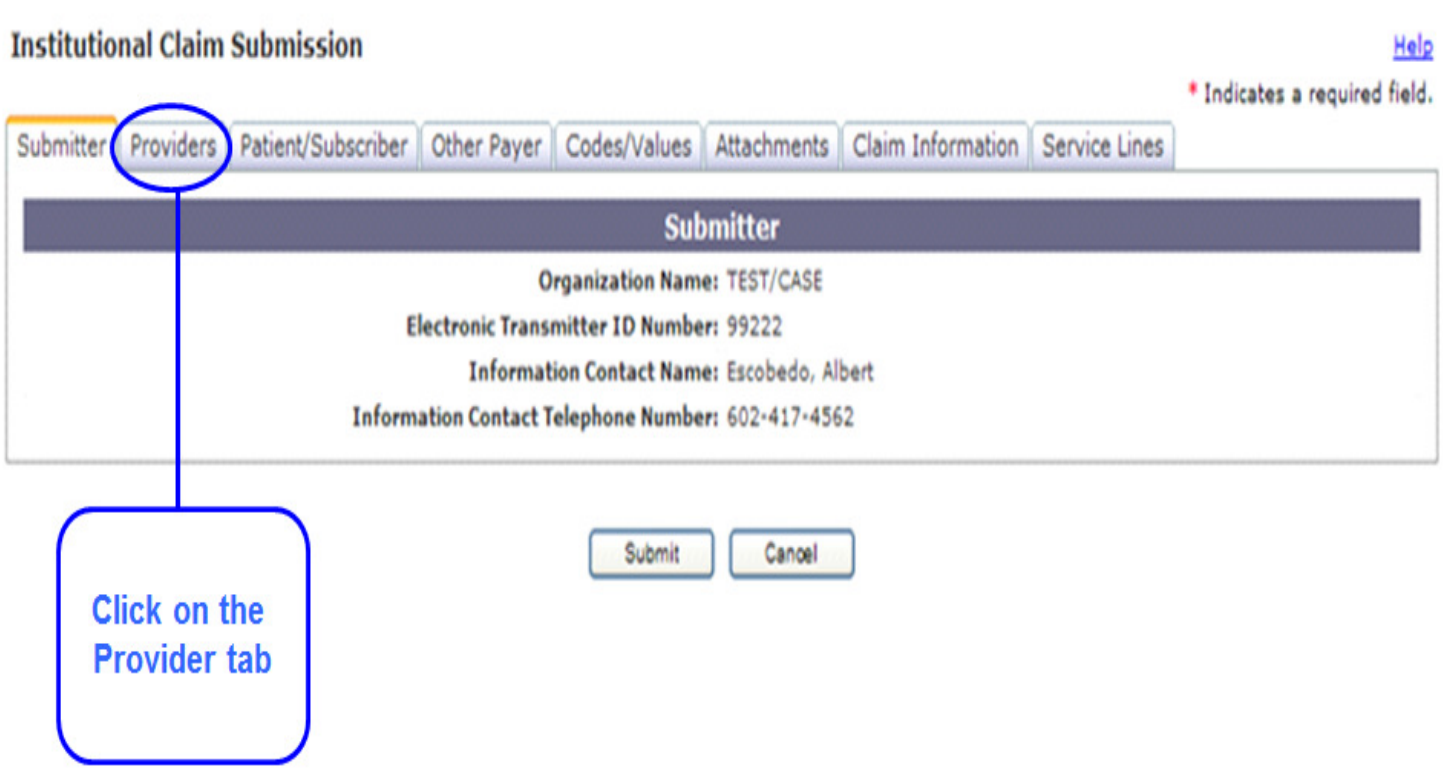
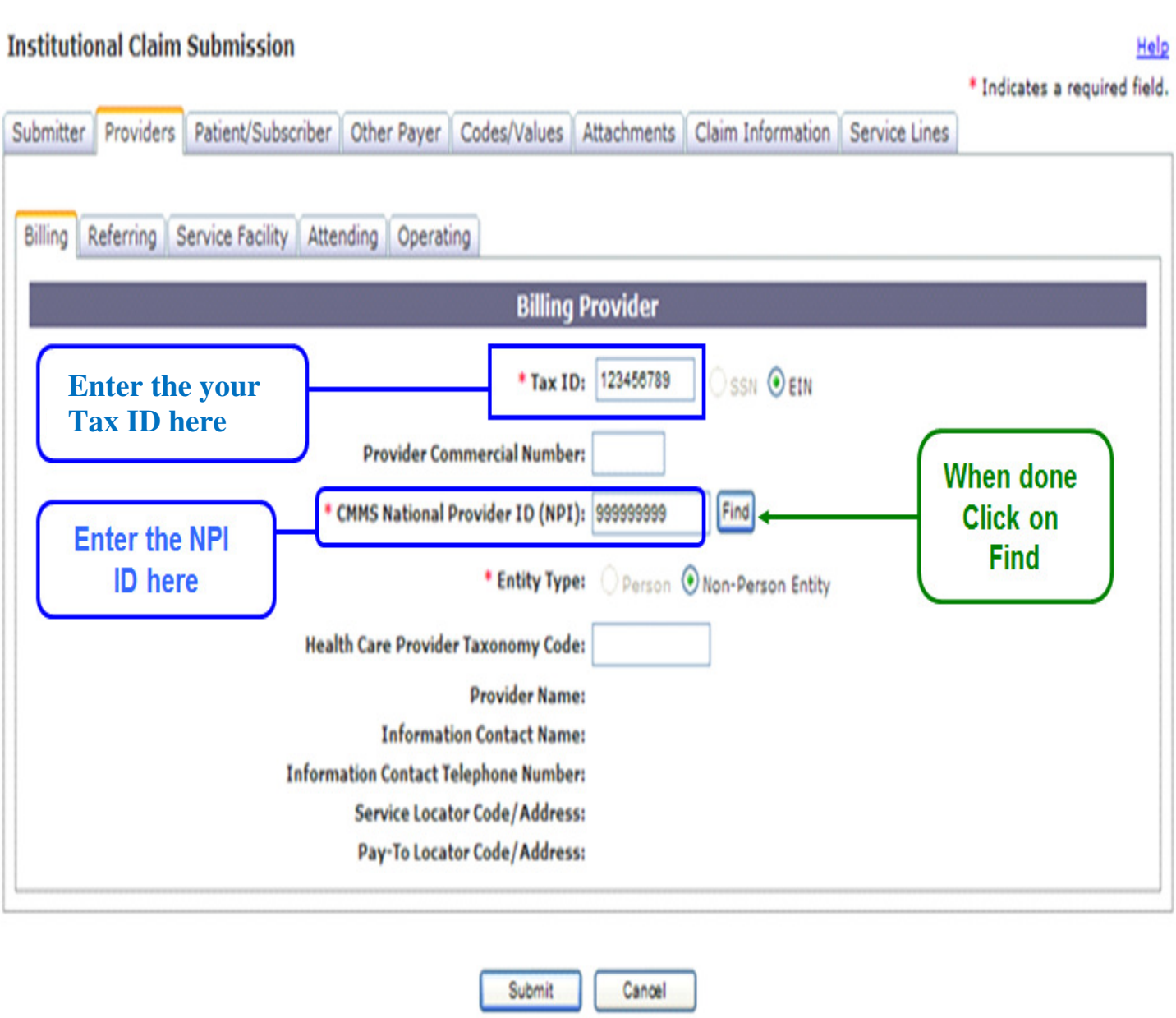
