

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

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HOME	AHCCCS INFO	MEMBERS/APPLICANTS	PLANS/PROVIDERS	AMERICAN INDIANS	RESOURCES	FRAUD PREVENTION	CRISIS?	
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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

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	Arizo		CS S		Coogle" (Justom Search	Q	
	HOME	AHCCCS INFO	MEMBERS/APPLICANTS	PLANS/PROVIDERS AMERICA	N Request (EMCR)	l .	post date.	אוצי חיסוד חוסריב נחמוד סוופי נחוסים. דווא וואר שווי סיב טףטמנפט חוסחנדווץ מחע שווי חוכוטעפי נחפי חוסאר דפנפחו
					Self Directed Attendant Ca	re	Tribal Business Lice	ense list 📆
	AH	CCCS Onlir	ne	Current Providers	Direct Care Workers	Ð	NEMT Billing	a Instructions & Exhibits for FFS:
	Hea	alth Plans		Provider Reenrollment	Nursing Facility Information	n	• Chapter 14: 🃆 Tra	ansportation Services
	MCO	Update Meetings		CRS Referrals ALTCS Electronic Member Cha	n Hospital Assessment		 Exhibit 14-1 Exhibit 14-2 	🃆 , Daily Trip Report ————————————————————————————————————
	Minin Repo	num Subcontract rting Third-Party	Provisions Liability	(EMCR) Self Directed Attendant Care	Provider Survey		EAHOR IT 2	k non emergency neurear mansport bury mp report and decisions
	ALTC (EMC	S Electronic Mem	ber Change Request	Direct Care Workers Nursing Facility Information	Non-Emergency Medical		NEMT Billing	g Instructions & Exhibits for IHS:
	Solici	itations & Contrac	ts	Hospital Assessment	Transportation		Chapter 11 1: Tra	ansportation Services
					EHR Incentive Program	Ð	• Exhibit 11-1 • Exhibit 11-2	ж, Daily Trip Report
	Abo	out Al	ICCCS O	nline Prov	Data Access	Ð	NEMT Provi	der & Process Changes:

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

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

Guides - Manuals - Policies

Rates and Billing

Pharmacy

Revised Provider Profile for NEMT Provider Type Effective April 1, 2014 1. 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.

· At this time AHCCCS is currently in the process of consultation with the Tribes to pursue the development of an 'RFP

will continue to post updated developments to the website regarding Non-emergency Transportation Providers.

for a Transportation Broker and as such AHCCCS is not expanding the Non-Emergency network at this time. AHCCCS

Launch the training

AHCCCS Provider Registration:

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

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

nsive

website.

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.



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NEMT Provider Registration records update

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



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Mandatory requirements for NEMTs

NEMT updates on changes can be found on the website.

PROVIDER	28	28 NON-EMERGENCY TRANSPORTATION PROVIDERS					
REIMBURSE- MENT TYPE	02		FEE FOR SERVICE EFFECTIVE 10-01-82				
CATEG	ORIES	OF SERVICE	LICENSE/CERTIFICATION				
MANDATORY	31	NON-EMERGENCY	PROOF OF VEHICLE INSURANCE				
		TRANSPORTATION	COPY OF ONLINE TRAINING CERTIFICATE				
			COPY OF REGISTRATION FOR EACH VEHICLE REQUIRED				
			COMPANY'S NAME AND LOGO MUST BE ON ALL VEHICLES				
			COPY OF CPR AND FIRST AID CARD FOR EACH DRIVER				
			COMPLETED DRIVER INFORMATION PROFILE				
			HIPPA TRAINING ANNUALLY, PROOF WILL BE VERIFIED ON SITE VISIT				
			SERVICES PROVIDED ON RESERVATION MUST SUBMIT COPY OF TRIBAL BUSINESS LICENSE				
			TAXI COMPANIES MUST SUBMIT A COPY OF THEIR LICENSE FROM THE DEPARTMENT OF WEIGHTS AND MEASURES.				
MANDATORY							
MANDATORY							
OPTIONAL							
OPTIONAL							
As the Owner /alid Arizona cards, & HIPP Owner/Provice employment this form. Any you are indic: request.	r/Provid drivers PA train der is re end dat y chang ating th	ler you are responsible f license for each driver a ing documents. As part quired to disclose each e (if applicable), and da les to the above must be at this information will be	or maintaining and providing upon request a and proof of insurance, CPR and First Aid of the registration process the employee's name, employment begin date, te of birth information using the 2 nd page of a reported within 30 days. By signing below a kept on file and made available upon				
Company Na	me		ID Number:				
Sompany Na	e		D Number.				

