CMS 1500 Claim Submission Using the AHCCCS Online Provider Portal

DFSM Provider Training Unit

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 the CMS 1500 Professional claim using the AHCCCS Online Provider Portal.

If you have any questions about this presentation, please email the providertrainingffs@azahcccs.gov
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.

Only AHCCCS registered providers can use the Online Provider Portal and 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:

• https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f

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
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.
General Billing Information

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 paper CMS 1500 Claim Form please visit Chapter 5, of the FFS Provider Billing Manual at:
  
The AHCCCS Online Provider Portal

How to Submit Claims
AHCCCS Online

From the www.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.
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.

TRIBHIA MEMBER TRANSPORT Effective 01/01/2017. Non-DHS/638 NEMT providers transporting TRIBHIA 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.
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 AIMH. 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.
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  
Click on the drop down and select Professional, Click “GO”

**View Claim Processing Status**

Submission Date(s):  -  
Go...
1) Confirm the Submitter information is correct
   • Organization Name, Electronic Transmitted ID Number, Information Contact Name and Telephone Number

2) Then Click the **Providers** tab at the top of the page
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.
Tax ID Field

Enter the 9 digit TAX ID number and click on EIN.
Providers **without an NPI** will use their AHCCCS 6 digit AHCCCS provider number in the Provider Commercial Number field. They will leave the NPI field blank.

Providers **WITH a valid NPI** will enter their NPI in the CMMS National Provider ID field. Click “Find” when the required fields are completed.

**NOTE:** Required fields are denoted with a red asterisk.
Entity Type Qualifier

Click your Entity Type: Person or Non-Person

<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>Billing Provider</td>
<td>Rendering Provider</td>
<td>Referring Provider</td>
<td>Service Facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Billing Provider**

- **Tax ID:** 123456789
- **Provider Commercial Number:** 007835
- **CMMS National Provider ID (NPI):**
- **Entity Type:**
  - 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.

**Health Care Provider Taxonomy Code:**

**Provider Name:** NEMT TEST

**Information Contact Name:**

**Information Contact Telephone Number:** 6024177000

**Service Locator Code/Address:** 01 701 E JEFFERSON PHOENIX, AZ 85034

**Pay-To Locator Code/Address:** 01 701 E JEFFERSON PHOENIX, AZ 85034
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.
Rendering Provider Tab
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. They will leave the NPI field blank.

Providers with a valid NPI shall enter their NPI in the CMMS National Provider ID field. Click “Find” when required fields are completed.

Click “Find” – Provider information should be displayed.
Patient/Subscriber Tab
Patient/Subscriber Tab