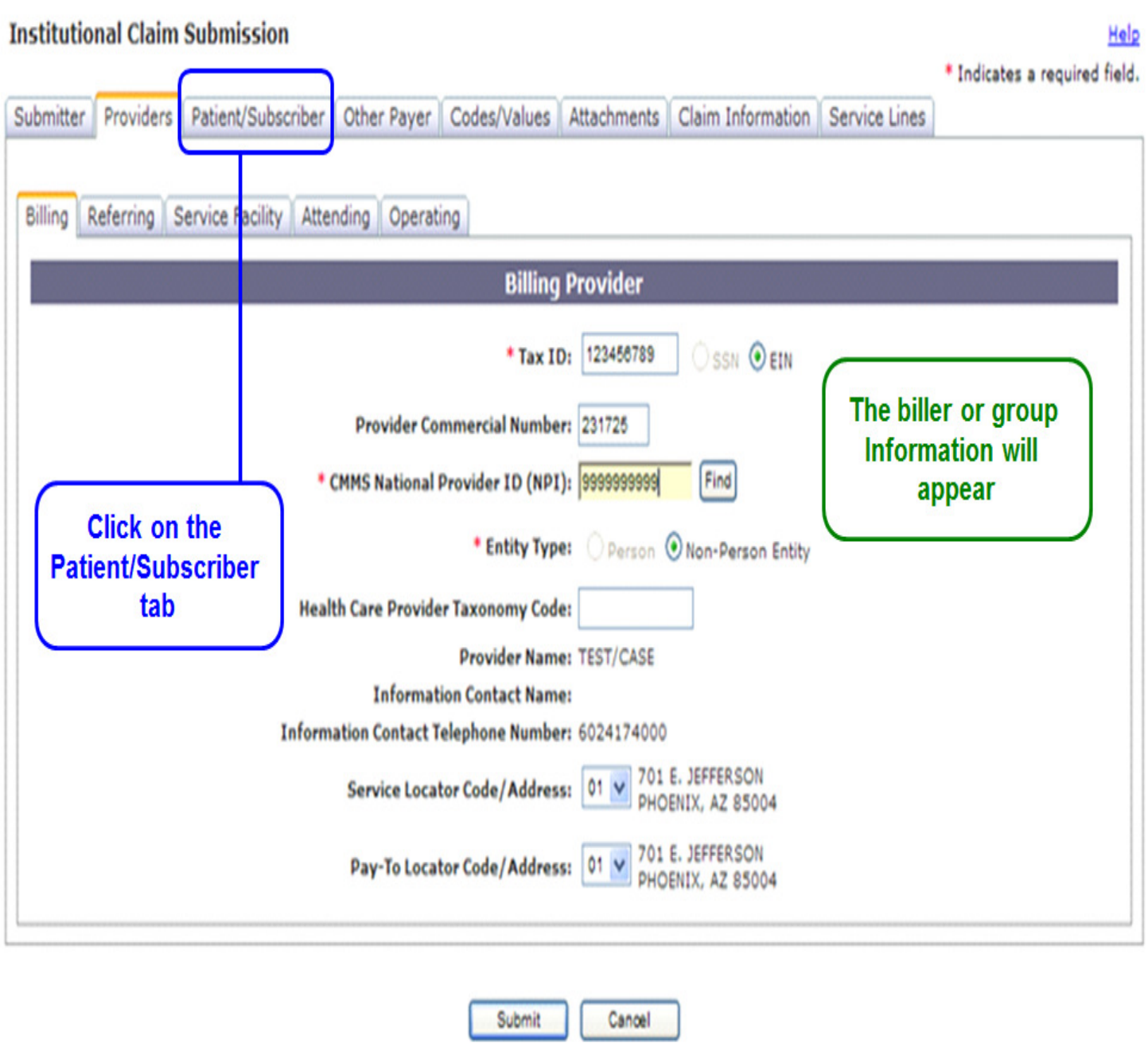
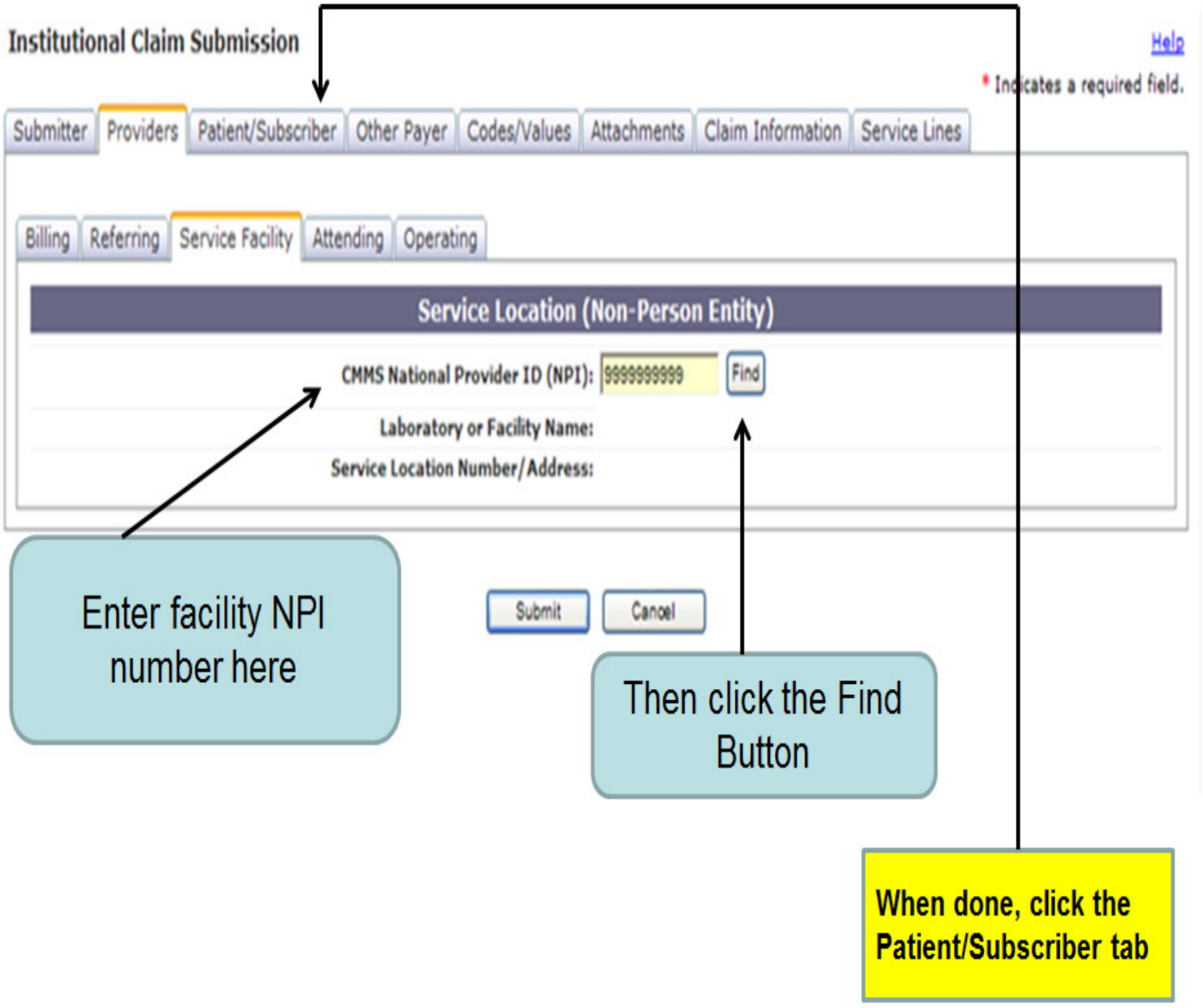


