Claims submission using the AHCCCS Online portal.

- Claim Type Professional (1500 Form)
- Claim Type Institutional (UB Form)
- Claim Type Dental (ADA Form)
5010 Online Claim Submission

Claim Type Professional (15000 Form)
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) 417-4431.

** 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 user name 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.
Main Page

For security purposes, your session will be logged out after 15 minutes of inactivity.

AHCCCS Online is an AHCCCS website designed for registered providers. It offers the convenience and efficiency of several online services.

CLAIM STATUS
Claim Status allows providers to check the status of Fee-For-Service claims submitted to AHCCCS. If a recipient is enrolled in a capitated Health Plan, the Health Plan can be contacted for further information. For a listing of the Health Plan contact information, please click on Health Plan Listing.

CLAIM SUBMISSION
Claim Submission allows providers to submit Professional, Dental and Institutional claims to AHCCCS for nightly processing. Claims submitted prior to 4:00 PM on a business day will be processed the following business day. The status of the claims can be viewed online by searching for the claim number. Processing time may take 24-72 hours, depending on the number of claims processed and the time of the submission.

MEMBER VERIFICATION
Eligibility and Enrollment Status allows providers to verify an AHCCCS recipient's eligibility and their enrollment in a Health Plan. Providers can also obtain Medigap coverage information for a recipient.

NEWBORN NOTIFICATION
Newborn Notification allows providers to submit newborn information to AHCCCS during the hours when the COM Center is not available. Status of these submissions will be updated within 48 business hours.

PROVIDER VERIFICATION
Provider Information allows providers to update their correspondence addresses. Providers may also view (but not update) their Service and Pay-To Addresses, signatures, and other information. For further information, please click on AHCCCS Provider Registration.

PROVIDER RE-ENROLLMENT/REVALIDATION
Provider Re-Enrollment/Revalidation allows providers to submit their re-enrollment information electronically. Providers who were registered with AHCCCS prior to the AHCCCS implementation will be required to submit their information. Providers must visit the website to receive a re-enrollment notice. If documents are received prior to the re-enrollment notice, the documents will be processed according to the AHCCCS system requirements. For further information, please click on AHCCCS Provider Re-Enrollment.

PRIOR AUTHORIZATION INQUIRY

1. Select Claims Submission on the Menu
Claim Submission

Claims submitted to AHCCCS prior to 4:00 PM, Monday through Friday, 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...

1. Select Professional in the

2. Click GO...
1. This is the Submitter screen—verify the correct provider information (some providers may have more than 1 ID)

2. Select the Providers tab next
1. This is the Billing Provider screen – fill out all the areas marked by red asterisks

2. Tax ID – enter biller or group tax ID

3. Provider Commercial Number – enter in the 6 digit AHCCCS ID here- if you do not have a valid NPI# leave that field blank

4. CMMS National Provider ID (NPI) – enter valid NPI#, leaving the Provider Commercial Number blank

5. Entity type – select “person” if the id number belongs to a person or “non-person” if a company is identified

6. Click “Find” – provider information should be displayed

7. Select the Rendering Provider tab next
This is the Rendering Provider screen—fill out all areas marked with red asterisks, refer to previous slide since all definitions remain the same.

2. CMMS National Provider ID (NPI) – Enter NPI.

2. Click “Find” – the provider information should be displayed.

3. Select the Referring Provider tab next, if there is a referring provider. Select the Patient/Subscriber tab next, if there is not a referring provider.
Referring Provider Tab – to be filled out only for specific providers

PLease refer to the list below.

The following services require submission of a Referring/Ordering provider:

1. Laboratory, Radiology, Medical and Surgical Supplies, Respiratory DME, Enteral and Parenteral Therapy, Durable Medical Equipment, Drugs (J-Codes), Temporary K and Q codes, Orthotics, Prosthetics, Vision codes (V-codes), 97001-97546

2. Ordering providers must be M.D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Podiatrist, Psychologist or Certified Nurse Midwife.

