AHCCCS ON-LINE CLAIM SUBMISSION MANUAL

Section 4.d:

ADA (Dental)

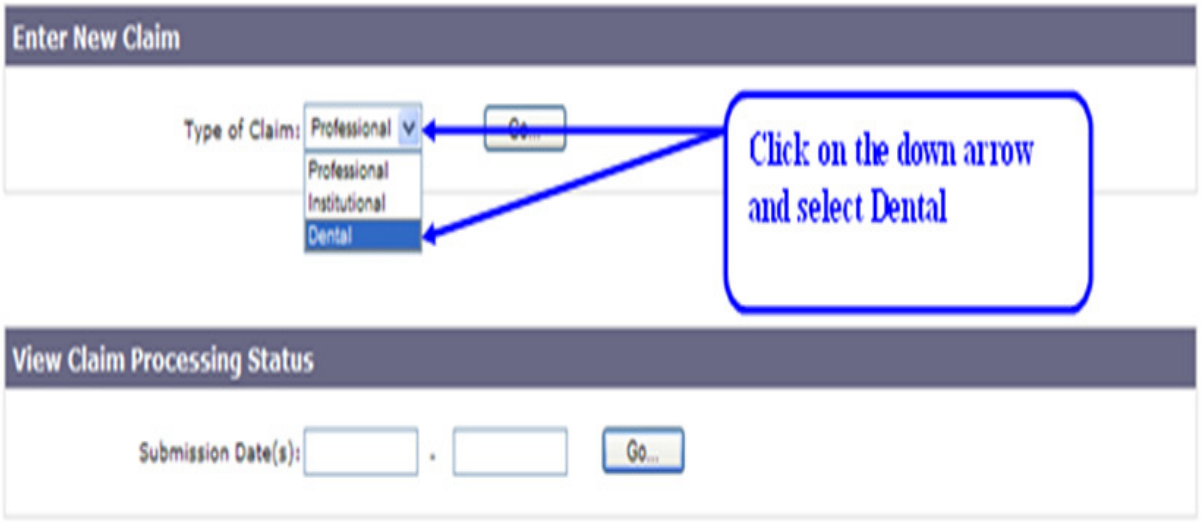
Dental

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.



