Institutional (UB-04) Claim Submission Using the AHCCCS Online Provider Portal

DFSM Provider Training Team

June 2021
About this Course

Please note that these materials are designed for Fee-for-Service programs, including the American Indian Health Program (AIHP), Tribal Regional Behavioral Health Authorities (TRBHAs), and Tribal Arizona Long Term Care Services (ALTCS).

This training presentation will cover how to submit Institutional (UB-04) Claims using the AHCCCS Online Provider Portal.

If you have any questions about this presentation please email the providertrainingffs@azahcccs.gov
AHCCCS Online Provider Portal
AHCCCS Online Provider Portal

The AHCCCS Online Provider Portal can be used for:

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

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 and only AHCCCS registered providers can use the Online Provider 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. There can be multiple master account holders.
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

How to Submit Claims
AHCCCS Online

From the [www.azahcccs.gov](http://www.azahcccs.gov) website click on plans and providers from the toolbar, once the drop down appears click one [AHCCCS Online](http://www.azahcccs.gov). This link will take you to the AHCCCS Online Provider Portal.
AHCCCS Online

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 website can be terminated if the Terms of Use are violated.

TRBHA MEMBER TRANSPORT Effective 01/01/2017. Non DSHS/538 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.

11
On the left-hand side of the page select “Claim Submission”.

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 IHS/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.
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:
The AHCCCS Online Provider Portal

How to Submit Claims
AHCCCS Online

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AHCCCS Online User Manuals

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Username
Password

Sign In

1. Enter Username
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Forget your Password? Click Here

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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] [Institutional] [Dental]

Go...

View Claim Processing Status

Submission Date(s): [ ] [ ] [Go...]

1 Enter New Claim – Select Institution on the ▼
2 Click on “Go”...
# Institutional Claim Submission

This is the Submitter screen—verify the correct provider information (some providers have more than 1 ID)

1. **Select the Providers tab next**
Billing Provider Tab
Billing Provider Tab

• This is where you will enter the provider or group billing information.
  o 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 a valid NPI**, will leave the provider commercial number field blank. They will then enter the 10-digit NPI in the **CMMS National Provider ID field** and click find.

• **Providers who do not have a valid NPI** will use the 6 digit AHCCCS Provider ID in the **Provider Commercial Number field**.
This is the Billing screen – fill out all the areas marked by red asterisks

1. Tax ID – enter biller or group tax ID
2. CMMS National Provider ID (NPI) – enter valid NPI#, leaving the Provider Commercial Number blank (Hospital or facility can only bill using the NPI number)
3. Entity type – select “non-person”
4. Click Find – either hospital or facility information should be displayed
5. Select the Referring tab next
Tax ID Field

Enter the 9 digit TAX ID (Biller or Group number) and click on EIN
Providers **WITH a valid NPI** enter their NPI in the CMMS National Provider ID field. Click “Find” when the required fields are completed. Leave the Provider Commercial Number blank (Hospitals and Facilities can only bill using an NPI number).
Entity Type Qualifier

Click your Entity Type: Person or Non-Person

• Click Person, if the ID number comes up as a person’s name.
• Click Non-Person Entity, if the ID comes up with a company’s name.
Selecting locator code is **required** for the “Service Locator Code/Address” and the “Pay-To Locator Code/Address” Fields.

The locator code determines the address to which payment is sent. The Remittance Advice will be mailed to the provider’s pay-to address if the provider is not set up for electronic remittance advices.

![Billing Provider form](image)
Referring and Attending Provider Tabs
Patient/Subscriber Tab
<table>
<thead>
<tr>
<th>Step</th>
<th>Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>This is the Referring Providers screen</td>
</tr>
<tr>
<td>2</td>
<td>CMMS National Provider ID– Enter NPI number</td>
</tr>
<tr>
<td>3</td>
<td>Click Find – the Referring Provider information should be displayed</td>
</tr>
<tr>
<td>4</td>
<td>Select the Attending Provider tab next</td>
</tr>
</tbody>
</table>
1. This is the Attending Provider screen – required for Institutional/UB-04
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
Enter the member’s **AHCCCS ID and Date of Birth (MM/DD/YYYY)**. Click “Find” and verify that the member’s information is correct.

