WELCOME TO TRAINING!

• Non-emergency Medical Transportation (NEMT)
• 5010 Online Claim Submission (1500 Form Type)
• Transaction Insight (TI) Portal 275 Attachments
• Daily Trip Reports
AHCCCS WEBSITE

Welcome to Arizona Health Care Cost Containment System (AHCCCS)

Arizona Health Care Cost Containment System (AHCCCS) is Arizona’s Medicaid agency that offers health care programs to serve Arizona residents. Individuals must meet certain income and other requirements to obtain services.

Reaching across Arizona to provide comprehensive quality health care for those in need
About AHCCCS Online Providers

AHCCCS Online is an AHCCCS website designed for registered providers. It provides online services, including:

- Fee-For-Service (FFS) Claims Status
- Fee-For-Service (FFS) Claims Submissions
- Health Plan Member Address Updates
- Member Eligibility and Enrollment Verifications
  - Phone Verifications:
    - Maricopa County: 602-417-7200
    - Outside of Maricopa County, within Arizona: 1-800-331
- Newborn Notifications
- Prior Authorization Inquiries
- Provider Information
  - Correspondence address updates
  - Demographic information (view only)
  - Group affiliations (view only)
  - Authorized signatures (view only)
- Provider Verifications (view only)
  - Provider enrollment
  - Provider business addresses
  - Medical services offered

Note: AHCCCS Fee-For-Service Technical Assistance Documents help registered AHCCCS providers use the AHCCCS Online website.

AHCCCS Provider Registration:

For more information about registering as a provider with AHCCCS, please visit the AHCCCS Provider Registration page.

Non-Emergency Medical Transportation Provider Training:

- Providers registering with AHCCCS as a non-emergency medical transportation provider (provider type 28) completing Provider Participation Agreement's on or after 7/1/13 must complete the online training module and submit the training certificate in order for their applications to be processed.
- Launch the training

NEMT Billing Instructions & Exhibits for FFS:

- Chapter 14: Transportation Services
  - Exhibit 14-1, Daily Trip Report
  - Exhibit 14-2, Non-emergency Medical Transport Daily Trip Report Instructions

NEMT Billing Instructions & Exhibits for IHS:

- Chapter 11: Transportation Services
  - Exhibit 11-1, Daily Trip Report
  - Exhibit 11-2, Non-emergency Medical Transport Daily Trip Report Instructions

NEMT Provider & Process Changes:

- At this time AHCCCS is currently in the process of consultation with the Tribes to pursue the development of an RFP for a Transportation Broker and as such AHCCCS is not expanding the Non-Emergency network at this time. AHCCCS will continue to post updated developments to the website regarding Non-emergency Transportation Providers.
- Revised Provider Profile for NEMT Provider Type Effective April 1, 2014.
What is NEMT?

• **NEMT** stands for **Non-Emergency Medical Transportation**

• AHCCCS covers medically necessary non-emergency ground ambulance and air transportation to and from a required, covered medical service for most recipients. Non-emergency transportation is not covered for Emergency Services Program recipients.

• **NEMT** providers must be **AHCCCS Registered Providers**

• Provider registration and a list of requirements can be found on the AHCCCS web site.
The AHCCCS Provider Participation Agreement for NEMT providers requires that Provider Registration be notified within 30 days of any updates and/or changes to:

- Fleet vehicles list
- Current registration for each fleet vehicle listed
- Current insurance coverage for each fleet vehicle listed
- Employed drivers

The Quarterly QC audits for NEMT claims will now include verifying fleet vehicle, registration, insurance and employed drivers from the information submitted on the claim’s trip report. If the trip report information does not match to Provider Registration documentation an audit error will be charged. Audit letters of finding will be sent out to providers detailing deficiencies in the Provider Registration files for the claim audit errors. The provider must submit the updated documentation to Provider Registration to avoid audit error recoupment.

Refer to the Provider Registration webpage for the NEMT Provider Profile form at https://www.azahcccs.gov/PlansProviders/Downloads/NonEmergencyTransportationProvider.pdf
Mandatory requirements for NEMTs

NEMT updates on changes can be found on the website.

### PROVIDER TYPE PROFILE

<table>
<thead>
<tr>
<th>PROVIDER TYPE</th>
<th>28</th>
<th>NON-EMERGENCY TRANSPORTATION PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>REIMBURSEMENT TYPE</td>
<td>02</td>
<td>FEE FOR SERVICE</td>
</tr>
<tr>
<td>CATEGORY OF SERVICE</td>
<td>LICENSE/CERTIFICATION</td>
<td></td>
</tr>
<tr>
<td>MANDATORY</td>
<td>31</td>
<td>NON-EMERGENCY TRANSPORTATION</td>
</tr>
<tr>
<td>PROOF OF VEHICLE INSURANCE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPY OF ONLINE TRAINING CERTIFICATE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPY OF REGISTRATION FOR EACH VEHICLE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COMPANY’S NAME AND LOGO MAST BE ON ALL VEHICLES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPY OF CPR AND FIRST AID CARD FOR EACH DRIVER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COMPLETED DRIVER INFORMATION PROFILE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIPAA TRAINING ANNUALLY, PROOF WILL BE VERIFIED ON SITE VISIT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SERVICES PROVIDED ON RESERVATION MUST SUBMIT COPY OF TRIBAL BUSINESS LICENSE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TAXI COMPANIES MUST SUBMIT A COPY OF THEIR LICENSE FROM THE DEPARTMENT OF WEIGHTS AND MEASURES</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### NON EMERGENCY DRIVER INFORMATION