10/04/13

Claim Submission

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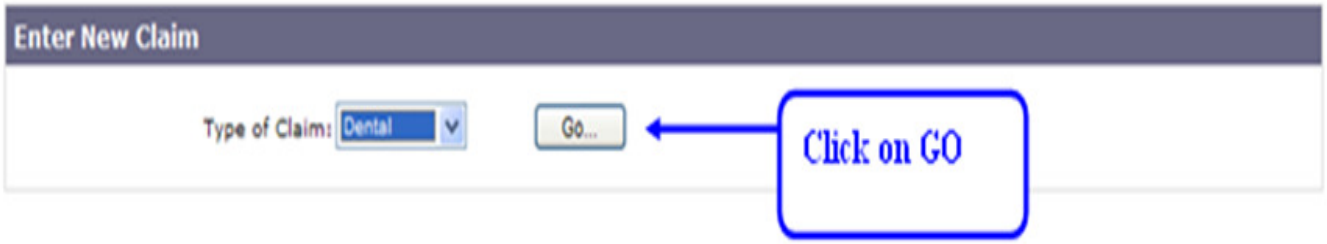
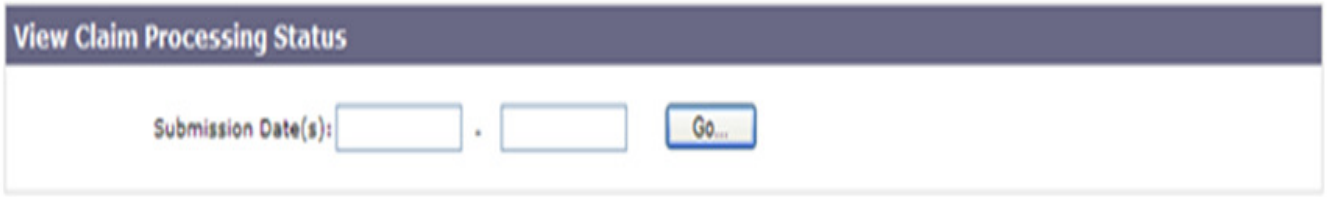