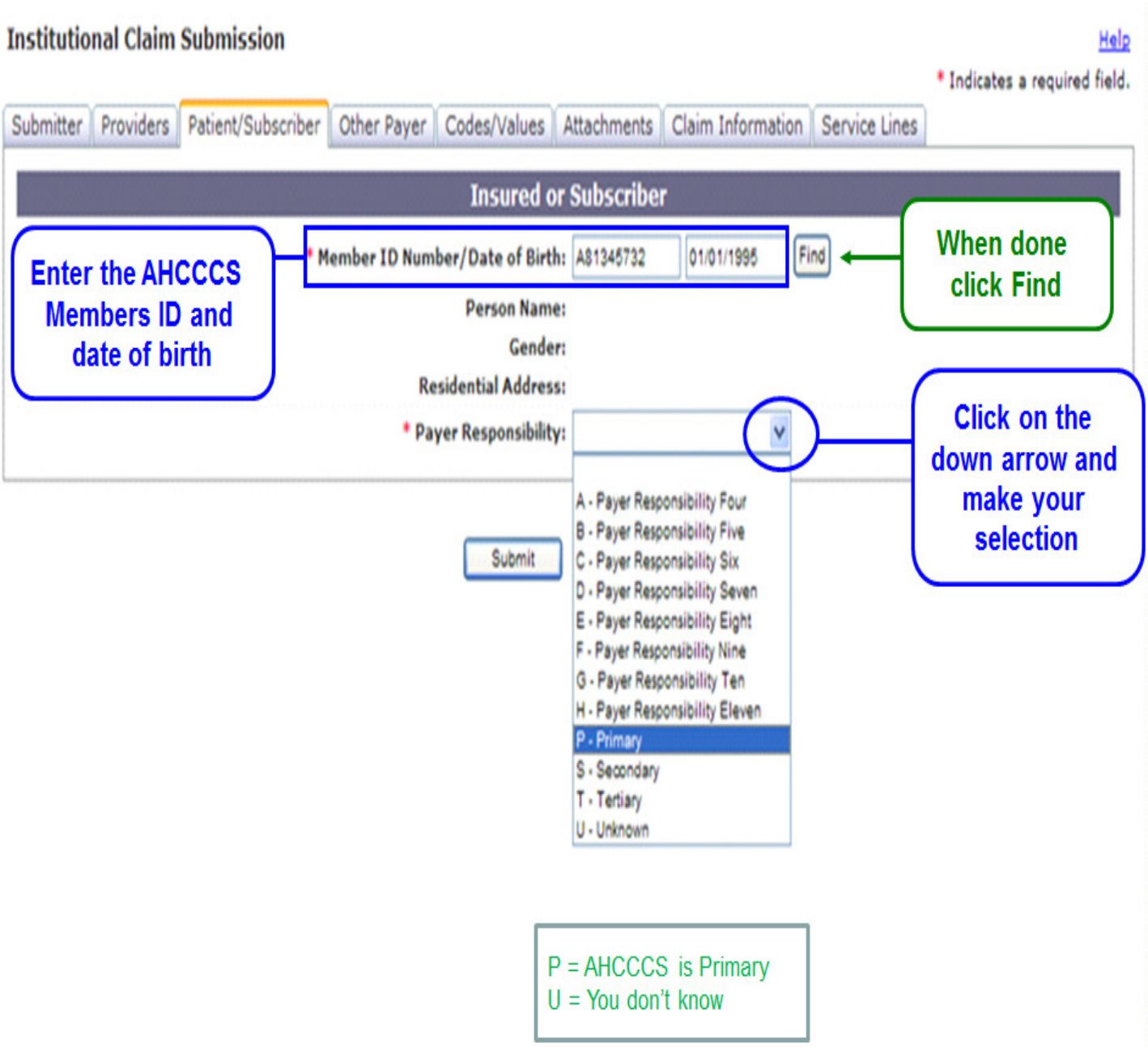


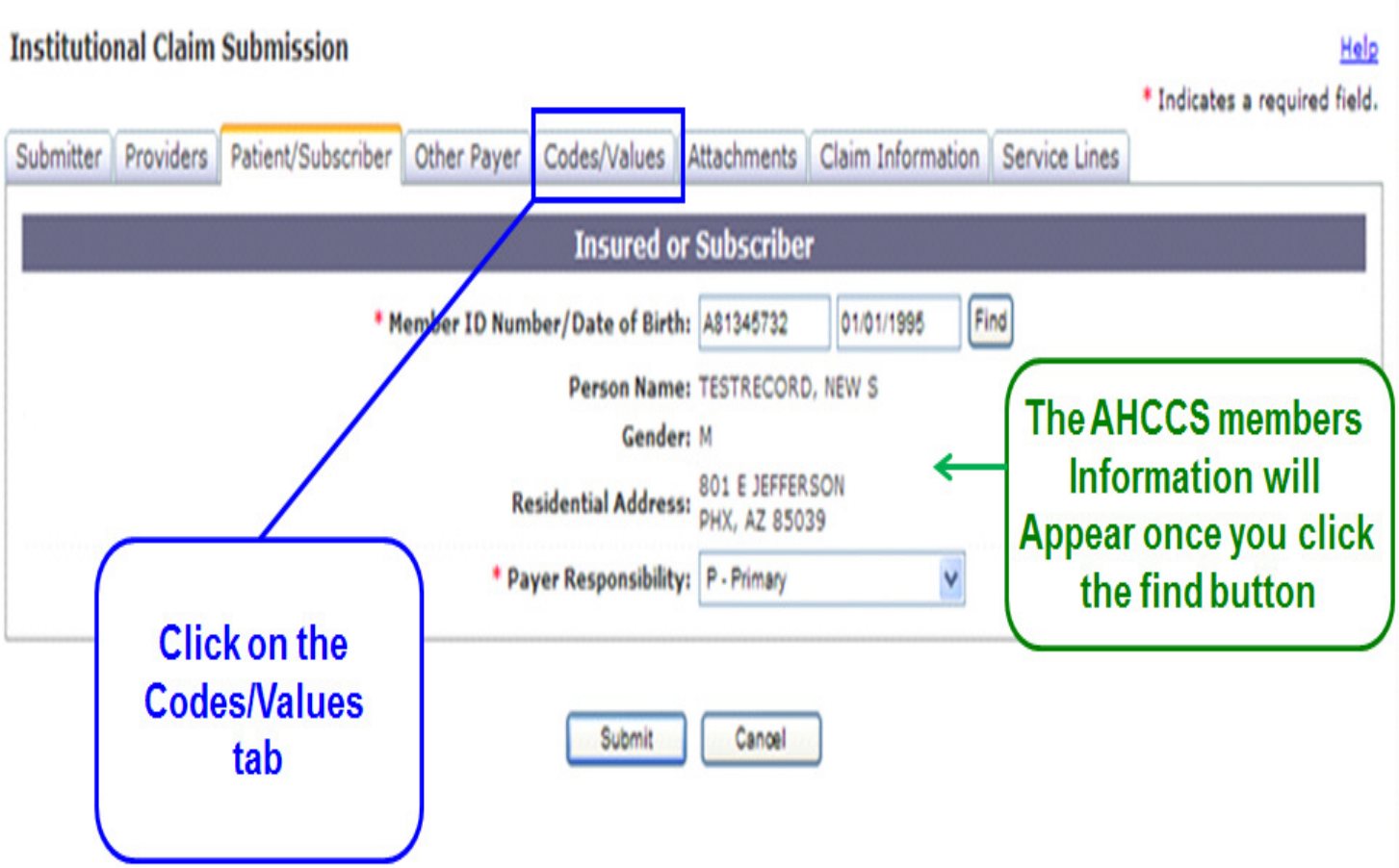

Institutional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Codes/Values
Attachments
Claim Information
Service Lines
Submitter
Organization Name: TEST/CASE
Electronic Transmitter ID Number: 99222
Information Contact Name: Escobedo, Albert
Information Contact Telephone Number: 602-417-4562
Submit
Cancel
Click on the Provider tab