**List of Employees**

*ALL FIELDS ARE MANDATORY*

- **SSN is optional**

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name, Middle Initial:</th>
<th>SSN (optional):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment Begin Date:</td>
<td>Employment End Date:</td>
<td>Date of Birth: (MM/DD/YYYY)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name, Middle Initial:</th>
<th>SSN (optional):</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Employment End Date:</td>
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<td>Employment End Date:</td>
<td>Date of Birth: (MM/DD/YYYY)</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Last Name:</th>
<th>First Name, Middle Initial:</th>
<th>SSN (optional):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment Begin Date:</td>
<td>Employment End Date:</td>
<td>Date of Birth: (MM/DD/YYYY)</td>
</tr>
</tbody>
</table>

**SPECIAL INSTRUCTIONS:** ALL NON-EMERGENCY TRANSPORTATION SERVICES GREATER THAN 100 MILES REQUIRE PRIOR AUTHORIZATION. FOR PRIOR AUTHORIZATION OF ITS CLAIMS, CALL 1-800-433-8425

**REVIEWED:** 04/02/2014

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*Reaching across Arizona to provide comprehensive quality health care for those in need*
5010 Online Claim Submission

Claim Type Professional (15000 Form Type)
Thank you for visiting AHCCCS Online. In order to use the site, you must have an active account. Please login or register a new account. For questions, please contact our Customer Support Center at (602) 417-4451.

**ATTENTION - SHARING ACCOUNTS IS PROHIBITED!**

Please remember that sharing account logins is prohibited and violates the AHCCCS User Acceptance Agreement. You should NOT share your username and password with any other individuals. Each user must have their own web account. Access to the web site can be terminated if the User Acceptance Agreement is violated.

AHCCCS Online User Manuals

Sign In

Username
Password
Sign In

Forgot your Password? Click Here

- Passwords are case-sensitive. After 3 failed attempts, within 15 minutes, your account will be locked out, and you will either need to contact your Master Account holder to unlock your account or use the Password Recovery feature.

Your web browser must have JavaScript enabled in order to use AHCCCS Online.
Click on Claim Submission
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.

Enter New Claim

Type of Claim: Professional

Go...

View Claim Processing Status

Submission Date(s): [ ] - [ ]

Go...
Click on the Providers Tab

The submitter screen will come up
The Billing Provider Screen will come up
This is where you will enter the provider or group billing information

If you do not have a valid NPI # Enter your 6 digit AHCCCS provider ID here, and leave the NPI field blank

If you have a valid NPI you must enter it here and leave the Provider Commercial field # blank

Enter the biller or the group tax ID here

Click on SSN = (Social Security Number) or EIN = (Employee Identification Number)

When done entering the data Click the Find Button

Click Person (if the ID number comes up as a person’s name) or Non-person (if the ID comes up with a company’s name)

Do not click Submit
Your provider information should come up here

Now click on the Rendering tab
The Rendering Provider screen will come up
If you do not have a valid NPI # Enter your 6 digit AHCCCS provider ID here, and leave the NPI field blank.

If you have a valid NPI you must enter it here and leave the Provider Commercial field # blank.

When done click on the Find Button.

Click Person (if the ID number comes up as a person’s name)

or

Non-person (if the ID comes up with a company’s name)
After clicking the Find button, the Rendering provider’s Name will appear.

Next click on the Patient/Subscriber tab.
The Patient/subscriber screen will come up, this is where you will enter the members AHCCCS information.
This is where you will enter the information for the AHCCCS member you are billing for.

Enter the members AHCCCS ID and date of birth (MM/DD/YYYY).

Click on the down arrow and make your Payer Responsibility selection.

When done click Find.

See next page.

P = AHCCCS is Primary
U = You don’t know
If you want to send an attachment click the ATTACHMENTS tab.

If no attachments click the CLAIM INFORMATION tab.

When you click the Find button the AHCCCS members information will come up.
### Professional Claim Submission