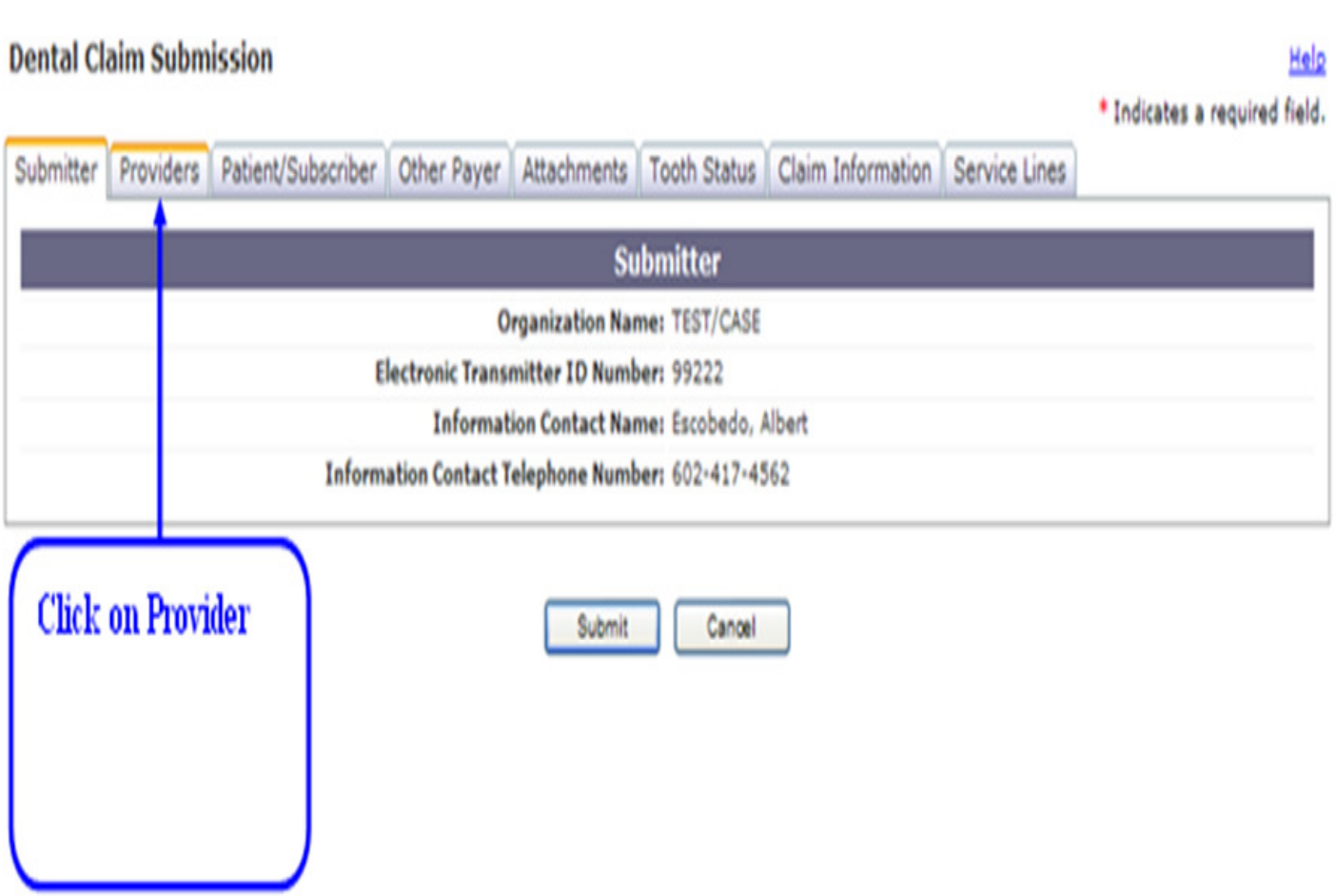
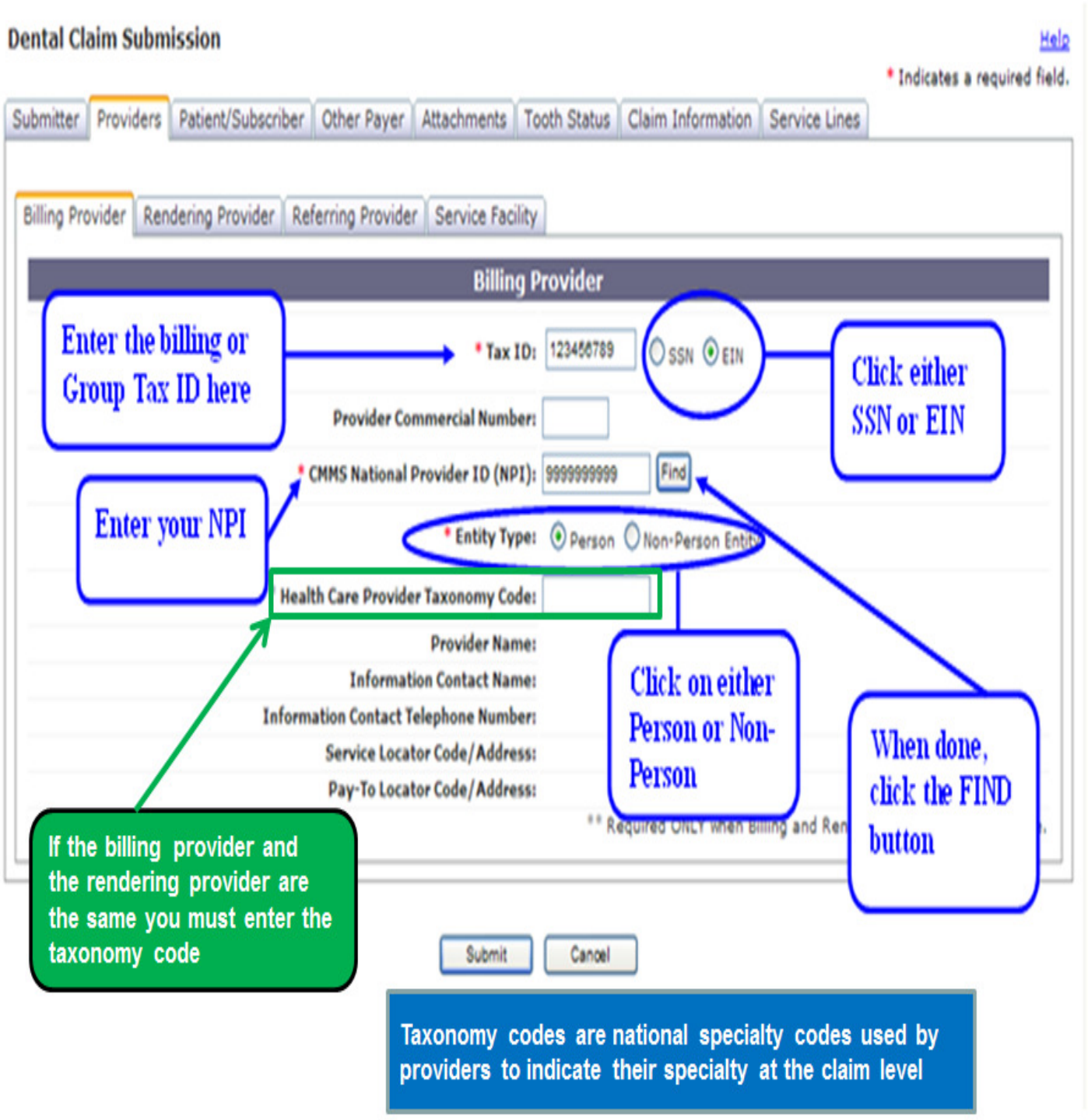
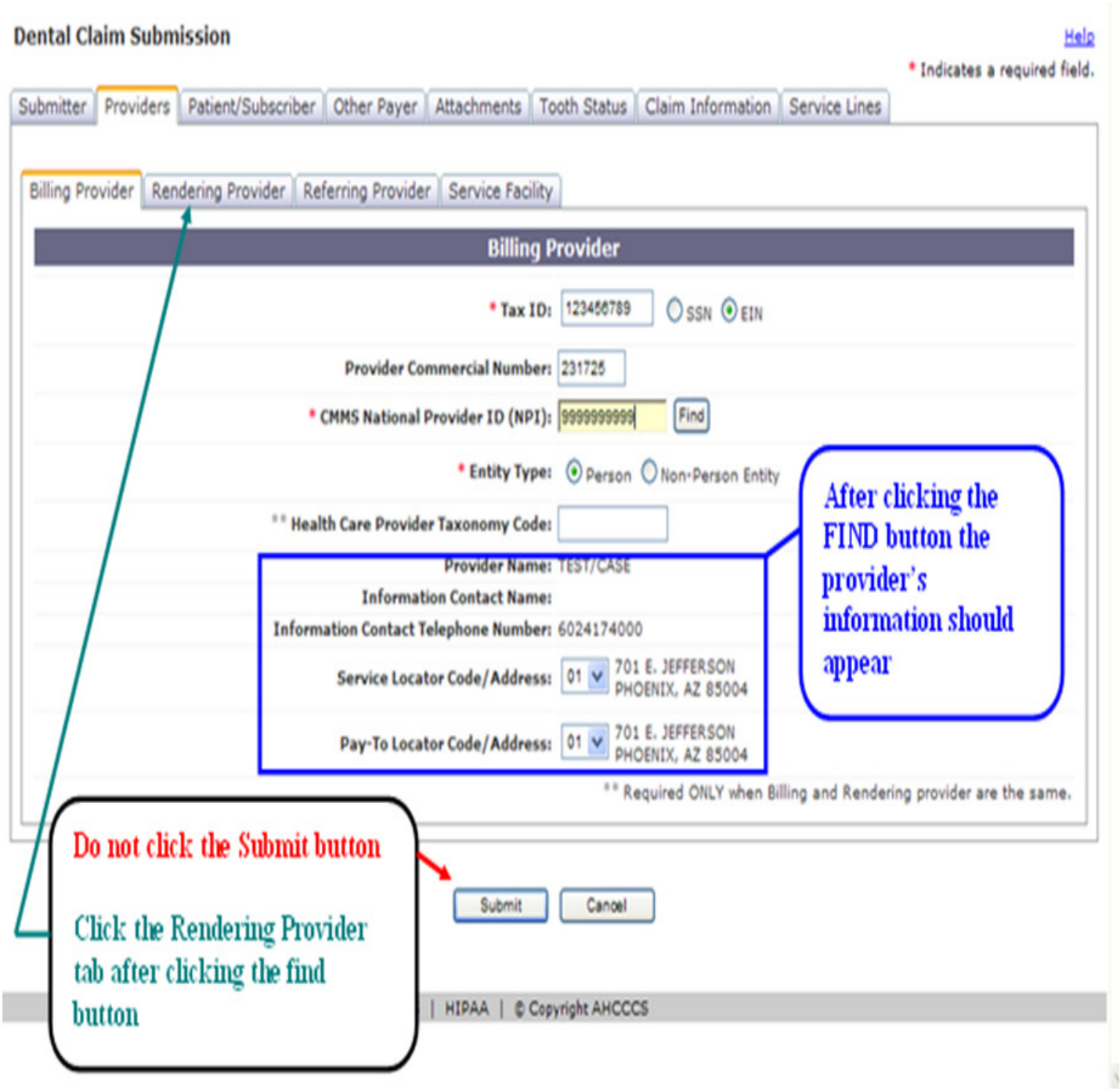





