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10/15/2015 CORRECTIONS; 09/17/2015 EFFECTIVE 10/01/2015; 12/01/2014; 05/29/2014

## General Information

Claims for services must be submitted to the AHCCCS Administration on the correct form for the type of service billed. This chapter outlines the requirements for completing the CMS 1500, UB-04 and American Dental Association (ADA) 2012 claim forms.

This chapter applies to *paper* CMS 1500, UB-04, and ADA claims submitted to AHCCCS.

- Note: The preferred method of claims submission remains the HIPAA-compliant 837D transaction process.

If a provider is not set up to perform the 837D transaction process, then submission of a claim via the AHCCCS Online Provider Portal is the preferred method of claim submission.

For information on how to submit claims using the HIPAA-compliant 837D transaction process or the AHCCCS Online Provider Portal please refer to Chapter 4, General Billing Rules, of the Fee-For-Service Provider Billing Manual and the appropriate implementation guides. Companion documents for 837 transactions are available on the AHCCCS website at [www.azahcccs.gov](http://www.azahcccs.gov). The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

The **CMS 1500 claim form** is used to bill for:

- IHS/638 tribal claims for individual provider services,
- Emergency and non-emergency transportation services,
- FQHC services,
- Ambulatory surgical centers,
- Independent laboratories,
- Durable medical equipment, and
- KidsCare *outpatient* services.

CPT and HCPCS procedure codes must be used to identify all services.

ICD-10 diagnosis codes are required. AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.

The **UB-04 claim form** is used to bill for:

- IHS/638 Facility Inpatient and Outpatient Claims for Title XIX (Medicaid) for reimbursement at the AIR,
- *Inpatient* Title XXI (KidsCare) members,
- Nursing facility services,
- Free-standing birthing centers,
- Hospice services,
- Residential treatment center services, and
- Dialysis facility services.

Revenue codes appropriate for the services provided are used to bill facility line-item services.

ICD diagnosis codes are required. AHCCCS does not accept DSM-4 diagnosis codes and behavioral health services billed with DSM-4 diagnosis codes will be denied.

**ICD-10 codes must be used to identify surgical procedures billed on the UB-04.**

AHCCCS will only accept the ADA 2012 claim form. Other ADA forms received will be returned to the provider. Timely filing will not begin until a claim is submitted that is compliant.

Note: Effective 8/1/2014, the ADA 2012 claim form became mandatory and the old ADA 2006 claim form was no longer accepted by AHCCCS. There was a grace period between 6/1/2014 and 7/31/2014 where both forms were accepted. Since 8/1/2014 AHCCCS has only accepted the 2012 claim form.

## General Information on Claim Submissions

Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system. Liquid paper correction fluid ("White Out") **may not** be used. Correction tape **may not** be used.

Claim forms with labels and stamps will not be accepted, as that is considered an alteration of the claim. However, stamped provider signatures will be accepted in field 53.

The preferred font for claims submission is Lucinda Console and the preferred font size is 10.

If a claim will be submitted with multiple pages (a multi-page claim) then the following must occur:

- On the CMS 1500 claim form, then **all lines (1-6) under field 24 (A-J) must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines* will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-4 filled out, but lines 5 and 6 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page cannot be submitted unless all lines on page 1 are utilized and completely filled in first.**
- On the UB-04 claim form **all lines (1-22) under fields 42-48 must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines* will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-20 filled out, but lines 21 and 22 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page cannot be submitted unless all lines on page 1 are utilized and completely filled in first.**
- **On the ADA 2012 claim form all lines (1-10) under fields 24-31 must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines* will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-8 filled out, but lines 9 and 10 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page cannot be submitted unless all lines on page 1 are utilized and completely filled in first.**

For the purposes of this chapter the term “member” refers to an AHCCCS eligible member.

## Completing the CMS 1500 Claim Form

The revised CMS-1500 health insurance claim form version 02/12 replaces version 08/05. On the new version 02/12 the 1500 symbol at the top left corner is replaced with a scannable Quick Response (QR) code symbol and the date approved by the NUCC.

Effective 4/1/2014, the revised CMS 1500 (02/12) will be required. Data receipt for 4/1/2014 and forward received with the old CMS 1500 08/05 form will be returned to the provider, regardless of the date of service being billed for on the claim.

The following instructions explain how to complete the **paper** CMS 1500 claim form and whether a field is “Required,” “Required if applicable,” or “Not required.”

**NOTE:** This section applies to **paper** CMS 1500 (02/12) claims submitted to AHCCCS. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide.

**1. Program Block**

**Required**

Check the second box labeled "Medicaid."

MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
<input type="checkbox"/> (Medicare #)	<input checked="" type="checkbox"/> (Medicaid #)	<input type="checkbox"/> (ID# / DoD#)	<input type="checkbox"/> (member ID #)	<input type="checkbox"/> (ID#)	<input type="checkbox"/> (ID#)	<input type="checkbox"/> (ID#)

**1a. Insured's ID Number**

**Required**

Enter the member's *AHCCCS ID number*. If there are questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. For additional information please refer to Chapter 2, Eligibility, of the Fee-For-Service Provider Billing Manual. Behavioral Health providers must be sure to enter the client's AHCCCS ID number, *not* the client's BHS number.

1a. INSURED'S ID NUMBER	(FOR PROGRAM IN ITEM 1)
<b>A99999999</b>	

**2. Patient's Name**

**Required**

Enter member's last name, first name, and middle initial as shown on the AHCCCS ID card.

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
<b>Doe, John</b>

**3. Patient's Date of Birth and Sex**

**Date of Birth is Required  
Sex is Required if Applicable**

Enter the member's date of birth. Check the appropriate box to indicate the patient's gender, if applicable.

3. PATIENT'S BIRTH DATE	SEX
MM DD YY	

01	1	19XX	M <input checked="" type="checkbox"/>	F <input type="checkbox"/>
----	---	------	---------------------------------------	----------------------------

- |  |                               |
|--|-------------------------------|
| <b>4. Insured's Name</b>   | <b>Not required</b>           |
| Enter the insured person's last name, first name, and middle initial.  |                               |
| <b>5. Patient Address</b>  | <b>Not required</b>           |
| Enter the member's street number, street name, city, state, zip code, and telephone (including area code) in the indicated fields.   |                               |
| <b>6. Patient Relationship to Insured</b>  | <b>Not required</b>           |
| Mark the appropriate box to indicate the patient's relationship to the insured person (self, spouse, child, or other).   |                               |
| <b>7. Insured's Address (Street &amp; Street Number)</b>   | <b>Not required</b>           |
| <b>8. Reserved for NUCC Use</b>  | <b>Not required</b>           |
| <b>9. Other Insured's Name</b>   | <b>Required if applicable</b> |
| If the member has no coverage other than AHCCCS, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the member, enter "Same."  |                               |
| <b>9a. Other Insured's Policy or Group Number</b>  | <b>Required if applicable</b> |
| Enter the policy or group number of the other insured.   |                               |
| <b>9b. Reserved for NUCC Use</b>   | <b>Not Required</b>           |
| <b>9c. Reserved for NUCC Use</b>   | <b>Not Required</b>           |
| <b>9d. Insurance Plan Name or Program Name</b>   | <b>Required if applicable</b> |
| Enter name of insurance company or program name that provides the insurance coverage.  |                               |
| <b>10. Is Patient's Condition Related to:</b>  | <b>Required if applicable</b> |
| Check "YES" or "NO" to indicate whether the patient's condition is related to employment, an auto accident, or other accident. If the patient's condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured. |                               |