#### Claim Attachments

**Report Type**

<table>
<thead>
<tr>
<th>Report Type **</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Document Justifying Treatment Beyond Utilization</td>
</tr>
<tr>
<td>2. Drugs Administered</td>
</tr>
<tr>
<td>3. Treatment Diagnosis</td>
</tr>
<tr>
<td>4. Initial Assessment</td>
</tr>
<tr>
<td>5. Functional Goals</td>
</tr>
<tr>
<td>6. Plan of Treatment</td>
</tr>
<tr>
<td>7. Progress Report</td>
</tr>
<tr>
<td>8. Continued Treatment</td>
</tr>
<tr>
<td>9. Chemical Analysis</td>
</tr>
<tr>
<td>10. Certified Test Report</td>
</tr>
<tr>
<td>11. Justification for Admission</td>
</tr>
<tr>
<td>12. Recovery Plan</td>
</tr>
<tr>
<td>13. Allergies/Sensitivities Document</td>
</tr>
<tr>
<td>14. Autopsy Report</td>
</tr>
<tr>
<td>15. Ambulance Certification</td>
</tr>
<tr>
<td>16. Admission Summary</td>
</tr>
<tr>
<td>17. Prescription</td>
</tr>
<tr>
<td>18. Physician Order</td>
</tr>
<tr>
<td>19. Referral Form</td>
</tr>
<tr>
<td>20. Benchmark Testing Results</td>
</tr>
<tr>
<td>21. Baseline</td>
</tr>
<tr>
<td>22. Blanket Test Results</td>
</tr>
<tr>
<td>23. Chiropractic Justification</td>
</tr>
<tr>
<td>24. Consent Form(s)</td>
</tr>
<tr>
<td>25. Certification</td>
</tr>
<tr>
<td>26. Drug Profile Document</td>
</tr>
<tr>
<td>27. Dental Models</td>
</tr>
<tr>
<td>28. Durable Medical Equipment Prescription</td>
</tr>
<tr>
<td>29. Diagnostic Report</td>
</tr>
</tbody>
</table>

**Report Transmission**

- Select Referral Form

**Control Number**

- Required ONLY if attachment information is submitted.

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Click the down arrow

Select B4 Referral Form

Now click the Report Transmission down arrow
Select EL Electronically Only
This is where you would enter the PWK N number

Note:
The PWK number is a unique number that you will create for each claim/document that you submit, this will allow the system to link the attachment to the correct claim. The PWK number is used only when submitting an electronic claim and attachment on the same day.

When done entering the information click the CLAIM INFORMATION tab.

** Required ONLY if Attachment information is submitted.
Example of a PWK number using a member’s AHCCCS ID and the Date of Service

AHCCCS ID (9-character AHCCCS ID) A12345678
The A in AHCCCSID must be in capital letter

Date of Service 08/05/15

PWK for Claim 1, Document 1 A12345678080515

Different AHCCCS ID member with the Same Date of Services

AHCCCS ID (9-character AHCCCS ID) A87654321
The A in AHCCCSID must be in capital letter

Date of Service 08/05/15

PWK for Claim 2, Document 2 A87654321080515

The combination of the member’s AHCCCS ID and the Date of Service is what makes the PWK number unique to each claim.
The Claim Information Screen will come up

### Claim Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Reference Number</td>
<td></td>
</tr>
<tr>
<td>Prior Authorization Number</td>
<td></td>
</tr>
<tr>
<td>* Patient Control Number</td>
<td></td>
</tr>
<tr>
<td>Medical Record ID Number</td>
<td></td>
</tr>
<tr>
<td>Initial Treatment Date</td>
<td></td>
</tr>
<tr>
<td>Date of Current Injury</td>
<td>(Accident)</td>
</tr>
<tr>
<td>** Patient's Condition Related To</td>
<td></td>
</tr>
<tr>
<td>** Place in which accident occurred:</td>
<td>(State)</td>
</tr>
<tr>
<td>Special Program Indicator</td>
<td></td>
</tr>
<tr>
<td>* Provider Signature on File</td>
<td>Yes/No</td>
</tr>
<tr>
<td>* Provider Accept Assignment</td>
<td>Assigned/Not Assigned/Accepted on Clinical Lab Services Only/Not Assigned</td>
</tr>
<tr>
<td>* Benefit Assignment</td>
<td>Yes/No/Not Applicable</td>
</tr>
<tr>
<td>* Release of Information Consent</td>
<td>Informed Consent/Yes</td>
</tr>
<tr>
<td>EPSDT Screening Referral</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

** Required ONLY if "Date of Current Injury" is entered.
*** Required ONLY if "Auto Accident" selected.
Enter the patients account number. If your office doesn’t use one you can enter their AHCCCS ID, their name, etc..

Provider Signature on File; Mark YES if you are a billing agency billing for the provider and you have their signature on file in your office

Provider Accepts Assignments; Click yes if you are accepting payment from AHCCCS

Benefit Assignments; Mark yes if member has indicated that payment should go directly to the provider

Benefit Assignment: Yes No Not Applicable

When done entering the claim information data, click on the Service Lines tab

Release of Information Consent; a signed statement by the patient authorizing the release of medical data to other organizations
Enter the diagnosis’s without the decimal here (up to 12)

Enter the to and from dates of service.

Number of units or minutes.

The HCPCS (procedure code).

When done, click the ADD button. This will clear the screen and allow you to enter a new service line if applicable, the first service line you added will appear at the bottom of the screen.

Click on the down arrow and select the place of service.

If applicable you can enter up to four modifiers.

Click on the Pointer box that correlates to the diagnosis entered in the diagnosis field, if more than one diagnosis was entered click all the boxes that apply.

Note: with date of service 10/01/15 you must select ICD-10.