	NON EN	IERGENCY DRIVER IN	IFORM/	ATION			
PROVIDER TYPE	28 NON-EMERGENCY TRANSPORTATION *(Page 2 of 2) COMPANIES ONLY						
REIMBURSE- MENT TYPE	02	FEE FOR S EFFECTIVE	FEE FOR SERVICE EFFECTIVE 04/01/2014				
		List of Employees (ALL FIELDS ARE MANDATOR SSN is optional	Y)				
Last Name:		First Name, Middle Initial:		SSN (optional):			
Employment Begin Date:		Employment End Date:	Employment End Date: Date				
Last Name:		First Name, Middle Initial:	First Name, Middle Initial:				
Employment Begin Date:		Employment End Date:	Employment End Date: Date				
Last Name:		First Name, Middle Initial:		SSN (optional):			
Employment Begi	n Date:	Employment End Date:	Date o	of Birth: (MM/DD/YYYY)			
Last Name:		First Name, Middle Initial:		SSN (optional):			
Employment Begi	n Date:	Employment End Date:	Date	of Birth: (MM/DD/YYYY)			
Last Name:		First Name, Middle Initial:		SSN (optional):			
Employment Begi	n Date:	Employment End Date:	Date	of Birth: (MM/DD/YYYY)			
Copy if additional	pages are nee	ded.					

AHCCCS Arizona Health Care Cost Containment System

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5010 Online Claim Submission

Claim Type Professional (1500 Form Type)



FAQ | LogIn |



Arizona Health Care Cost Containment System Our first care is your health care

New Account

Register for an AHCCCS Online account.

To learn more about AHCCCS Online, Click Here

Hospital Assessment

View Hospital Assessment Invoice

Make a Hospital Assessment Payment

Health Plan Links

View Health Plan Links

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 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



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Main | FAQ | LogOut |

Main Page

	main Page
Menu	
Claim Status	For security purposes, your session will be logged out after 15 minutes of inactivity.
Claims Submission	AHCCCS Online is an AHCCCS website designed for registered providers. It offers the convenience and efficiency of several online services.
Member Verification	
Newborn Notification	Claim Submission
Prior Authorization Inquiry	Claim St inquiries -For-Service claims submitted to AHCCCS. If a recipient is enrolled in a capitated Health Plan, the Health Plan must be contacted for claim
Prior Authorization Submission	For a listing se click on Health Plan Listing.
Provider Verification	CLAIM SUBMISSION
Support and Manuals	Claim Submission allows providers to submit Professional, Dental and Institutional claims to AHCCCS for nightly processing. Claims submitted prior to 4:00 PM each business day are processed that night. Claims submitted after 4:00 PM Friday will be processed the following Monday. The status of the claims can be viewed online by searching for the claim by submission date. Average processing time may take 24-72 hours, depending on the number of claims processed and the time of the submission.
AHCCCS Online User Manuals	MEMBER VERIFICATION
AHCCCS Online Learn More	Eligibility and Enrollment Status allows providers to verify an AHCCCS recipient's eligibility and their enrollment in a Health Plan. Providers can also obtain Medicare, Share Of Cost and other third
Frequently Asked Questions	party coverage information for a recipient.
	NEWBORN NOTIFICATION
Account Information	Newborn Notification allows providers to submit newborn information to AHCCCS during the hours when the COM Center is not available. Status of these submissions can also be viewed from the web site within 48 business hours.
Username: Test56	PROVIDER VERIFICATION
	Provider Information allows providers to update their correspondence addresses. Providers may also view (but not update) their Service and Pay-To Addresses, Group Affiliations and Authorized Signatures. For further information, please click on AHCCCS Provider Registration
	PRIOR AUTHORIZATION INQUIRY Prior Authorization Inquiry will allow providers to verify the status of previously submitted prior authorization requests. Inquiries can be performed by Case Number, AHCCCS ID or Provider ID. The related case, event and activity data related to the prior authorization will be diplayed.
~	PRIOR AUTHORIZATION SUBMISSION
	Prior Authorization Submission allows providers to submit requests for services.
	HEALTH PLAN ADDRESS CHANGES
	HealthPlan Address Changes allows acute health plans to send address changes from members via the web. All address changes will be processed by the eligibility source within a few business days.
	The AHCCCS mainframe systems will have scheduled downtimes that occur on a weekly basis. During these downtimes (usually weekends), the web site will be unavailable. During system downtimes, please contact the AHCCCS COM Center at 602-417-7000 for immediate assistance regarding eligibility/enrollment. The Interactive Voice Response (IVR) System is also available for eligibility inquiries at 602-417-7200. For claim inquiries, please contact the AHCCCS Comments, please contact the AHCCCS Comments are contacted as a comment of the analysis of contacts.