10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (CURRENT OR PREVIOUS)	
<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
b. AUTO ACCIDENT? (State)	PLACE
<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
c. OTHER ACCIDENT?	
<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO

- |  |                               |
|--|-------------------------------|
| <b>10d. Claim Codes (Designated by NUCC)</b>   | <b>Not Required</b>           |
| <b>11. Insured's Group Policy or FECA Number</b>   | <b>Required if applicable</b> |
| <b>11a. Insured's Date of Birth and Sex</b>  | <b>Required if applicable</b> |
| <b>11b. Other Claim ID (Designated by NUCC)</b>  | <b>Not Required</b>           |
| <b>11c. Insurance Plan Name or Program Name</b>  | <b>Required if applicable</b> |
| <b>11d. Is There Another Health Benefit Plan</b>   | <b>Required if applicable</b> |
| Mark the appropriate box to indicate coverage other than AHCCCS. If "Yes" is marked, you must complete Fields 9a-d.  |                               |
| <b>12. Patient or Authorized Person's Signature</b>  | <b>Required</b>               |
| If the signature is on file, then stating that the signature is on file is acceptable.   |                               |
| The signature may be handwritten, but it must be done in black pen.  |                               |
| <b>13. Insured's or Authorized Person's Signature</b>  | <b>Required if applicable</b> |
| If the member is under 18 years of age, then a signature is required from the insured member/authorized person. If the signature is on file, then stating that the signature is on file is acceptable. |                               |
| The signature may be handwritten, but it must be done in black pen.  |                               |
| <b>14. Date of Illness or Injury</b>   | <b>Required if applicable</b> |

- |   |                               |
|---|-------------------------------|
| <b>15. Other Date</b>   | <b>Not required</b>           |
| <b>16. Dates Patient Unable to Work in Current Occupation</b> | <b>Not required</b>           |
| <b>17. Qualifier / Name of Provider or Other Source</b>       | <b>Required if applicable</b> |
- If applicable, enter the appropriate Qualifier:
- DN Referring Provider
  - DK Ordering Provider\*
  - DQ Supervising Provider

Then enter the Name of the provider or other source

\* The ordering provider is required for:

Laboratory	Drugs (J-codes)
Radiology	Temporary K and Q codes
Medical and surgical supplies	Orthotics
Respiratory DME	Prosthetics
Enteral and Parenteral Therapy	Vision codes (V-codes)
Durable Medical Equipment	97001 – 97546

Ordering providers can be any of the following: M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Psychologist or Certified Nurse Midwife.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

- |  |                               |
|--|-------------------------------|
| <b>17a. ID Number of Provider</b>                            | <b>Required if applicable</b> |
| <b>17b. NPI # of Referring Provider</b>                      | <b>Required</b>               |
| <b>18. Hospitalization Dates Related to Current Services</b> | <b>Not required</b>           |
| <b>19. Additional Claim Information</b>                      | <b>Required if applicable</b> |

Any additional information required for the processing of a claim (that is not found in another field) shall be entered under the Additional Claim Information field.

The standard format is as follows:

FQHC Indicator\Any other additional information

**See Chapter 4, General Billing Rules, for information on replacements, adjustments, and voids.**

The CRN and the original reference number are the same.

In the remarks section, for FQHC professional claims, the claims processing system is only able to accept *one* provider name at a time. If two providers are providing services to a member at the FQHC, please see Chapter 10, Addendum FQHC/RHC, for additional information. The standard FQHC format is as follows:

- If the provider has a NPI: XXNPIProviderName; *or*
- If the provider does not have a NPI: 999999999ProviderName  
Example: XX1234567890Smith, Hillary

For additional information on how to indicate that the provider is an FQHC please see Chapter 10 Addendum, FQHC/RHC, of the Fee-For-Service Provider Billing Manual.

Examples:

- An FQHC provider is submitting an original claim:  
XX1234567890Smith, Andrew

If this provider had additional information to add after the FQHC indicator, then a backslash would be needed after the provider name.  
XX1234567890Smith, Andrew\Additional information here

- An FQHC provider is billing for a replacement claim of a previous submission:  
XX1234567890Smith, Hillary

If this provider had additional information to add after the FQHC indicator, then a backslash would be needed after the provider name.  
XX1234567890Smith, Stacy\Additional information here

For questions on this field please outreach the provider training e-mail inbox at [ProviderTrainingFFS@azahcccs.gov](mailto:ProviderTrainingFFS@azahcccs.gov).

<b>20.</b>	<b>Outside Lab and (\$) Charges</b>	<b>Not required</b>
<b>21.</b>	<b>Diagnosis Codes</b>	<b>Required</b>

Enter at least one *ICD diagnosis code* describing the member's condition. Behavioral health providers must **not** use DSM-4 diagnosis codes. Up to twelve diagnosis codes in priority order (principal diagnosis, secondary diagnosis, etc.) may be entered.



**ICD Ind. Field:** Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

0 = ICD-10-CM

9 = ICD-9-CM (no longer accepted)

- If this field is left blank the claim will be returned to the provider for correction. Please ensure it is filled out correctly.

Enter the ICD indicator between the vertical, dotted lines in the upper-right hand area of the field.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)				ICD Ind.		
A. _____	B. _____	C. _____	D. _____			
E. _____	F. _____	G. _____	H. _____			
I. _____	J. _____	K. _____	L. _____			

Field A is the Principal Diagnosis.

Relate diagnosis lines A – L to the lines of service in 24E by the letter.

**22. Medicaid Resubmission Code Required if applicable**

Enter the appropriate code (“7” or “8”) to indicate whether this claim is a replacement (resubmission) of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the AHCCCS Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled "Original Reference No."

See Chapter 4, General Billing Rules, for information on replacements, adjustments, and voids.

22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.
7 or 8	130010004321	

**23. Prior Authorization Number Not required**

The AHCCCS claims system will automatically match claims to approved prior authorization (PA) requests when the claim is submitted. This means that if there is an existing PA on file, when the claim is submitted it will automatically match

and process. See Chapter 6, Authorizations, of the IHS/Tribal Provider Billing Manual for information on prior authorization.

**24. A NOTE regarding field 24 (A-J) and multi-page claim submissions:**

If a claim will be submitted with multiple pages (a multi-page claim) then **all lines (1-6) under field 24 (A-J) must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines* will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-4 filled out, but lines 5 and 6 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page cannot be submitted unless all lines on page 1 are utilized and completely filled in first.**

**24. Service line (shaded area) Required if applicable**

***Effective 07/01/2016 for IHS/tribally operated 638***

Enter the NDC Qualifier N4 in the first 2 positions, followed by the 11-digit NCD *immediately* after the NDC Qualifier N4, with no dashes or spaces separating them. Follow this with a space, followed by the NDC Unit of Measure Qualifier, followed by the NDC quantity *administered* to the patient.