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>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>
```

**Insured or Subscriber**

<table>
<thead>
<tr>
<th>* Member ID Number/Date of Birth:</th>
<th>A10093242</th>
<th>06/23/1988</th>
<th>Find</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person Name:</td>
<td>AHCCCS, SEDONA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender:</td>
<td>F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential Address:</td>
<td>701 E JEFFERSON ST</td>
<td>PHOENIX, AZ 85038</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>* Payer Responsibility:</th>
<th>P - Primary</th>
</tr>
</thead>
</table>

*Indicates a required field.

**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.

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

**NOTE:** AHCCCS no longer accepts ADOC claims.
Attachments Tab

If no attachments, click “Claim Information” tab next
The Attachments Tab (AHCCCS Online Provider Portal) & the Transaction Insight Portal

Certain types of claims require additional documentation to be submitted.

Documentation is submitted using the Transaction Insight Portal, and it links to the correct claim based on information entered into the Attachments Tab.

- In order for the documentation (submitted through the Transaction Insight Portal) to attach to the claim (submitted through the AHCCCS Online Provider Portal) it is **vital** that the documentation be linked to the claim.

Linking occurs by using the exact same Control/PWK Number in both the Transaction Insight Portal and the AHCCCS Online Provider Portal.
The Attachments Tab (AHCCCS Online Provider Portal) & the Transaction Insight Portal

What is the Control/PWK Number?

- It is a unique number that a provider creates for each claim/document that they submit.
- This unique number forms an electronic match between the submitted documentation (Transaction Insight Portal) and the claim (AHCCCS Online Provider Portal).
- It allows the system to link the attachment to the correct claim.

The Control/PWK Number is entered in **twice**.
- **First,** it is entered in by the provider when they submit their claim via the AHCCCS Online Provider Portal; and then
- **It is entered in a second time** when they submit their documentation on the Transaction Insight Portal.
The Control/PWK Number and Provider Identifier

The blue circled areas must match, and the red circled areas must match.
Information on the Transaction Insight Portal

Transaction Insight Portal

For additional information on how to submit documentation using the Transaction Insight Portal, so that the documentation matches to the correct claim, please visit the DFSM Provider Training web page at:


• Trainings on the Transaction Insight Portal can be found under “Trainings by Subject” and under the Video Library.
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

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

<table>
<thead>
<tr>
<th>Report Type **</th>
<th>Report Transmission **</th>
<th>Control Number **</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 B4 - Referral Form</td>
<td>EL - Electronically Only</td>
<td>A0934000709232019</td>
</tr>
</tbody>
</table>

Attachments Tab

<table>
<thead>
<tr>
<th>Attachments (1-10):</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>10</td>
</tr>
</tbody>
</table>
Attachments Tab

The control number is also referred to as the PWK number. A PWK number is a unique number that the provider creates for each claim/document they 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. AXXXXXXMMDDYYYY
Attachments Tab

The Attachment tab is the only way to notify the AHCCCS processing system that the provider is 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>Report Type **</th>
<th>Report Transmission **</th>
<th>Control Number **</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 84 - Referral Form</td>
<td>✓ EL - Electronically Only</td>
<td>✓ A0934000709232019</td>
</tr>
<tr>
<td>2</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>6</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>7</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>8</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>9</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>10</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Attachments (1-10):**
## Control Number (PWK number)

<table>
<thead>
<tr>
<th>Example of a PWK number using a member’s AHCCCS ID and the Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AHCCCS ID (9-character AHCCCS ID)</strong></td>
</tr>
<tr>
<td>The A in AHCCCSID must be in uppercase</td>
</tr>
<tr>
<td><strong>Date of Service</strong></td>
</tr>
<tr>
<td><strong>PWK for Claim 1, Document 1</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Different AHCCCS ID member with the Same Date of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AHCCCS ID (9-character AHCCCS ID)</strong></td>
</tr>
<tr>
<td>The A in AHCCCSID must be in uppercase</td>
</tr>
<tr>
<td><strong>Date of Service</strong></td>
</tr>
<tr>
<td><strong>PWK for Claim 2, Document 2</strong></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

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Reference Number</td>
<td></td>
</tr>
<tr>
<td>Prior Authorization Number</td>
<td></td>
</tr>
<tr>
<td>* Patient Control Number</td>
<td>A093400007</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</td>
</tr>
<tr>
<td>*** Place in which accident occurred:</td>
<td>Yes</td>
</tr>
<tr>
<td>Special Program Indicator</td>
<td></td>
</tr>
<tr>
<td>* Provider Signature on File</td>
<td>Yes</td>
</tr>
<tr>
<td>* Provider Accept Assignment</td>
<td>Assigned</td>
</tr>
<tr>
<td>* Benefit Assignment</td>
<td>Yes</td>
</tr>
<tr>
<td>* Release of Information Consent:</td>
<td>Informed Consent</td>
</tr>
</tbody>
</table>
Claim Information Tab

• Provider Signature on File – Click yes if 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
To the right side of the screen, you will see the Diagnosis Codes field.

- Enter the DX codes. **Do not include the decimal point when entering the DX codes** (ex. correct format (R6889) incorrect format (R68.89)).
- Up to 12 DX codes can be entered **WITHOUT the decimal.**

**Service Lines**

<table>
<thead>
<tr>
<th>Service Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Diagnosis Code Pointers: 1</td>
</tr>
<tr>
<td>* Line Charges: $14.54</td>
</tr>
<tr>
<td>* Quantity: 2</td>
</tr>
<tr>
<td>* HCPCS Code: A0120</td>
</tr>
<tr>
<td>National Drug Code:</td>
</tr>
<tr>
<td><strong>Place of Service Code (POS): 99 - OTHER UNLISTED FACILITY</strong></td>
</tr>
<tr>
<td>* Modifier Codes: 1</td>
</tr>
</tbody>
</table>

On the left side click the radio dial next to ICD-10.

- **NOTE:** Effective 10/01/15, you must select ICD-10.
Service Lines

Enter the following:
- Diagnosis Code Pointers
- Service Dates (To and From)
- Line Charges
- Number of Units or Minutes
- CPT / HCPCS code
Service Lines

Diagnosis Code Pointers
• Click the corresponding pointer to each diagnosis code.
• If more than one diagnosis code is entered be sure to click all the boxes that apply.
### 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>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>* Diagnosis Codes:</th>
<th>1</th>
<th>R6889</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7</td>
<td></td>
<td>8</td>
<td></td>
<td>9</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td></td>
<td>12</td>
<td></td>
<td>13</td>
<td></td>
<td>14</td>
</tr>
</tbody>
</table>

#### Service Line

* Diagnosis Code Pointers: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12

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

**Modifier Codes:** 1, 2, 3, 4

**National Drug Code:**

**Prescription Date:**

**Prescription #/Identifier:**
When done, click the ADD button.

1. This will clear the screen and allow you to enter a new service line if needed.
2. This newly added service line will appear at the bottom of the screen.
3. The service line tab will allow you to add more service lines (each new one appearing at the bottom of the screen) until you proceed with the submission of the claim.
Entered lines will appear at the bottom of the Service Lines tab, as shown here.

As each new line is added, a blank Service Line section will appear.
- New Service Lines may be entered here.
- Click “Add” to add new service lines.

Once you’ve completed entering all the relevant claim(s) information, click “Submit”.
Professional - 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.

**Ahcccs**

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After all services lines are entered, review the claim information, if okay, Click the “Submit” Button.
If a required field is missing information, the Online system will identify the fields that have an error. Make the necessary correction(s) and proceed with the claim submission.
# Claim Entry Confirmation

<table>
<thead>
<tr>
<th><strong>Transmission Status:</strong></th>
<th>Successful</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claim Type:</strong></td>
<td>Professional</td>
</tr>
<tr>
<td><strong>Patient Account Number:</strong></td>
<td>A09340007</td>
</tr>
<tr>
<td><strong>Confirmation Code:</strong></td>
<td>P-297</td>
</tr>
</tbody>
</table>

## 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.

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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**
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.
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.