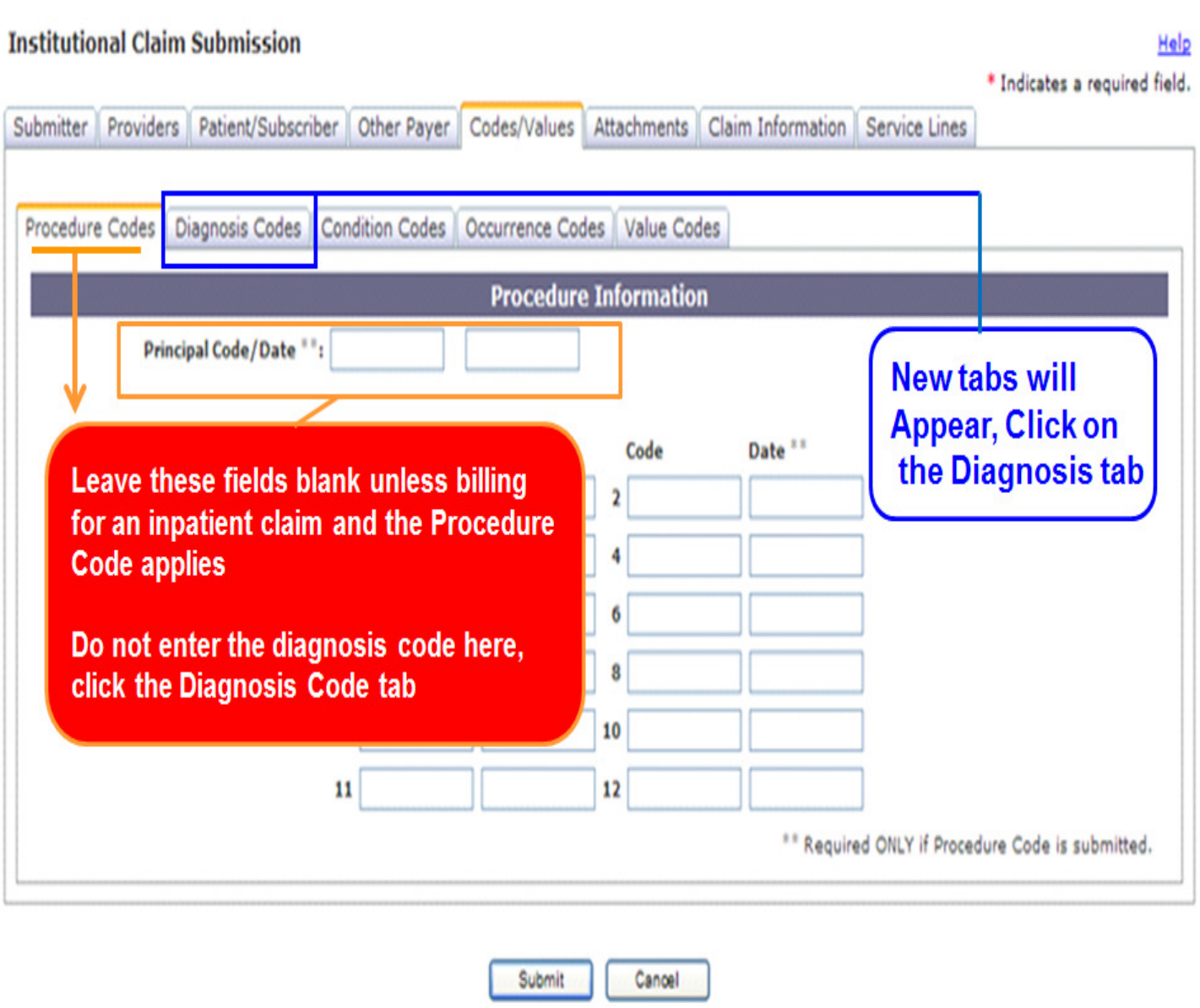

Institutional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Codes/Values
Attachments
Claim Information
Service Lines
Billing
Referring
Service Facility
Attending
Operating
Billing Provider
Enter the your Tax ID here
* Tax ID: 123456789
SSN
EIN
Provider Commercial Number:
Enter the NPI ID here
* CMMS National Provider ID (NPI): 999999999
Find
When done Click on Find
* 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:
Submit
Cancel

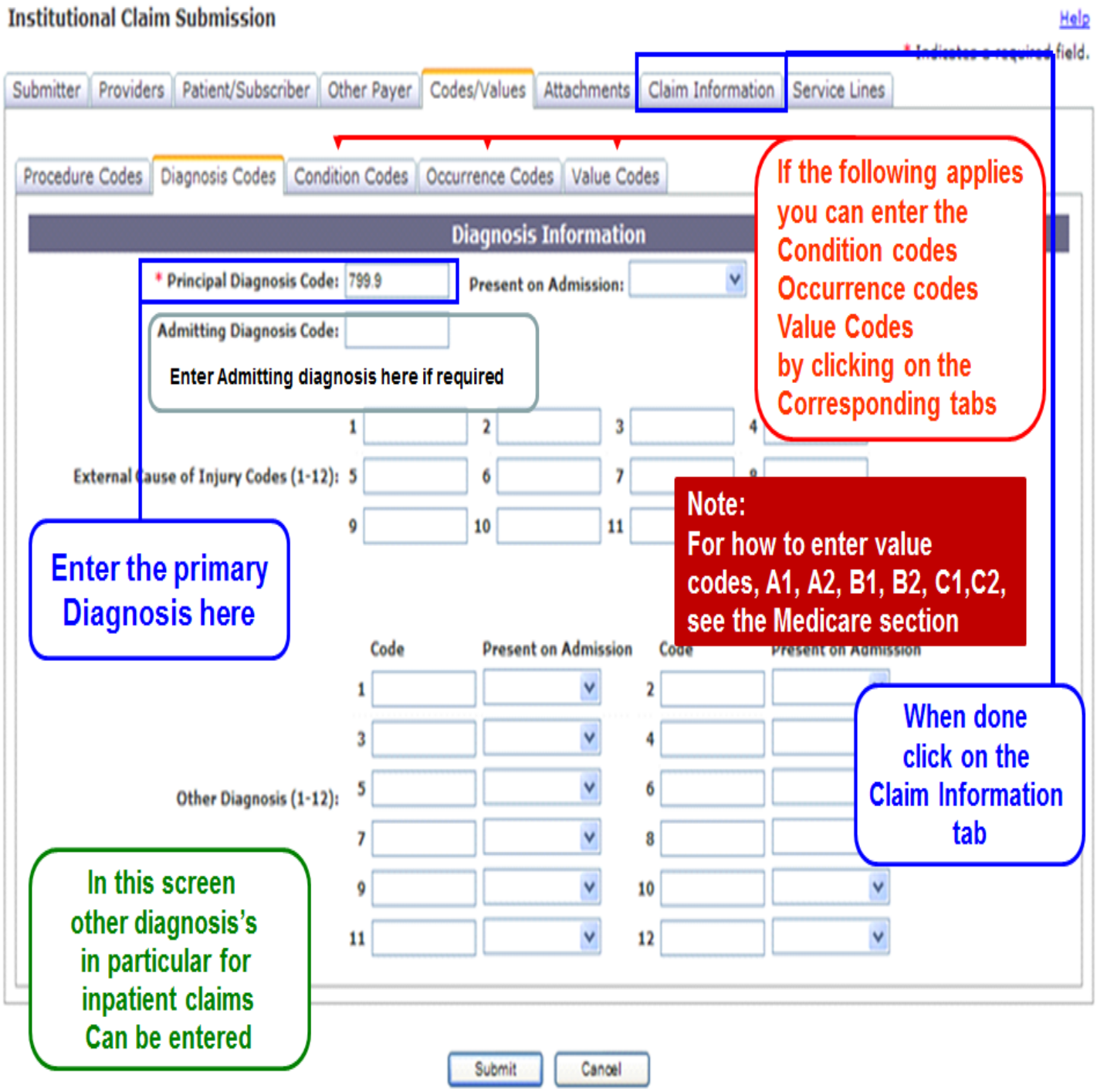

Institutional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Codes/Values
Attachments
Claim Information
Service Lines
Billing
Referring
Service Facility
Attending
Operating
Billing Provider
* Tax ID: 123456789
SSN
EIN
Provider Commercial Number: 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 on the Patient/Subscriber tab
The biller or group Information will appear
Submit
Cancel

