



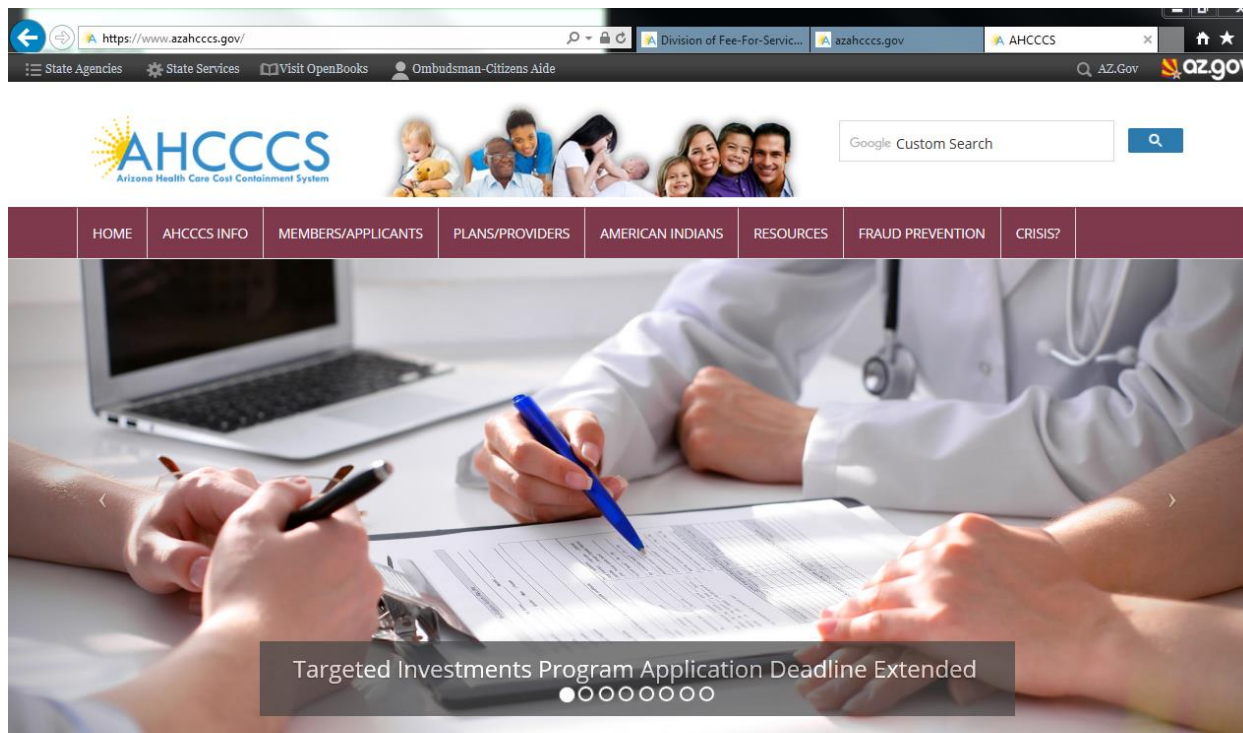
Online Claims Submission: Dental Claim ADA Type

March 8, 2018



Start at the AHCCCS Website

<https://www.azahcccs.gov/>



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.



Click Plans/Providers

HOME

AHCCCS INFO

MEMBERS/APPLICANTS

PLANS/PROVIDERS

AMERICAN INDIANS

RESOURCES

PREVENTION

CRISIS?

AHCCCS Online

Health Plans

MCO Update Meetings
Minimum Subcontract Provisions
Reporting Third-Party Liability
ALTCS Electronic Member Change Request (EMCR)
Solicitations & Contracts

Current Providers

Provider Website
Provider Reenrollment
CRS Referrals
ALTCS Electronic Member Change Request (EMCR)
Self Directed Attendant Care
Direct Care Workers
Nursing Facility Information
Hospital Assessment

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Managed Care
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Hospital Presumptive Eligibility
Hospital Reimbursement
PCP Parity

Pharmacy

- From the toolbar at the top of the page, click **Plans/Providers**
- Once the drop down appears, click on **AHCCCS Online**

Log in to AHCCCS Online



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.

***** ATTENTION! *****

Effective January 1, 2017, Non IHS/638 NEMT providers transporting TRBHA members over 100 miles, one way or round trip, must receive prior authorization for the transport. Behavioral health transports must be to and from a covered behavioral health service. Prior Authorization requests:

1. Must be submitted prior to service delivery in order to be considered timely.
2. Must contain a valid behavioral health diagnosis.

AHCCCS Online User Manuals

Sign In

Username

Password

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.