Here is the link where you can find this information in the AHCCCS Provider Manual:

1. This is the Patient/Subscriber screen—fill out all areas marked with red asterisks.

2. Member ID Number/Date of Birth - Enter the members AHCCCS information (ID and Date of Birth).

3. Payer Responsibility- Enter the Payer Responsibility information by selecting P-Primary.

4. Click “Find” - member information should be displayed.

5. To send an attachment, select the Attachments tab. If you do not have an attachment, select the Claim Information tab. *For today’s training, we will be choosing to send an attachment.*
1. This is the Claim Attachments screen
2. Report Type - Click the ▼ and select B4 – Referral Form
3. Report Transmission - Click the ▼ and select EL – Electronically Only
4. Control Number - Enter the PWK number. We recommend you use the members AHCCCS ID followed by the Date of Service, making sure the “A” in the ID is capitalized (see the next screen for additional information)
5. Select the Claim Information tab
Example of a PWK number using a member’s AHCCCS ID and the Date of Service

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

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)  
The A in AHCCCSID must be a capital letter  
A87654321

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.

PWK? The PWK is a number that you will create for each document you want to submit, this number will allow the system to link the attachment to the appropriate claim. Ensure there are no spaces and you use a capital letter.
1. This is the Claim Information screen—fill out all the areas marked by red asterisks.

2. **Patient Control Number** - Enter the member's AHCCCS ID or Patient Acct Number.

3. **Provider Signature on File**—select “yes” since you are a billing agency & you have the provider’s signature on file.

4. **Provider Accept Assignment** – select “Assigned” if you are accepting payment from AHCCCS.

5. **Benefit Assignment** – select “Not Applicable”.


7. Select the Service Lines tab.
1. This is the Service Lines screen – fill out all areas marked with red asterisks

2. **Diagnosis Code** – Enter ICD-10 Diagnosis Codes, you can enter more than one code

3. **Diagnosis Code Pointers** – Select the number of diagnosis codes you have entered. In our example, we entered 1 diagnosis code and then selected 1 under the Diagnosis Code Pointer

4. **Service Dates** – enter the date service was provided

5. **Line Charges** – enter billing charges per line

6. **Quantity** – enter in units/days

7. **HCPCS Code** – enter the procedure code

8. **Place of Service Code (POS)** – click ▼ and choose from the list

9. **Modifier Code** – if applicable, you can enter up to 4 codes
1. Click Add - when you have entered all information under the Service Line section

2. At the bottom of the screen, the Service Line/s entered will populate, after which the Service Line section fields will clear allowing you to add another service line
The Service Line will allow you to continue to Add more lines unless you click the edit or the remove button.

When you have entered all Service Lines whether you edited or removed items, you will have the option to Update the changes.
1. When you have completed entering all the relevant claim/s information, click Submit.
1. This is the Claim Entry Confirmation screen
2. The Transmission status will let you know the claim was submitted successfully
3. You have 2 options: View Claim to give you a summary of the claim that will be sent to AHCCCS or Enter New Claim
4. Select the “View Claim” button
1. The summary screen will be displayed and you can now review the entire information you entered for this claim.

2. You have the option to edit the claim again or start a new claim.
Enter New Claim – If you enter the “Type of Claim” and click “go” in this area, you will be re-directed back to the main screen.

View Claim Processing Status – If you enter data here by either entering the day of service or by entering a span and click the “go” in this area, you can view the processing status for this claim.

NOTE: You cannot view the processing status of claims submitted by other users.
1. Entering a span of months allows you to see previous claims submitted. These are only snapshots of the claims.

2. You have the option to view the Claim Processing Status by entering the day of service or enter a span.
Questions?
5010 Online Claim Submission

Institutional (UB Form)
Claim Submission

Claims submitted to AHCCCS prior to 4:00 PM, Monday through Friday, 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: Institutional

**View Claim Processing Status**

Submission Date(s):  -  

1. **Enter New Claim – Select Institution on the**
2. **Click on “Go”...**
This is the Submitter screen—verify the correct provider information (some providers have more than 1 ID)

Select the Providers tab next
1. This is the Billing screen – fill out all the areas marked by red asterisks.

2. Tax ID – enter biller or group tax ID.

3. CMMS National Provider ID (NPI) – enter valid NPI#, leaving the Provider Commercial Number blank (Hospital or facility can only bill using the NPI number).