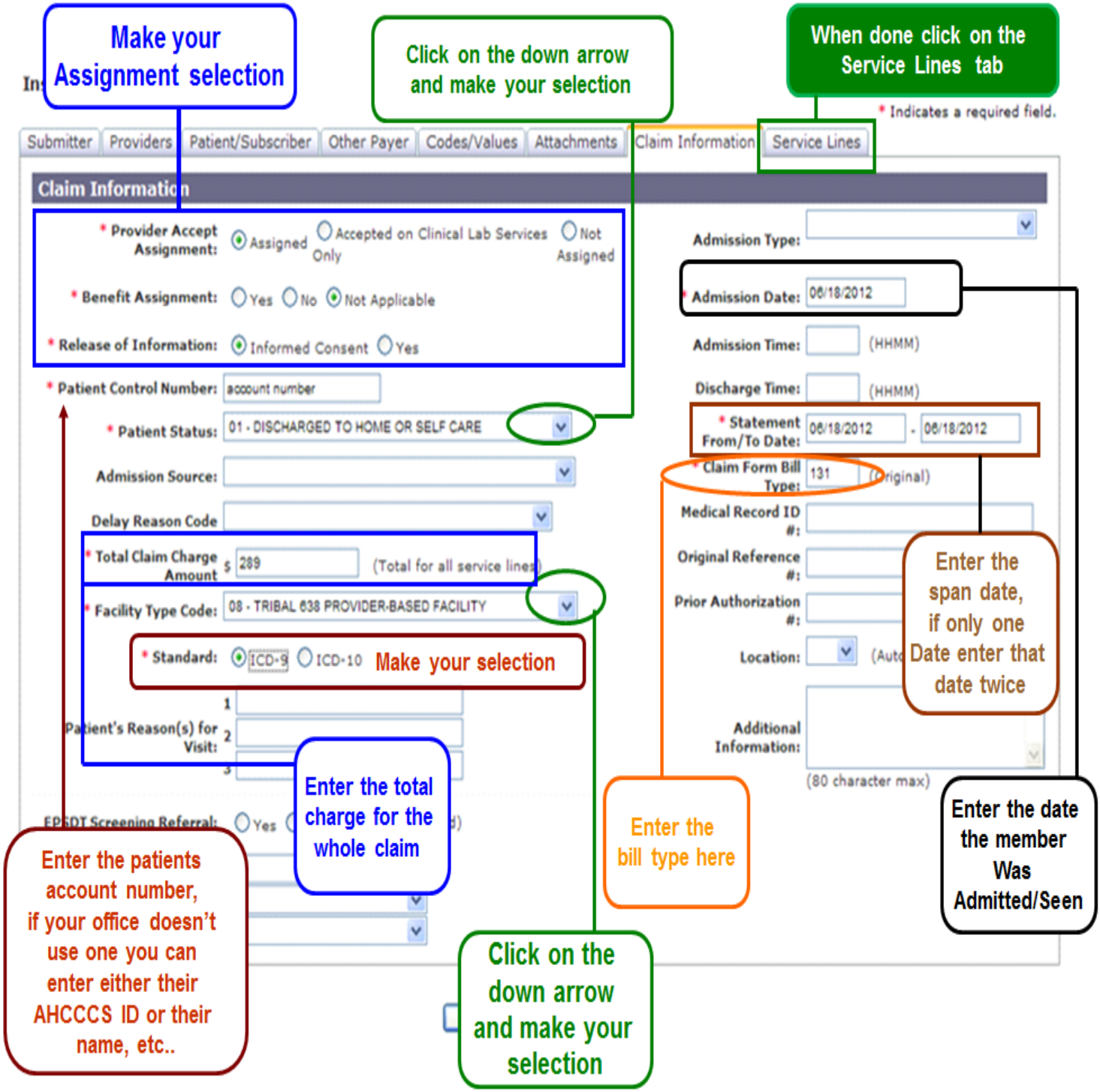

Institutional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Codes/Values
Attachments
Claim Information
Service Lines
Billing
Referring
Service Facility
Attending
Operating
Service Location (Non-Person Entity)
CMMS National Provider ID (NPI):
999999999
Find
Laboratory or Facility Name:
Service Location Number/Address:
Submit
Cancel
Enter facility NPI number here
Then click the Find Button
When done, click the Patient/Subscriber tab