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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







Help

								* Indicates a required field.
Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines	
		U						
	Dendering (Defension Consists (
Billing	Kendering	Referring Service i	achity					
					Billing	Provider		
					* Tax I	D:	SSN © EIN	
				Provider Com	mercial Numbe	r:		
			* CM	MS National P	rovider ID (NPI):	Find	
					* Entity Typ	e: 🔘 Person 🔘 Non	-Person Entity	
			Health	Care Provider	Taxonomy Cod	e:		
					Provider Nam	e:		
				Informatio	on Contact Nam	e:		
			Informati	on Contact Te	lephone Numbe	r:		
				Service Locato	or Code/Addres	5:		
				Pay-To Locato	or Code/Addres	5:		



Submit

Cancel

Save

Professional Claim Submission



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Arizona Health Care Cost Containment System

The Rendering Provider screen will come up

Professional Claim Submission

Arizona Health Care Cost Containment System

* In	dic
Submitter Providers Patient/Subscriber Ambulance Other Payer Attachments Claim Information Service Lines	
Billing Rendering Referring Service Facility	_
Rendering Provider	
Provider Commercial Number:	
* CMMS National Provider ID (NPI): Find	
* Entity Type: O Person O Non-Person Entity	
Provider Name:	
Performing Health Care Provider Taxonomy Code:	
	_



Professional Claim Submission Help * Indicates a required field. Submitter Providers Patient/Subscriber Ambulance Other Payer Attachments Claim Information Service Lines Billing Rendering Referring Service Facility **Rendering Provider** If you do not have a valid NPI # **Provider Commercial Number:** When done click on **Enter your 6 digit AHCCCS provider** CMMS National Provider ID (NPI): 9999999999 Find the Find Button ID here, and leave the NPI field Entity Type: O Person O Non-Person Entity blank Provider Name: Performing Health Care Provider Taxonomy Code: If you have a valid NPI you must enter Click it here and leave the Provider Person (if the ID number comes up as a person's **Commercial field # blank** Save Submit Cancel name) or Non-person (if the ID comes up with a company's name) Privacy Policy | Contact AHCCCS | HIPAA | © Copyright AHCCCS 801 E. Jefferson, Phoenix, AZ 85034



* Indicates a required field.

Help



Submit

Cancel

Save



The Patient/subscriber screen will come up, this is where you will enter the members AHCCCS information

Professional Claim Submission

Submitter Providers Patient/Subscriber Ambulance Other Payer Attachments O	Claim Information Service Lines
Insured or	Subscriber
* Member ID Number/Date of Birth:	Find
Person Name:	
Gender:	
Residential Address:	
* Payer Responsibility:	
	NO.



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Arizona Health Care Cost Containment System

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Help



Providers Patient/Subscriber Ambulance Other Payer Claim Information Service Lines Submitter Attachments **Claim Attachments** Report Type ** Control Number ** Report Transmission ** 1 B4 - Referral Form • Ŧ 2 • AA - Available on Request at Provider Site Select BM - By Mail 3 ▼ EL - Electronically Only EM - E-Mail **Electronically Only** 4 Ŧ FT - File Transfer FX - By Fax 5 Ŧ • Attachments (1-10): 6 Ŧ Ŧ 7 • Ŧ 8 ▼ Ŧ 9 ▼ Ŧ 10 Ŧ Ŧ ** Required ONLY if Attachment information is submitted.

Save Submit



Professional Claim Submission

Cancel

Help

* Indicates a required field.



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 in capital letter

Date of Service

PWK for Claim 1, Document 1

08/05/15

A12345678

A12345678080515

Different AHCCCS ID member with the Same Date of Services

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

Date of Service

PWK for Claim 2, Document 2

A87654321

08/05/15 A87654321080515

The combination of the member's AHCCCS ID and the Date of Service is what makes the PWK number unique to each claim.



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Professional Claim Submission The Claim Informatic	on Screen will come up
	* Indicates a required field.
Submitter Providers Patient/Subscriber Ambulance Other Payer Attach	ments Claim Information Service Lines
Cla	aim Information
Original Reference Number:	C Replacement Void
Prior Authorization Number:	
* Patient Control Number:	
Medical Record ID Number:	
Initial Treatment Date:	
Date of Current Injury:	(Accident)
** Patient's Condition Related To:	Employment Other Accident Auto Accident
*** Place in which accident occurred:	 (State)
Special Program Indicator:	
* Provider Signature on File:	O Yes O No
* Provider Accept Assignment:	\odot Assigned \odot Accepted on Clinical Lab Services Only \odot Not Assigned
* Benefit Assignment:	🔘 Yes 🔘 No 🔘 Not Applicable
* Release of Information Consent:	Informed Consent O Yes
EPSDT Screening Referral:	\bigcirc Yes \bigcirc No (Mutually Defined)
Condition Indicator:	1 2 3 V
	** Required ONLY if "Date of Current Injury" is entered.
	*** Required ONLY if "Auto Accident" selected.
Save	Submit Cancel
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801 E. Jefferson, Phoenix, AZ 85	034