Dental Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Attachments
Tooth Status
Claim Information
Service Lines
Submitter
Organization Name: TEST/CASE
Electronic Transmitter ID Number: 99222
Information Contact Name: Escobedo, Albert
Information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


Dental Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Attachments
Tooth Status
Claim Information
Service Lines
Billing Provider
Rendering Provider
Referring Provider
Service Facility
Billing Provider
Enter the billing or Group Tax ID here
* Tax ID: 123456789
SSN
EIN
Click either SSN or EIN
Provider Commercial Number:
* CMMS National Provider ID (NPI): 9999999999
Find
Enter your NPI
* Entity Type: Person
Health Care Provider Taxonomy Code:
Provider Name:
Information Contact Name:
Information Contact Telephone Number:
Service Locator Code/Address:
Pay-To Locator Code/Address:
Click on either Person or Non-Person
When done, click the FIND button
If the billing provider and the rendering provider are the same you must enter the taxonomy code
Submit
Cancel
Taxonomy codes are national specialty codes used by providers to indicate their specialty at the claim level


Dental Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Attachments
Tooth Status
Claim Information
Service Lines
Billing Provider
Rendering Provider
Referring Provider
Service Facility
Billing Provider
* Tax ID: 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
** Required ONLY when Billing and Rendering provider are the same.
After clicking the FIND button the provider's information should appear
Do not click the Submit button
Click the Rendering Provider tab after clicking the find button