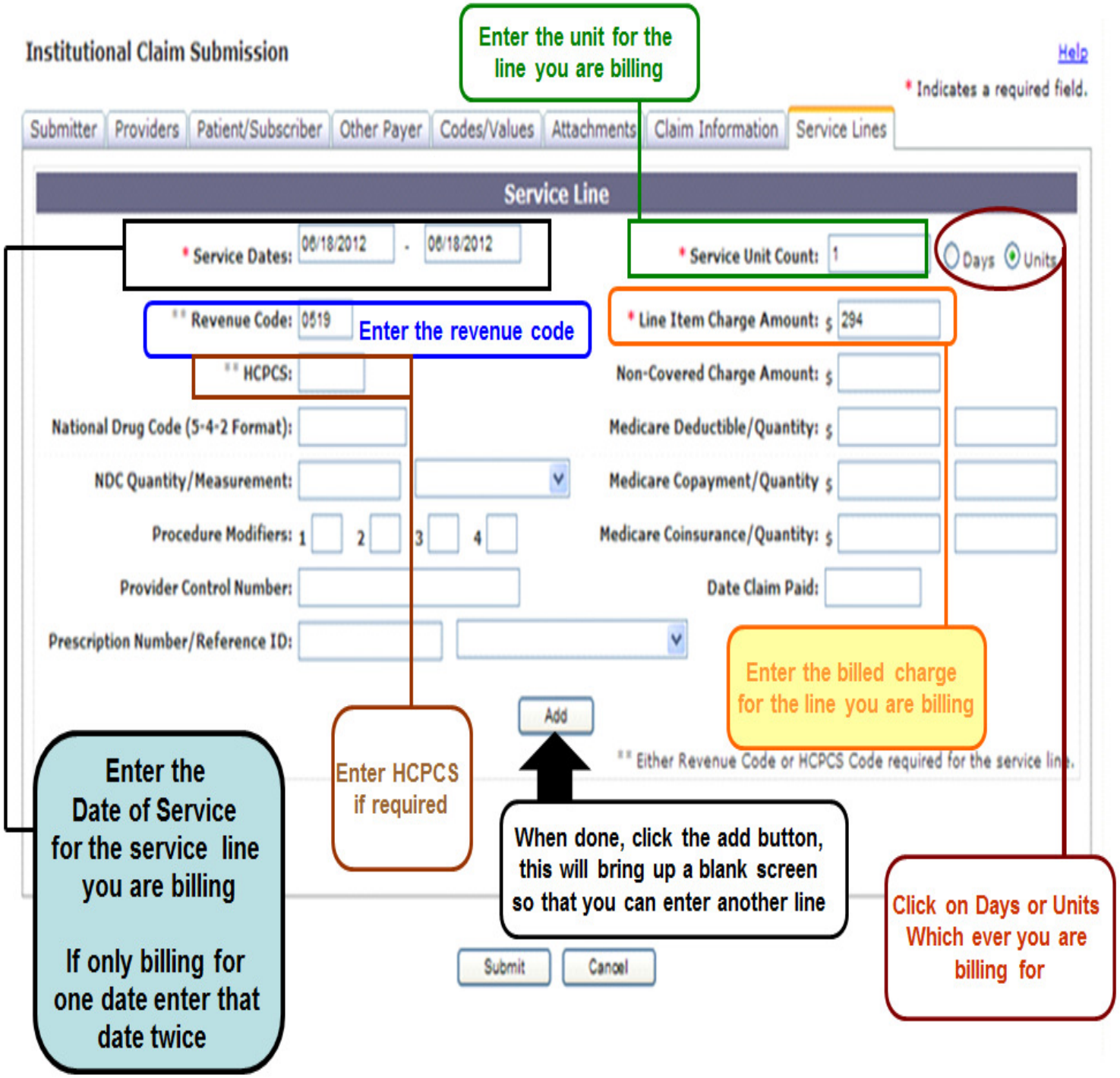

Institutional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Codes/Values
Attachments
Claim Information
Service Lines
Insured or Subscriber
Enter the AHCCCS Members ID and date of birth
* Member ID Number/Date of Birth:
A81345732
01/01/1995
Find
When done click Find
Person Name:
Gender:
Residential Address:
* Payer Responsibility:
Click on the down arrow and make your selection
A - Payer Responsibility Four
B - Payer Responsibility Five
C - Payer Responsibility Six
D - Payer Responsibility Seven
E - Payer Responsibility Eight
F - Payer Responsibility Nine
G - Payer Responsibility Ten
H - Payer Responsibility Eleven
P - Primary
S - Secondary
T - Tertiary
U - Unknown
Submit
P = AHCCCS is Primary
U = You don't know

