

AHCCCS ON-LINE CLAIM SUBMISSION MANUAL

Section 7.b:

Medicare Deductible/Coinsurance

**Medicare Inpatient/Outpatient
Deductible and Co-insurance**

(Institutional) Medicare Inpatient/Outpatient Deductible /Co-insurance

Institutional Claim Submission

[Help](#)

* Indicates a required field.

Submitter Providers Patient/Subscriber Other Payer **Codes/Values** Attachments Claim Information Service Lines

Procedure Codes Diagnosis Codes Condition Codes Occurrence Codes **Value Codes**

Value Codes/Amounts			
Code	Amount **	Code	Amount **
1 B1	\$ 140	2 B2	\$ 23.20
3	\$	4	\$
5	\$	6	\$
7	\$	8	\$
9	\$	10	\$

Values (1-12):

** Required ONLY if Value Code is submitted.

Submit Cancel

- A1 DEDUCTIBLE
- A2 CO-INSURANCE
- B1 DEDUCTIBLE
- B2 CO-INSURANCE
- C1 DEDUCTIBLE
- C2 CO-INSURANCE

Effective 08/01/2013 value codes A1, A2, B1, B2, and C1, C2 will no longer be accepted if entered in the Value code fields.

The deductible and co-insurance must be entered in the service line tab.

All other Value codes will be accepted here.

Enter Medicare Inpatient/Outpatient Deductible /Co-insurance Amounts

Institutional Claim Submission

[Help](#)

* Indicates a required field.

Submitter Providers Patient/Subscriber Other Payer Codes/Values Attachments Claim Information **Service Lines**

Service Line

* Service Dates: 07/15/2013 - 07/15/2013 * Service Unit Count: 1 Days Units

** Revenue Code: 0510 * Line Item Charge Amount: \$ 330

** HCPCS: Non-Covered Charge Amount: \$

National Drug Code (5-4-2 Format): Medicare Deductible/Quantity: \$ 50.00

NDC Quantity/Measurement: Medicare Copayment/Quantity: \$

Procedure Modifiers: 1 2 3 4 Medicare Coinsurance/Quantity: \$ 10.00

Provider Control Number: Date Claim Paid:

Prescription Number/Reference ID:

Enter the Medicare Deductible and or the Co-insurance here. No need to enter Quantity.

The Bill Type entered in the Claim Information tab will determine if the deductible/co-insurance entered here is inpatient/outpatient.

Submit Cancel

**Professional (1500)
Medicare Deductible and Co-insurance**

(Professional) Medicare Deductible and Co-insurance

* Indicates a required field.

Submitter | Providers | Patient/Subscriber | Ambulance | Other Payer | Attachments | Claim Information | **Service Lines**

Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, 4, 5, 6, 7 or 8 by line to the Diagnosis Code Pointer)

* Standard: ICD-9 ICD-10 * Diagnosis Codes: 1 2 3 4 5 6 7 8

Service Line

* Service Dates: - * Diagnosis Code Pointers: 1 2 3 4 5 6 7 8

* Line Charges: \$ * Place of Service Code (POS):

* Quantity: Minutes Units Modifier Codes: 1 2 3 4

* HCPCS Code: Prescription Date:

National Drug Code: ** Prescription #/Identifier:

** NDC Quantity/Measure: Taxonomy Code: (Performing HC Provider)

Immunizat: Patient Count:

Provide: PSDT

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

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

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

** Durable Medical Equipment: HCPCS Purchase Price \$ Rental Price \$ Length of Medical Necessity

** Ordering Physician: Plan ID Last Name First Name

line or group.

Enter the Medicare Deductible here if appropriate

Enter the Medicare Coinsurance here if appropriate