4. Entity type – select “non-person”.

5. Click Find – either hospital or facility information should be displayed.

6. Select the Referring tab next.
1. This is the Referring Provider screen
2. CMMS National Provider ID— Enter NPI number
3. Click Find – the Referring Provider information should be displayed
4. Select the Attending Provider tab next
1. This is the Attending Provider screen – required for Institutional/UB
2. National Provider ID (NPI) - Enter NPI number
3. Click Find – the Attending Provider information should be displayed
4. Select the Patient/Subscriber tab next
1. This is the Patient/Subscriber screen – fill out all the areas marked by red asterisks.
2. Member ID number/Date of Birth – Enter the members AHCCCS ID and date of birth.
3. Payer Responsibility – select P-Primary.
4. Click Find – member information should be displayed.
5. Select the Codes/Values tab next.
**Institutional Claim Submission**

<table>
<thead>
<tr>
<th>Submitter</th>
<th>Providers</th>
<th>Patient/Subscriber</th>
<th>Other Payer</th>
<th>Codes/Values</th>
<th>Attachments</th>
<th>Claim Information</th>
<th>Service Lines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Codes</td>
<td>Diagnosis Codes</td>
<td>Condition Codes</td>
<td>Occurrence Codes</td>
<td>Value Codes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Procedure Information**

<table>
<thead>
<tr>
<th><strong>Principal Code/Date:</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code</strong></td>
<td><strong>Date</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
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<tr>
<td>11</td>
<td></td>
<td></td>
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<tr>
<td><strong>Other Procedures (1-12):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
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<tr>
<td>12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Required ONLY if Procedure Code is submitted.*

1. **This is the Codes/Values screen**
2. **Principal Code/Date** – If billing for inpatient, enter procedure code/s and date
3. **Select the Diagnosis Codes tab next**
Institutional Claim Submission

<table>
<thead>
<tr>
<th>Diagnosis Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Principal Diagnosis Code:</strong> R6889</td>
</tr>
</tbody>
</table>
| Present on Admission: 
  ▼ |
| Admitting Diagnosis Code: |
| External Cause of Injury Codes (1-12):  |
| 1  | 2  | 3  | 4  |
| 5  | 6  | 7  | 8  |
| 9  | 10 | 11 | 12 |

<table>
<thead>
<tr>
<th>Code</th>
<th>Present on Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>▼</td>
</tr>
<tr>
<td>3</td>
<td>▼</td>
</tr>
<tr>
<td>5</td>
<td>▼</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>2</td>
<td>▼</td>
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<tr>
<td>4</td>
<td>▼</td>
</tr>
<tr>
<td>6</td>
<td>▼</td>
</tr>
</tbody>
</table>

1. This is the Diagnosis Codes tab
2. Principal Diagnosis Code – Enter the Principal Diagnosis Code
3. For the rest of the fields on this screen, enter information if they apply to you
4. Select the Claim Information tab next
### Claim Information

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>This is the Claim information screen</strong> – fill out all the areas marked by red asterisks</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>Provider Accept Assignment</strong> – select “Assigned” if you are accepting payment from AHCCCS</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><strong>Benefit Assignment</strong> – select “Not Applicable”</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td><strong>Release of Information Consent</strong> – select “Informed Consent” if a signed consent by the patient to release medical data is on file</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td><strong>Patient Control Number</strong> – Enter patients acct # or AHCCCS ID depending on your office</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td><strong>Patient Status</strong> – click the ▼ and choose from the list</td>
<td></td>
</tr>
</tbody>
</table>

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**Admission Type:**

**Admission Date:**

**Admission Time:**

**Discharge Time:**

**Statement From/To Date:**

**Claim Form Bill Type:**

**Medical Record ID #:**

**Original Reference #:**

**Prior Authorization #:**

**Location:**

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**AHCCCS**

Arizona Health Care Cost Containment System

Reaching across Arizona to provide comprehensive quality health care for those in need
Continuation in the Claim information screen