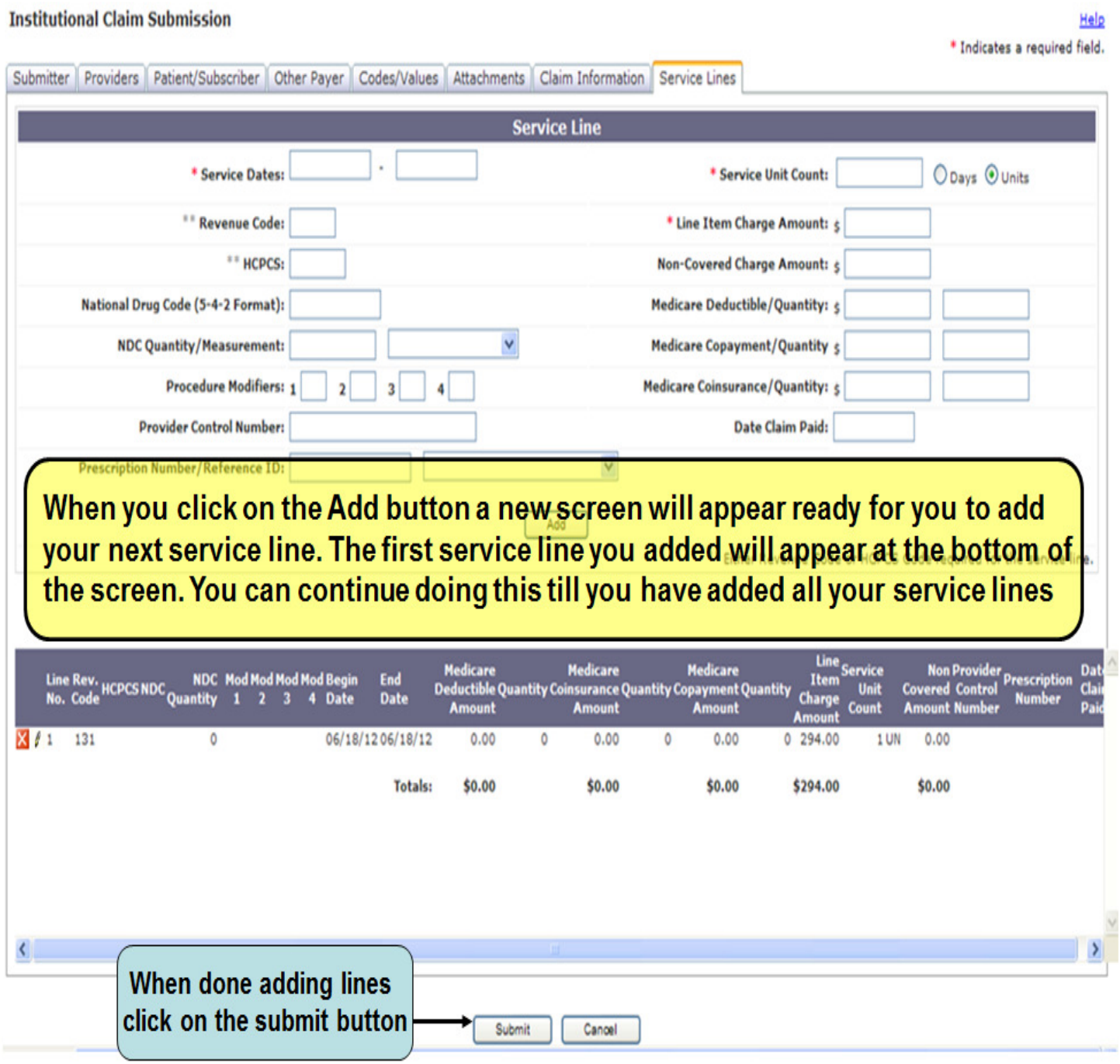

Institutional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Codes/Values
Attachments
Claim Information
Service Lines
Insured or Subscriber
* Member ID Number/Date of Birth:
A81345732
01/01/1995
Find
Person Name: TESTRECORD, NEW S
Gender: M
Residential Address: 801 E JEFFERSON
PHX, AZ 85039
* Payer Responsibility:
P - Primary
Submit
Cancel
Click on the Codes/Values tab
The AHCCS members Information will Appear once you click the find button


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 **:
Code
Date **
2
4
6
8
10
11
12
** Required ONLY if Procedure Code is submitted.
Leave these fields blank unless billing for an inpatient claim and the Procedure Code applies
Do not enter the diagnosis code here, click the Diagnosis Code tab
New tabs will Appear, Click on the Diagnosis tab
Submit
Cancel


Institutional Claim Submission
Help
Submitter
Providers
Patient/Subscriber
Other Payer
Codes/Values
Attachments
Claim Information
Service Lines
Procedure Codes
Diagnosis Codes
Condition Codes
Occurrence Codes
Value Codes
If the following applies you can enter the Condition codes Occurrence codes Value Codes by clicking on the Corresponding tabs
Diagnosis Information
* Principal Diagnosis Code: 799.9
Present on Admission:
Admitting Diagnosis Code:
Enter Admitting diagnosis here if required
External Cause of Injury Codes (1-12):
Enter the primary Diagnosis here
Note:
For how to enter value codes, A1, A2, B1, B2, C1,C2, see the Medicare section
Code
Present on Admission
Other Diagnosis (1-12):
When done click on the Claim Information tab
In this screen other diagnosis's in particular for inpatient claims Can be entered
Submit
Cancel


Make your Assignment selection
Click on the down arrow and make your selection
When done click on the Service Lines tab
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Codes/Values
Attachments
Claim Information
Service Lines
Claim Information
* Provider Accept Assignment:
Assigned
Accepted on Clinical Lab Services Only
Not Assigned
* Benefit Assignment:
Yes
No
Not Applicable
* Release of Information:
Informed Consent
Yes
* Patient Control Number:
account number
* Patient Status:
01 - DISCHARGED TO HOME OR SELF CARE
Admission Source:
Delay Reason Code
* Total Claim Charge Amount
$ 289
(Total for all service lines)
* Facility Type Code:
08 - TRIBAL 638 PROVIDER-BASED FACILITY
* Standard:
ICD-9
ICD-10
Make your selection
Patient's Reason(s) for Visit:
1
2
3
EPSDT Screening Referral:
Yes
Admission Type:
* Admission Date:
06/18/2012
Admission Time:
(HHMM)
Discharge Time:
(HHMM)
* Statement From/To Date:
06/18/2012
06/18/2012