Note: NEMT providers starting with dates of service 10/01/2015 and forward must use R68.89 instead of 799.9.
When you click on the Add button the first service line will appear at the bottom of the screen as line 1 and the screen will clear allowing you to add another service line if applicable, you can continue to add new service lines by clicking the ADD button after each service line you’ve entered.
Enter the information for service line 2 if applicable and click Add.
This is how it looks with two service lines

<table>
<thead>
<tr>
<th>Line No.</th>
<th>Begin Date</th>
<th>End Date</th>
<th>POS</th>
<th>HCPCS Code</th>
<th>NDC Code</th>
<th>Diag 1</th>
<th>Diag 2</th>
<th>Diag 3</th>
<th>Diag 4</th>
<th>Diag 5</th>
<th>Diag 6</th>
<th>Diag 7</th>
<th>Diag 8</th>
<th>Diag 9</th>
<th>Diag 10</th>
<th>Diag 11</th>
<th>Diag 12</th>
<th>Min. Units</th>
<th>Medicare Paid Amount</th>
<th>Medicare Deductible Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1-1/2014</td>
<td>10-1/2014</td>
<td>99</td>
<td>A0120</td>
<td></td>
<td>2</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1-1/2014</td>
<td>10-1/2014</td>
<td>99</td>
<td>50213</td>
<td></td>
<td>2</td>
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</tbody>
</table>
To edit a line, click on the middle icon.
The screen with the service line that you clicked to edit will come up, make your changes and click the update button.
If you are done adding or editing the claim, click the submit button
You will get the message that it was successful.

You can go to the 275 portal to upload your document by clicking on the attachment link.

Here you will have two choices, View Claims, or Enter New Claims.

Clicking on View Claim will give you a summary of the information that will be sent over to AHCCCS and will allow you to edit the claim if needed.

Clicking on Enter New Claims allows you to enter a new claim.
This is the summary if you click view

To edit the claim click on edit
When you click on enter new claim it takes you to the main screen where you can start entering a new claim.
To view the claims you entered on-line, enter a Single date or a span date and click GO.
### Claim Submission Status

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Submission Date/Time</th>
<th>Patient Account #</th>
<th>Service Prov. NPI</th>
<th>Billing Prov. NPI</th>
<th>Date From</th>
<th>Date Thru</th>
<th>Status</th>
<th>Processing Date/Time</th>
<th>CRN</th>
<th>Adjudication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>06/05/12 12:40 PM</td>
<td>ACCT # TEST</td>
<td>REPLACE</td>
<td></td>
<td>05/15/12</td>
<td>05/13/12</td>
<td>Processed 06/05/12 04:00 PM</td>
<td></td>
<td>121575600003</td>
<td>Denied</td>
</tr>
<tr>
<td>Professional</td>
<td>06/07/12 04:58 PM</td>
<td>REPLACEMENT TEST</td>
<td></td>
<td></td>
<td>05/15/12</td>
<td>05/13/12</td>
<td>Processed 06/08/12 09:44 AM</td>
<td></td>
<td>121605600002</td>
<td>Denied</td>
</tr>
<tr>
<td>Professional</td>
<td>06/18/12 05:19 PM</td>
<td>ACCOUNT NUM NO TPL</td>
<td></td>
<td></td>
<td>06/18/12</td>
<td>06/18/12</td>
<td>Pending</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Record Count: 3
Transaction Insight (TI) Portal
275 Claim Attachments
https://tiwebprd.statemedicaid.us

Entering Provider, Patient and Attachment Detail Information and File

Revised: 8/10/15
Enter Login ID’s and then Click sign-in

Due to scheduled nightly maintenance, files processed after 5:00 p.m. will not be available for viewing in Transaction Insight until the next business day.
* * * NOTICE * * *

Due to scheduled nightly maintenance, files processed after 5:00 p.m. will not be available for viewing in Transaction Insight until the next business day.
Reaching across Arizona to provide comprehensive quality health care for those in need

This screen will appear with a menu to the left

Click on the 275 attachments link

Note: Menu appearance will vary per user
Reaching across Arizona to provide comprehensive quality health care for those in need.
This is the main screen and it’s divided into two parts:

**Part I:** 275 claims attachment upload this is where the attachment is uploaded. This part is done after part II has been completed.

**Part II:** 275 Attachment Details  *(Provider and member information is entered here.)*

*Part II Must be completed before processing to Part I.*
Enter the last name of the person who logged in or the name of the practice (e.g. Lennon’s Clinic)

02-Add = Unsolicited request, this is when a PWK number would be used to submit a claim and the document. A PWK is a unique number you will create to link the claim and document.

11-Response = Solicited, this is when you receive a letter asking for documentation. This is when you would use the CRN to submit the document only and attach it to the claim.
Enter the provider’s last name (e.g. Smith) or the name of the Organization or clinic (e.g. Penney Lane Clinic)

The provider’s first name is optional; you can leave this field blank
**Provider Identifier Type**: Choose Provider ID Type

<table>
<thead>
<tr>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Identifier</td>
</tr>
<tr>
<td>Provider Secondary Identifier</td>
</tr>
</tbody>
</table>

**Example**: If you are billing with a NPI number

If you selected Provider Identifier, you must enter your 10 digit NPI number in this field.