Example: N400074115278 ML10

NDC Unit of Measure:

- F2 International Unit
- GR gram
- ML milliliter
- UN unit (each)

24.	A	B	C	D
	DATE(S) OF SERVICE	Place	EM G	PROCEDURE, SERVICES, OR SUPPLIES
	From                      To	of		(Explain Unusual Circumstances)
	MM DD YY      MM DD Y	Service		CPT/HCPCS   MODIFIER
		e		
	N400074115278 ML10			
	07   01   13	07   01   13	11	J1642

Note: Only 1 NDC per service line/HCPCS code.

**24A. Date(s) of Service**

**Required**

Enter the beginning and ending service dates.

24.	A						B	C	D	
	DATE(S) OF SERVICE						Place	EM G	PROCEDURE, SERVICES, OR SUPPLIES	
	From		To				of		(Explain Unusual Circumstances)	
	MM	DD	YY	MM	DD	YY	Service	CPT/HCPCS	MODIFIER	
	N400074115278 ML10									
	07	01	13	07	01	13	11	J1642		

**24B. Place of Service**

**Required**

Enter the two-digit code that describes the place of service.

Refer to the Current Procedural Terminology (CPT) manual for a complete place of service listing.

24.	A						B	C	D	
	DATE(S) OF SERVICE						Place	EM G	PROCEDURE, SERVICES, OR SUPPLIES	
	From		To				of		(Explain Unusual Circumstances)	
	MM	DD	YY	MM	DD	YY	Service	CPT/HCPCS	MODIFIER	
	N400074115278 ML10									
	07	01	13	07	01	13	11	J1642		

**24C. EMG – Emergency Indicator**

**Required if applicable**

Mark this box with a “Y” if the service was an emergency service, regardless of where it was provided.

24.	A						B	C	D	
	DATE(S) OF SERVICE						Place		PROCEDURE, SERVICES, OR	

From			To			Of Service	EMG	SUPPLIES (Explain Unusual Circumstances)		
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER	
							Y			

**24D. Procedures, Services, or Supplies** **Required**

Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the *same date of service*, enter the procedure only once. Use the **Units** field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT coding manuals.

For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provider and avoid delay or denial of payment.

24.	A						B	C	D			
	DATE(S) OF SERVICE						Place of Service	EMG	PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			
	MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER		
									<b>71010</b>	<b>26</b>		

24.	F	G	H	I
	\$ Charges	Days Or Units	EPST Family Plan	ID Qual.
		3		

**24E. Diagnosis Pointer** **Required**

Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the letter of the appropriate diagnosis. Enter only the reference letter from Field 21 (A - L), not the diagnosis code itself. If more than one letter is entered, they

should be in descending order of importance. Do not separate letters with commas.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS POINTERS	\$ CHARGES	DAYS	EPSDT
CPT/HCPCS	MODIFIER			OR	Family
		A		UNITS	Plan
		AB			

**24F. \$ Charges** **Required**

Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units.

For example, if each unit is billed at \$50.00 and three units were provided, enter \$150.00 here and three units in Field 24G.

**24G. Units** **Required**

Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS coding manuals.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	\$ CHARGES	DAYS	EPSDT
CPT/HCPCS	MODIFIER			OR	Family
				UNITS	Plan
				3	
				1	

**24H. EPSDT/Family Planning** **Not required**

**24I. ID Qualifier** **Required**

Enter in the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24J in the shaded area. ZZ should be entered to indicate a Taxonomy Code.

E	F	G DAY	H EPSD	I	J
---	---	----------	-----------	---	---

DIAGNO SIS POINTER	\$ CHARGES	S OR UNIT S	T Famil y Plan	ID QUA L	RENDERING PROVIDER  ID #
				<b>ZZ</b>	Taxonomy Code
					<b>NPI</b> Rendering Provider NPI ID #

**24J. Rendering Provider ID # Required if applicable**  
**(SHADED AREA) – Use for Taxonomy Code Reporting**

Use this SHADED field to report the provider's 10 digit alpha-numeric Taxonomy Number.

**NOTE:** Previously this section was used to report Medicare and/or other insurance information. This does not need to be reported on the CMS 1500. Instead, always attach a copy of the Medicare or other insurer's EOB to the claim.

See Chapter 7, Medicare/Other Insurance Liability, of the IHS/Tribal Provider Billing Manual for details on billing claims with Medicare and other insurance.

E DIAGNO SIS POINTER	F \$ CHARGES	G DAY S OR UNIT S	H EPSD T Famil y Plan	I ID QUA L	J RENDERING PROVIDER  ID #
					Taxonomy Code
					<b>NPI</b> Rendering Provider NPI ID #

**24J. Rendering Provider ID # Required**  
**(NON SHADED AREA) – RENDERING PROVIDER ID #**

Rendering Provider's NPI is required for all providers that are mandated to maintain an NPI #.

For atypical provider types, the AHCCCS ID must be used unless the provider has chosen to obtain an NPI and has provided this NPI to AHCCCS.

E DIAGNOSIS POINTER	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID #
					Taxonomy Code
				NPI	000000000

**25. Federal Tax ID Number**

**Required**

Enter the tax ID number and check the box labeled "EIN." If the provider does not have a tax ID, enter the provider's Social Security Number and check the box labeled "SSN."

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.
861234567	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

**26. Patient Account Number**

**Required if applicable**

This is a number that the provider has assigned to uniquely identify this claim in the provider's records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and the provider's own accounting or tracking system.

**27. Accept Assignment**

**Not required**

**28. Total Charge**

**Required**

Enter the total for all charges for all lines on the claim.

27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
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(For govt claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	\$ 179	00	\$	\$
---	--------	----	----	----

**29. Amount Paid** **Required if applicable**

Enter the total amount that the provider has been paid for this claim by all sources *other than AHCCCS*. Do *not* enter any amounts expected to be paid by AHCCCS.

**30. Reserved for NUCC Use** **Not required**

**31. Signature and Date** **Required**

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable. Enter the date on which the claim was signed.

The signature may be handwritten, but it must be done in black pen.

<b>31. SIGNATURE OF PHYSICIAN OR SUPPLIER</b> INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	
SIGNATURE	John Doe
DATE	03/01/13

**32. Service Facility Location Information** **Required if applicable**

**32a. Service Facility NPI #** **Required if applicable**

**32b. Service Facility AHCCCS ID # (Shaded Area)** **Required if applicable**

<b>32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED</b> (if other than home or office) Arizona Hospital 123 Main Street
--



Phoenix, AZ 85XXX	
a. NPI <input style="width: 80%;" type="text"/>	b. AHCCCS ID <input style="width: 80%;" type="text"/>

**33. Billing Provider Name, Address and Phone # Required**

Enter the provider name, address, and phone number. If a group is billing, enter the group biller's name, address, and phone number.

**33a. Billing Provider NPI # Required if applicable**

**33b. Other ID – AHCCCS ID # (Shaded Area) Required if applicable**

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	
<p style="margin-left: 40px;">Doc Holliday 123 OK Corral Drive Tombstone, AZ 85XXX</p>	
a. NPI <input style="width: 80%;" type="text"/>	b. Taxonomy Code <input style="width: 80%;" type="text"/>

### Completing the UB-04 Claim Form

The following instructions explain how to complete the *paper* UB-04 claim form and whether a field is “Required,” “Required if applicable,” or “Not required.” The instructions should be used to supplement the information in the *AHA Uniform Billing Manual for the UB-04*.