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	Help * Indicates a required field.
Submitter Providers Patient/Subscriber An	nbulance Other Payer Attachments Claim Information Service Lines
Diagnosis or Nature	e of Illness or Injury (Relate Items 1 - 12 by line to the Diagnosis Code Pointer)
* Standard: 🔘 ICD-9 🔘 ICD-10	* Diagnosis Codes: 1 7999 2 3 4 5 6
	7 8 9 10 11 12
	Service Line
* Diagnosis Code Pointers: 1 📃 2 🔲 3	3 4 5 5 6 7 8 9 9 10 11 12
* Service Dates:	-
* Line Charges: \$	* Place of Service Code (POS):
* Quantity:	Minutes O Units Modifier Codes: 1 2 3 4
* HCPCS Code:	
National Drug Code:	When you click on the Add button the first convice line
**NDC Quantity/Measure:	When you click off the Add batton the first service line
Immunization Batch Number:	will appear at the bottom of the screen as line 1 and
Indicators: Emergency	the screen will clear allowing you to add another
Provider Control Number:	service line if applicable, you can continue to add
**Other Payer: Primary ID	new service lines by clicking the ADD button
**Medicare: Paid Amount \$	after each comice line working the ADD button
Other Adjustment(s): Medicare Deduc	after each service line you've entered
**Durable Medical Equipment: HCPCS	
Ordering Physician: Plan 10	
	Add
	** All or none of the information is required for the line or group.
Line Begin End Date POS HCPCS Mod No. Date	lod Mod Mod NDC NDC Diag Diag Diag Diag Diag Diag Diag Diag
X 1 10/1/201410/1/2014 99 A0120 TN	0 2 UN 14.54 0
	Totals: \$14.54 \$0.00

Δ

Diagnosis of Hatar	e of Illness or Inju	ry (Relate Ite	ems 1 - 12	by line to	o the Diag	nosis Code	Pointer)	
* Standard: 🖲 ICD-9 🔘 ICD-10	* Dia	gnosis Codes:	1 7999	2	3	4	5	6
			7	8	9	10	11	12
		Service	Line					
* Diagnosis Code Pointers: 1 🖉 2 🔲 3 🗐	4 5 6 7 7	8 9	10 11 11	12				
* Service Dates: 10/01/2014 - 10/	01/2014							
* Line Charges: \$ 155.90		* Place of Se	rvice Code (PC	DS): 99 - OT	HER UNLISTED	FACILITY	•	
* Quantity: 101.9 O Minute	es 🖲 Units		Modifier Co	des: 1 TN	2	3 4		
* HCPCS Code: \$0215			Prescription D	ate:				
National Drug Code:		**Prescrip	tion #/Identi	fier:				•
**NDC Quantity/Measure:	•	-	Taxonomy Co	ode:	(Per	forming HC Provi	der)	-
munization Batch Number:			Patient Co	unte				
Provider Control Number:	r the informat	ion for sei	rvice line	e 2 if ap	oplicabl	e and cli	ck Add	
**Other Payer: Primary ID	Paid Amount \$	Unit	ts	Proced	ure Code/Qual	ifier		
** Medicare: Paid Amount \$	Units	Procedure	e Code/Qualifier	·	-			
Other Adjustment(s): Medicare Deductible \$	Medicare	Coinsurance \$		Medicare Co	opay \$			
Durable Medical Equipment: HCPCS	urchase Price \$	Rental Price	\$		Lengt	h of Medical Nece	ssity Day	5)
**Ordering Physician: Plan ID	Last Name		First Nam	ne	C	îty		
		Add						
					88	All or none of th	e information is req	uired for the line o
ne Begin rad pate posteros Mod Mod Mod M	lod NDC NDC Diag Diag [Diag Diag Diag Dia	ig Diag Diag Di	ag Diag Diag	Diag Min./	Line ^k	ledicare	Medicare
Date End Date POSICICS 1 2 3	4 Code Units 1 2	3 4 5 6	7 8 9) 10 11	12 Units	Charges	Amount Cod	le Amount
10/1/201410/1/2014 99 A0120 TN	0				2	UN 14.54	0	
					Т	otals: \$14.54	\$0.00	\$0.00

Diagnosis or Nature of Illne	ss or Injury (Relate I	tems 1 - 12 by line	e to the Diagno	sis Code Poi	nter)	
* Standard: 🖲 ICD-9 🔘 ICD-10	* Diagnosis Codes:	1 /999 2	3	4	5	6
		7 8	9	10	11	12
	Servi	ce Line	-			
* Diagnosis Code Pointers: 1 2 3 4 5	6 7 8 8 9	10 11 12 12				
* Service Dates:						
* Line Charges: >	* Place of	Service Code (POS):				
* Quantity: O Minutes (a) Units		Modifier Codes:	2 3			
* HCPCS Code:		Prescription Date:				
National Drug Code:	**Presc	ription #/Identifier:			•	
**NDC Quantity/Measure:		Taxonomy Code:	(Perform	ming HC Provider)		
Immunization Batch Number:		Patient Count:				
Indicators: Emergency EPSDT						
Provider Control Number:						
**Other Payer: Primary ID Paid	Amount \$ U	Inits Pr	ocedure Code/Qualifie		•	
** Medicare: Paid Amount \$ U	Inits Proced	ure Code/Qualifier	•			
Other Adjustment(s): Medicare Deductible \$	Medicare Coinsurance \$	Medicar	re Copay \$			
**Durable Medical Equipment: HCPCS Purchase Price	\$ Rental Pr	ice \$	 Length of 	Medical Necessit	(Days)	
**Ordering Physician: Plan ID Last	Name	First Name	City			
This is how it look	s with two serv	ice lines	** All	or none of the inf	ormation is require	ed for the line or gro
				Madi	5350	Nedicare No.
Line Begin End Date POS HCPCS Mod Mod Mod Mod NDC ND No. Date End Date POS HCPCS 1 2 3 4 Code Unit	C Diag Diag Diag Diag Diag I ts 1 2 3 4 5	Diag Diag Diag Diag Diag Diag Diag Diag	Diag Diag Min./ Typ 11 12 Units	e Line Charges Am	Paid Units Proc	Deductible Coinsu
10/1/201410/1/2014 99 A0120 TN	0		2 UN	14.54	0	Amount Ar
X / 2 10/1/201410/1/2014 99 S0215 TN			101.9 UN	155.90	0	
						10.00
			Tota	is:\$1/0.44 \$	0.00	\$0.00