**Note**: If you have a valid NPI and you are billing with it you must select “Provider Identifier” and enter the NPI number.
Reaching across Arizona to provide comprehensive quality health care for those in need

Provider secondary Identifier = AHCCCS 6 digit provider ID number
Chose this if you only have a 6 digit ID and are only billing with it

Example: If you are billing with a Ahcccs 6 digit ID number

Click on the down arrow and make your selection

If you selected Provider Secondary Identifier, you must enter your 6 digit ID number in this field
Reaching across Arizona to provide comprehensive quality health care for those in need

<table>
<thead>
<tr>
<th>275 Claim Attachment Upload</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.</td>
</tr>
</tbody>
</table>

Browse to your file: (maximum file size limit 54MB)

<table>
<thead>
<tr>
<th>275 Attachment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Submitter Last or Organization Name</strong></td>
</tr>
<tr>
<td><strong>Provider Last or Organization Name</strong></td>
</tr>
<tr>
<td><strong>Provider Identifier Type</strong></td>
</tr>
<tr>
<td><strong>Provider Address</strong></td>
</tr>
<tr>
<td><strong>Provider State</strong></td>
</tr>
<tr>
<td><strong>Provider City</strong></td>
</tr>
<tr>
<td><strong>Zip Code</strong></td>
</tr>
</tbody>
</table>

Enter the providers Address, City, State, Zip.
Enter the members AHCCCS ID number here

Enter the patients account number here, if you don’t have one, enter the members AHCCCS ID number here
Using the PWK is an automatic process and the claim will pay quicker, using the CRN is a manual process and can take 2 to 3 weeks to pay- when using a CRN number ONLY, there is no need to re-submit a claim.

**Note:**

02-Add = *Unsolicited request*, this is when a PWK number would be used to submit a claim and the document, A PWK is a unique number you will create to link the claim and document.

11-Response = *Solicited*, this is when you receive a letter asking for documentation, This is when you would use the CRN to submit the document only and attach it to the claim.

This is an optional field and can be left blank.

Enter the PWK number or the CRN here.
Reaching across Arizona to provide comprehensive quality health care for those in need

Enter the begin date of service

Click on the month and date of service

Click on the calendar icon

This field is optional and can be left blank
When done with the 275 attachment details section it should look something like this

275 Claim Attachment Upload

During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.

Browse to your file: (maximum file size limit 64MB)  

Note: At this point do not click the save attachment button, go to the top and click the browse button
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.

<table>
<thead>
<tr>
<th>Submitter Last or Organization Name*</th>
<th>Ahcccs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Last or Organization Name*</td>
<td>Ahcccs</td>
</tr>
<tr>
<td>Provider Identifier Type*</td>
<td>Provider Secondary Identifier</td>
</tr>
<tr>
<td>Provider Address*</td>
<td>701 E jefferson</td>
</tr>
<tr>
<td>Provider State*</td>
<td>Arizona</td>
</tr>
<tr>
<td>Patient Last Name*</td>
<td>Smith</td>
</tr>
<tr>
<td>Patient Primary Identifier*</td>
<td>A99999999</td>
</tr>
<tr>
<td>Medical Record Identification Number</td>
<td></td>
</tr>
<tr>
<td>Claim Service Period Start Date*</td>
<td>10/1/2015</td>
</tr>
</tbody>
</table>

* - Required Fields

Click the "Browse" button.
The file search window will come up

Look for the folder you saved your trip report to, highlight the folder and click open
Reaching across Arizona to provide comprehensive quality health care for those in need
TIBCO Foresight™ Transaction Insight®

Home :: 275 Attachments

Files
275 Attachments

User
My Account

275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.

Browse to your file: (maximum file size limit 64MB)

\nasos05\user\desktop\SAE  Browse...  Upload Attachment

<table>
<thead>
<tr>
<th>275 Attachment Details</th>
<th></th>
<th>Transaction Set Purpose Code*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitter Last or Organization Name*</td>
<td>Ahccoes</td>
<td>11-Response</td>
</tr>
<tr>
<td>Provider Last or Organization Name*</td>
<td>Ahccoes</td>
<td></td>
</tr>
<tr>
<td>Provider Identifier Type*</td>
<td>Provider Secondary Identifier</td>
<td></td>
</tr>
<tr>
<td>Provider Address*</td>
<td>701 E jeffeson</td>
<td></td>
</tr>
<tr>
<td>Provider State*</td>
<td>Arizona</td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Claim Service Period Start Date*</td>
<td>10/1/2015</td>
<td></td>
</tr>
</tbody>
</table>

* - Required Fields

Click the Upload “Attachment” button

The documents location and file name will appear here
If you downloaded the wrong file you can remove it and start over by clicking the "Remove This File" link.
By clicking “Remove This File” the file will be removed and you’ll have to start over by clicking the “Browse” button.
Once you have downloaded the correct file, click the “Upload Attachment” button.
After you click the “Upload Attachment” button you should get the following message:

- Successfully uploaded file: A9999999100115.pdf

Once you have successfully uploaded the correct file, click the “Save Attachment” button.
If successful you will get the following message:

**275 Attachment file and details uploaded successfully.**
How to fill out daily trip reports?

• One ways
• Round trips
• Multi-trips
1. AHCCCS Online
2. Plans/Providers
3. Current Providers
   • Non-Emergency Medical Transportation
4. NEMT Billing Instructions for FFS (exhibit 14-1)
Exhibit 14-2

Non-emergency Medical Transport Daily Trip Report Instructions

Effective 7/1/2013 AHCCCS requires the use of this standard Daily Trip Report format. The upper left area of the form is for the Provider’s name and demographic information.