Submit
Cancel
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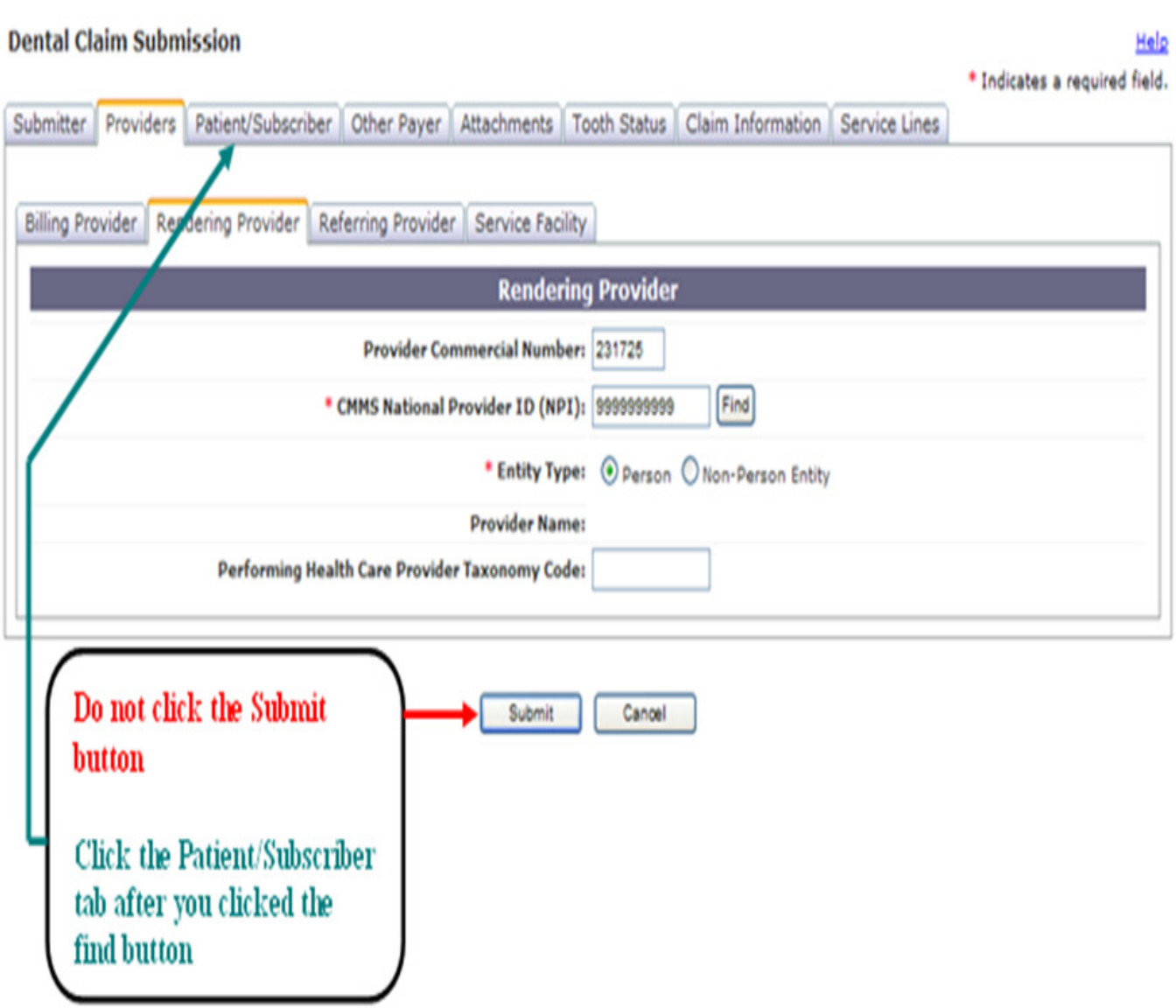
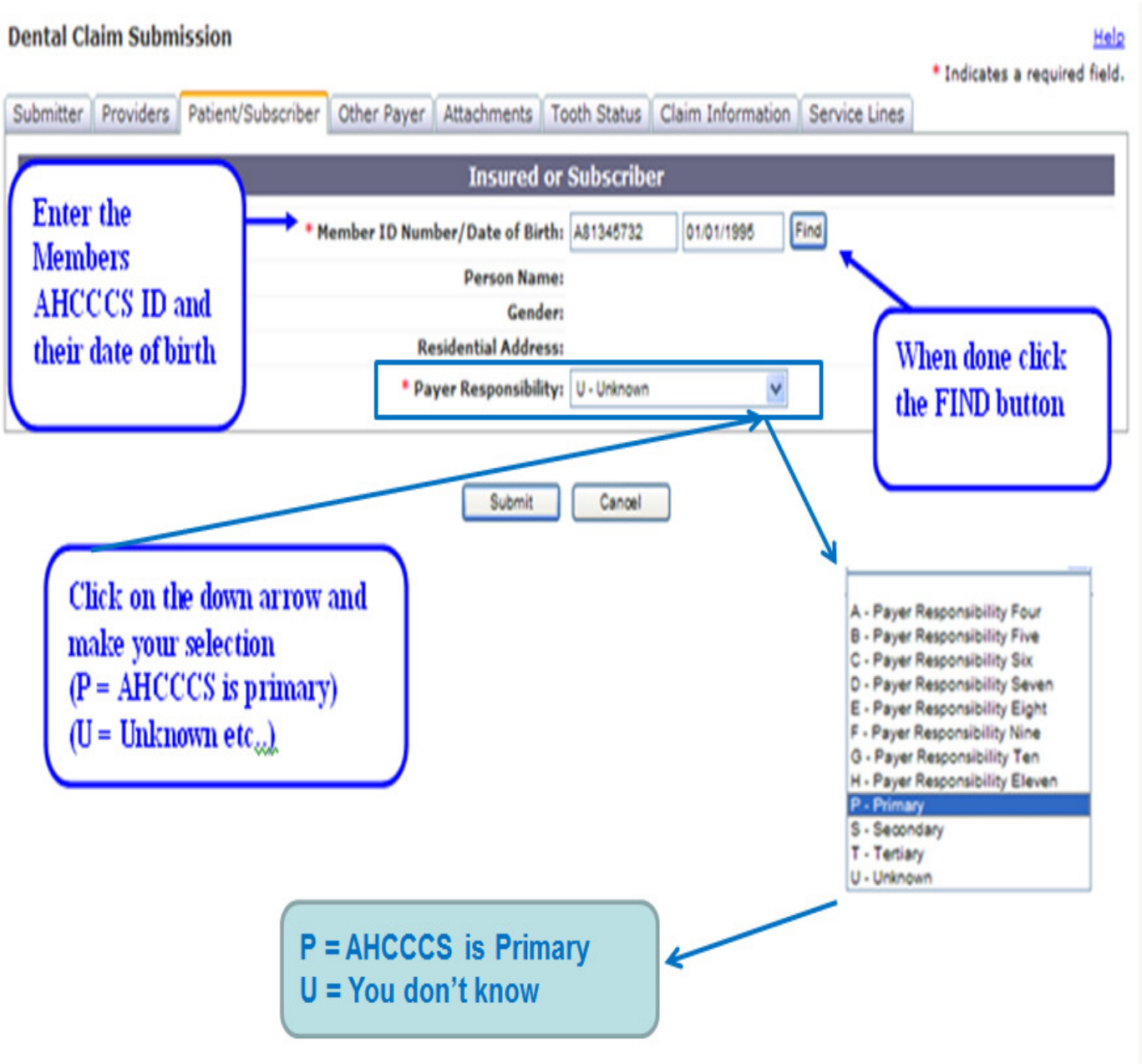
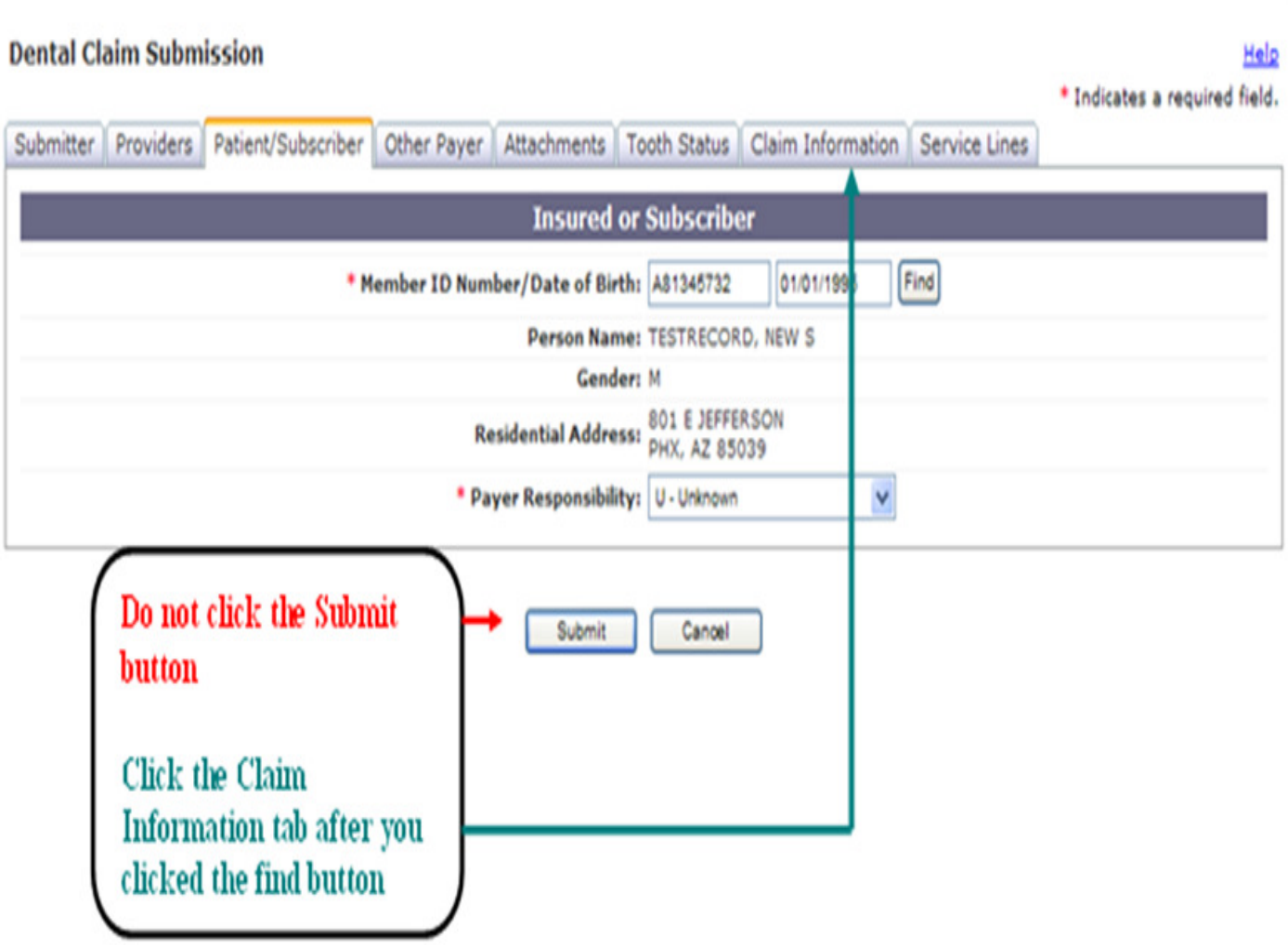
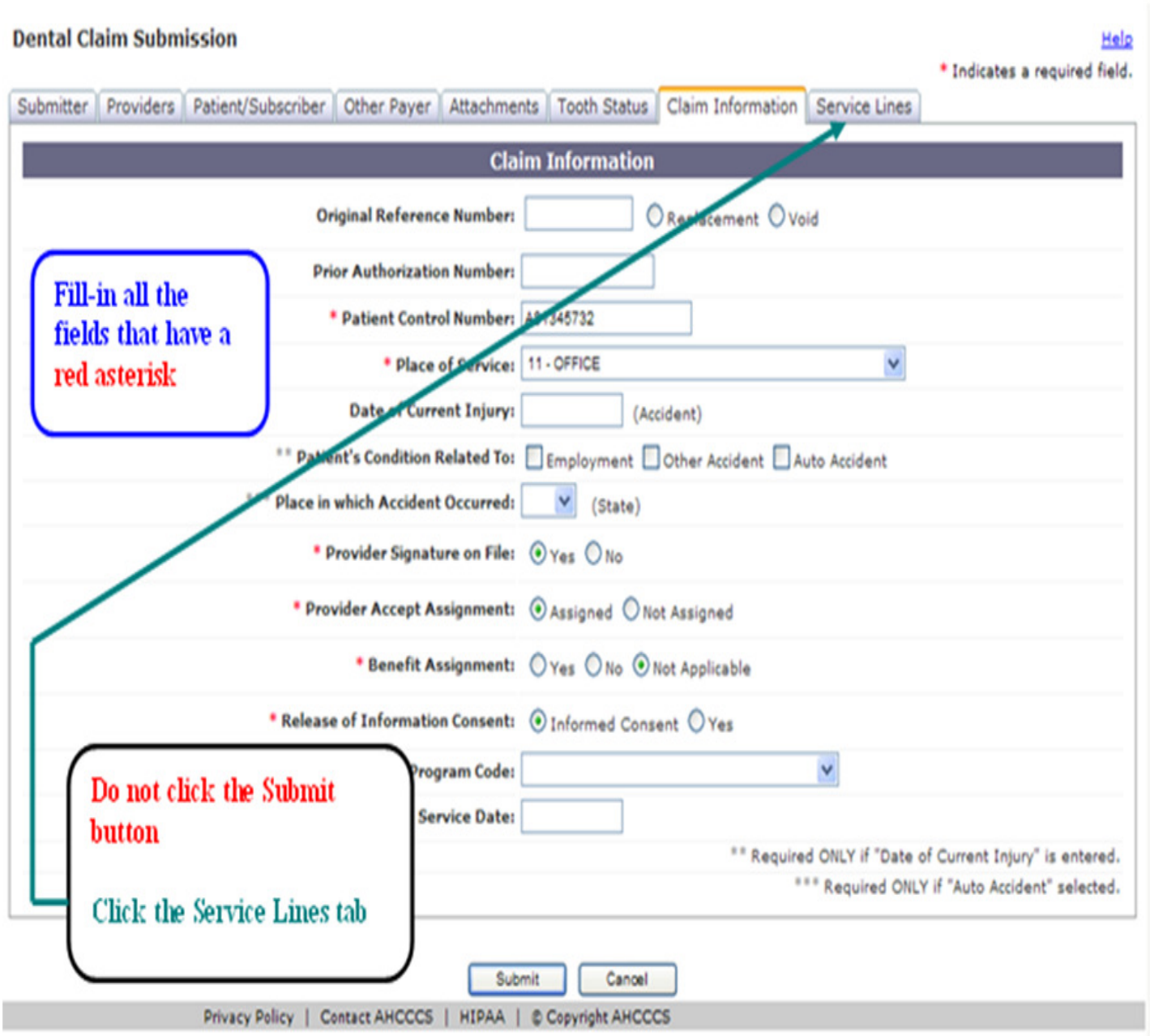
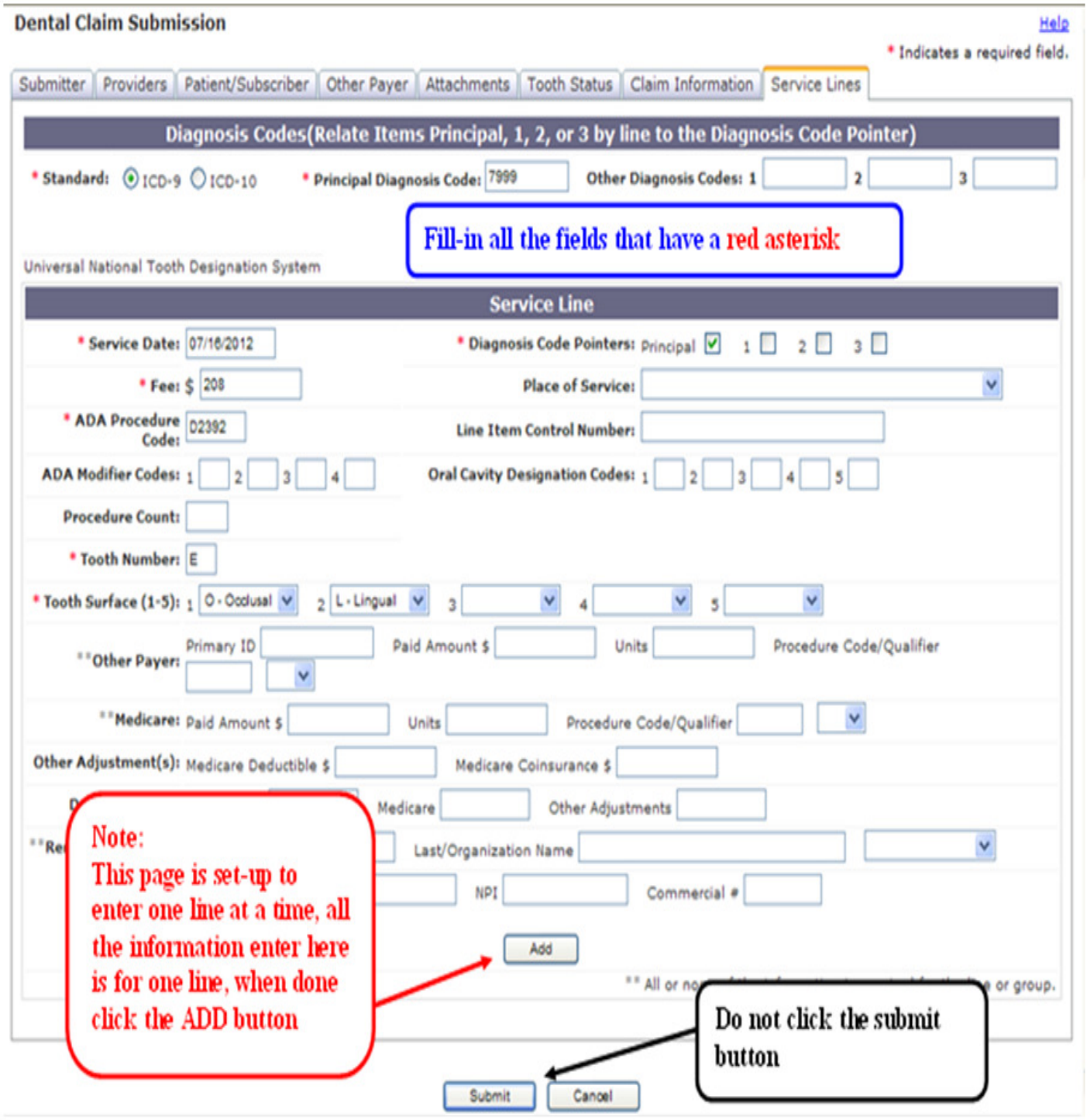
Dental Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Attachments
Tooth Status
Claim Information
Service Lines
Billing Provider
Rendering Provider
Referring Provider
Service Facility
Rendering Provider
Provider Commercial Number:
* CMMS National Provider ID (NPI):
999999999
Find
* Entity Type:
Person
Non-Person Entity
Provider Name:
Performing Health Care Provider Taxonomy Code:
Submit
Cancel
Enter the NPI
Click either Person or Non-Person
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)
When done entering information, click FIND