Line Begin No. Date End Date POSHCPCS Mod Mod Mod Mod NDC N No. Date	IDC I nits	Diag 1	Diag 2	Diag 3	Diag 4	Diag 5	Diag 6	Diag 7	Diag 8	Min./ Units	Туре	Line Charges	Medicare Paid U Amount	nits Code	Medicare Deductible Co Amount	Medicare I sinsurance Amount	Medicare Othe Copay Paye Amount ID
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X / 2 6/18/2012 6/18/2012 99 50215 TN	0	V								110	UN	168.10	0.00	0	0.00	0.00	0.00
										8	Totals	\$182.64	\$0.00		\$0.00	\$0.00	\$0.00
To edit a line, click on the middle icon		(Save	9		Su	ıbm	it		Car	ncel						



Professional	Claim Su	bmission
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									* In	Help dicates a required field.
Submitter Providers Patient/S	ubscriber Ambulance	Other Payer	Attachments	Claim Info	rmation Se	ervice Lines				-
Ĩ)iagnosis or Natu	re of Illness	or Injury (Relate It	ems 1 - 1	L2 by line to	o the Diagnos	sis Code Poir	nter)	
* Standard: @ ICD-9	© ICD-10		* Diagno	sis Codes:	1 7999	2	3	4	5	6
	0 100 10				7	8	0	10	11	12
							, , , , , , , , , , , , , , , , , , ,	10		
				Servic	e Line					
* Diagnosis Code Pointe	rs: 1 🛛 2 🗖 3 🗖	4 5 5 6	6 🗖 7 🗖 8	9 🗆	10 🔲 11	12				
* Service Date	es: 10/7/2014 - 10	7/2014								
* Line Charge	es: \$ 102.00			* Place of S	ervice Code	(POS): 99 - OT	HER UNLISTED FAC	ILITY	•	
* Quanti	ty: 101.9 © Minut	es 🚇 Units			Modifier	Codes: 1 TN	2 3	4		
* 110000 0-4		es o onics			Deservit	- Data				
National David Con	le: 50215			a Decembra	Prescriptio	n Date:				
				**Prescri	T	entiner:	(Perform	ning HC Provider)		
Tomunization Ratch Numb					Dationt	y Code:	(Periori	ing ne Provider)		
Indicator					Patient	count:				
Provider Control Number	er: Emergency EPS	The scr	een with	the se	rvice liı	ne that vo	ou clicked	to edit wi	ll come up	.)
**Other Pav	er: Primary ID	makay			d aliak t	the under	to hutton			′
**Medica	e: Paid Amount \$	паке у	our chan	iges and		ine upua	le bullon			
Other Adjustment(s): Medicare Deductible \$	l								<u> </u>
**Durable Medical Equipment	nt: HCPCS	urchase Price \$		Rental Pric	• \$		 Length of 	Medical Necessity	(Days)	
**Ordering Physicia	n: Plan ID	Last Nar	me		First	Name	City			
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Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Info	rmation Service Lin	ies			
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Arizona Health Care Cost Containment System Professional Claim Submission

Print Date: 6/19/2012 9:45:45 AM Confirmation Code: P-30

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Information Contact Name: Excohedo, Albert		Type		Transmission	Control Numbe
Information Contact Talanhons #: 602.412.4862		1			
Electronic Transmitter ID: 99222		2			
Billing Provider		3			
		4			
Tax 10: 123436769 (3Y)	Attachments (1-10):	5			
Rabonal Provider ID (NPA):		6			
Provider Commercial Number/Name: 231/20 (TEST/CASE)		7			
Provider Taxonomy Code:					
Entity Type: Person					
Information Contact Name:					
Information Contact Telephone #: 6024174000		10			
Service Address: 701 E. JEFFERSON	Other Payer Information				
Pay-To Provider Address 201 E. METERSON	Insured Identifier:)			
PHOENIX, AZ 85004	Insured/Subscriber Name: ()			
Rendering Provider	Insured Address (City):				
Resident for a second strength of the second state of the second s	Payer Primary ID:				
Entity Tores (TEST/CASE)	Payer Name:				
National Densides TO (NDT)	Payer Address (City):				
Performing Provider Als (PFA)	Responsibility				
Codei	Insured Group or Policy Numbers				
Service Facility	Insured Group Name:				
National Provider TO (NDT)	Individual Relationship:				
National Provider ID (NP1):	Insurance Type:				
Laboratory of Pacinty Name:	Claim Filing Indicators				
Address	Benefit Assignment				
Kelerring Provider	Certification				
National Provider ID (NPI):	Release of Informations				
Provider Commercial Number/Name: ()	Payer Amount Paid				
Patient/Insured	Date Claim Paid:				
Member ID Number/Name: A81345732 (TESTRECORD, NEW S)	Claim Detail				
Date of Birth: 01/01/1995	Original Reference Numbers				
Gender: M	Prior Authorization Numbers				
Residential Address: BO1 E JEFFERSON	Patient's Control Numbers /	CCOUNT NU	MBER		
PHX, AZ 83039	Medical Record ID Numberi				
Payer Responsibility: Primary	Initial Treatment Date:				
Ambulance Information	Date of Current Injury:				
Pick-up Address:	Place in which accident				
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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

When you click on enter new claim it takes you to the main screen where you can start entering a new claim

View Claim	Processina	Status
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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.

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Enter New Claim Type of Claim: Professional 🖌 Go	To view the claims you entered on-line, enter a Single date or a span date and click GO
View Claim Processing Status	
Submission Date(s): 06/19/2012 - 06/19/2012	Go



Claim Submission Status

<u>Claim Type</u>	Submission Date/Time	Patient Account # Service Prov.	<u>Billing Prov.</u> NPI	Date From	<u>Date</u> Thru	<u>Status</u>	Processing Date/Time	CRN	Adjudication
Professional	06/05/12 12:40 PM	ACCT # TEST REPLACE		05/15/12	05/15/12	Processed	06/05/12 04:00 PM	12157560000	Denied
Professional	06/07/12 04:58 PM	REPLACEMENT TEST		05/15/12	05/15/12	Processed	06/08/12 09:44 AM	12160560000	2 Denied
Professional	06/18/12 05:19 PM	ACCOUNT NUM NO		06/18/12	06/18/12	Pending			
Record Count:	3								

< Previous





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

Entering Provider, Patient and Attachment Detail Information and File







TIBCO Fore	esight™ Transaction Insig	ht® with	a menu to the left	J	Welcome Arlyn Valencia! Logoff
Files 275 Attachments User My Account	Click on the 2 attachments	275 ete, at a minimum, link	, all required fields in the 275 Attachment Details secti Browse Upload Attachment	on.	
	275 Attachment Details				
	Submitter Last or Organization Name*		Transaction Set Purpose Code*	Choose a Value 🔻	
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	Provider Address*		Provider City*		
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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

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Home :: 275 Attachments

Arizona Health Care Cost Containment System

Files 275 Attachments	275 Claim Attachment Upload During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.					
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AHCC	Reaching across Arizona to provide comprehensive quality health care for those in need	45				

Home :: 275 Attachments

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



Example: If you are billing with a NPI number

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Arizona Health Care Cost Containment System

My Account	Browse to your file: (maximum file :	size limit 64MB)	Browse Upload Attachment			
	275 Attachment Details					
	Submitter Last or Organization Name	Penney Lane Clinic	Transaction Set Purpose Code*	02-Add 🔻		
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quality health care for those in need

Welcome Arlyn Valen

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

Welcome Arlyn Vale

F iles 275 Attachments	275 Claim Attachment Upload During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
User My Account	Browse to your file: (maximum file size limit 64MP) Browse Upload Attachment Click on the down
	275 Attachment Details arrow and make Submitter Last or Organization your selection Provider Last or Organization Provider First Name
	Provider Identifier Type* Choose Provider ID Type Choose Provider ID Type Provider Identifier Provider Secondary Identifier Provider Secondary Identifier
	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



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Welcome Arlyn Valencia

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

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



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

Home :: 275 Attachments



TIBCO Foresight™ Transaction Insight®

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The file search window will come up





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





AHCCCS Arizona Health Care Cost Containment System

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

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Welcome Arlyn Val

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Welcome Arlyn Val

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How to fill out daily trip reports?

- One ways
- Round trips
- Multi-trips

Where can you find the trip reports?



AHCCCS Provider Registration:

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



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 <u>each trip must be fully</u> <u>documented</u>.

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

Type of the 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?

- Effective 7/1/13 AHCCCS <u>requires</u> the use of this standard Daily Trip Report format.
- 2. The letter box in the upper left corner area <u>must</u> 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)



This is the letter box where the Provider's name and demographic information is entered.			Exh 14-1 Driver Nam Date: Vehicle #_	AffCCCS Name:		
Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
	_					
Pick up location & address						
Drop off location & address						
AHCCCS #: Date of Birth:	Mailing Add	iress:		Round Tri	p One Way Mult :	stops
Reason for Visit e specific): Name of Escort:	R	elationship:				_
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Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Pick up location & address						
Drop off location & address						
AHCCCS #: Date of Birth:	Mailing Add	lress:		Round Tri	p One Way Mult :	stops
Name of Escort:	R	elationship:				-

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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.

	Exh 14-1 DAILY TRIP REPORT Driver Name: Date: Vehicle #	Albert Heelth Care Carl Carbineter Fyriter
Driver name: print full name Date: indicate the day of the wee Vehicle #: license plate # and sta NOTE: if driver uses a 2nd vehicle bottom right) the page number of that service date.	ek (Sa Su M T W Th F) and the month/day/year Ite (If Provider requires make/model/color details, use space below e for same date of service, use a new Daily Trip Report and indicate detail. All pages become the <i>complete</i> Daily Trip Report for the dri	() e (at the ver on
NEMT Test Provider 701 E Jefferson Phoenix, AZ 85034	Exh 14-1 DAILY TRIP REPORT Driver Name: John Doe Date: W 07/31/13 Vehicle # AZ000000 type_	AHCCCS AHCCCS AHCCCS A AHCCCS A AHCCCS A AHCCCS A AHCCCS A AHCCCS A AHCCCS A AHCCCS A AHCCCS A AHCCCS A AHCCS A AHCCS
The upper left area of the form is demographic information.	s for the provider's name and	
AHCCCS	Reaching across Arizona to provide comprehensive	70

	NEMT Test Provider 701 E Jefferson Phoenix, AZ 85034 Ex: ROUND TRIP Same driver			Exh 14-1 DAILY TRIP REPORT Driver Name: John Doe Date: W 07/31/13 Vebicle # AZ000000 Type VAN				
[Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles	
1	Jane Smith	9:00am	0001	9:30am	0009	Jane Emith	8	
•	Jane Smith	10:00am	0009	10:30am	0017	Jane Emith	8	
	Pick up location & address	Safeway	store, Sacato	n, AZ	•		•	
	Drop off location & address	DoctorJo	hn, 2345 S St	trawberry Fi	elds, Phoeni	ix, AZ 89999		
	AHCCCS #: <u>A99999999</u> Date of Birth: 10/10/10	Round Trip√ One Way Mult Stops CCS #:						
	Reason for Visit	Pain in	the arm afte	er a fall				
l	Name of Escort:			_ Relations	11p:			
[Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles	
	Pick up location & address							
ł	Drop off location & address Round TripOne WayMult Stops AHCCCS #: Mailing Address: Date of Birth: Mailing Address: Reason for Visit/Diagnosis (Be specific): Relationship:							
							Mult Stops	
•	Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles	
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	Dick up location & address							
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	AHCCCS #: Mailing Address: Date of Birth: Reason for Visit/Diagnosis (Be specific): Name of Escort:				REMEMBER: Driver's Signature: each page must be signed and dated Page of: all transports per driver with date of service.			
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	NEMT Test Provide 701 E Jefferson Phoenix, AZ 85034 Ex: ROUND TRIP 2 different drivers			Exh 14-1 DAILY TRIP REPORT Driver Name: <u>John Doe</u> Date: <u>W 6//31/13</u> Vehicle # A7000000 Type			AHCCCS Alises Health Care Cart Cartainnerl System		
	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		
	Pick up location & address	Sareway store, Sacaton, AZ							
	Drop off location & address Doctor John, 2345 S Strawberry Fields, Phoenx, AZ 89999 Round Trip One Way Mult Stops AHCCCS #: A999999999 Date of Birth: 10/10/10 Pain in the arm after fall								
l	Name of Escort:			Relations	nip:				
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	Drop off location & address								
	AHCCCS #:						Mult Stops		
	Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles		
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	Date of Birth: Reason for Visit Name of Escort:								
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	NEMT Test Provider 701 E Jefferson Phoenix, AZ 85034 2 differ	Ex: ROUND TRIP Erson Z 85034 2 different drivers			Exh 14-1 DAILY TRIP REPORT Driver Name: Leroy Doe Date: W 7/31/13 Vehicle # AZ000000 Type VAN				
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	Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles		
	Jane Smith	10:00am	0011	10:30am	0019	Jane Smith	8		
•									
	Pick up location & address	Doctor Jo	hn, 2345 S S	trawberry Fi	elds, Phoeni	x, AZ 89999			
	Drop off location & address	Safeways	tore, Sacato	n, AZ					
	AHCCCS #:A999999999 Date of Birth:10/10/10 Reason for Visit Name of Escort:	Maili Pain in	ng Address: the arm afte	One Way _√Mı n, AZ 89999	ult Stops				
-	Name of Recipient	Pick up time	Pick up odomete	Drop off time	Drop off odometer	Recipient Signature	Trip miles		
	Pick up location & address								
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	Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles		
	Pick up location & address								
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	Name of Recipient		Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
F	Jane Smith		9:00am	0001	9:30am	0009	Jane Emith	8
ł	Pick up location & add	Iress	Safeway	store, Sacato	n, AZ			
	Drop off location & ad	dress	DoctorJo	hn, 2345 S St	rawberry Fi	elds, Phoeni	x, AZ 89999	
Bit op of indeation deaters Doctor Joint, 2345 3 Strawberry Heids, Prioent, A2 059595 Round Trip One Way Mult Stops AHCCCS #: Mailing Address: PO Box 1234, Sacaton, AZ 89999 Date of Birth: Mailing Address: PO Box 1234, Sacaton, AZ 89999 Reason for Visit/Diagnosis (Be specific): Pain in the arm after a fall Relationship:							Mult Stops√	