**1. Provider Data Required**

Enter the name, address, and phone number of the provider rendering service.

1	<p style="margin-left: 20px;"><b>Arizona Hospital</b> <b>123 Main Street</b> <b>Scottsdale, AZ 85252</b></p>
---	--

**2. Billing Provider’s Designated Pay-to Address Required if applicable**

Report this only when it is different from the address reported in Field 1.

**3.a PAT CNTL # (Patient Control No.) Required**

This is a number that the facility assigns to uniquely identify a claim in the facility's records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS Claim Reference Number (CRN) and the facility's accounting or tracking system.

- 3.b MED REC. # (Medical/Health Record No.)** **Required if applicable**
- 4. Type of Bill** **Required**

Facility type (1st digit), bill classification (2nd digit), and frequency (3rd digit). See the *UB-04 Manual* for codes. Note: Do not add an extra zero to the 3 digit number. Adding a 4<sup>th</sup> digit will result in the claim to deny.

Example 1 (Inpatient):

2.	3a PATIENT CONTROL NO.	<b>4. TYPE OF BILL</b>
	3b MED REC #	<b>111</b>

Example 2 (Outpatient):

2.	3a PATIENT CONTROL NO.	<b>4. TYPE OF BILL</b>
	3b MED REC #	<b>131</b>

Example 2 (Dental):

2.	3a PATIENT CONTROL NO.	<b>4. TYPE OF BILL</b>
	3b MED REC #	<b>131</b>

Note: Bill Type 131 is used for both outpatient and dental visits.

- 5. Fed Tax No.** **Required**

Enter the facility's federal tax identification number. This should be a 9 digit number.

5. FED TAX NO.	6. STATEMENT COVERS PERIOD FROM	THROUGH	7. COV D
861234567			

**6. Statement Covers Period Required**

Enter the beginning and ending dates of the billing period.

5. FED TAX NO.	6. STATEMENT COVERS PERIOD FROM	THROUGH	7. COV D
	MM/DD/CCYY MM/DD/CCYY		

**Or**

	MM/DD/CCYY MM/DD/CCYY		
--	--------------------------	--	--

**7. Blank Field Not Required**

**8. Patient Name/Identifier Required**

Enter the member's last name, first name, and middle initial as they appear on the AHCCCS ID card.

- 8a. Enter the member's identification number, from their AHCCCS ID card.
- 8b. Enter the member's name.

8 Patient Name	a
	b

**9. Patient Address Required**

- 9a. Enter the member's street number and street address.
- 9b. Enter the member's city.
- 9c. Enter the member's State
- 9d. Enter the member's zip code.
- 9e. Enter the member's country.

9 Patient Address	a		
b	c	d	e

**10. Birthdate Required**

Member's date of birth.

**11. Sex Required if applicable**

Member's sex, if applicable.

**12. Date (Admission Start of Care Date) Required**

This is the admission start of care date.

Admission			
12 Date	13 HR	14 Type	15 SRC
MM/DD/CC YY			

**13. HR (Admission Hour) Required if applicable**

Enter the hour in which the patient is admitted for inpatient or outpatient care, using Military Standard Time (00-23) in top-of-hour times only.

Note: **Admission hour requires a 2 digit number.** See example times under field 16, DHR (Discharge Hour).

Admission			
12 Date	13 HR	14 Type	15 SRC
MM/DD/CC YY	08		

**14. Type (Priority of Admission/Visit) Required**

This is required for all claims. Enter the code that best describes the member's status for this billing period. See the *UB-04 Manual* for codes.

- 1 for Emergency
- 2 for Urgent
- 3 for Elective
- 4 for Newborn
- 5 for Trauma

Admission			
12 Date	13 HR	14 Type	15 SRC
MM/DD/CC YY	08	1	

**15. Point of Origin for Admission or Visit**

**Required**

This indicates the point of patient origin for the admission or visit. It is the source of referral for the admission or visit, and will always be entered in as 1 character. (Example: 1 will be 1, not 01.)

Admission			
12 Date	13 HR	14 Type	15 SRC
MM/DD/CC YY	08	1	8

**16. DHR (Discharge Hour)**

**Required if applicable**

Enter the time (two digits), which best indicates the member's time of discharge. This is required for inpatient claims when the member has been discharged. See the *UB-04 Manual* for code structure.

12:00 a.m. = 00	6:00 a.m. = 06	12:00 p.m. = 12	6:00 p.m. = 18
1:00 a.m. = 01	7:00 a.m. = 07	1:00 p.m. = 13	7:00 p.m. = 19
2:00 a.m. = 02	8:00 a.m. = 08	2:00 p.m. = 14	8:00 p.m. = 20
3:00 a.m. = 03	9:00 a.m. = 09	3:00 p.m. = 15	9:00 p.m. = 21
4:00 a.m. = 04	10:00 a.m. = 10	4:00 p.m. = 16	10:00 p.m. = 22
5:00 a.m. = 05	11:00 a.m. = 11	5:00 p.m. = 17	11:00 p.m. = 23

**17. STAT (Patient discharge status) Required**

Required for all claims. Enter the 2 digit code that best describes the member's status for this billing period. See the *UB-04 Manual* for codes.

**18-28 Condition Codes Required if applicable**

Enter the appropriate condition codes that apply to this bill. See the *UB-04 Manual* for codes.

Examples:

In-state, non-IHS inpatient hospitals may request outlier consideration for a claim by entering "61" in any Condition Code field.

To bill for self-dialysis training, free-standing dialysis facilities approved to provide self-dialysis training must enter "73" in any Condition Code field and bill revenue code 841 (Continuous Ambulatory Peritoneal Dialysis, per day) or revenue code 851 (Continuous Cycling Peritoneal Dialysis, per day).

To bill for multiple distinct/independent outpatient visits on the same day facilities must enter "GO".

**29. ACDT State (Accident State) Required if applicable**

**31-34 Occurrence Codes and Dates Required if applicable**

**35-36. Occurrence Span Codes and Dates Required if applicable**

**38. Responsible Party Name and Address Required if applicable**

**39-41 Value Codes and Amounts Required if applicable**

Value codes identify special circumstances that may affect the processing of the claim. See the NUBC manual for specific codes.

**42. Revenue Code Required**

Enter the appropriate revenue code(s) that describe the service(s) provided. See *UB-04 Manual* for revenue codes and abbreviations. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes. Accommodation days should not be billed on outpatient bill types.

If this field is left blank the claim will be returned to the provider.

Example 1 (Billing for Clinic Visit):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	0510		
2			
3			
4			

Example 2 (Billing for Dental):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	0512		
2			
3			
4			

Example 3 (Billing for Urgent Clinic):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	0516		
2			
3			
4			

Example 4 (Billing for Pharmacy):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	0519		
2			
3			
4			

**43. Revenue Code Description / NDC code\* (effective 7/1/16) Required/NCD if applicable**

\*Effective 07/01/2016 -NDC information will be **required** for outpatient pharmacy claims.

Enter the description of the revenue code billed in Field 42. See the *UB-04 Manual* for the descriptions of revenue codes.