7. Total Claim Charge Amount – Enter the total charges from the whole claim

8. Facility Type Code – click the ▼ and choose from the list

9. Standard – select ICD-10

10. If inpatient – Enter Admission type - click the ▼ and choose from the list

11. If inpatient – Enter Admission date – Enter the date the member was seen

12. If inpatient – Enter Admission/Discharge time

13. Statement From/To Date – Enter span date or single date

14. Select the Service Lines tab next
1. This is the Service Lines screen - fill out all the areas marked by red asterisks
2. Service Dates – Enter the date(s) of service
3. Revenue Code – Enter a Revenue Code
4. Service Unit Count – enter the unit or days you are billing
5. Line Item Charge Amount – Enter the dollar amount that will be charged to the line billed
6. Click Add to complete the entry - you can enter additional lines, if needed
1 All added lines will appear at the bottom of the screen

2 Click Submit if you are done

Reaching across Arizona to provide comprehensive quality health care for those in need
This is the Claim Entry Confirmation screen

The Transmission status will let you know the claim was submitted successfully.

You have 2 options: View Claim to give you a summary of the claim that will be sent to AHCCCS or Enter a New Claim.
Questions?

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

Claim Type Dental (ADA Form)
Enter New Claim – Select Dental in the ▼

Click on “GO”...
1. This is the Submitter screen—verify the correct provider information (some providers have more than 1 ID)

2. Select the Providers tab next
This is the Billing Provider screen – fill out all the areas marked by red asterisks

1. **Tax ID** – enter biller or group tax ID
2. **CMMS National Provider ID (NPI)** – enter valid NPI#, leaving the Provider Commercial Number blank
3. **Entity type** – select “person” if the ID belongs to a person, or “non-person” if a company is identified
4. **Health Care Provider Taxonomy Code** (When/if required depending on service)
   http://www.healthlink.com/tech_tip_taxonomy_code.asp
5. Click Find – provider information should be displayed
6. Select the Patient/Subscriber tab next
Dental Claim Submission

1. This is the Patient/Subscriber screen – fill out all the areas marked by red asterisks
2. Member ID Number/Date of Birth – Enter members AHCCCS ID and Date of Birth
3. Payer Responsibility – Select a Payer Responsibility using the ▼ P - Primary
4. Select the Claim Information tab next
1. This is the Claim Information screen – fill out all the areas marked by red asterisks.

2. Patient Control Number – Enter the members AHCCCS ID or Patient Acct Number.

3. Place of Service – click the ▼ and choose from the list.

4. Provider Signature on File – select “yes” if you are a billing agency & you have the provider’s signature on file.

5. Provider Accept Assignment – select “Assigned” if you are accepting payment from AHCCCS.


7. Release of Information Consent – select “Informed Consent” if a signed consent by the patient to release medical data is on file.

8. Select the Service Lines tab.
This is the Service Lines screen – fill out all the areas marked by red asterisks and additional information required specifically for Dental Claims (i.e. Principal Diagnosis code, Diagnosis Code Pointer, tooth number, and tooth surface).

1. Principal Diagnosis Code – Enter Principal Diagnosis Code
2. Service Date – Enter Service Date
3. ADA Procedure Code – Enter ADA Procedure Code
Continuation in the Service Lines screen

5. Tooth Number – Enter Tooth Number

6. Tooth Surface – click the ▼ and choose from the list as needed for 1 through 5

7. Diagnosis Code Pointer – Select Principal

8. Click Add to complete the entry - you can enter additional lines, if needed
1. Click “Add” when you have completed entering all information under the Service Line section.

2. At the bottom of the screen, the Service Line/s entered will populate, after which the Service Line section fields will clear allowing you to add another service line.

3. When the claim is completed, click Submit.
This is the Claim Entry Confirmation screen

The Transmission status will let you know the claim was submitted successfully.

You have 2 options: View Claim to give you a summary of the claim that will be sent to AHCCCS or Enter a New Claim.
Questions?
Contact Information and Survey Link

ProviderTrainingFFS@azahcccs.gov

Claim Customer Service 602-417-7670
  Option 4 – Claims
  Option 5 – Provider registration
  Option 6 – Fee For Service

Please take a few minutes to complete a survey on today’s training session. We appreciate your feedback. Here is the survey link:
https://www.surveymonkey.com/r/CLBKXF6
Thank You.