Claim Submission using the AHCCCS Online Provider Portal

The purpose of this training is to how to submit a claim using the AHCCCS Online Provider Portal.

*Materials are designed for FFS programs, including AIHP, TRBHAs and Tribal ALTCS

October 2020
AHCCCS Online Provider Portal
The AHCCCS Online Provider Portal can be used for:

- Claim Submission, Replacements and Voids
- Checking a Claim Status
- Submitting a Prior Authorization (PA) Request and Checking a PA Status
- Checking Member Eligibility and Enrollment

We highly recommend using the AHCCCS Online Provider Portal for the fastest service.
AHCCCS Online Provider Portal

Providers typically register after they have received approval as an AHCCCS registered provider.

Providers **must** have a valid Username and Password to use the portal.

To create an account and begin using AHCCCS Online providers must go to the following web address and follow the instructions provided on the website:


There is no charge for creating an account and there is no transaction charge.
Master Account Holder

When a newly registered provider registers with AHCCCS Online for the first time the user must request designation as the master account holder.

**Note:** The master account holder is typically the first employee or agent to register an account from that provider. However, another user can be designated as the master account holder at the provider’s request.
Master Account Holder

Once the master account holder’s account has been “registered”, the following things occur:

1. AHCCCS sends the master account holder a temporary password.
2. The master account holder logs into the AHCCCS Online Provider Portal with that temporary password, and they change it to a new password.
3. After the master account holder is set up, other employees and agents of the newly registered provider (such as a biller) may then register for an account on AHCCCS Online.
4. At that point, *it will be the master account holder’s responsibility to change that user’s account settings to ensure they have been granted the appropriate access* to the subsystems that are directly related to that user’s specific employment related duties.
Master Account Holder

The Master Account Holder is responsible for granting other users within their office/hospital/clinic/provider organization their user permissions within the AHCCCS Online Provider Portal.

Please note, that if a Master Account Holder leaves an organization (changes jobs, retires, resigns, etc.) that a new Master Account Holder needs to be designated.

• If this is not done, then new users will not have the settings they need to submit claims, prior authorizations, check eligibility status, etc.

Please keep your login information safe and remember account information may not be shared. https://azweb.statemedicaid.us
The AHCCCS Online Provider Portal

Accessing and Logging-In to Submit Claims
AHCCCS Online

From the azahcccs.gov website click on plans and providers from the toolbar, once the drop down appears click one AHCCCS Online. This link will take you to the AHCCCS Online Provider Portal.
** 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 website can be terminated if the Terms of Use are violated.

TRBHA MEMBER TRANSPORT Effective 01/01/2017. Non DHHS/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.

ATTENTION! For information regarding the Coronavirus, please refer to the AHCCCS COVID-19 website for ADHS and CDC resources and AHCCCS Frequently Asked Questions.


AHCCCS Online User Manuals

Sign In

1 Enter Username

2 Enter Password

Forget 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.
Select Claim Submission on the main menu located on the left side of the screen.

AIMH SERVICES PROGRAM
Pending SPA approval by CMS, AHCCCS proposes to offer services that support an American Indian Medical Home Program, including Primary Care Case Management (PCCM), diabetes education, care coordination, and promoting participation in the state Health Information Exchange, to AHCCCS AI/AN members who are enrolled in AIHP. AIMH PCCMs will be charged with addressing health disparities between American Indians and other populations in Arizona, specifically by enhancing case management and care coordination. AHCCCS registered JHS/638 facilities who meet AIMH registration criteria will be eligible for prospective per member per month payments based on the services and activities they are providing to empaneled members. For further details on the program, please click on AIMH Home.

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 must be contacted for claim inquiries. 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 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.
Professional CMS 1500
General Billing Information

Claims for the Capped FFS Rate are often submitted on the CMS 1500 Claim Form. The CMS 1500 claim form is used to bill for:

- IHS/638 tribal claims for individual provider services, that are not included in the AIR;
- Individual professional services at the FFS rate for FFS providers;
- Emergency and Non-Emergency Medical Transportation (NEMT) services;
- FQHC services
- Ambulatory Surgical Centers (ASC);
- Independent laboratories,
- Durable Medical Equipment (DME), and
- KidsCare outpatient services.
General Billing Information

- **Claim Form:** CMS 1500 Claim Form (Professional)
- **Diagnosis Code:** ICD-10
- **Revenue Code:** N/A
- **CPT/HCPCS Codes:** The appropriate CPT/HCPCS Code for the service provided. AHCCCS hosts a coding resource webpage on the Medical Coding Resources webpage at:
  - [https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html](https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html)
- **Modifiers:** The appropriate modifiers should always be used, in accordance with national coding standards.
On a CMS-1500 Claim Form:

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

• For detailed, step-by-step instructions on how to fill out the CMS 1500 Claim Form please visit Chapter 5, of the FFS Provider Billing Manual at:
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...**

**Click on the drop down and select Professional, Click “GO”**

### View Claim Processing Status

- Submission Date(s):
- **Go...**
Confirm the Submitter information is correct

Then Click the Providers tab at the top of the page
Billing Provider Tab

*Materials are designed for FFS programs, including AIHP, TRBHAs and Tribal ALTCS
Billing Provider Tab

• This is where you will enter the provider or group billing information. In the Tax ID field enter the Billing Provider’s Tax ID, if a group is billing enter the Group Biller Tax ID number.

• Providers with valid NPI, will leave the provider commercial number field blank. Enter the 10 digit NPI in the CMMS National Provider ID field and click find.

• Providers who do not have a valid NPI will be use the 6 digit AHCCCS Provider ID in the Provider Commercial Number field.
Enter the 9 digit TAX ID number and click on EIN
NPI or AHCCCS ID

Providers without an NPI will use their AHCCCS 6 digit AHCCCS provider number in the Provider Commercial Number field. Leaving the NPI field blank.

If you do have an NPI enter the number in the CMMS National Provider ID field. Click Find when you have completed the required fields.
Entity Type Qualifier
Click your entity type: Person or Non-Person

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).
Selecting locator code is **required** for service and pay-to-locator.

The locator code determines the address to which payment is sent to. The Remittance Advice is will be mailed to the provider’s pay-to address if the provider is not set up for electronic remittance advices.
Rendering Provider Tab
The process for completing the Rendering Provider Tab is almost identical to the Billing Tab.

Enter the rendering provider’s NPI in the appropriate field. If the rendering provider does not have a NPI, enter their 6-digit AHCCCS Provider ID and leave the NPI field blank.

Providers without an NPI will use their AHCCCS 6 digit AHCCCS provider number in the Provider Commercial Number field. Leave the NPI field blank.

If you do have an NPI enter the number in the CMMS National Provider ID field. Click “Find” when you have completed the required fields.
Patient/Subscriber Tab
Patient/Subscriber Tab

Enter the member’s AHCCCS ID and Date of Birth (MM/DD/YYYY) click FIND and verify the member’s information.

* Member ID Number/Date of Birth: A10093242 06/23/1988
  Person Name: AHCCCS, SEDONA
  Gender: F
  Residential Address: 701 E JEFFERSON ST
  PHOENIX, AZ 85038
* Payer Responsibility: P - Primary

NOTE: AHCCCS no longer accepts ADOC claims.
Patient/Subscriber Tab

Click on the **Payer Responsibility** drop down. Providers must determine the AHCCCS payment after Medicare and all other first and third party payers.

This mock claim will identify AHCCCS as the Primary Payer and highlight P-Primary.

*Member ID Number/Date of Birth:* A10093242 06/23/1988

**Person Name:** AHCCCS, SEDONA

**Gender:** F

**Residential Address:** 701 E JEFFERSON ST
PHOENIX, AZ 85038

* **Payer Responsibility:** P-Primary

NOTE: AHCCCS no longer accepts ADOC claims.
Attachments Tab

If no attachments, click “Claim Information” tab next
The Attachment tab is the only way to notify the AHCCCS processing system that you are submitting an Electronic attachment with the claim. From the time of claim submission, providers have **15 days** to upload attachments using the Transaction Insight Portal.

### Claim Attachments

<table>
<thead>
<tr>
<th>Report Type **</th>
<th>Report Transmission **</th>
<th>Control Number **</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4 - Referral Form</td>
<td>EL - Electronically Only</td>
<td>A0934000709232019</td>
</tr>
</tbody>
</table>

**Attachments (1-10):**
Attachments Tab

- **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

<table>
<thead>
<tr>
<th>Submitter</th>
<th>Providers</th>
<th>Patient/Subscriber</th>
<th>Ambulance</th>
<th>Other Payer</th>
<th>Attachments</th>
<th>Claim Information</th>
<th>Service Lines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Attachments</td>
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**Claim Attachments**

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<td>1 B4 - Referral Form</td>
<td>EL - Electronically Only</td>
<td>A0934000709232019</td>
</tr>
</tbody>
</table>

**The Report Type (B4) and Report Transmission (EL) codes should be used only.**
The control number is also referred to as the PWK number. A PWK number is a unique number that you will create for each claim/document that you submit. It allows the system to link the attachment to the correct claim.