\* For outpatient pharmacy clinic claims report the NDC on the UB04 claim form, entering the following information into the Form Locator 43 (Revenue Code Description):

- The NDC Qualifier of N4 in the first 2 positions on the left side of the field.
- The NDC 11-digit numeric code, without hyphens or spaces.
- The NDC Unit of Measurement Qualifier\*
  - UN = Unit
  - ML = Milliliters
  - GR = Gram
  - F2 = International Unit
- The NDC Unit Quantity is the amount of medication administered. **If** it includes a decimal point, a decimal point **must** be used and a blank space cannot be left in place of the decimal point. There is a **limit** of 3 characters to the right of the decimal point. (i.e. 1234.456). Any unused spaces are left blank.

**IMPORTANT NOTE:** If the NDC Unit Quantity has a space in it, it can result in errors.

Example 1 (Incorrect Example): A provider is attempting to bill for 20 milliliters, and enters the following on their claim:

**N412345678901ML20 500**

This would be read as **20500.000** and not as **20.500**

To correct the above example, the provider would enter:

**N412345678901ML20.500**

Example 2 (Incorrect Example):



A provider is attempting to bill for 1 unit, and enters the following on their claim.

**N412345678901ML1 000**

This would be read as **1000.000** and not as **1.000**

To correct the above example, the provider would enter:

**N412345678901ML1.000** or **N412345678901ML1**

Example 4 (Correct Example):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278ML10	J1642	2.00
2				
3				

Example 5 (Correct Example):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278ML10.000	J1642	2.00
2				
3				

**NOTE: The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens.**

\*Refer to the AHCCCS Pharmacy webpage for billing details at:

<https://azahcccs.gov/Resources/GuidesManualsPolicies/pharmacyupdates.html>

**44. HCPCS/Rates Required if applicable**

Enter the inpatient (hospital or nursing facility) accommodation rate. Dialysis facilities must enter the appropriate CPT/HCPCS code for lab, radiology, and pharmacy

revenue codes (See Chapter 15, Dialysis Services, for the FFS Provider Billing Manual). Hospitals must enter the appropriate CPT/HCPCS codes and modifiers when billing for outpatient services.

HCPCS/Rates are not required for NDC lines on outpatient pharmacy clinic claims.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0519	N400074115278 ML10		1.00
2				
3				

**45. Service Date Required**

The dates indicated outpatient service was provided on a series bill. The date of service should only be reported if the From and Through dates in Form Locator 6 are not equal to each other on the form. Enter the date in MM/DD/YY or MM/DD/YYYY format.

Note: if the Service Date is outside the date span in Field 6, Statement Covers Period, the claim will deny.

**46. Service Units Required**

If accommodation days are billed, the number of units billed must be consistent with the patient status field (Field 22) and statement covers period (Field 6). If the member has been discharged, AHCCCS covers the admission date to, but not including, the discharge date. Accommodation days reported must reflect this. If the member expired or has not been discharged, AHCCCS covers the admission date through last date billed.

Enter the number of units for AIR

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0519	N400074115278 ML10		1
2				
3				

**Note: Only 1 AIR can be billed per UB-04. If more than 1 AIR per claim is billed then the entire claim will deny.**

**47. Total Charges Required**

Total charges are obtained by multiplying the units of service by the unit charge for each service. Each line other than the sum of all charges may include charges up to \$999,999.99.

In line 23, the total charges are represented by revenue code 0001. In Field 47, the total charges must be the last entry. Total charges on one claim cannot exceed \$999,999,999.99.

On the UB-04 form also indicate the corresponding page number of the claim.

Note: For multi-page claims, **all lines (1-22) must be completed on the first page, before proceeding to the second page** of the claim. AHCCCS has received claims where page 1 has had lines (for example) 1-20 filled out, but lines 21 and 22 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page cannot be submitted unless all lines on page 1 are utilized and filled in first.**

**48. Non-covered Charges Required if applicable**

Enter any charges that are not payable by AHCCCS. The last entry is total non-covered charges, represented by revenue code 0001. Do not subtract this amount from total charges.

**50. (A–C) Payer Required**

Enter the name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the member and from which the provider might expect some reimbursement. If there are payers other than AHCCCS, AHCCCS should be the last entry. If there are no payers other than AHCCCS, AHCCCS will be the only entry.

	50. PAYER NAME	51. Health Plan Identification.	52. REL INFO	53. ASG BEN
A	AHCCCS			
B	Medicare Part B			
C				

**51. (A–C) Health Plan Identification No Required**

Enter your facility’s ID number as assigned by the payer(s) listed in Fields 50 A, B, and/or C. The facility’s six-digit *AHCCCS service provider ID number* should be listed last. Behavioral health providers must not enter their BHS provider ID number.

	50. PAYER NAME	51. Health Plan Identification No.	52. REL INFO	53. ASG BEN
A		654321		
B				
C				

**52. (A–C) REL INFO (Release of Information) Not required**

**53. (A–C) ASG BEN (Assignment of Benefits) Not required**

**54. (A–C) Prior Payments Required if applicable**

Enter the amount received from Medicare or any other insurance or payer *other than AHCCCS*, including the patient, listed in Field 50. If the member has other insurance but no payment was received, enter “Ø.” The “Ø” indicates that a reasonable attempt was made to determine available coverage and obtain payment. Enter only actual payments received. Do not enter any amounts expected from AHCCCS.

**55. (A–C) Est. Amount due Not required**

**56. NPI - National Provider Identifier - Billing Provider Required**

**57. Other (Billing) Provider Identifier Required if applicable**

**58. (A–C) Insured's Name Required**

Enter the name of insured (AHCCCS member) covered by the payer(s) in Field 50.

	58. INSURED’S NAME	59. P.REL.	60. INSURED’S UNIQUE ID
A	Doe, John		
B			
C			

**59. (A–C) P Rel. (Patient's Relationship To Insured) Not required**

**60.A Insured's Unique ID Required**

Enter the member's AHCCCS ID number. If you have questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. (See Chapter 2, Eligibility).

Behavioral health providers must be sure to enter the client's AHCCCS ID number, not the client's BHS number.

	58. INSURED'S NAME	59. P.REL.	60. CERT. -SSN - HIC. - ID NO.
A			A99999999
B			
C			

**61. (A-C) Group Name Required**

Enter "AIHP"

60. CERT. -SSN - HIC. - ID NO.	61. GROUP NAME	62. INSURANCE GROUP NO.

**62. (A-C) Insurance Group Number Not required**

**63. (A-C) Treatment Authorization Not required**

The AHCCCS claims system will automatically match claims to approved prior authorization (PA) requests when the claim is submitted. This means that if there is an existing PA on file, when the claim is submitted it will automatically match and process. See Chapter 6, Authorizations, of the IHS/Tribal Provider Billing Manual for information on prior authorization.

**64. Document Control Number Required if applicable**

If the claim is a replacement or void, the original CRN shall be entered in this field.

65. (A–C) Employer Name Not required
66. Diagnosis and Procedure Code Qualifier Required

**Note: ICD Ind. Field:** Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

0 = ICD-10-CM

9 = ICD-9-CM (no longer accepted)

- If this field is left blank the claim will be returned to the provider for correction. Please ensure it is filled out correctly.