<table>
<thead>
<tr>
<th>Insured or Subscriber</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Member ID Number/Date of Birth:</td>
</tr>
<tr>
<td>Person Name:</td>
</tr>
<tr>
<td>Gender:</td>
</tr>
<tr>
<td>Residential Address:</td>
</tr>
<tr>
<td>* Payer Responsibility:</td>
</tr>
</tbody>
</table>

**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 identifies AHCCCS as the Primary Payer and highlight P-Primary.

**Insured or Subscriber**

- **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.
Optional Tabs
Optional Tabs (if applicable)

• Procedure Codes
• Condition Codes
• Occurrence Codes
• Value Codes
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
## Diagnosis Codes Tab

### Institutional Claim Submission

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

### Diagnosis Information

**Principal Diagnosis Code:** T78.40XA

**Admitting Diagnosis Code:**

**External Cause of Injury Codes (1-12):**

1  
2  
3  
4  
5  
6  
7  
8  
9  
10 
11 
12

**Other Diagnosis (1-24):**

<table>
<thead>
<tr>
<th>Code</th>
<th>Present on Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>E11.65</td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
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<td>11</td>
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<tr>
<td>12</td>
<td></td>
</tr>
</tbody>
</table>

**Present on Admission:**

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

**AHCCCS**
Attachments Tab
Attachments Tab

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.

<table>
<thead>
<tr>
<th>Attachments (1-10):</th>
<th>Report Type **</th>
<th>Report Transmission **</th>
<th>Control Number **</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>B4 - Referral Form</td>
<td>✔ EL - Electronically Only</td>
<td>✔ A093400709232019</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
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<tr>
<td>10</td>
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</tr>
</tbody>
</table>
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>
</table>

**Claim Attachments**

**Report Type**

|   | 1 | B4 - Referral Form |

**Report Transmission**

|   |   | EL - Electronically Only |

**Control Number**

- A0934000709232019

The Report Type (B4) and Report Transmission (EL) codes should be used only.
Attachments Tab

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 recommend to use:
Members AHCCCS ID followed by the date of service. AXXXXXXXMMDDYYYY
## 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>PWK for Claim 1, Document 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>A12345678</td>
<td>A1234567801032018</td>
</tr>
</tbody>
</table>

The A in AHCCCSID must be in uppercase.

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>01/03/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>PWK for Claim 1, Document 1</td>
<td></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>PWK for Claim 2, Document 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>A87654321</td>
<td>A8765432101032018</td>
</tr>
</tbody>
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<td></td>
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</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
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 down arrow and choose from the list
Continuation in the Claim information screen

7. Total Claim Charge Amount – Enter the total charges from the whole claim
8. Facility Type Code – click the ▼ and choose from the list
9. Standard – select ICD-10
10. If inpatient – Enter Admission type - click the ▼ and choose from the list
11. If inpatient – Enter Admission date – Enter the date the member was seen
12. If inpatient – Enter Admission/Discharge time
13. Statement From date span or single date
14. Select the Service Lines tab next
Service Line Tab
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.
This is the Claim Entry Confirmation screen

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

You have 2 options: View Claim to give you a summary of the claim that will be sent to AHCCCS or Enter a New Claim
DFSM Provider Education and Training Unit
DFSM Provider Training

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 (i.e. the AHCCCS Daily Trip report, requested medical records, etc.).

Additionally, the DFSM Provider 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
  o 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.

The DFSM Provider Training Team can be reached at ProviderTrainingFFS@azahcccs.gov
Technical Questions?

For technical assistance with the AHCCCS Online Provider Portal, please call:
• AHCCCS ISD Customer Support Desk at 602-417-4451 or
  ISDCustomerSupport@azahcccs.gov
Claims Questions?

For claims questions that cannot be resolved on the portal, please outreach the Claims Customer Service team at:

- Phone: (602) 417-7670 – Select Option 4
- From: Monday – Friday from 7:30am – 4:00pm (Phoenix Time).

The Claims Customer Service team can assist with the following items:

- Details regarding a claim status that cannot be answered on the AHCCCS Online Provider Portal;
- Providing denial codes and general information regarding denied claims; and
- Providing general information about approved and pended claims.

**NOTE:** Providers should not call the Claims Customer Service team if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, the address a check was mailed to, and payment details for approved claims.
Policy Information

AHCCCS FFS Provider Billing Manual:
•  https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

AHCCCS IHS/Tribal Provider Billing Manual:
•  https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.html

AHCCCS Medical Policy Manual
•  https://www.azahcccs.gov/shared/MedicalPolicyManual/
Thank You.