The drivers must print clearly. Illegible Daily Trip Reports may result in audit error and recoupment.

Original Daily Trip Reports must be completed in pen. If an error is made, draw a single line through the error and print the correct information.

If a recipient’s transport has more than one “stop” or destination, then each trip must be fully documented.

For example:
- Recipient is picked up at home and transported to the doctor’s office (1st trip).
- The doctor gives the recipient a prescription for medication.
- The recipient is transported from the doctor’s office to Walgreen Pharmacy (2nd trip).
- Recipient is returned home (3rd trip).

The Daily Trip Report would have 3 trips documented as indicated.

**Letterhead box:** must have provider’s complete information

**Driver name:** print full name

**Date:** indicate the day of the week (Sa Su M T W Th F) and the month/day/year

**Vehicle #:** license plate # and state (if Provider requires make/model/color details, use space below)

**NOTE:** if driver uses a 2nd vehicle for same date of service use a new Daily Trip Report and indicate (at the bottom right) the page number detail. All pages become the complete Daily Trip Report for the transport services, for that recipient, on that service date.

**Name:** print the AHCCCS recipient’s full name

**Pick-up Time:** clock time including the AM/PM indicator (example: 4:12 AM)

**Pick-up Odometer:** document the actual odometer reading at the pick-up location

**Drop-off Time:** clock time including the AM/PM indicator (example: 4:46 AM)

**Drop-off Odometer:** document the actual odometer reading at the drop-off location

**Trip miles:** subtract the pick-up odometer reading from the drop-off odometer reading = trip miles

**Pick-up physical address:** full address or detailed directions, including name of the village/town

**Drop-off physical address:** full name and address, including name of village/town

**Type of trip:** check the appropriate type

**AHCCCS ID#:** the recipient’s ID number

**Mailing address:** recipient’s full mailing address

**Reason for Visit:** only as much information as the recipient is willing to share

**Name of Escort:** if recipient is traveling with a parent/guardian or attendant, print their full name

**Relationship:** indicate the Escort’s relationship to the recipient

**Driver’s Signature:** each page must be signed and dated

**Page ____ of ____:** indicate each page number and the total number of pages used to document all transports for this driver, this service date.
Important to know about trip reports?

1. Effective 7/1/13 – AHCCCS requires the use of this standard Daily Trip Report format.

2. The letter box in the upper left corner area must have the Provider’s name and demographic information.

3. Driver must enter in their information and vehicle license plate. Enter the day and date of service.

4. The form must be filled out legibly.
   - Errors can be corrected by drawing one line through the mistake and writing the correct information above it.

5. Hand written in PEN (Black or Blue)
**Standard Daily Trip Report**

<table>
<thead>
<tr>
<th>Name of Recipient</th>
<th>Pick up time</th>
<th>Pick up odometer</th>
<th>Drop off time</th>
<th>Drop off odometer</th>
<th>Recipient Signature</th>
<th>Trip miles</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pick up location & address**

**Drop off location & address**

---

**AHCCCS #:**

**Mailing Address:**

**Date of Birth:**

**Reason for Visit:**

**Name of Escort:**

**Relationship:**

---

**AHCCCS #:**

**Mailing Address:**

**Date of Birth:**

**Reason for Visit:**

**Name of Escort:**

**Relationship:**

---

**AHCCCS #:**

**Mailing Address:**

**Date of Birth:**

**Reason for Visit:**

**Name of Escort:**

**Relationship:**

---

This is to certify that the information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.
Driver name: print full name  
Date: indicate the day of the week (Sa Su M T W Th F) and the month/day/year  
Vehicle #: license plate # and state (If Provider requires make/model/color details, use space below)  
NOTE: if driver uses a 2nd vehicle for same date of service, use a new Daily Trip Report and indicate (at the bottom right) the page number detail. All pages become the complete Daily Trip Report for the driver on that service date.
**Ex: ROUND TRIP**

**Same driver**

---

### Driver's Signature: each page must be signed and dated

**Page ___ of ___:** all transports per driver with date of service.
### Ex: ROUND TRIP
2 different drivers

### 1st page – driver one

<table>
<thead>
<tr>
<th>Name of Recipient</th>
<th>Pick up time</th>
<th>Pick up odo meter</th>
<th>Drop off time</th>
<th>Drop off odo meter</th>
<th>Recipient Signature</th>
<th>Trip miles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Smith</td>
<td>9:00am</td>
<td>0001</td>
<td>9:30am</td>
<td>0009</td>
<td>Jane Smith</td>
<td>8</td>
</tr>
</tbody>
</table>

**Pick up location & address:** Safeway store, Sacaton, AZ

**Drop off location & address:** Doctor John, 2345 S Strawberry Fields, Phoenix, AZ 85099

**AHCCCS #:** A999999999

**Mailing Address:** PO Box 1234, Sacaton, AZ 85099

**Date of Birth:** 10/10/10

**Reason for Visit:** Pain in the arm after a fall

**Name of Escort:**

**Relationship:**

---

<table>
<thead>
<tr>
<th>Name of Recipient</th>
<th>Pick up time</th>
<th>Pick up odo meter</th>
<th>Drop off time</th>
<th>Drop off odo meter</th>
<th>Recipient Signature</th>
<th>Trip miles</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pick up location & address**