66. DX	67		A	B	C	D	E	F	G	H
X			J	K	L	M	N	O	P	Q

67. Principal Diagnosis Required

Enter the **principal ICD diagnosis code**.

Behavioral health providers must **not** use DSM-4 diagnosis codes.

Note: In each diagnosis code box there is a grayed out area. This is the diagnosis indicator area. If a diagnosis code is entered in, please enter in the appropriate diagnosis indicator (i.e. Y or N).

66. DX	67		A	B	C	D	E	F	G	H
			J	K	L	M	N	O	P	Q

69. Admitting Diagnosis Required

This field is required for inpatient bills. Enter the ICD diagnosis code that represents the significant reason for admission.

- |            |  |                               |
|------------|--|-------------------------------|
| <b>70.</b> | <b>Patient Reason DX (Patient’s Reason for Visit)</b>  | <b>Required if applicable</b> |
| <b>71.</b> | <b>PPS Code</b>  | <b>Required if applicable</b> |
|            | Enter the DRG diagnosis code for the claim in this field.  |                               |
| <b>72.</b> | <b>E-Codes</b>   | <b>Required if applicable</b> |
|            | Enter the trauma diagnosis code, if applicable.  |                               |
| <b>74.</b> | <b>Principal Procedure Code and Dates</b>  | <b>Required if applicable</b> |
|            | Enter the principal ICD procedure code and the date the procedure was performed during the inpatient stay or outpatient visit. Enter the date in MM/DD/YY or MM/DD/YYYY format. If more than one procedure is performed, the principal procedure should be the one that is related to the primary diagnosis, performed for definitive treatment of that condition, and which requires the highest skill level. |                               |

**For fields concerning provider information:**

After January 1<sup>st</sup>, 2016, if a provider is not enrolled with AHCCCS as a valid and/or active provider, claims will deny. All providers, including but not limited to out-of-state providers, attending and servicing providers both within and outside of a hospital setting, and billing providers must be registered with AHCCCS in order to be reimbursed for covered services provided to AHCCCS members. This applies to *all* providers, including attending providers.

For additional information on this requirement, refer to Chapter 3, Provider Records and Registration, of the IHS/Tribal Provider Billing Manual.

- |            |  |                               |
|------------|--|-------------------------------|
| <b>76.</b> | <b>Attending Provider Name and Identifiers</b>                   | <b>Required if applicable</b> |
|            | <i>Effective 01/01/2016 this will be <b><u>required</u></b>.</i> |                               |
|            | NPI, ID (QUAL), First and Last name                              |                               |
| <b>77.</b> | <b>Operating Physician Name and Identifiers</b>                  | <b>Required if applicable</b> |
|            | NPI, ID (QUAL), First and Last name                              |                               |
| <b>78.</b> | <b>Referring Provider</b>  | <b>Required if applicable</b> |

NPI, ID (QUAL), First and Last name

**79. Other Physician** **Not required**

NPI, ID (QUAL), First and Last name

**80. Remarks** **Required if applicable**

This field is required on replacements, adjustments, and voids.

Enter the CRN of the claim that is being replaced by this resubmission, adjustment, or void. For resubmissions of denied claims, write "Resubmission" in this field.

**81.A Other Procedure Codes** **Not required**

Taxonomy code

### Revision History

Date	Description of changes	Page(s)
11/23/2018	Clarification added to the following field's on the CMS 1500 form: <ul style="list-style-type: none"> <li>• 24I – Qualifier ZZ if a Taxonomy Code is entered</li> <li>• 24J – Shaded Section – Taxonomy Code</li> <li>• 24J – Unshaded Section – NPI</li> <li>• 33a – NPI</li> <li>• 33b – Taxonomy Code</li> </ul> Note: The previous instruction to include the COB information in the shaded section of 24 J has been removed.	13-17
	The order of the examples in Field 16 was updated, so that midnight (12 a.m.) is now first.	21
	Clarification and examples added to Field 43 on the UB-04 form. Clarification added to the following field's on the CMS 1500 form: <ul style="list-style-type: none"> <li>• 24I – Qualifier ZZ if a Taxonomy Code is entered</li> <li>• 24J – Shaded Section – Taxonomy Code</li> <li>• 24J – Unshaded Section – NPI</li> <li>• 33a – NPI</li> <li>• 33b – Taxonomy Code</li> <li>• Note: The previous instruction to include the COB information in the shaded section of 24 J has been removed.</li> </ul>	23-15



	The ADA 2012 claim form instructions were removed (please refer to the FFS Provider Billing Manual, Chapter 7, Billing on the ADA 2012 Claim Form instructions for this.	35-48
11/1/2018	Examples added to the Type of Bill section. Examples added to the Rev Code section.	18 22-23
10/1/2018	The General Information section was updated regarding HIPAA-compliant 837D transaction process. The section on services the CMS-1500 claim form is used to bill for was updated. The section on services the UB-04 claim form is used to bill for was updated. Clarification added to the General Information section, including that this chapter applies to paper claims only, the preferred font type and size, and information on what can make a claim deny.  Information for the CMS 1500, ADA 2012, and UB-04 regarding fields 24A-J (CMS 1500), 42-48 (UB-04), and 24-31 (ADA 2012) as follows: (the appropriate fields for each form) <b><u>“must be completed on the first page, before proceeding to the second page”</u></b> of the claim. (Please note that only the required fields on <i>all lines</i> will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-4 filled out, but lines 5 and 6 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because <b><u>a second page cannot be submitted unless all lines on page 1 are utilized and completely filled in first.”</u></b>	1 1 2 3  3
10/1/2018	Under the <u>Completing the CMS 1500 Claim Form</u> section:  Reworded the information (no content change) for clarity: <b><u>“Effective 4/1/2014, the revised CMS 1500 (02/12) will be required. Data receipt for 4/1/2014 and forward received with the old CMS 1500 08/05 form will be returned to the provider, regardless of the date of service being billed for on the claim.”</u></b> Examples updated throughout section. Clarification added to field 1a. Clarification added to field 3. Clarification added to field 4. Clarification added to field 5. Clarification added to field 6. Clarification added to field 7. Clarification added to field 9a. Clarification added to field 11d. Clarification added to field 12. Clarification added to field 13.	3-17