Enter the PWK number, it is recommended to use:
Members AHCCCS ID followed by the date of service. AXXXXXXXMMDDYYYY

<table>
<thead>
<tr>
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<th>Control Number</th>
</tr>
</thead>
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<tr>
<td>1</td>
<td>B4 - Referral Form</td>
<td>✓</td>
<td>EL - Electronically Only</td>
</tr>
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<td>3</td>
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<tr>
<td>9</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
Control Number (PWK number)

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

<table>
<thead>
<tr>
<th>AHCCCS ID (9-character AHCCCS ID)</th>
<th>Date of Service</th>
<th>PWK for Claim 1, Document 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>A12345678</td>
<td>01/03/18</td>
<td>A1234567801032018</td>
</tr>
</tbody>
</table>

Different AHCCCS ID member with the Same Date of Services

<table>
<thead>
<tr>
<th>AHCCCS ID (9-character AHCCCS ID)</th>
<th>Date of Service</th>
<th>PWK for Claim 2, Document 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>A87654321</td>
<td>01/03/18</td>
<td>A8765432101032018</td>
</tr>
</tbody>
</table>

The combination of the member’s AHCCCS ID and the Date of Service is what makes the PWK number unique to each claim.
Claim Information Tab
The Patient Control Number is **NOT** the same thing as the PWK number. The Patient Control Number is a number that the provider uses internally.

If your office doesn’t use a patient control number, you may enter the members AHCCCS ID or First/Last Name, etc...
## Claim Information Tab

### Claim Information Table

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Reference Number</td>
<td>[ ] Replacement [ ] Void</td>
</tr>
<tr>
<td>Prior Authorization Number</td>
<td></td>
</tr>
<tr>
<td>* Patient Control Number</td>
<td>A09340007</td>
</tr>
<tr>
<td>Medical Record ID Number</td>
<td></td>
</tr>
<tr>
<td>Initial Treatment Date</td>
<td></td>
</tr>
<tr>
<td>Date of Current Injury</td>
<td>[ ] (Accident)</td>
</tr>
<tr>
<td>** Patient’s Condition Related To:</td>
<td>[ ] Employment [ ] Other Accident [ ] Auto Accident</td>
</tr>
<tr>
<td>*** Place in which accident occurred:</td>
<td>[ ] (State)</td>
</tr>
<tr>
<td>Special Program Indicator</td>
<td></td>
</tr>
<tr>
<td>* Provider Signature on File</td>
<td>[ ] Yes [ ] No</td>
</tr>
<tr>
<td>* Provider Accept Assignment</td>
<td>[ ] Assigned [ ] Accepted on Clinical Lab Services Only [ ] Not Assigned</td>
</tr>
<tr>
<td>* Benefit Assignment</td>
<td>[ ] Yes [ ] No [ ] Not Applicable</td>
</tr>
<tr>
<td>* Release of Information Consent</td>
<td>[ ] Informed Consent [ ] Yes</td>
</tr>
</tbody>
</table>
Claim Information Tab

- Provider Signature on File
- Provider Accepts Assignments - Click yes if you are accepting payment from AHCCCS
- Benefit Assignments - Mark yes if member has indicated that payment should go directly to the provider.
- Release of Information Consent - A signed statement by the patient authorizing the release of medical data to other organizations.
Service Lines Tab

On the left side click the radio dial next to ICD-10. **NOTE: Effective 10/01/15, you must select ICD-10**

To the right side of the screen you will see the Diagnosis Codes field. Up to 12 DX codes can be entered **WITHOUT the decimal.**
Service Lines Tab

Click the corresponding pointer to each diagnosis code, if more then one diagnosis code is entered be sure to click all the boxes that apply.

| Diagnosis or Nature of Illness or Injury (Relate Items 1 - 12 by line to the Diagnosis Code Pointer) |
| * Standard: **ICD-9** ○ICD-10 | * Diagnosis Codes: | 1 | R6889 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |

| Service Line |
| * Diagnosis Code Pointers: | 1 | ✔ | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| * Line Charges: | $14.54 |
| ** Place of Service Code (POS): | 99 - OTHER UNLISTED FACILITY |
| Modifier Codes: | 1 | 2 | 3 | 4 |
| Prescription Date: |
| National Drug Code: |
| ** Prescription #: Identifier: |
## Service Lines Tab

### Diagnosis or Nature of Illness or Injury

<table>
<thead>
<tr>
<th>Standard:</th>
<th>ICD-9</th>
<th>ICD-10</th>
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<table>
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<tr>
<th>Diagnosis Codes:</th>
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<tbody>
<tr>
<td>1</td>
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<tr>
<td>7</td>
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</table>