* Claim Form Bill Type:
131
(Original)
Medical Record ID #:
Original Reference #:
Prior Authorization #:
Location:
Additional Information:
(80 character max)
Enter the span date, if only one Date enter that date twice
Enter the total charge for the whole claim
Enter the bill type here
Enter the date the member Was Admitted/Seen
Enter the patients account number, if your office doesn't use one you can enter either their AHCCCS ID or their name, etc..
Click on the down arrow and make your selection


Institutional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Codes/Values
Attachments
Claim Information
Service Lines
Service Line
* Service Dates: 06/18/2012 - 06/18/2012
* Service Unit Count: 1
Days
Units
** Revenue Code: 0519
Enter the revenue code
* Line Item Charge Amount: $ 294
** HCPCS:
Non-Covered Charge Amount: $
National Drug Code (5-4-2 Format):
Medicare Deductible/Quantity: $
NDC Quantity/Measurement:
Medicare Copayment/Quantity $
Procedure Modifiers: 1 2 3 4
Medicare Coinsurance/Quantity: $
Provider Control Number:
Date Claim Paid:
Prescription Number/Reference ID:
Enter the unit for the line you are billing
Enter the billed charge for the line you are billing
Add
** Either Revenue Code or HCPCS Code required for the service line.
Enter HCPCS if required
Enter the Date of Service for the service line you are billing
If only billing for one date enter that date twice
When done, click the add button, this will bring up a blank screen so that you can enter another line
Click on Days or Units Which ever you are billing for
Submit
Cancel


Institutional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Codes/Values
Attachments
Claim Information
Service Lines
Service Line
* Service Dates:
* Service Unit Count:
Days
Units
** Revenue Code:
* Line Item Charge Amount: $
** HCPCS:
Non-Covered Charge Amount: $
National Drug Code (5-4-2 Format):
Medicare Deductible/Quantity: $
NDC Quantity/Measurement:
Medicare Copayment/Quantity $
Procedure Modifiers: 1 2 3 4
Medicare Coinsurance/Quantity: $
Provider Control Number:
Date Claim Paid:
Prescription Number/Reference ID:
When you click on the Add button a new screen will appear ready for you to add your next service line. The first service line you added will appear at the bottom of the screen. You can continue doing this till you have added all your service lines
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 Covered Amount
Provider Control Number
Prescription Number
1 131 0 06/18/12 06/18/12 0.00 0 0.00 0 0.00 0 294.00 1 UN 0.00
Totals: $0.00 $0.00 $0.00 $294.00 $0.00
When done adding lines click on the submit button
Submit
Cancel