Enter your username & password

Click "Sign In"

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AHCCCS Online User Manuals	
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Account Information	
Username: Training01	
User: Albert Escobedo	
Type: Master	
IP: 170.68.81.110	
Provider ID: 231725	

Main Page

Click on "Claim Submission"

▲ 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 contact information is available. 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 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 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 Medicaid 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 can be viewed on the web site 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 and Signatures. 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 re-enrollment notice must wait to receive a re-enrollment notice. All data must be submitted by the indicated timeframe on the letter or the AHCCCS identification number will be terminated. Providers must wait to receive a re-enrollment notice. If documents are received prior to the re-enrollment notices being mailed out, the documents will be processed according to system requirements. Data may be submitted by authorized signers on file with AHCCCS. For further information, please click on [AHCCCS Provider Re-Enrollment/Revalidation](#).

PRIOR AUTHORIZATION INQUIRY

Claim Submission Screen

- Under “enter new claim”, click on the drop down and select **Dental**
- Click “Go”

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:

View Claim Processing Status

Submission Date(s): -

Submitter Screen

Dental Claim Submission

* Indicates a required

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
Submitter							
Organization Name: NEMT TEST							
Electronic Transmitter ID Number: 99222							
Information Contact Name: Test							
Information Contact Telephone Number: 602-555-5555							
<input type="button" value="Save"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/>							

Verify that the information is correct

Next click on the "providers" tab

This is where you will enter the provider or group billing information

Dental Claim Submission

Enter the biller or the group tax ID here

Help

* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
Billing Provider	Rendering Provider	Referring Provider	Service Facility				

Billing Provider

* Tax ID: SSN EIN

Provider Commercial Number:

* CMMS National Provider ID (NPI):

* Entity Type: Person Non-Person Entity

** Health Care Provider Taxonomy Code:

Provider Name: _____

Information Contact Name: _____

Information Contact Telephone Number: _____

Service Locator Code/Address: _____

Pay-To Locator Code/Address: _____

** Required ONLY when Billing and Rendering provider are the same.

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

When done entering all the
required fields, click the
"find" button

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

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

Save Submit Cancel

Billing Provider Screen

Dental Claim Submission

[Help](#)

* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
Billing Provider	Rendering Provider	Referring Provider	Service Facility				

Billing Provider

* Tax ID: SSN EIN

Provider Commercial Number:

* CMMS National Provider ID (NPI):

* Entity Type: Person Non-Person Entity

** Health Care Provider Taxonomy Code:

Provider Name: NEMT TEST

Information Contact Name:

Information Contact Telephone Number: 6024177000

Service Locator Code/Address: 701 E JEFFERSON
PHOENIX, AZ 85034

Pay-To Locator Code/Address: 701 E JEFFERSON
PHOENIX, AZ 85034

** Required ONLY when Billing and Rendering provider are the same.

Your provider
information
should
populate here

Next click on the rendering
tab

Rendering Provider Screen

Dental Claim Submission

Next click on the Patient/Subscriber tab

Help
* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
Billing Provider	Rendering Provider	Referring Provider	Service Facility				

Rendering Provider

Provider Commercial Number: 231725

* CMMS National Provider ID (NPI):

* Entity Type: Person Non-Person Entity

Provider Name: TEST/CASE

Performing Health Care Provider Taxonomy Code:

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 entering all the required fields, 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)

Save Submit Cancel

Insured or Subscriber Screen

Dental Claim Submission

[Help](#)

* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
Insured or Subscriber							
* Member ID Number/Date of Birth: <input type="text"/> <input type="text"/> <input type="button" value="Find"/>							
Person Name:							
Gender:							
Residential Address:							
* Payer Responsibility: <input type="text"/> ▼							
<small>NOTE: AHCCCS no longer accepts ADOC claims.</small>							

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

Dental Claim Submission

[Help](#)

* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
Insured or Subscriber							
* Member ID Number/Date of Birth:		A12345678	01/01/1995	Find			
Person Name:							
Gender:							
Residential Address:							
* Payer Responsibility:		P - Primary					

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

When done entering all the required fields, click the "find" button

Click on the down arrow and make your Payer Responsibility selection

NOTE: AHCCCS no longer accepts ADOC claims.

Save Submit Cancel

- A - Payer Responsibility Four
- B - Payer Responsibility Five
- C - Payer Responsibility Six
- D - Payer Responsibility Seven
- E - Payer Responsibility Eight
- F - Payer Responsibility Nine
- G - Payer Responsibility Ten
- H - Payer Responsibility Eleven
- P - Primary**
- S - Secondary
- T - Tertiary
- U - Unknown

Dental Claim Submission

* Indicates a required f

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
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Insured or Subscriber

* Member ID Number/Date of Birth:

Person Name: TEST

Gender: M

Residential Address: 701 E Jefferson St, Phoenix AZ 85004

* Payer Responsibility: ▼

NOTE: AHCCCS no longer accepts ADOC clai

The members information will populate under person name, gender, residential address.