### Service Line

- **Service Dates:** 09/23/2019 - 09/23/2019
- **Line Charges:** $14.54
- **Quantity:** 2
  - Minutes □  Units □
- **HCPCS Code:** A0120

**Notes:**
- Enter the to and from dates of service
- Line Charges
- Number of Units or Minutes
- HCPCS code (procedure code)
Service Lines Tab

Diagnosis or Nature of Illness or Injury (Relate Items 1 - 12 by line to the Diagnosis Code Pointer)

<table>
<thead>
<tr>
<th>* Standard:</th>
<th>ICD-9</th>
<th>ICD-10</th>
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<th>1</th>
<th>R6889</th>
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Service Line

<table>
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<tr>
<th>* Diagnosis Code Pointers:</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
</table>

Click the down arrow and select POS
If applicable you can enter up to four modifiers.

* Place of Service Code (POS): 99 - OTHER UNLISTED FACILITY

Modifier Codes:

1 | 2 | 3 | 4

Prescription Date:

**Prescription #/Identifier:
When done, click the `Add` button to clear the screen and allow you to enter a new service line if applicable.
Service Lines – Continued

**Top screen**  The Service Line will allow you to continue to Add more lines unless you click the edit or the remove button.

**Bottom screen**  When you have entered all Service Lines whether you edited or removed items, you will have the option to Update the changes.

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### Service Lines – Continued

<table>
<thead>
<tr>
<th>Line Begin Date</th>
<th>End Date</th>
<th>POS HCPCS</th>
<th>Mod Mod Mod Mod Mod Mod Code Units</th>
<th>NDC</th>
<th>NDC</th>
<th>Diag Diag Diag Diag Diag Diag Diag Diag Diag Diag Diag Min./ Units</th>
<th>Type</th>
<th>Line Charges</th>
<th>Medicare Paid Amount</th>
<th>Procedural Code</th>
<th>Medicare Deductible Amount</th>
<th>Medicare Coinsurance Amount</th>
<th>Medicare Other Copay Amount</th>
<th>Medicare Other Copay Amount ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/23/2019</td>
<td>9/28/2019</td>
<td>03</td>
<td>A0120</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>UN</td>
<td>14.34</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Totals: $14.34 $0.00 $0.00 $0.00 $0.00

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**All or none of the information is required for the line or group.**
Claim Entry Confirmation

- **Transmission Status:** Successful
- **Claim Type:** Professional
- **Patient Account Number:** A09340007
- **Confirmation Code:** P-297

**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.

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
Institutional (UB-04) Claim Form
General Billing Information

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

- IHS/638 Facility Inpatient and Outpatient Claims for Title XIX (Medicaid) for reimbursement at the AIR;
- Inpatient Title XXI (KidsCare) members;
- Nursing facility services;
- Free-standing birthing centers;
- Hospice services;
- Residential Treatment Center (RTC) services; and
- Dialysis facility services.
General Billing Information

- **Claim Form:** UB-04 Claim Form (Institutional)
- **Diagnosis Code:** ICD-10
- **Revenue Code:** The appropriate revenue code for the services provided are used to bill facility line-item services.
- **CPT/HCPCS Codes:** The appropriate CPT/HCPCS Code must be used to identify the service(s) rendered.
- **Modifiers:** The appropriate modifiers should always be used, in accordance with national coding standards.

AHCCCS hosts a coding resource webpage on the Medical Coding Resources webpage at:

- [https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html](https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html)
General Billing Information

On a UB-04 Claim Form:

• For detailed, step-by-step instructions on how to fill out the UB-04 Claim Form please visit Chapter 6, of the FFS Provider Billing Manual at:
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
- Professional
- Dental

Go...

View Claim Processing Status

Submission Date(s):

Go...

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
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
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
1. This is the Claim information screen – fill out all the areas marked by red asterisks
2. Provider Accept Assignment – select “Assigned” if you are accepting payment from AHCCCS
3. Benefit Assignment – select “Not Applicable”
4. Release of Information Consent – select “Informed Consent” if a signed consent by the patient to release medical data is on file
5. Patient Control Number – Enter patients acct # or AHCCCS ID depending on your office
6. Patient Status – click the ▼ and choose from the list
7. Total Claim Charge Amount – Enter the total charges from the whole claim.
8. Facility Type Code – click the ▼ and choose from the list.
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 date span 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
<table>
<thead>
<tr>
<th><strong>1</strong></th>
<th>This is the Claim Entry Confirmation screen</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2</strong></td>
<td>The Transmission status will let you know the claim was submitted successfully</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>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</td>
</tr>
</tbody>
</table>
Claim Type Dental (ADA Form)
General Billing Information