**Drop off location & address**

**AHCCCS #:**

**Mailing Address:**

**Date of Birth:**

**Reason for Visit:**

**Name of Escort:**

**Relationship:**

---

<table>
<thead>
<tr>
<th>Name of Recipient</th>
<th>Pick up time</th>
<th>Pick up odo meter</th>
<th>Drop off time</th>
<th>Drop off odo meter</th>
<th>Recipient Signature</th>
<th>Trip miles</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pick up location & address**

**Drop off location & address**

**AHCCCS #:**

**Mailing Address:**

**Date of Birth:**

**Reason for Visit:**

**Name of Escort:**

**Relationship:**

---

This is to certify that the information is true and complete. I understand that payment and satisfaction of Federal and State funds by the AHCCCS, and that any false claims, statements or documents, or concealment of prosecuted under applicable Federal or State laws.

**Driver Signature:** John Doe

**Date:** 07/31/13

Page 1 of 2
Ex: ROUND TRIP
2 different drivers

<table>
<thead>
<tr>
<th>Name of Recipient</th>
<th>Pick up time</th>
<th>Pick up odometer</th>
<th>Drop off time</th>
<th>Drop off odometer</th>
<th>Recipient Signature</th>
<th>Trip miles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Smith</td>
<td>10:00am</td>
<td>0011</td>
<td>10:30am</td>
<td>0019</td>
<td>Jane Smith</td>
<td>8</td>
</tr>
</tbody>
</table>

Pick up location & address: Doctor John, 2345 S Strawberry Fields, Phoenix, AZ 85099
Drop off location & address: Safeway store, Sacaton, AZ

Round Trip _____ One Way _____ Mult Stops _____

AHCCCS #: A999999999  Mailing Address: PO Box 1234, Sacaton, AZ 89999
Date of Birth: 10/10/10  Reason for Visit: Pain in the arm after a fall
Name of Escort:  Relationship:  

2nd page – driver two
**Ex: MULTI - TRIP**
Same day, driver, & member.

### Daily Trip Report

**Exh 14-1**

<table>
<thead>
<tr>
<th>Name of Recipient</th>
<th>Pick up time</th>
<th>Pick up odometer</th>
<th>Drop off time</th>
<th>Drop off odometer</th>
<th>Recipient Signature</th>
<th>Trip miles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Smith</td>
<td>9:00am</td>
<td>0001</td>
<td>9:30am</td>
<td>0009</td>
<td>Jane Smith</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pick up location &amp; address</td>
<td>Safeway store, Sacaton, AZ</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drop off location &amp; address</td>
<td>Doctor John, 2345 S Strawberry Fields, Phoenix, AZ 89999</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**AHCCCS #:**

**Mailing Address:** PO Box 1234, Sacaton, AZ 89999

**Date of Birth:**

**Reason for Visit/Diagnosis (Be specific):** Pain in the arm after a fall

**Name of Escort:**

**Relationship:**

<table>
<thead>
<tr>
<th>Name of Recipient</th>
<th>Pick up time</th>
<th>Pick up odometer</th>
<th>Drop off time</th>
<th>Drop off odometer</th>
<th>Recipient Signature</th>
<th>Trip miles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Smith</td>
<td>10:00am</td>
<td>0009</td>
<td>10:30am</td>
<td>0014</td>
<td>Jane Smith</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pick up location &amp; address</td>
<td>Doctor John, 2345 S Strawberry Fields, Phoenix, AZ 89999</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drop off location &amp; address</td>
<td>X-ray United, 2222 EX-ray Rd, Phoenix, AZ 89999</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**AHCCCS #:**

**Mailing Address:**

**Date of Birth:**

**Reason for Visit/Diagnosis (Be specific):** Pain in the arm after a fall

**Name of Escort:**

**Relationship:**

<table>
<thead>
<tr>
<th>Name of Recipient</th>
<th>Pick up time</th>
<th>Pick up odometer</th>
<th>Drop off time</th>
<th>Drop off odometer</th>
<th>Recipient Signature</th>
<th>Trip miles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Smith</td>
<td>11:00am</td>
<td>0014</td>
<td>11:30am</td>
<td>0019</td>
<td>Jane Smith</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pick up location &amp; address</td>
<td>X-ray United, 2222 EX-ray Rd, Phoenix, AZ 89999</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**AHCCCS #:**

**Mailing Address:**

**Date of Birth:**

**Reason for Visit/Diagnosis (Be specific):** Pain in the arm after a fall

**Name of Escort:**

**Relationship:**

This is to certify that the information is true, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal of State laws.

