AHCCCS ON-LINE CLAIM SUBMISSION MANUAL

Section 6:

View Status (Online Claims)

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

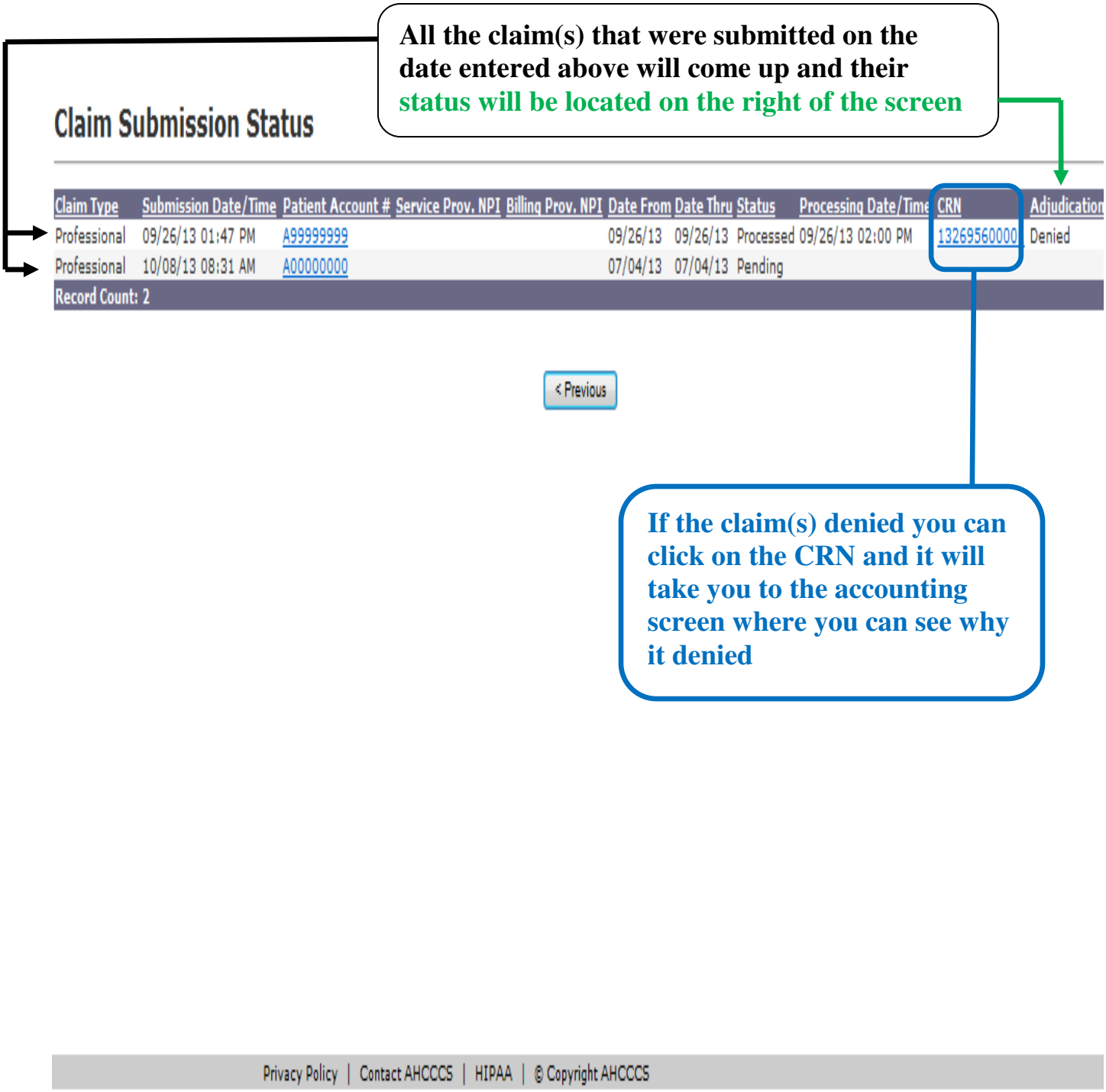
NOTE: You cannot view the processing status of claims submitted by other users.

To status claims that were entered online only

To see the status of a claim(s) entered on a specific date type the date that the claim(s) was entered and click GO

(You can either enter one date of do a span date)

All the claim(s) that were submitted on the date entered above will come up and their status will be located on the right of the screen



If the claim(s) denied you can click on the CRN and it will take you to the accounting screen where you can see why it denied

This is the accounting screen

Claim Status Summary

Claim Header

Claim Number:	132695600001	Admission Type:		Accident (Employment):	N
Claim Status:	DENIED	Admission Date:	/ /	Accident (Auto):	N
Status Date:	09/26/2013	Admission Hour:		Accident (Other):	N
Medical Record #:		Admission Source:		Discharge Hour:	
Patient Account #:	A99999999	Service Provider ID:	231725	Form Type:	HCFA 1500
Patient Status:		Received Recipient ID:	A85131244	Bill Type:	

Accounting Summary

Line #	Claim Status	Service Begin Date	Service End Date	Service Code	Billed Amount	Payment Amou
01	DENIED	9/26/2013	9/26/2013	99	14.00	
02	DENIED	9/26/2013	9/26/2013	99	50.00	
				Totals:	$64.00	$0.(