The ADA 2012 claim form is used to bill for dental claims.
AHCCCS will only accept the ADA 2012 claim form. Other ADA forms received will be returned to the provider.
For detailed, step-by-step instructions on how to fill out the ADA 2012 Claim Form please visit Chapter 7, of the FFS Provider Billing Manual at:

General Billing Information

• **Claim Form:** ADA 2012 Claim Form (Dental)
• **Diagnosis Code:** When an applicable dental claim requires a diagnosis, code, it must use an ICD-10 diagnosis code.
• **CPT/HCPCS Codes:** Enter the appropriate CDT procedure code from the CDT-4 Manual.
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: 065004791

NOTE: You cannot view the processing status of claims submitted by other users.

Enter New Claim

Type of Claim: Professional

View Claim Processing Status

Submission Date(s): Go...

1 Enter New Claim – Select Dental in the
2 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
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. CMMS National Provider ID (NPI) – enter valid NPI#, leaving the Provider Commercial Number blank.
4. Entity type – select “person” if the ID belongs to a person, or “non-person” if a company is identified.
5. Health Care Provider Taxonomy Code (When/if required depending on service)
   http://www.healthlink.com/tech_tip_taxonomy_code.asp
6. Click Find – provider information should be displayed.
7. 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 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
<table>
<thead>
<tr>
<th>Step</th>
<th>Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>This is the Claim Information screen – fill out all the areas marked by red asterisks</td>
</tr>
<tr>
<td>2</td>
<td>Patient Control Number – Enter the members AHCCCS ID or Patient Acct Number</td>
</tr>
<tr>
<td>3</td>
<td>Place of Service – click the ▼ and choose from the list</td>
</tr>
<tr>
<td>4</td>
<td>Provider Signature – select “yes” if you are a billing agency &amp; you have the provider’s signature on file</td>
</tr>
<tr>
<td>5</td>
<td>Provider Accept Assignment – select “Assigned” if you are accepting payment from AHCCCS</td>
</tr>
<tr>
<td>6</td>
<td>Benefit Assignment – select “Not Applicable”</td>
</tr>
<tr>
<td>7</td>
<td>Release of Information Consent – select “Informed Consent” if a signed consent by the patient to release medical data is on file</td>
</tr>
<tr>
<td>8</td>
<td>Select the service lines tab</td>
</tr>
</tbody>
</table>
1. 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)

2. Principal Diagnosis Code – Enter Principal Diagnosis Code

3. Service Date – Enter Service Date

4. ADA Procedure Code – Enter ADA Procedure Code
Continuation in the Service Lines screen

5 Tooth Number – Enter ToothNumber

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
Service Lines – Continued

Top screen

The Service Line will allow you to continue to Add more lines unless you click the edit or the remove button.

Bottom screen

When you have entered all Service Lines whether you edited or removed items, you will have the option to Update the changes.
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 a New Claim
DFSM Provider Education and Training Unit
Education and Training Questions?

The DFSM Provider Education and Training Unit can assist providers with the following:

- How to submit and status claims or prior authorization requests through the AHCCCS Online Provider Portal (FFS programs, including AIHP, TRBHAs and Tribal ALTCS)
- Submission of documentation using the Transaction Insight Portal (e.g. The AHCCCS Daily Trip report, requested medical records, etc.)

Additionally the DFSM education and training unit offers trainings with informational updates to program changes, system updates, and changes to the AHCCCS policy, AHCCCS guides and manuals.
Education and Training Questions?

The DFSM Provider Education and Training Unit does not instruct providers on how to code or bill for a particular service.

For additional information on rates and coding please follow the below guidelines:

❖ **Rates** - Questions on AHCCCS FFS rates should be directed to the rates team at **FFSRates@azahcccs.gov**

❖ **Coding** - Questions on AHCCCS Coding should be directed to the coding team at **CodingPolicyQuestions@azahcccs.gov**

**NOTE:** The Coding team cannot instruct providers on how to code or bill for a particular service. Those questions should be directed to the provider’s professional coder/biller.

❖ **ACC Plan Claims** - Questions regarding the submission of claims to an AHCCCS Complete Care (ACC) Health Plan should be directed to the appropriate ACC Health Plan.
Education and Training Questions?

The DFSM Provider Training Team can be outreached at providertrainingffs@azahcccs.gov.
Questions?

Please outreach
ProviderTrainingFFS@azahcccs.gov
Thank You.