Dental Claim Submission

* Indicates a required field

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
Insured or Subscriber							
		* Member ID Number/Date of Birth:		<input type="text" value="A12345678"/>	<input type="text" value="01/01/1995"/>	<input type="button" value="Find"/>	
		Person Name:		TEST			
		Gender:		M			
		Residential Address:		701 E Jefferson St, Phoenix AZ 85004			
		* Payer Responsibility:		<input type="text" value="P - Primary"/>			

NOTE: AHCCCS no longer accepts ADOC claims

If you want to send an attachment click the "attachments" tab

If no attachments, click "tooth status" tab next

For the purpose of this training, we will be sending an attachment

Claim Attachments Screen

- **Report Type** – Click the drop down and select type of attachment
- **Report Transmission** – Click the drop down and select EL – Electronically Only
- **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 AHCCCS ID is capitalized

Claim Attachments			
	Report Type **	Report Transmission **	Control Number **
1	B4 - Referral Form	EL - Electronically Only	A88734947080117
2			
3			
4			
Attachments (1-10):			
5			
6			
7			
8			
9			
10			

** Required ONLY if Attachment information is submitted.

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.

Example of a PWK number using a member's AHCCCS ID and the Date of Service

AHCCCS ID (9 – character AHCCCS ID)	A12345678
<i>Note: The A in AHCCCS ID must be a capital letter</i>	
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
<i>Note: The A in AHCCCS ID must be a capital letter</i>	
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.

Tooth Status

Dental Claim Submission

[Help](#)

* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
Tooth Status							
Tooth No.	E - To be Extracted M - Missing	Tooth Number/Status **		Tooth Number/Status **			
1		2		3			
4		5		6			
7		8		9			
10		11		12			
13		14		15			
16		17		18			
19		20		21			
22		23		24			
25		26		27			
28		29		30			
31		32		33			
34		35					

** Tooth Number and Status are both required if one or the other is entered.

Save Submit Cancel

Claim Information Screen

Dental Claim Submission

Help

* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
Claim Information							
Original Reference Number:		<input type="text"/>	<input type="radio"/> Replacement <input type="radio"/> Void				
Prior Authorization Number:		<input type="text"/>					
* Patient Control Number:		<input type="text"/>					
* Place of Service:		<input type="text"/>	▼				
Date of Current Injury:		<input type="text"/>	(Accident)				
** Patient's Condition Related To:		<input type="checkbox"/> Employment <input type="checkbox"/> Other Accident <input type="checkbox"/> Auto Accident					
*** Place in which Accident Occurred:		<input type="text"/>	(State)				
* Provider Signature on File:		<input checked="" type="radio"/> Yes <input type="radio"/> No					
* Provider Accept Assignment:		<input checked="" type="radio"/> Assigned <input type="radio"/> Not Assigned					
* Benefit Assignment:		<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Applicable					
* Release of Information Consent:		<input checked="" type="radio"/> Informed Consent <input type="radio"/> Yes					
Special Program Code:		<input type="text"/>	▼				
Service Date:		<input type="text"/>					
<small>** Required ONLY if "Date of Current Injury" is entered. *** Required ONLY if "Auto Accident" selected.</small>							
<input type="button" value="Save"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/>							

Enter the patients account number. If your office doesn't use one you can enter their AHCCCS ID, their name, etc..

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

Release of Information Consent; a signed statement by the patient authorizing the release of medical data to other organizations.

Provider Signature on File

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

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

Service Line Screen

Dental Claim Submission

Note: Effective 10/1/15, you must select ICD-10

Enter the diagnosis without the decimal here

Help
* Indicates a required field.

Submitter Providers Patient/Subscriber Other Payer Attachments Tooth Status Claim Information Service Lines

Diagnosis Codes(Relate Items Principal, 1, 2, or 3 by line to the Diagnosis Code Pointer)

*** Standard: ICD-9 ICD-10

Principal Diagnosis Code: Other Diagnosis Codes: 1 2 3

Universal National Tooth Designation System

Service Line

* Service Date:

* Fee: \$

* ADA Procedure Code:

ADA Modifier Codes: 1 2 3 4

Procedure Count:

Tooth Number:

Tooth Surface (1-5): 1 2 3 4 5

**Other Payer: Primary ID Paid Amount \$ Units Procedure Code/Qualifier

**Medicare: Paid Amount \$ Units Procedure Code/Qualifier

Other Adjustment(s): Medicare Deductible \$ Medicare Coinsurance \$

Date Claim Paid: Other Payer Medicare Other Adjustments

**Rendering Provider: Taxonomy Code Last/Organization Name

First Name NPI Commercial #

Add

** All or none of the information is required for the line or group.
*** Required ONLY if diagnosis codes are entered.

Save Submit Cancel

TPL payer information is entered here.

Click on the dropdown and select the place of service

Enter the following:

- Service Date
- Fee
- ADA 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

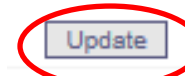
Service Lines Add and Updates

The service line will allow you to continue to “ADD” more lines, unless you click edit or remove buttons.



Line No.	Service Date	ADA Proc Code	Mod 1	Mod 2	Mod 3	Mod 4	Tooth #	Surface 1	Surface 2	Surface 3	Surface 4	Surface 5	Other Fee Payer ID	Payer Paid Amount	Procedure Code	Units	Medicare Paid Amount	Procedure Code	Units	Medicare Deductible Amount	Medicare Coinsurance Amount
1	01/01/18	D0150											65.00			0			0		
Totals:													\$65.00	\$0.00	\$0.00	\$0.00	\$0.00				

Line No.	Service Date	ADA Proc Code	Mod 1	Mod 2	Mod 3	Mod 4	Tooth #	Surface 1	Surface 2	Surface 3	Surface 4	Surface 5	Other Fee Payer ID	Payer Paid Amount	Procedure Code	Units	Medicare Paid Amount	Procedure Code	Units	Medicare Deductible Amount	Medicare Coinsurance Amount
1	01/01/18	D0150	-	-	-	-	-	-	-	-	-	-	65.00		--	0		--	0	-	-
Totals:													\$65.00	\$0.00	\$0.00	\$0.00	\$0.00				



Once you’ve entered all services lines (edited or removed), you will have the option to update the changes.

Submit

Dental Claim Submission

Help

* Indicates a required field.

Submitter Providers Patient/Subscriber Other Payer Attachments Tooth Status Claim Information Service Lines

Diagnosis Codes(Relate Items Principal, 1, 2, or 3 by line to the Diagnosis Code Pointer)

*** Standard: ICD-9 ICD-10 Principal Diagnosis Code: Other Diagnosis Codes: 1 2 3

Universal National Tooth Designation System

Service Line

* Service Date: *** Diagnosis Code Pointers: Principal 1 2 3

* Fee: \$ Place of Service:

* ADA Procedure Code: Line Item Control Number:

ADA Modifier Codes: 1 2 3 4 Oral Cavity Designation Codes: 1 2 3 4 5

Procedure Count:

Tooth Number:

Tooth Surface (1-5): 1 2 3 4 5

**Other Payer: Primary ID Paid Amount \$ Units Procedure Code/Qualifier

**Medicare: Paid Amount \$ Units Procedure Code/Qualifier

Other Adjustment(s): Medicare Deductible \$ Medicare Coinsurance \$

Date Claim Paid: Other Payer Medicare Other Adjustments

**Rendering Provider: Taxonomy Code Last/Organization Name

First Name NPI Commercial #

** All or none of the information is required for the line or group.
*** Required ONLY if diagnosis codes are entered.

Line No.	Service Date	ADA Proc Code	Mod 1	Mod 2	Mod 3	Mod 4	Tooth #	Surface 1	Surface 2	Surface 3	Surface 4	Surface 5	Other Fee Payer ID	Payer Paid Amount	Procedure Code	Units	Medicare Paid Amount	Medicare Procedure Code	Medicare Units	Medicare Deductible Amount	Medicare Coinsurance Amount	Pntr 1	Pntr 2	Pntr 3	Pntr 4	POS	Code 1	Code 2	Code 3	Code 4	Code 5	Control Number	Adjustment Pmt Date	Medicare Pmt Date	Payer Pmt Date	Taxonomy Code	Procedure Count	Renderin Provider NPI									
1	01/01/18	D0150	-	-	-	-	-	-	-	-	-	-		\$55.00											11																						
Totals:													\$65.00	\$0.00	\$0.00	\$0.00	\$0.00																														

Once you've completed entering all the relevant claim(s) information, click "Submit"

Claim Entry Confirmation Screen

Claim Entry Confirmation

Transmission Status: Successful

Claim Type: Dental

Patient Account Number: A98734947

Confirmation Code: P-269

You will receive a message that it was successful

Error:

Attachments

Beginning with services incurred on 7/1/2013, all NEMT claims must be submitted with the new AHCCCS standard Daily Trip Report. Effective with service dates 8/1/2013 and forward, any non-emergency transport claim that is submitted without the standard Daily Trip Report will be denied. It is the provider's responsibility to maintain all documentation that supports each transport service claimed. Please click [here](#) to submit an attachment.

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

View Claim

Enter New Claim

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.

Please send your questions
regarding this training to:

ProviderTrainingFFS@azahcccs.gov



Thank you!