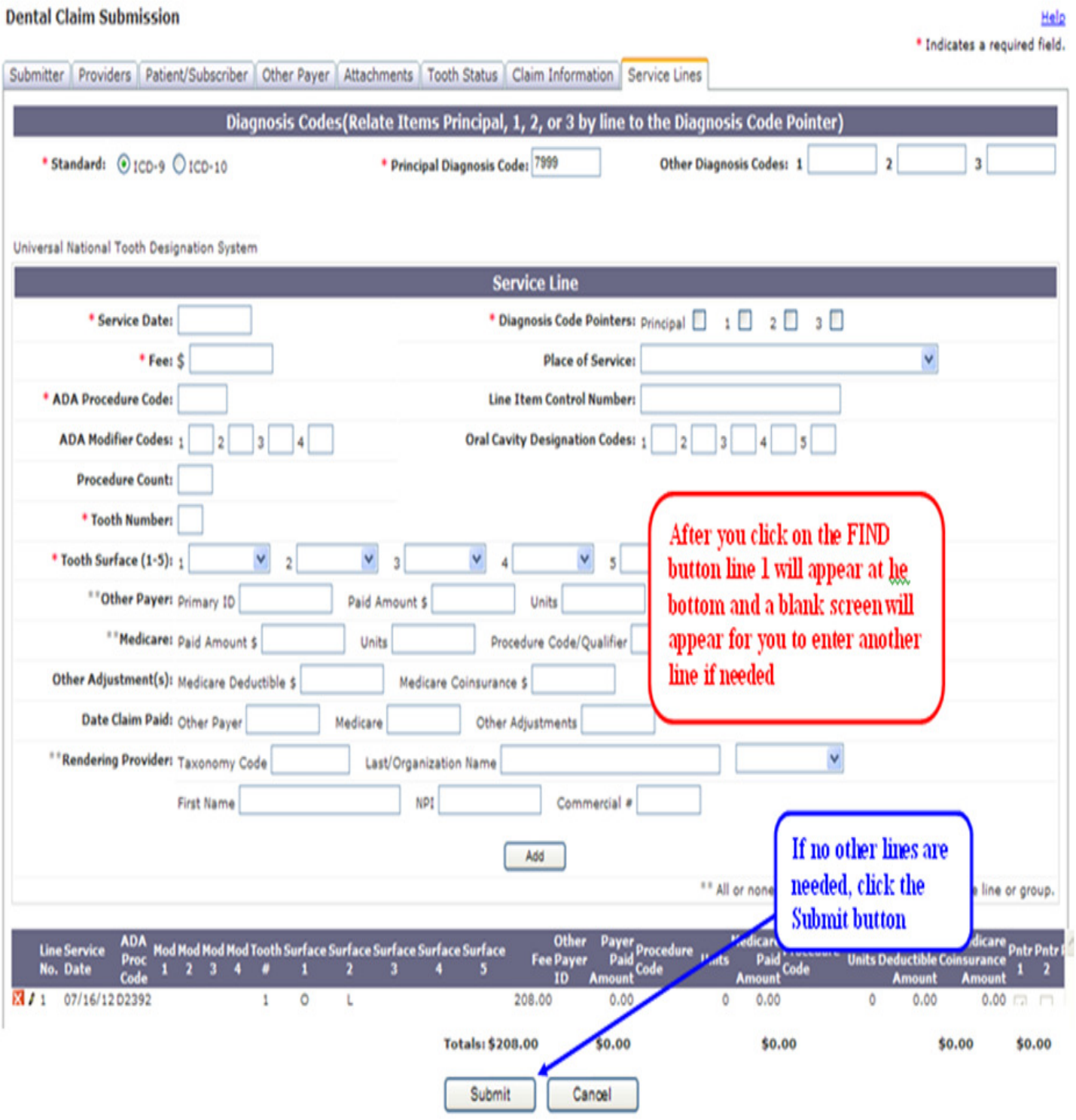

Dental Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Attachments
Tooth Status
Claim Information
Service Lines
Billing Provider
Rendering Provider
Referring Provider
Service Facility
Rendering Provider
Provider Commercial Number:
231725
* CMMS National Provider ID (NPI):
9999999999
Find
* Entity Type:
Person
Non-Person Entity
Provider Name:
Performing Health Care Provider Taxonomy Code:
Do not click the Submit button
Submit
Cancel
Click the Patient/Subscriber tab after you clicked the find button