10/1/2018	<p>Clarification added to field 17.</p> <p>Field 19 was updated to include a new standard format, that will allow providers to indicate if services were at an FQHC, along with any additional information that may be needed</p> <p>Clarification added to field 21 so it now reads as:</p> <p style="padding-left: 40px;"><b>“ICD Ind. Field:</b> Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p style="padding-left: 40px;">0 = ICD-10-CM 9 = ICD-9-CM (no longer accepted)</p> <ul style="list-style-type: none"> <li>▪ If this field is left blank the claim will be returned to the provider for correction. Please ensure it is filled out correctly.</li> </ul> <p style="padding-left: 40px;">Enter the ICD indicator between the vertical, dotted lines in the upper-right hand area of the field. “</p> <p>Clarification added to field 22. It was updated to read as 7 or 8 rather than A or V.</p> <p>Clarification added to field 23. “The AHCCCS claims system will automatically match claims to approved prior authorization (PA) requests when the claim is submitted. This means that if there is an existing PA on file, when the claim is submitted it will automatically match and process. See Chapter 6, Authorizations, of the IHS/Tribal Provider Billing Manual for information on prior authorization.”</p> <p>A NOTE regarding field 24 (A-J) and multi-page claim submissions. It now reads: “If a claim will be submitted with multiple pages (a multi-page claim) then <b><u>all lines (1-6) under field 24 (A-J) must be completed on the first page, before proceeding to the second page</u></b> of the claim. (Please note that only the required fields on <i>all lines</i> will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-4 filled out, but lines 5 and 6 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because <b><u>a second page cannot be submitted unless all lines on page 1 are utilized and</u></b></p>	
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10/1/2018	<p style="text-align: center;"><b><u>completely filled in first.</u></b></p> <p>Clarification added to field 24.  Clarification added to field 24A.  Clarification added to field 24B.  Clarification added to field 24C.  Clarification added to field 24D.  Clarification added to field 24E. The following was added: "Do not separate letters with commas."  Clarification added to field 24J.  Clarification added to field 25.  Clarification added to field 28.  Clarification added to field 31.  Clarification added to field 32b.  Clarification added to field 33b.</p> <p>Under the <u>Completing the UB-04 Claim Form</u> section:</p> <p>Examples updated throughout section.  Clarification added to field 1.  Clarification added to field 2.  Clarification added to field 3a.  Clarification added to field 3b.  Clarification added to field 4.  Clarification added to field 5.  Clarification added to field 6.  Clarification added to field 7.  Clarification added to field 8.  Clarification added to field 9.  Clarification added to field 10.  Clarification added to field 11.  Clarification added to field 12.  Clarification added to field 13.  Clarification added to field 14. The following was added: "This is required for all claims. Enter the code that best describes the member's status for this billing period. See the <i>UB-04 Manual</i> for codes.</p> <ul style="list-style-type: none"> <li>• 1 for Emergency</li> <li>• 2 for Urgent</li> <li>• 3 for Elective</li> <li>• 4 for Newborn</li> <li>• 5 for Trauma"</li> </ul> <p>Clarification added to field 15.</p>	17-30
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<p>10/1/2018</p>	<p>Clarification added to field 16 (examples added).          Clarification added to field 17.          Clarification added to field 18-28.          Clarification added to field 29.          Clarification added to field 39-41.          Clarification added to field 42.          Clarification added to field 43.          Clarification added to field 44.          Clarification added to field 47. The following clarification was added:          “Total charges are obtained by multiplying the units of service by the unit charge for each service. Each line other than the sum of all charges may include charges up to \$999,999.99.</p> <p style="padding-left: 40px;">In line 23, the total charges are represented by revenue code 0001. In Field 47, the total charges must be the last entry. Total charges on one claim cannot exceed \$999,999,999.99.</p> <p style="padding-left: 40px;">On the UB-04 form also indicate the corresponding page number of the claim.</p> <p style="padding-left: 80px;">Note: For multi-page claims, <b><u>all lines (1-22) must be completed on the first page, before proceeding to the second page</u></b> of the claim. AHCCCS has received claims where page 1 has had lines (for example) 1-20 filled out, but lines 21 and 22 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because <b><u>a second page cannot be submitted unless all lines on page 1 are utilized and filled in first.</u></b>”</p> <p>Clarification added to field 50 and 50 (A-C)          Clarification added to field 51.          Clarification added to field 52.          Clarification added to field 53.          Clarifications added to fields 55 – 59.          Clarification added to field 60 A.          Clarification added to field 61.          Clarification added to field 63.          Clarification added to field 64.          Clarification added to field 66. The following was added: “<b>Note: ICD Ind. Field:</b> Enter the applicable ICD indicator to identify which version of ICD codes is being reported.              0 = ICD-10-CM              9 = ICD-9-CM (no longer accepted)              ▪ If this field is left blank the claim will</p>	
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10/1/2018	<p style="text-align: right;">be returned to the provider for correction. Please ensure it is filled out correctly.”</p> <p>Clarification added to field 67. Clarifications added to fields 69 -72. Clarification added to field 74. The following information was added: <b><u>“For fields concerning provider information:”</u></b></p> <p style="padding-left: 40px;">After January 1<sup>st</sup>, 2016, if a provider is not enrolled with AHCCCS as a valid and/or active provider, claims will deny. All providers, including but not limited to out-of-state providers, attending and servicing providers both within and outside of a hospital setting, and billing providers must be registered with AHCCCS in order to be reimbursed for covered services provided to AHCCCS members. This applies to <i>all</i> providers, including attending providers.</p> <p style="padding-left: 40px;">For additional information on this requirement, refer to Chapter 3, Provider Records and Registration, of the IHS/Tribal Provider Billing Manual.”</p> <p>Clarifications added to fields 76-81A.</p> <p>Under the <u>Completing the ADA 2012 Claim Form</u> section:</p> <p>Examples updated throughout section. Individual Section ‘images’ added. Clarifications added to fields 1-15. (Names of fields were updated to match the ADA 2012 Claim Form and descriptions of what each field is had additional information added to them). Clarifications added to fields 19-23. <b><u>The following was added: “Record of Services Provided Section”</u></b></p> <p><b>A NOTE regarding multi-page claims and fields 24-31:</b></p> <p style="padding-left: 40px;">If a claim will be submitted with multiple pages (a multi-page claim) then <b><u>all lines (1-10) under fields 24-31 must be completed on the first page, before proceeding to the second page</u></b> of the claim. (Please note that only the required fields on <i>all lines</i> will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-8 filled out, but lines 9 and 10 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission,</p>	30-44
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10/1/2018	<p>because <b><u>a second page cannot be submitted unless all lines on page 1 are utilized and completely filled in first.</u></b></p> <p>Clarification added to field 25. The following was added: “Enter the code for the area of the oral cavity. Consult ANSI/ADA/ISO Specification No. 3950 <i>Designation System for Teeth and Areas of the Oral Cavity</i> for codes.</p> <p>Report the applicable area of the oral cavity when the procedure code nomenclature includes a general reference to an arch or quadrant, such as D4263 bone replacement graft-first site in quadrant.</p> <p>Do not report the applicable area of the oral cavity when the procedure either:</p> <ol style="list-style-type: none"> <li>1) Incorporates a specific area of the oral cavity in its nomenclature, such as D5110 complete denture-maxillary; or</li> <li>2) Does not relate to any portion of the oral cavity, such as D9220 deep sedation/general anesthesia for the first 30 minutes.”</li> </ol> <p>Clarification added to field 27. The following was added: “Enter the tooth number when the procedure directly involves a tooth</p> <p>If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines of the claim form. There are 10 lines on the ADA claim form and multiple pages of the ADA 2012 claim form may be used if needed.</p> <p>When using “JP” (ADA’s Universal/National Tooth Designation system) use only 1 letter to indicate the tooth.</p> <p>When using “JO” (ANSI/ADA/ISO Specification No. 3950) use <b><u>two</u></b> digits to indicate the tooth system. If a procedure is done to tooth 1 enter in 01. If a procedure is done to tooth 2, enter 02. <b><u>Failure to list the tooth number in a two digit format can result in return of the claim to the provider or denial.</u></b></p> <p>Clarification added to field 28. Clarification added to field 30. Clarification added to field 32. Clarification added to field 34. The following was added: <b><u>“When an applicable dental claim requires a diagnosis</u></b></p>	
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10/1/2018	<p><b><u>code, it must be submitted using an ICD-10 diagnosis code. Claims with an ICD-9 diagnosis code will be denied.</u></b></p> <p>Clarification added to field 35. The following was added: “Any additional information required for the processing of a claim that is not found in another field shall be entered under remarks.</p> <p style="text-align: center;">The standard format is as follows (with parentheses removed):</p> <p style="text-align: center;">(Replacement/Void Indication Status)\(CRN)\(Emergency Status Indication of Y for Yes or N for No)\(FQHC Indicator)\(Any other additional information)</p> <p>Enter the appropriate code (“7” or “8”) to indicate whether the claim is a replacement (resubmission/7) of a denied or paid claim, an adjustment of a previously paid or denied claim (7), or a void (8) of a paid claim. Enter the AHCCCS Claims Reference Number (CRN) for the denied or paid claim that you want to replace.</p> <p>Claims that are being submitted for the first time (original submissions) will not have any number or CRN entered here.</p> <p>Any claim that is submitted with <b>only</b> a CRN number and no indication of whether it is a replacement or void (with a 7 or 8) will be processed as an <b>original</b> claim submission, which can cause the claim to deny as a duplicate.</p> <p><b><u>See Chapter 4, General Billing Rules, for information on replacements, adjustments, and voids.</u></b></p> <p>If the claim is a replacement of a previously submitted claim or a request to void a claim, has a previous CRN number, or is a claim for emergency dental than the remarks section should <i>begin</i> with the following standard format, separated by backslashes:</p> <p style="text-align: center;">7 or 8 to indicate if the claim is a replacement or void (enter 7 for a replacement and 8 for a void), followed by the CRN, followed by a Y (to indicate emergency dental) or N (to indicate it was <i>not</i> emergency dental).</p>
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10/1/2018	<p>For example, if a provider was submitting:</p> <ul style="list-style-type: none"> <li>○ A replacement claim for an emergency dental visit, for a member over 21 years of age, the remarks section would begin with <b><u>7CRNY</u></b>.</li> <li>○ A request to void a previous claim, that was for a non-emergency dental visit, for a member under 21 years of age, then the remarks section would begin with <b><u>8CRNN</u></b>.</li> <li>○ An original claim for an emergency dental visit, for a member over 21 years of age, would have the remarks section <b>begin</b> with <b><u>Y</u></b>. There would be no number (7 or 8) or CRN since it would be an <b>original claim</b>.</li> </ul> <p>The CRN and the original reference number are the same.</p> <p>If the provider is an FQHC and the claim is for a professional practitioner it must be indicated here. To indicate this in a manner that will allow the claims system to read it, it must be entered in <b><u>after the CRN format described above and separated by a backslash</u></b> in the following format (with the parentheses removed):</p> <p style="text-align: center;">(Replacement/Void Indication Status)\(CRN)\(Emergency Status Indication of Y for Yes or N for No)\(FQHC Information in the Standard FQHC Format)</p> <p>In the remarks section, for FQHC professional claims, the claims processing system is only able to accept <i>one</i> provider name at a time. If two providers are providing services to a member at the FQHC, please see Chapter 10, Addendum FQHC/RHC, for additional information. The standard FQHC format is as follows:</p> <ul style="list-style-type: none"> <li>▪ If the provider has a NPI: XXNPIProviderName; or</li> <li>▪ If the provider does not have a NPI: 999999999ProviderName             <ul style="list-style-type: none"> <li>• Example: XX1234567890Smith, Hillary</li> </ul> </li> </ul> <p>For additional information on how to indicate that the provider is an FQHC please see Chapter 10 Addendum, FQHC/RHC, of the Fee-For-Service Provider Billing Manual.</p> <p>Any additional information should be entered in <b><u>after</u></b> this standard format of (with parentheses removed):</p>
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	<p style="text-align: center;">(Replacement/Void Indication Status)\(CRN)\(Emergency Status Indication of Y for Yes or N for No)\(FQHC)\(Additional information here)</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>○ An FQHC provider is submitting an original claim that is not a dental emergency. N\XX1234567890Smith, Andrew</li> </ul> <p style="padding-left: 40px;">If this provider had additional information to add after the FQHC indicator, then another backslash would be needed after the provider name. N\XX1234567890Smith, Andrew\Additional information here</p> <ul style="list-style-type: none"> <li>○ An FQHC provider is billing for a replacement claim of a previous submission. It was for a dental emergency 7\CRN\Y\XX1234567890Smith, Hillary</li> </ul> <p style="padding-left: 40px;">If this provider had additional information to add after the FQHC indicator, then another backslash would be needed after the provider name. 7\CRN\Y\XX1234567890Smith, Stacy\Additional information here</p> <p style="padding-left: 40px;">For questions on this field please outreach the provider training e-mail inbox at <a href="mailto:ProviderTrainingFFS@azahcccs.gov">ProviderTrainingFFS@azahcccs.gov</a>.”</p>	
10/1/2018	<p>Clarifications added to fields 36-40.</p> <p>Clarification added to field 42. The following was added: “Enter the total number of months required to complete the orthodontic treatment.</p> <p>Note: This is the total number of months from the start of the treatment to the end of the treatment. Some versions of the claim form incorrectly include the word “Remaining” at the end of this data element’s name, however the true number of months to be entered in this field is the total from start to finish.”</p> <p>Clarification added to field 43. The following was added: “Mark the appropriate box. If “Yes” is marked, complete Field 44. This item applies to crowns and all fixed or removable prostheses (e.g., bridges and dentures).”</p>	