**Driver Signature:** John Doe

**Date:** 08/31/13

**Page:** 1 of 2
**Ex: MULTI - TRIP**

Same day, driver, & member.
### Exh 14-1 DAILY TRIP REPORT

**Driver Name:** John Doe  
**Date:** 07/31/13  
**Vehicle #:** AZ000000  
**Type:** VAN

#### Name of Recipient | Pick up time | Pick up odometer | Drop off time | Drop off odometer | Recipient Signature | Trip miles
---|---|---|---|---|---|---
Jane Smith | 9:00am | 0001 | 9:30am | 0009 | Jane Smith | 8
Jane Smith | 10:00am | 0009 | 10:30am | 0017 | Jane Smith | 8

**Pick up location & address:** Safeway Store, Sacaton, AZ  
**Drop off location & address:** Doctor John, 2345 S Strawberry Fields, Phoenix, AZ 89999

**AHCCCS #:** A99999999  
**Mailing Address:** PO Box 1234, Sacaton, AZ 89999  
**Date of Birth:** 10/10/10  
**Reason for Visit:** Pain in the arm after a fall  
**Name of Escort:**  
**Relationship:**

#### Name of Recipient | Pick up time | Pick up odometer | Drop off time | Drop off odometer | Recipient Signature | Trip miles
---|---|---|---|---|---|---
Jane Smith | 1:00pm | 0020 | 1:30pm | 0030 | Jane Smith | 10

**Pick up location & address:** Safeway Store, Sacaton Az  
**Drop off location & address:** Casa Grande ER

**AHCCCS #:** A99999999  
**Mailing Address:**  
**Date of Birth:** 10/10/10  
**Reason for Visit:** Chest pain  
**Name of Escort:**  
**Relationship:**

---

This is to certify that the information is true, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

**Driver Signature:** John Doe  
**Date:** 07/31/13  
**Page:** 1 of 1
Quick Review – Trip Reports

R/T or O/W or Multi-trip

R/T-2 drivers Multi-trips

Multi-trips
FAQS

Q: Can you use lower case alpha on a PWK number?
A: If you are using the AHCCCS ID in your PWK number, make sure the A is in upper case. For example: A99999999082713

Q: If I have a valid NPI number (10 digit ID) do I have to use it or can I use my 6 digit AHCCCS Provider ID?
A: If you have a valid NPI number you must use it when billing the claim and on the 275 attachment TI portal. If you use your NPI in your claim and use your 6 digit Provider ID in the 275 TI Portal, the attachment will not link and will result in a denied claim.

Q: Can I make correction to the trip report?
A: Original Trip Report must be completed in pen. If an error is made, draw a single line through the error and rescan the trip report.

Q: Is there a file size limitation on the 275 claim attachments?
A: There is a 64 MB file size limit.

Q: Can multiple attachments be loaded at one time?
A: No. You can only upload one attachment/file at a time. However, you can scan multiple pages of trip reports and save this as one file.

Q: How do I reset my password?
A: You can call AHCCCS ISD Customer Support at 602.417.4451 to get your TI Portal password reset.

Q: How do I add other user(s)?
A: Email a request for TI account setup to EDICustomerSupport@azahcccs.gov and required to provide the following: 6 digit AHCCCS Provider ID or 10 digit NPI, Full Name and correct email address.

Q: What size should the document be?
A: 8 ½ by 11

Q: Can you upload color documents?
A: The documents should be in black and white

Q: What should the DPI (resolution) be?
A: They should be 300 DPI
REMINDERS/COMMON ERRORS

• NEVER SHARE YOUR TI PORTAL USERNAME AND PASSWORD. Doing so is a security violation.
  • Any user/staff that will be uploading to TI Portal must email a request for TI account setup to 
    EDICustomerSupport@azahcccs.gov and required to provide the following:
    6 digit AHCCCS Provider ID or 10 digit NPI, Full Name and correct email address
  • Provider Identifier Type:
    – Provider Identifier MUST be the 10 digit NPI Number
    – Provider Secondary Identifier MUST be the 6 digit AHCCCS Provider ID
• 9-character AHCCCS ID, beginning with an A, for example, A12345678
• The PWK submitted in your claim (837) or through AHCCCS Online must be the same PWK (Payer Claim Control Number) 
  entered in TI Upload. This will cause your claim to be denied due to this mismatch of PWK.
• Always verify your data before you click on Save Attachment.
• Always verify that the correct attachment has been selected before you click on Upload Attachment.
• Leave the fields blank if they are not required
• Please be careful when tabbing through the field and make sure you didn’t accidentally hit the space bar. The cursor should 
  always be in the first entry when entering data
• Make sure you subscribe to the 275 Claims Attachment and TI Users Listserv in order to receive important notification 
  pertaining to the 275 process or TI Portal
  – Go to: http://listserv.azahcccs.gov
  – Select the name of the list serv you would like to subscribe to:
    • ISD-275-CLAIMS-ATTACHMENT-L and ISD-EDI-TI-USERS-L (for 275 TI Portal users/info on TI Portal)
    • FFS-ALL-PROVIDERS-L (info from DFSM regarding Claims Processing, Updates, etc)
  – In the menu on the right, select “Join or Leave ListServ name”.
  – Complete the Name and Email address fields and select “Subscribe ListServ name”. An email will be sent to the user to 
    confirm the subscription request. Users wanting to unsubscribe from a particular list can do so by selecting the 
    “Unsubscribe ListServ name” option.
Questions?

Reaching across Arizona to provide comprehensive quality health care for those in need
Thank You.

Reaching across Arizona to provide comprehensive quality health care for those in need