Dental Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Attachments
Tooth Status
Claim Information
Service Lines
Insured or Subscriber
Enter the Members AHCCCS ID and their date of birth
* Member ID Number/Date of Birth:
A81345732
01/01/1995
Find
Person Name:
Gender:
Residential Address:
* Payer Responsibility:
U - Unknown
When done click the FIND button
Submit
Cancel
Click on the down arrow and make your selection
(P = AHCCCS is primary)
(U = Unknown etc.)
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
P = AHCCCS is Primary
U = You don't know


Dental Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Attachments
Tooth Status
Claim Information
Service Lines
Insured or Subscriber
* Member ID Number/Date of Birth:
A81345732
01/01/199
Find
Person Name:
TESTRECORD, NEW S
Gender:
M
Residential Address:
801 E JEFFERSON
PHX, AZ 85039
* Payer Responsibility:
U - Unknown
Do not click the Submit button
Click the Claim Information tab after you clicked the find button
Submit
Cancel


Dental Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Attachments
Tooth Status
Claim Information
Service Lines
Claim Information
Original Reference Number:
Replacement
Void
Prior Authorization Number:
* Patient Control Number:
* Place of Service:
11 - OFFICE
Date of Current Injury:
(Accident)
** Patient's Condition Related To:
Employment
Other Accident
Auto Accident
*** Place in which Accident Occurred:
(State)
* Provider Signature on File:
Yes
No
* Provider Accept Assignment:
Assigned
Not Assigned
* Benefit Assignment:
Yes
No
Not Applicable
* Release of Information Consent:
Informed Consent
Yes
Program Code:
Service Date:
** Required ONLY if "Date of Current Injury" is entered.
*** Required ONLY if "Auto Accident" selected.
Fill-in all the fields that have a red asterisk
Do not click the Submit button
Click the Service Lines tab
Submit
Cancel
Privacy Policy | Contact AHCCCS | HIPAA | © Copyright AHCCCS


Dental Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Attachments
Tooth Status
Claim Information
Service Lines
Diagnosis Codes(Relate Items Principal, 1, 2, or 3 by line to the Diagnosis Code Pointer)
* Standard: ICD-9 ICD-10
* Principal Diagnosis Code: 7999
Other Diagnosis Codes: 1 2 3
Fill-in all the fields that have a red asterisk
Universal National Tooth Designation System
Service Line
* Service Date: 07/16/2012
* Diagnosis Code Pointers: Principal 1 2 3
* Fee: $ 208
Place of Service:
* ADA Procedure Code: D2392
Line Item Control Number:
ADA Modifier Codes: 1 2 3 4
Oral Cavity Designation Codes: 1 2 3 4 5
Procedure Count:
* Tooth Number: E
* Tooth Surface (1-5): 1 O - Occlusal 2 L - Lingual 3 4 5
**Other Payer: Primary ID Paid Amount $ Units Procedure Code/Qualifier
**Medicare: Paid Amount $ Units Procedure Code/Qualifier
Other Adjustment(s): Medicare Deductible $ Medicare Coinsurance $
Medicare Other Adjustments
Last/Organization Name
NPI Commercial #
Add
** All or no or group.
Note:
This page is set-up to enter one line at a time, all the information enter here is for one line, when done click the ADD button
Do not click the submit button
Submit
Cancel


Dental Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Attachments
Tooth Status
Claim Information
Service Lines
Diagnosis Codes(Relate Items Principal, 1, 2, or 3 by line to the Diagnosis Code Pointer)
* Standard: ICD-9 ICD-10
* Principal Diagnosis Code: 7999
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Universal National Tooth Designation System
Service Line
* Service Date:
* Diagnosis Code Pointers: Principal 1 2 3
* Fee: $
Place of Service:
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Line Item Control Number:
ADA Modifier Codes: 1 2 3 4
Oral Cavity Designation Codes: 1 2 3 4 5
Procedure Count:
* Tooth Number:
* Tooth Surface (1-5): 1 2 3 4 5
**Other Payer: Primary ID Paid Amount $ Units
**Medicare: Paid Amount $ Units Procedure Code/Qualifier
Other Adjustment(s): Medicare Deductible $ Medicare Coinsurance $
Date Claim Paid: Other Payer Medicare Other Adjustments
**Rendering Provider: Taxonomy Code Last/Organization Name
First Name NPI Commercial #
Add
** All or none line or group.
After you click on the FIND button line 1 will appear at he bottom and a blank screen will appear for you to enter another line if needed
If no other lines are needed, click the Submit button
Line No. Service Date ADA Proc Code Mod 1 Mod 2 Mod 3 Mod 4 Tooth # Surface 1 Surface 2 Surface 3 Surface 4 Surface 5 Other Fee Payer ID Payer Paid Amount Procedure Code Units Paid Amount Code Units Deductible Amount Coinsurance Amount Pntr 1 Pntr 2
1 07/16/12 D2392 1 O L 208.00 0.00 0 0.00 0 0.00 0.00
Totals: $208.00 $0.00 $0.00 $0.00 $0.00
Submit
Cancel