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Pick up location & address	ocation & address Doctor John, 2345 S Strawberry Fields, Phoenix, AZ 89999						
Drop off location & address	X-ray Unit	ted, 2222 E X	-ray Rd, Pho	enix, AZ 8	9999		
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Date of Birth:							
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Name of Escort:			_ Relations	nip:			

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	Jane Smith	11:00am	0014	11:30am	0019	Jane Smith	5			
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	Drop off location & address Doctor John, 2345 S Strawberry Fields, Phoenix, AZ 89999									
				R	ound Trip _	One Way Mult S	tops√			
	AHCCCS #: Date of Birth:	Mail	ing Address:							
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	Federal and State funds, and that any	false claims	s, statements	or documen	ts, or conce	alment of a material fact, may	be			
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Driver Signature	John Doe	Date	08/31/13	Page	1	of	2
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	mo	mbor		Vehicle #	AZ000000)TypeV	AN	
Name of Recipient	IIIe	indei.		Drop off	Drop off	Recipient Signature	Trip miles	
		time	odometer	time	odometer			
Jane Smith		12:00pm	0019	12:30pm	0027	Jane Emith	8	
Pick up location & addre	SS	Doctor Jo	hn, 2345 S St	L trawberry Fi	ields, Phoeni	k, AZ 89999		
Drop off location & addr	ess	Safeway	store, Sacato	on. AZ	-	-		
				R	ound Trip	One Way Mu	It Stops 1	
AHCCCS #+ A999999	99	Mail	ing Address:	PO Box 1	234 Sacato	n AZ 89999	<u></u>	
Date of Birth: _10/10/10	0		ing Address.		201,04000			
Reason for Visit/~		Pain in	the arm afte	er a fall Deletionel				
Name of Escort:				_ Relations	11p:			
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Reason for Visit/Discos	is (Respecific)							
Name of Escort:				Relations	nip:			
Name of Recipient		Pick up	Pickup	Drop off	Drop off	Recipient Signature	Trip miles	
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Jane Smith								
Pick up location & addre	SS	I		-			•	
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AHCCCS #: Date of Birth: Reason for Visit/P*	in (Dennesifie)	Mail	ing Address:					

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NEMT Test Provide Another Ex: MULTI - TRIP 701 E Jefferson Phoenix, AZ 85034

Same day, driver, & member.

Exh 14-1 DAILY TRIP REPORT

Date: W 07/31/13

le la constante de la constante			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 Emith	8
Jane Smith	10:00am	0009	10:30am	0017	Jane Emith	8
Pick up location & address	Safeway S	Store, Sacato	n, AZ			I
Drop off location & address	Doctor Jo	hn, 2345 S St	rawberry Fi	elds, Phoeni	x, AZ 89999	
			Ro	ound Trip	_√One WayM	lult Stops
AHCCCS #: <u>A999999999</u> Mailing Address: <u>PO Box 1234, Sacaton, AZ 89999</u> Date of Birth: 10/10/10						
Reason for Visit/						

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 Emith	10		
Pick up location & address	Safeway Store, Sacaton, Az							
Drop off location & address	Casa Gra	nde ER						
			R	ound Trip _	One Way _√ Mult St	ops		
AHCCCS#: A99999999 Mailing Address:								
Date of Birth: <u>10/10/10</u>								
Name of Escort:	Che	supan	Relations	hip:				

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles	
Pick up location & address							
Drop off location & address							
			R	ound Trip _	One Way Mult S	itops	
AHCCCS#:	Mai	ling Address:					
Reason for Visit							
Name of Escort:	-		Relations	hip:			
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 claim	s, statements	or documer	nts, or conce	alment of a material fact, may	be	
prosecuted under applicable Federal of	r State laws	ē.					

Quick Review – Trip Reports

R/T or O/W or Multi-trip

R/T-2 drivers Multi-trips

Multi-trips





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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 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 <u>EDICustomerSupport@azahcccs.gov</u> 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 ¹/₂ 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



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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 <u>EDICustomerSupport@azahcccs.gov</u> 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: <u>http://listserv.azahcccs.gov</u>
 - 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?



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Thank You.



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