	<p>Clarifications added to fields 44-45.  Clarifications added to fields 48-52.  Clarification added to field 53.  Clarification added to field 55.  Clarification added to field 56.  Clarification added to field 56a. The following was added:  “Enter the specialty code that indicates the type of dental professional rendering the treatment (e.g., 1223X0400X for Orthodontics, 1223P0221X for Pediatric Dentistry). The general code listed as “Dentist” may be used instead of other dental practitioner codes.”</p>	
1/16/2018	<p>Clarification that only 1 AIR can be billed per UB-04  Updated UB-04 fields  Formatting</p>	<p>14  All  All</p>
06/03/2016	<p>UB-04 corrections to Fields 44, 46 and 47 as related to NDC billing requirements;  UB-04 Field 61 changed from “FFS” to “AIHP”</p>	<p>13, 14  15</p>
03/31/2016	<p>UB-04 corrections to Fields 64 &amp; 80</p>	<p>16</p>
10/15/2015	<p>Corrections to:  CMS 1500 fields 17, 19, 24  UB-04 field 43, added AHCCCS Pharmacy website address for NDC billing information  UB-04 fields 60, 71, 78, 79, 81  ADA field 35</p>	<p>5, 6  12  14, 15  19</p>
09/17/2015	<p>ICD-9 changed to “ICD”  ADA Form CHANGE: based on ADA manual, ICD diagnosis codes and related fields are “Required if Applicable”</p>	<p>All  18, 19</p>
12/01/2014	<p>Correction: added “Inpatient” to read “<i>Inpatient</i> Title XXI (KidsCare) members”</p>	<p>1</p>
05/29/2014	<p>New formatting  Updated ADA form to 2012 version</p>	<p>All</p>