Accounting Details

*** No accounting details found for the selected claim ***

Denial Reasons

Line #	Status Date	Denial Code	Description	Reason
01	9/26/2013	L016.3	CATEGORY OF SERVICE	PROVIDER IS NOT AUTHORIZED
01	9/26/2013	L083.2	PRIOR AUTHORIZATION	IS PENDED

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Denial edits

Description of the denial edits

Claim Status Screen

Claim Submission Status

Claim Type	Submission Date/Tim	Patient Account #	Service Prov. NPI	Billing Prov. NPI	Date From	Date Thru	Status	Processing Date/Time	CRN	Adjudication
Professional	09/26/13 01:47 PM	A99999999			09/26/13	09/26/13	Processed	09/26/13 02:00 PM	132695600001	Denied
Professional	10/08/13 08:31 AM	A00000000			07/04/13	07/04/13	Pending			

Record Count: 2

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Clicking on the patient account number will allow you to view the claim and information you submitted to AHCCCS

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A view of the claim and the information sent to AHCCCS

Arizona Health Care Cost Containment System
Professional Claim Submission

Print Date: 10/8/2013 10:55:18 AM
Confirmation Code: P-159

Submitter
Organization Name: TEST/CASE
Information Contact Name: Richmond, CSRF Updated First Name
Information Contact Telephone #: 602-417-4419
Electronic Transmitter ID: 99222

Billing Provider
Tax ID: 123456789 (EI)
National Provider ID (NPI):
Provider Commercial Number/Name: 231725 (TEST/CASE)
Provider Taxonomy Code:
Entity Type: Non-Person Entity
Information Contact Name:
Information Contact Telephone #: 6024174000
Service Address: 701 E. JEFFERSON
PHOENIX, AZ 85004
Pay-To Provider Address: 701 E. JEFFERSON
PHOENIX, AZ 85004

Rendering Provider
Provider Commercial Number/Name: 231725 (TEST/CASE)
Entity Type: Non-Person Entity
National Provider ID (NPI):
Performing Provider Taxonomy Code:

Service Facility
National Provider ID (NPI):
Laboratory or Facility Name:
Address:

Referring Provider
National Provider ID (NPI):
Provider Commercial Number/Name: ()

Patient/Insured
Member ID Number/Name: AB5131244 (HELLO, THERE)
Date of Birth: 04/23/1952
Gender: M
Residential Address: 801 E JEFFERSON
APACHE, AZ 85930
Payer Responsibility: Primary

Ambulance Information
Pick-up Address:
Dropoff Location Name:
Dropoff Address:

Attachments

	Type	Transmission	Control Number
1			
2			
3			
4			
Attachments (1-10): 5			
6			
7			
8			
9			
10			

Other Payer Information
Insured Identifier: ()
Insured/Subscriber Name: ()
Insured Address (City):
Payer Primary ID:
Payer Name:
Payer Address (City):
Responsibility:
Insured Group or Policy Number:
Insured Group Name:
Individual Relationship:
Insurance Type:
Claim Filing Indicator:
Benefit Assignment Certification:
Release of Information:
Payer Amount Paid:
Date Claim Paid:

Claim Detail
Original Reference Number:
Prior Authorization Number:
Patient's Control Number: A00000000
Medical Record ID Number:
Initial Treatment Date:
Date of Current Injury:
Patient's condition related to:
Place in which accident occurred:
Special Program Indicator:
Provider Signature on File: Yes
Provider Accept Assignment: Assigned
Benefit Assignment: Not Applicable
Release of Information Consent: Informed Consent
EPSDT Screening Referral:
Condition Indicator(s): 1 2 3
Coding Standard: ICD-9
Diagnosis Code(s): 1 7999 2 3 4 5 6 7 8

ervice Lines

Summary

ine 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	Quantity		Line Charges	Medicare Paid Amount	Medicare Deductible Amount	Medicare Coinsurance Amount	Medicare Copay Amount	Other Payer Paid Amount	EMG	EPSDT	Control
	07/04/2013	07/04/2013	99	A0120	TN					0.000	☑	☐	☐	☐	☐	☐	☐	☐	1.000	UN	14.00						☐	☐	
																				Totals:	$14.00	$0.00	$0.00	$0.00	$0.00	$0.00			

Details

Service Dates: 07/04/2013 - 07/04/2013
NDC Code/Units: 0.000
Quantity: 1.000 Units
Line Charges: 14.00
Medicare Paid/Units: 0.000
Medicare Deductible:
Medicare Coinsurance:
Medicare Copay:
Other Payer Paid/Units: 0.000
Other Payer Procedure Code:
Other Payer Primary ID:

Indicators: ☐ Emergency ☐ EPSDT
Modifier Codes: TN
Prescription #:
Prescription Qualifier:
Prescription Date:
DME Purchase Price: 0.00
DME Rental Price: 0.00
Length of Medical Necessity: 0
DME HCPCS:
Medicare Procedure Code:

Diagnosis Code Pointers 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐
HCPCS: A0120
Immunization Batch #:
Ordering Physician Plan ID:
Ordering Physician Name:
Ordering Physician City:
Place of Service: OTHER UNLISTED FACILITY
Provider Taxonomy Code:
Patient Count: 0
Provider Control #: