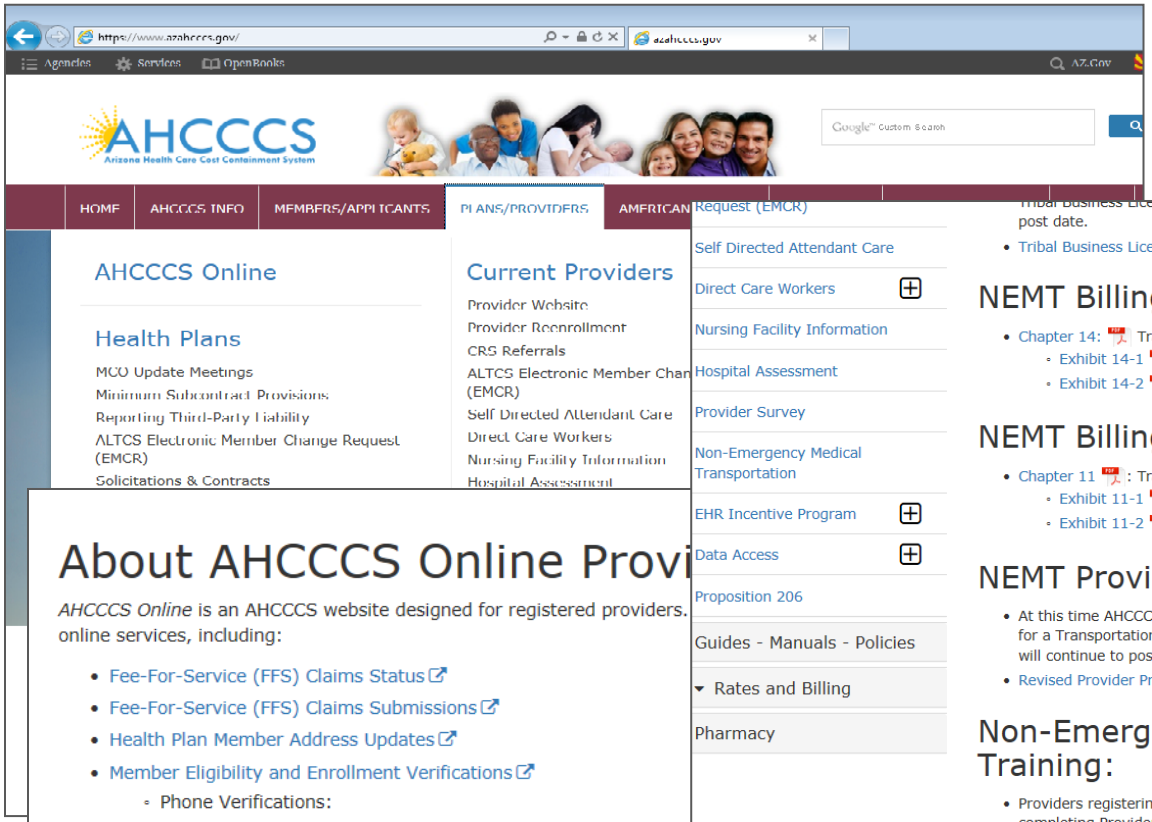
AHCCCS
Arizona Health Care Cost Containment System

WELCOME TO TRAINING!

- **Non-emergency Medical Transportation (NEMT)**
- **5010 Online Claim Submission (1500 Form Type)**
- **Transaction Insight (TI) Portal 275 Attachments**
- **Daily Trip Reports**

AHCCCS WEBSITE


AHCCCS
Arizona Health Care Cost Containment System
HOME
AHCCCS INFO
MEMBERS/APPLICANTS
PLANS/PROVIDERS
AMERICAN
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Health Plans
MCO Update Meetings
Minimum Subcontract Provisions
Reporting Third-Party Liability
ALTCS Electronic Member Change Request (EMCR)
Solicitations & Contracts
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Provider Website
Provider Reenrollment
CRS Referrals
Self Directed Attendant Care
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Nursing Facility Information
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NEMT Billing Instructions & Exhibits for FFS:
Chapter 14: Transportation Services
Exhibit 14-1, Daily Trip Report
Exhibit 14-2, Non-emergency Medical Transport Daily Trip Report Instructions
NEMT Billing Instructions & Exhibits for IHS:
Chapter 11: Transportation Services
Exhibit 11-1, Daily Trip Report
Exhibit 11-2, Non-emergency Medical Transport Daily Trip Report Instructions
NEMT Provider & Process Changes:
At this time AHCCCS is currently in the process of consultation with the Tribes to pursue the development of an 'RFP
for a Transportation Broker and as such AHCCCS is not expanding the Non-Emergency network at this time. AHCCCS
will continue to post updated developments to the website regarding Non-emergency Transportation Providers.
Revised Provider Profile for NEMT Provider Type Effective April 1, 2014.
Non-Emergency Medical Transportation Provider Training:
Providers registering with AHCCCS as a non-emergency medical transportation provider (provider type 28) completing Provider Participation Agreement's on or after 7/1/13 must complete the online training module and submit the training certificate in order for their applications to be processed.
Launch the training
AHCCCS Provider Registration:
For more information about registering as a provider with AHCCCS, please visit the AHCCCS Provider Registration page.
About AHCCCS Online Provi
AHCCCS Online is an AHCCCS website designed for registered providers.
online services, including:
Fee-For-Service (FFS) Claims Status
Fee-For-Service (FFS) Claims Submissions
Health Plan Member Address Updates
Member Eligibility and Enrollment Verifications
Phone Verifications:
Maricopa County: 602-417-7200
Outside of Maricopa County, within Arizona: 1-800-331
Newborn Notifications
Prior Authorization Inquiries
Provider Information
Correspondence address updates
Demographic information (view only)
Group affiliations (view only)
Authorized signatures (view only)
Provider Verifications (view only)
Provider enrollment
Provider business addresses
Medical services offered
Note: AHCCCS Fee-For-Service Technical Assistance Documents help registered AHCCCS providers use the AHCCCS Online website.

What is NEMT?

- **NEMT** stands for **Non-Emergency Medical Transportation**
- AHCCCS covers medically necessary non-emergency ground ambulance and air transportation to and from a required, covered medical service for most recipients. Non-emergency transportation is not covered for Emergency Services Program recipients.
- **NEMT** providers must be **AHCCCS Registered Providers**
- Provider registration and a list of requirements can be found on the AHCCCS web site.

NEMT Provider Registration records update

The AHCCCS Provider Participation Agreement for NEMT providers requires that Provider Registration be notified within 30 days of any updates and/or changes to:

- Fleet vehicles list
- Current registration for each fleet vehicle listed
- Current insurance coverage for each fleet vehicle listed
- Employed drivers

The Quarterly QC audits for NEMT claims will now include verifying fleet vehicle, registration, insurance and employed drivers from the information submitted on the claim's trip report. If the trip report information does not match to Provider Registration documentation an audit error will be charged.

Audit letters of finding will be sent out to providers detailing deficiencies in the Provider Registration files for the claim audit errors. The provider must submit the updated documentation to Provider Registration to avoid audit error recoupment.

Refer to the Provider Registration webpage for the NEMT Provider Profile form at https://www.azahcccs.gov/PlansProviders/Downloads/NonEmergencyTransportationProvider.pdf

Mandatory requirements for NEMTs

NEMT updates on changes can be found on the website.

PROVIDER TYPE PROFILE

PROVIDER TYPE	28	NON-EMERGENCY TRANSPORTATION PROVIDERS	
REIMBURSE-MENT TYPE	02	FEE FOR SERVICE EFFECTIVE 10-01-82	
CATEGORIES OF SERVICE			**LICENSE/CERTIFICATION**
MANDATORY	31	NON-EMERGENCY TRANSPORTATION	PROOF OF VEHICLE INSURANCE COPY OF ONLINE TRAINING CERTIFICATE COPY OF REGISTRATION FOR EACH VEHICLE REQUIRED COMPANY'S NAME AND LOGO MUST BE ON ALL VEHICLES COPY OF CPR AND FIRST AID CARD FOR EACH DRIVER COMPLETED DRIVER INFORMATION PROFILE HIPPA TRAINING ANNUALLY, PROOF WILL BE VERIFIED ON SITE VISIT SERVICES PROVIDED ON RESERVATION MUST SUBMIT COPY OF TRIBAL BUSINESS LICENSE TAXI COMPANIES MUST SUBMIT A COPY OF THEIR LICENSE FROM THE DEPARTMENT OF WEIGHTS AND MEASURES.
MANDATORY			
MANDATORY			
OPTIONAL			
OPTIONAL			

As the Owner/Provider you are responsible for maintaining and providing upon request a valid Arizona drivers license for each driver and proof of insurance, CPR and First Aid cards, & HIPPA training documents. As part of the registration process the Owner/Provider is required to disclose each employee's name, employment begin date, employment end date (if applicable), and date of birth information using the 2nd page of this form. Any changes to the above must be reported within 30 days. By signing below you are indicating that this information will be kept on file and made available upon request.

Company Name________________________ ID Number:____________

Signature__________________________ Date________________

SPECIAL INSTRUCTIONS: ALL NON-EMERGENCY TRANSPORTATION SERVICES GREATER THAN 100 MILES REQUIRE PRIOR AUTHORIZATION. FOR PRIOR AUTHORIZATION OF FFS CLAIMS, CALL 1-800-433-0425.

REVISED 04/01/2014

NON EMERGENCY DRIVER INFORMATION

PROVIDER TYPE	28	NON-EMERGENCY TRANSPORTATION *(Page 2 of 2) **COMPANIES ONLY**
REIMBURSE-MENT TYPE	02	FEE FOR SERVICE EFFECTIVE 04/01/2014

List of Employees

(ALL FIELDS ARE MANDATORY)

SSN is optional

Last Name:	First Name, Middle Initial:	SSN (optional):
Employment Begin Date:	Employment End Date:	Date of Birth: (MM/DD/YYYY)
Last Name:	First Name, Middle Initial:	SSN (optional):
Employment Begin Date:	Employment End Date:	Date of Birth: (MM/DD/YYYY)
Last Name:	First Name, Middle Initial:	SSN (optional):
Employment Begin Date:	Employment End Date:	Date of Birth: (MM/DD/YYYY)
Last Name:	First Name, Middle Initial:	SSN (optional):
Employment Begin Date:	Employment End Date:	Date of Birth: (MM/DD/YYYY)
Last Name:	First Name, Middle Initial:	SSN (optional):
Employment Begin Date:	Employment End Date:	Date of Birth: (MM/DD/YYYY)

Copy if additional pages are needed.

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Arizona Health Care Cost Containment System

5010 Online Claim Submission

Claim Type Professional (1500 Form Type)

FAQ | LogIn |

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.

AHCCCS Online User Manuals

Sign In

Username

Password

Sign In

Enter your Username and 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.

Your web browser must have JavaScript enabled in order to use AHCCCS Online.

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801 E. Jefferson, Phoenix, AZ 85034

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Menu

- Claim Status
- Claims Submission
- Member Verification
- Newborn Notification
- Prior Authorization Inquiry
- Prior Authorization Submission
- Provider Verification

Support and Manuals

- AHCCCS Online User Manuals
- AHCCCS Online Learn More
- Frequently Asked Questions

Account Information

Username: Test56

Click on

Claim Submission

Main Page

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

Claim St -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 listi ase 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.

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 Medicare, Share Of Cost and other third party 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 also be viewed from 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, Group Affiliations and Authorized Signatures.
For further information, please click on AHCCCS Provider Registration

PRIOR AUTHORIZATION INQUIRY

Prior Authorization Inquiry will allow providers to verify the status of previously submitted prior authorization requests. Inquiries can be performed by Case Number, AHCCCS ID or Provider ID. The related case, event and activity data related to the prior authorization will be diplayed.

PRIOR AUTHORIZATION SUBMISSION

Prior Authorization Submission allows providers to submit requests for services.

HEALTH PLAN ADDRESS CHANGES

HealthPlan Address Changes allows acute health plans to send address changes from members via the web. All address changes will be processed by the eligibility source within a few business days.

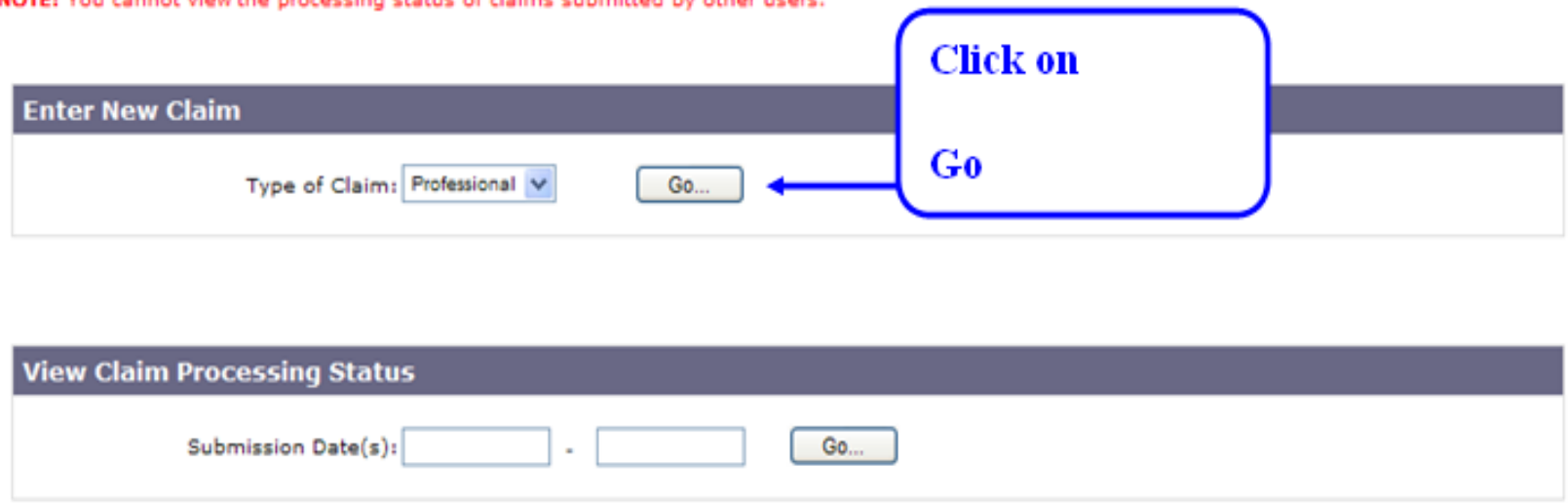
The AHCCCS mainframe systems will have scheduled downtimes that occur on a weekly basis. During these downtimes (usually weekends), the web site will be unavailable. During system downtimes, please contact the AHCCCS COM Center at **602-417-7000** for immediate assistance regarding eligibility/enrollment. The Interactive Voice Response (IVR) System is also available for eligibility inquiries at **602-417-7200**. For claim inquiries, please contact the AHCCCS Claims Customer Service at **602-417-7670**. For a full list of contacts, please click on AHCCCS Contacts.

Claim Submission

Claims submitted to AHCCCS prior to 4:00 PM 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.



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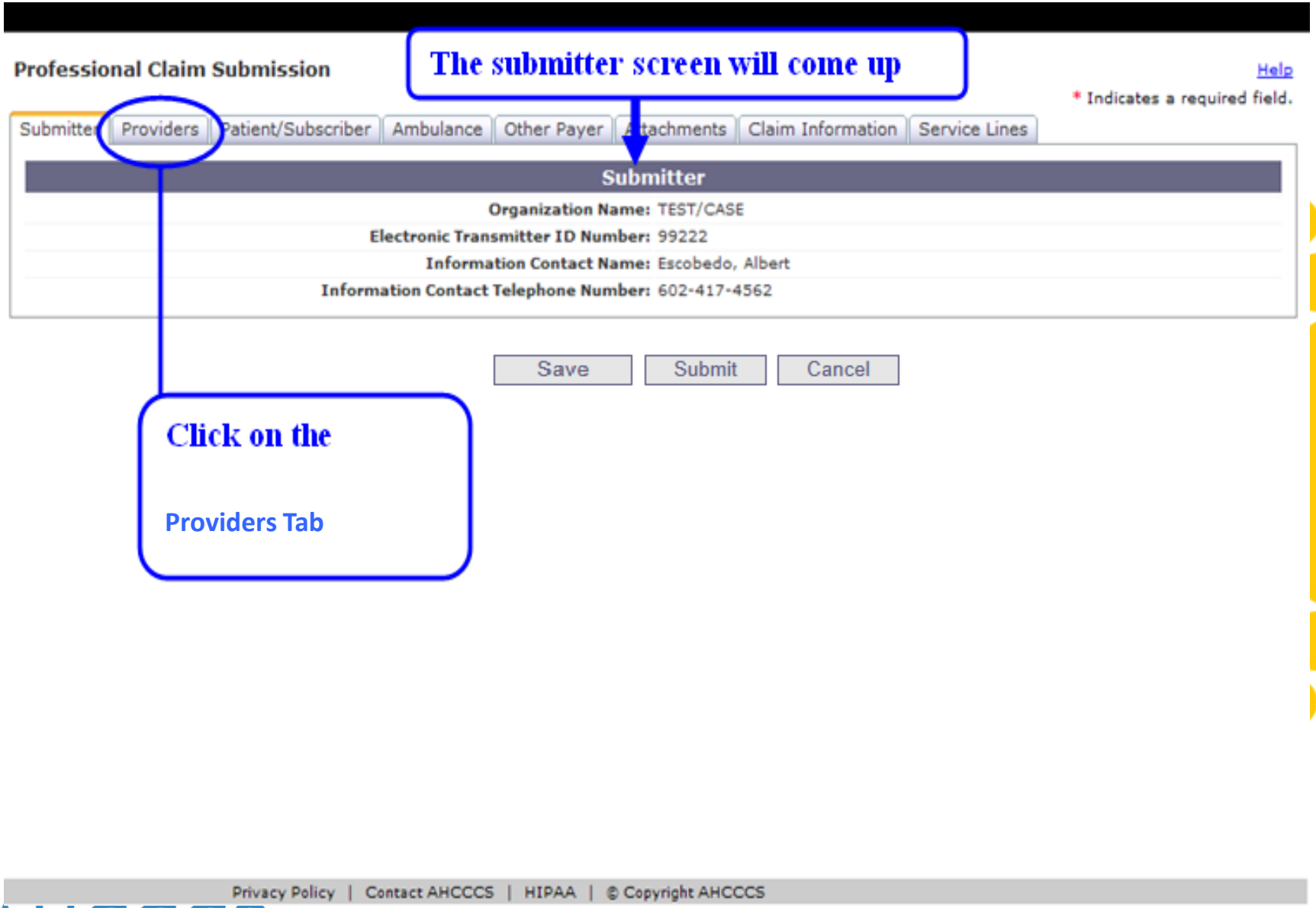
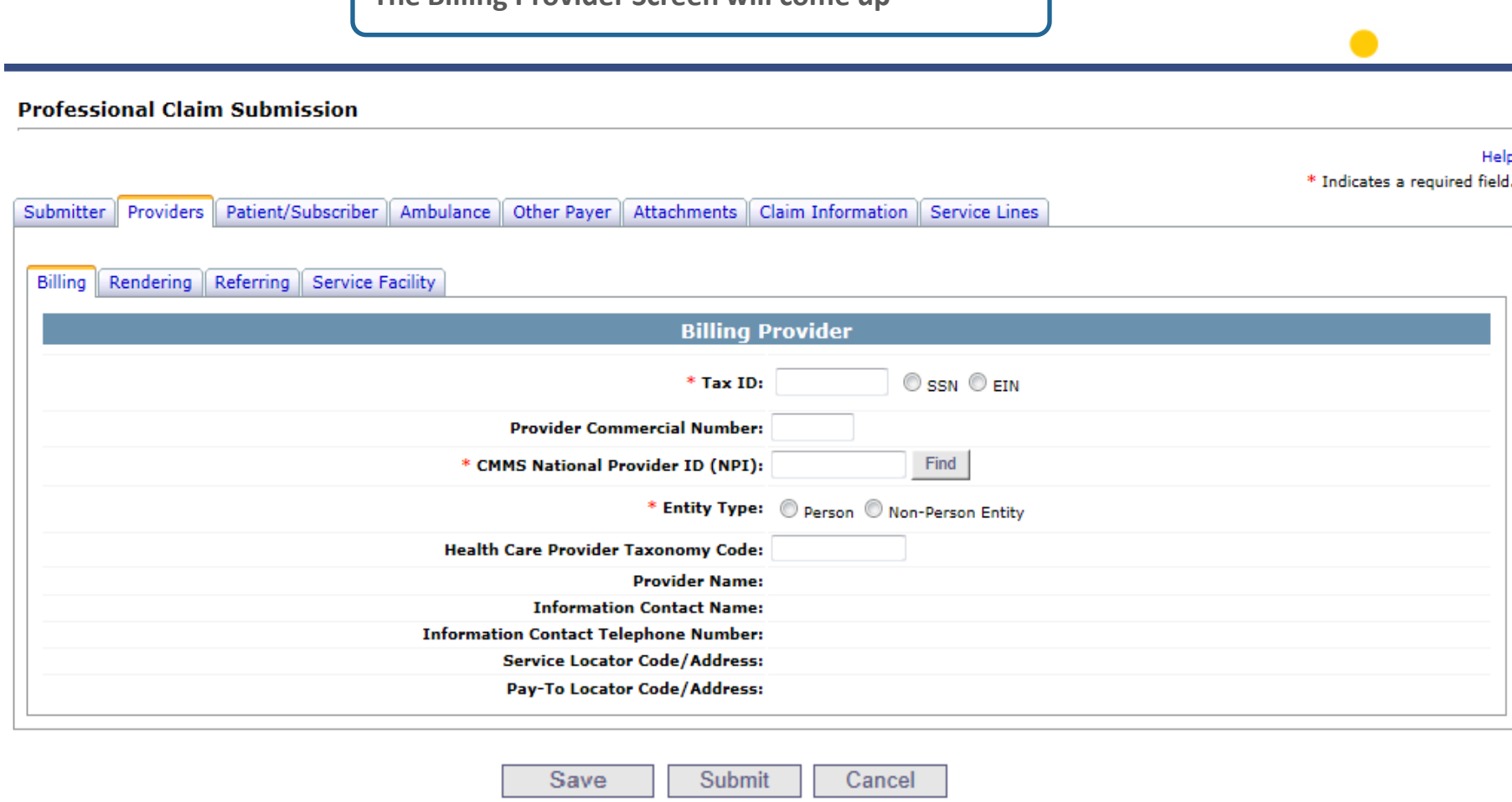


AHCCCS
Arizona Health Care Cost Containment System

The Billing Provider Screen will come up



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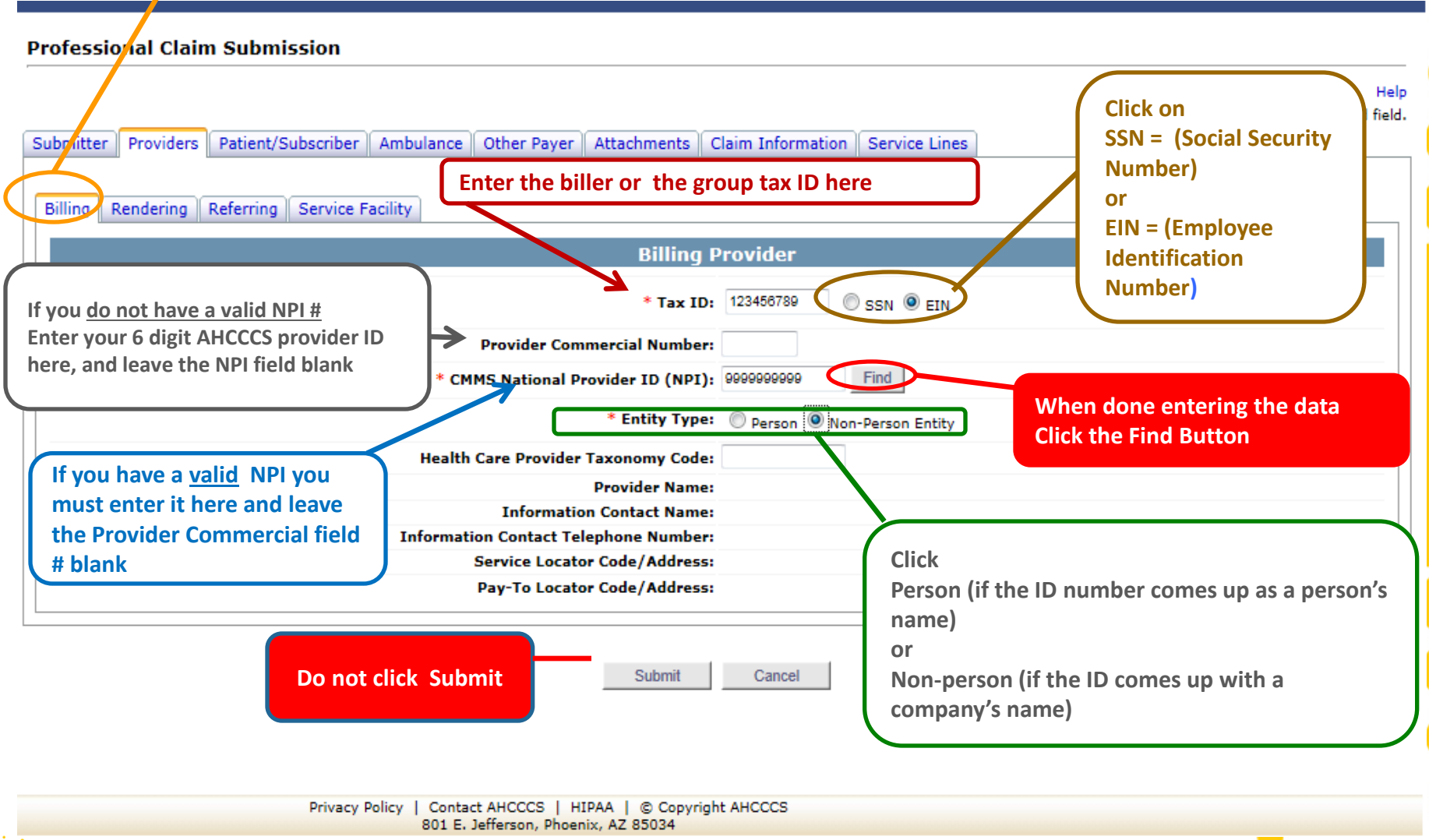
Arizona Health Care Cost Containment System

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



Enter the biller or the group tax ID here

Click on
SSN = (Social Security Number)
or
EIN = (Employee Identification Number)

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 the data
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

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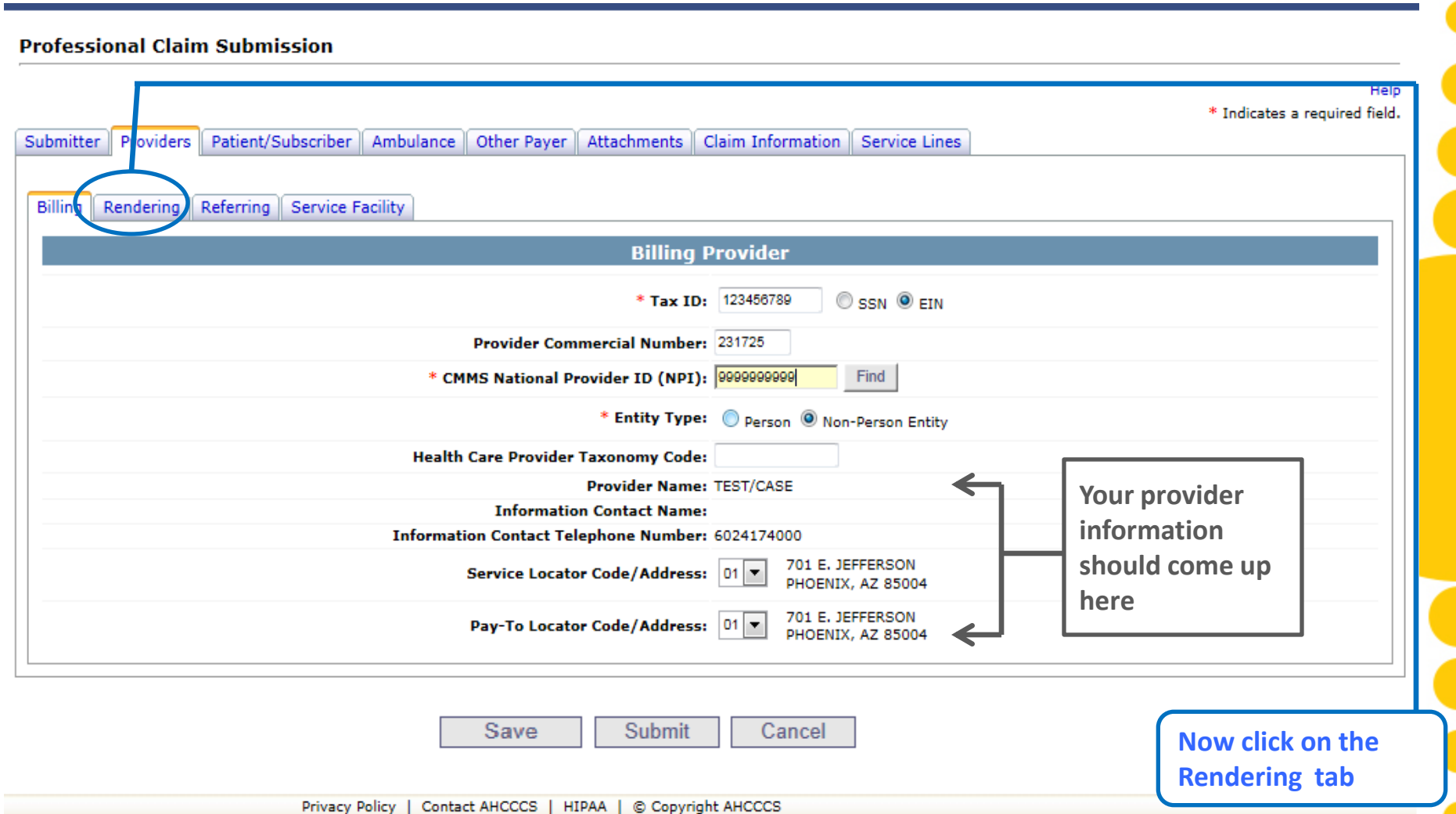

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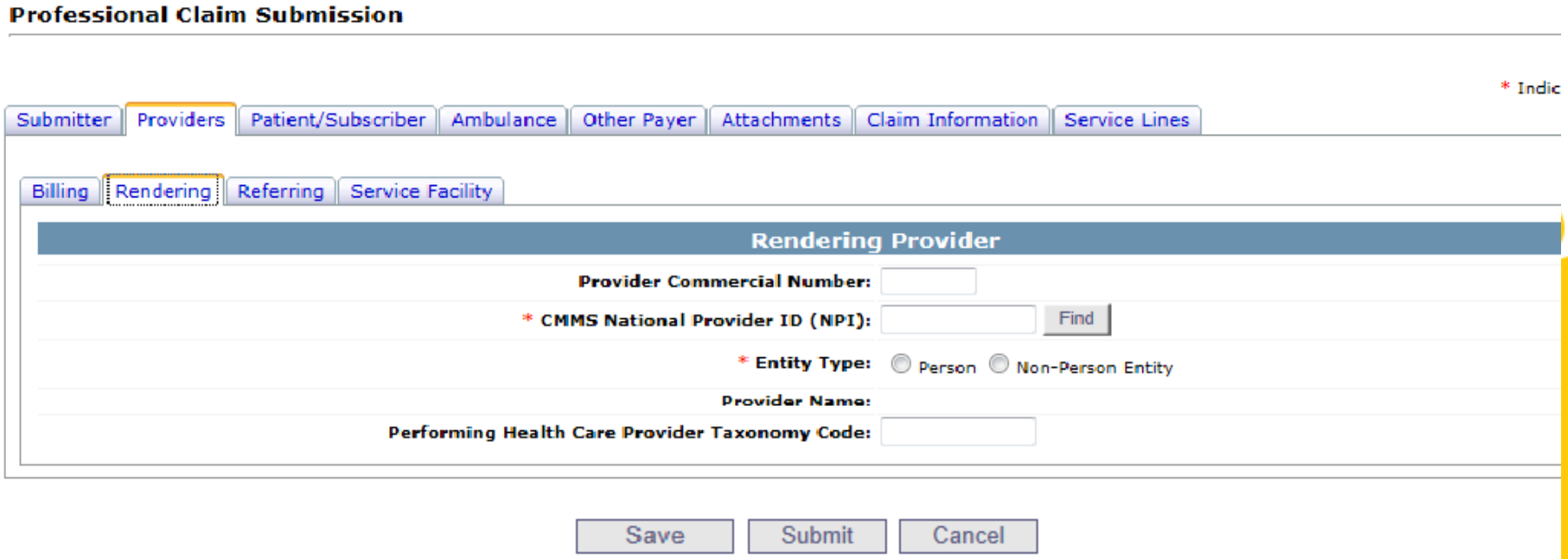
The Rendering Provider screen will come up



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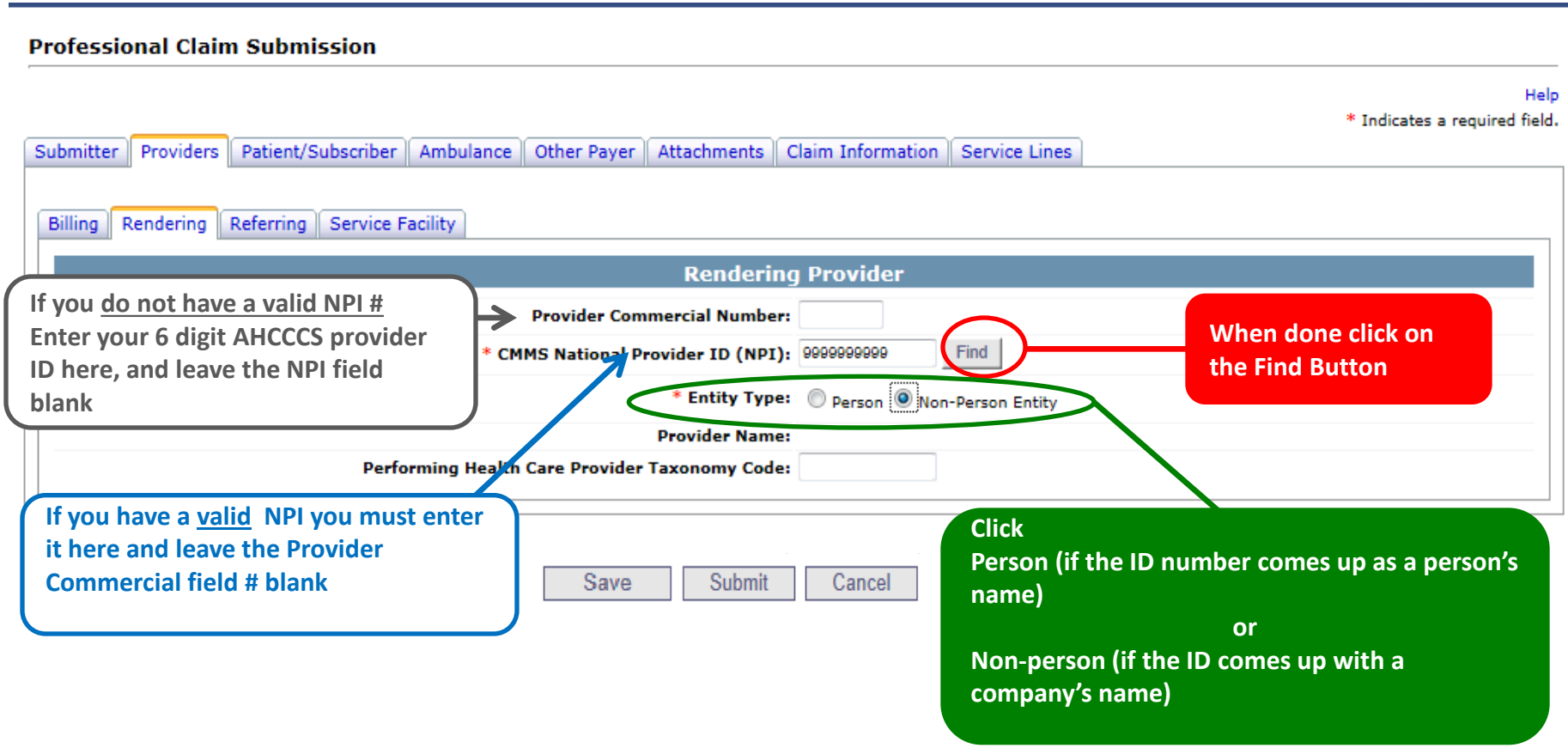

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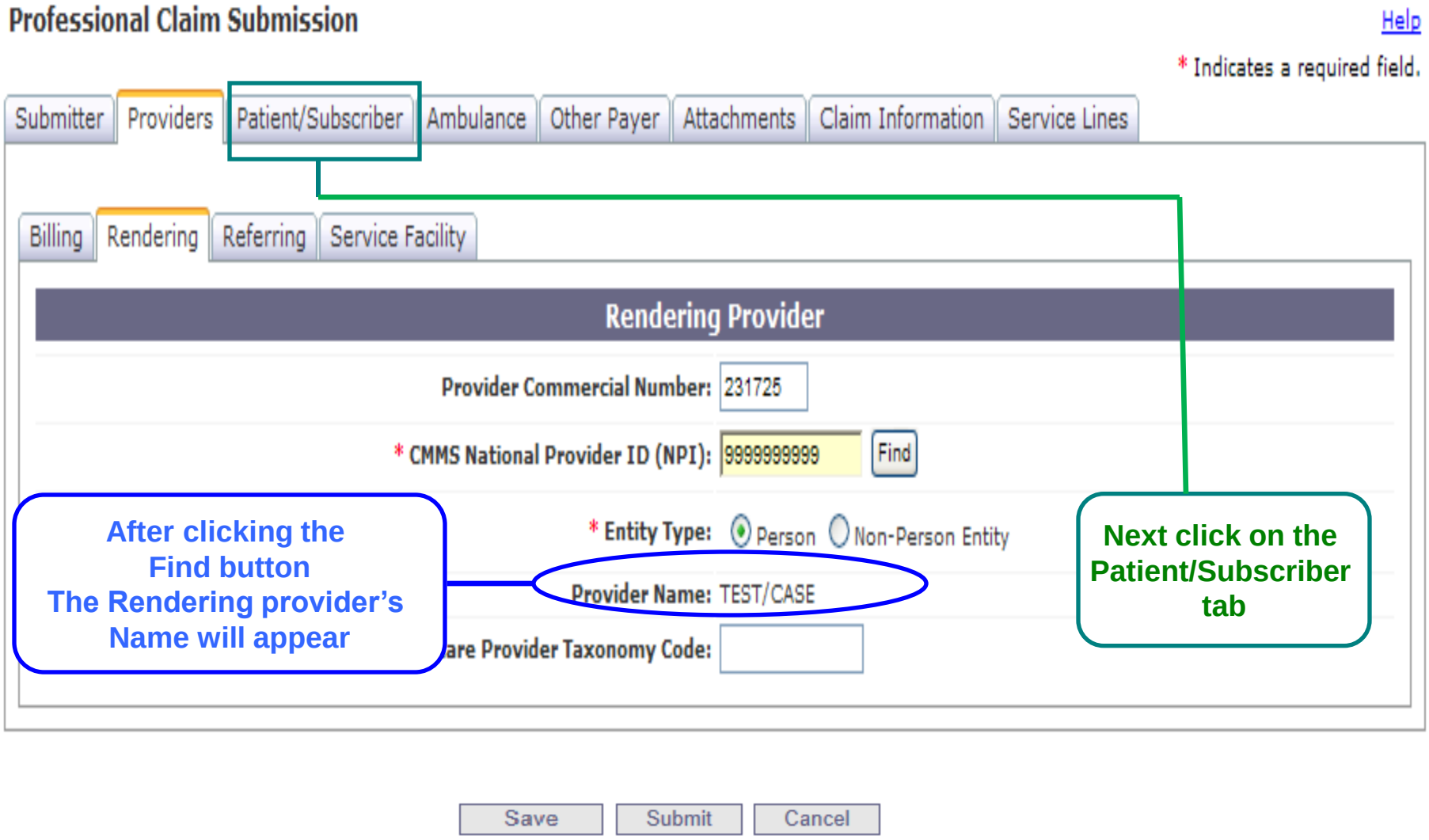

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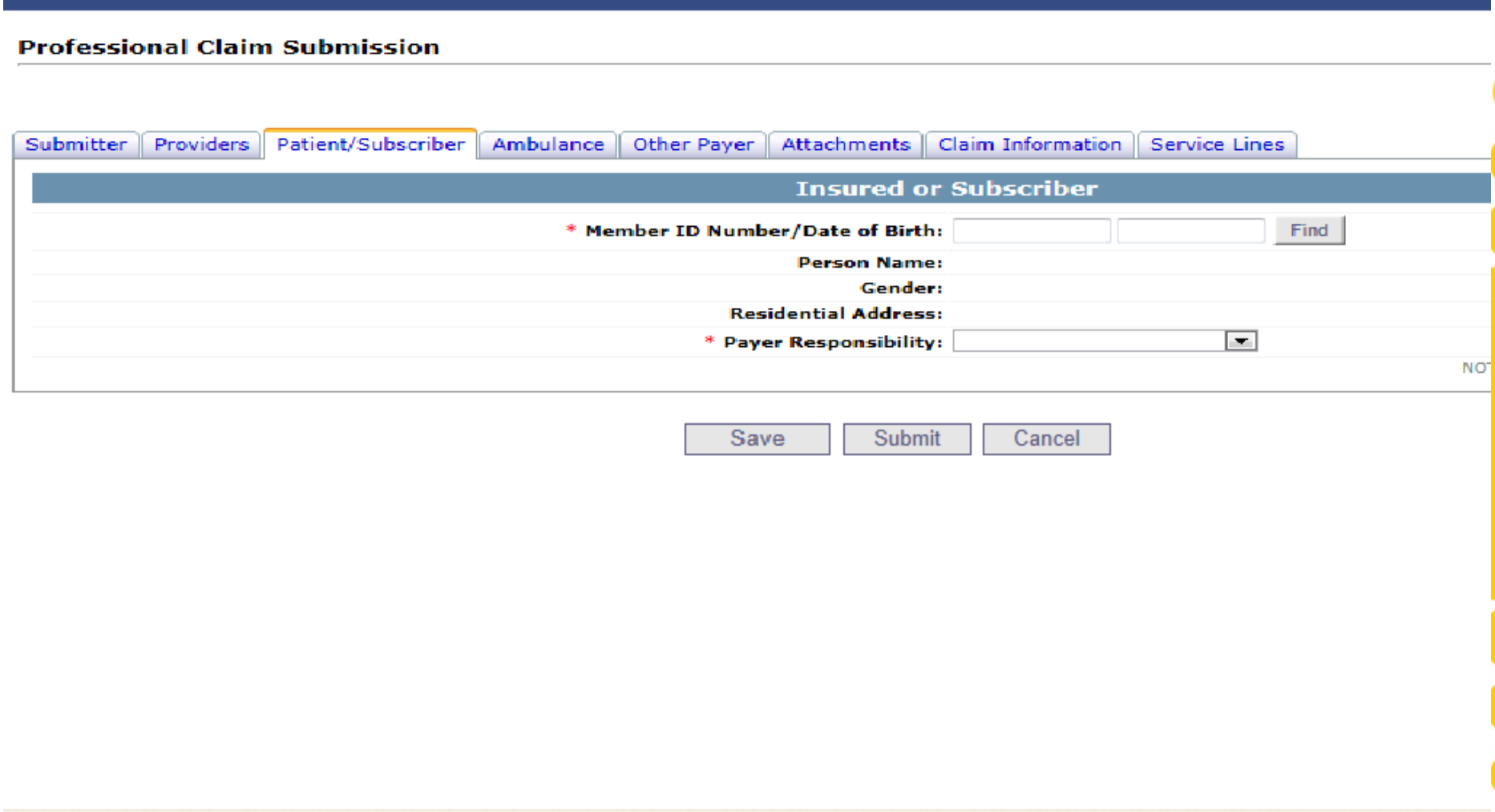
The Patient/subscriber screen will come up, this is where you will enter the members AHCCCS information



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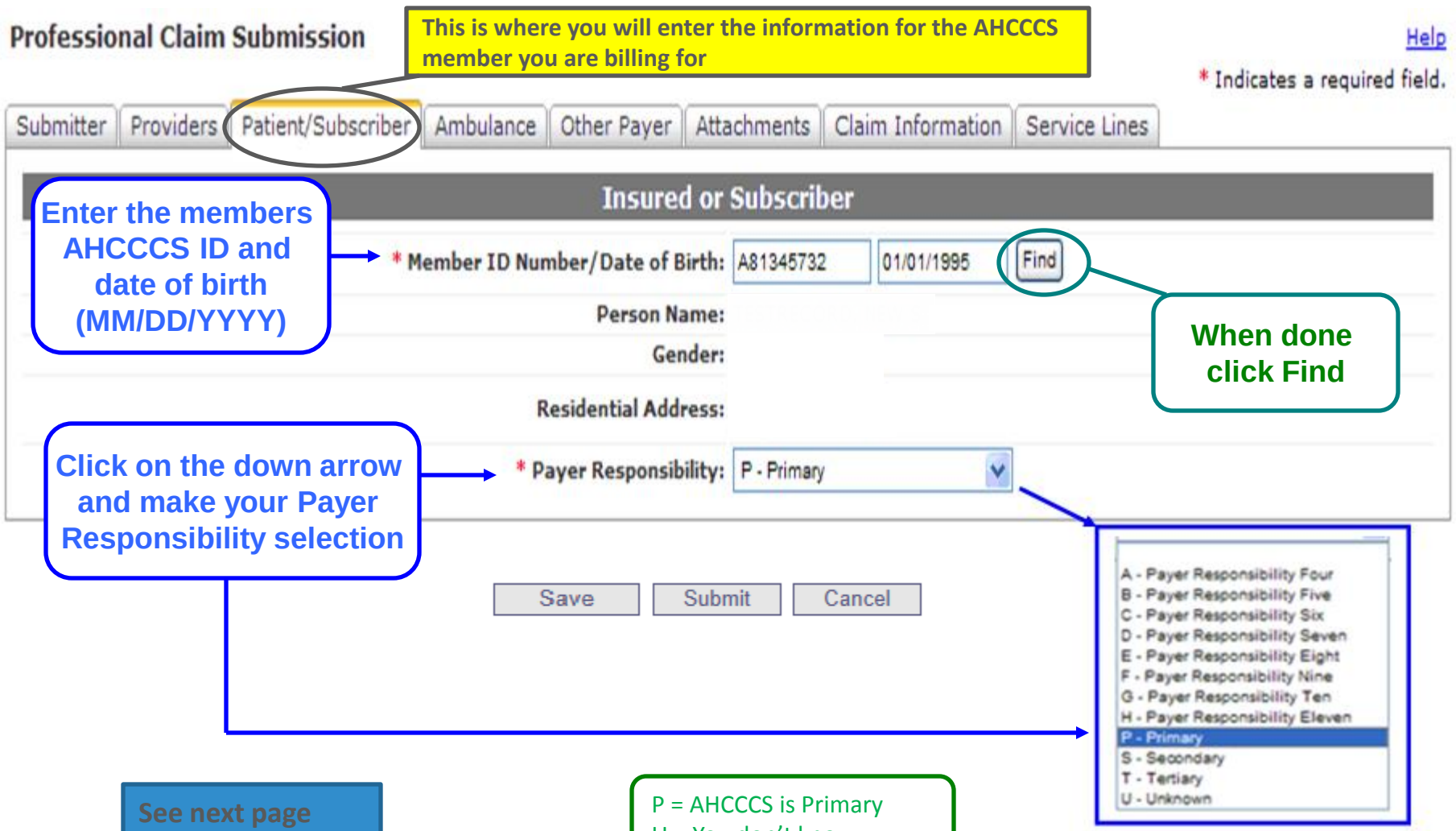

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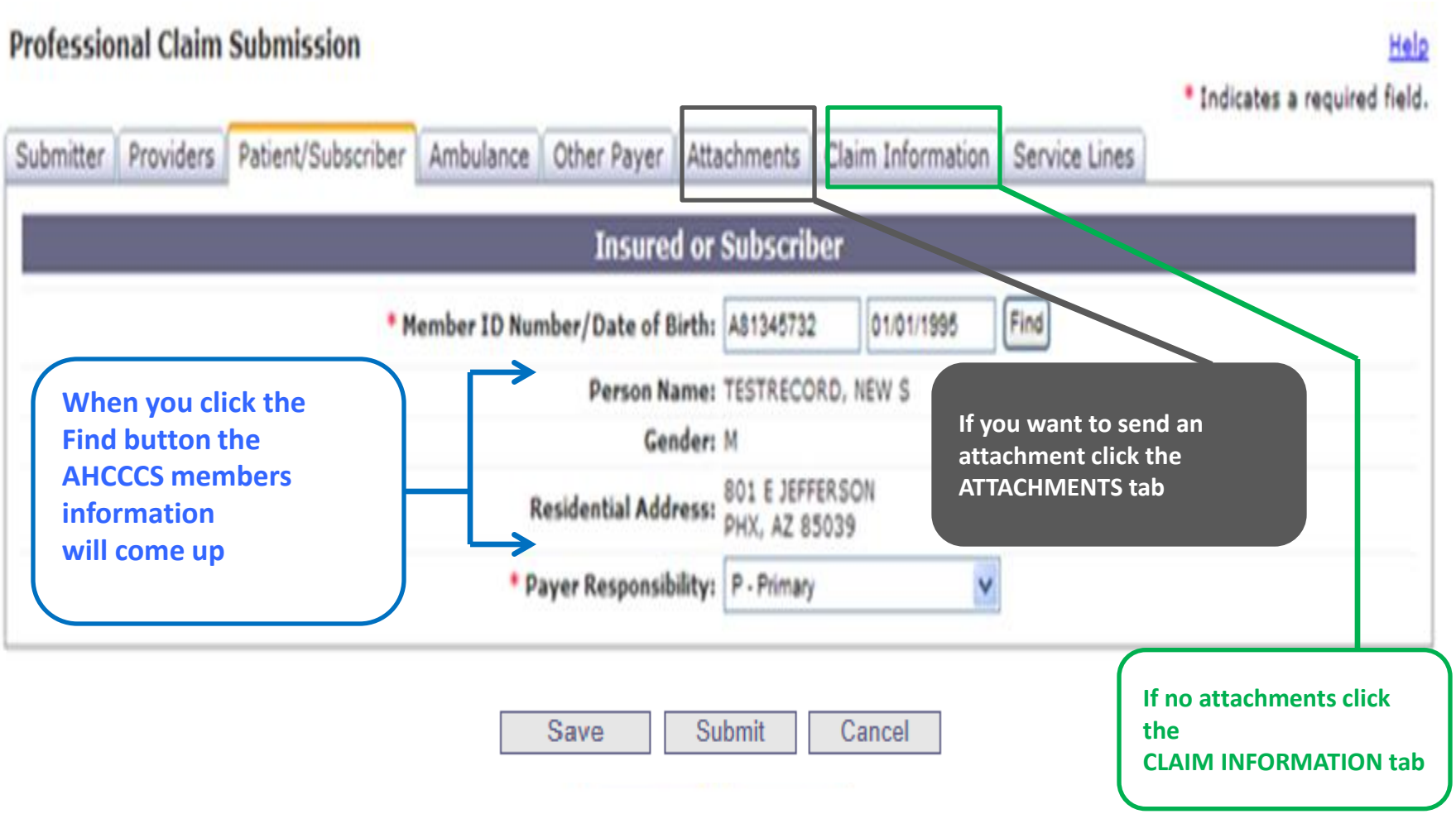

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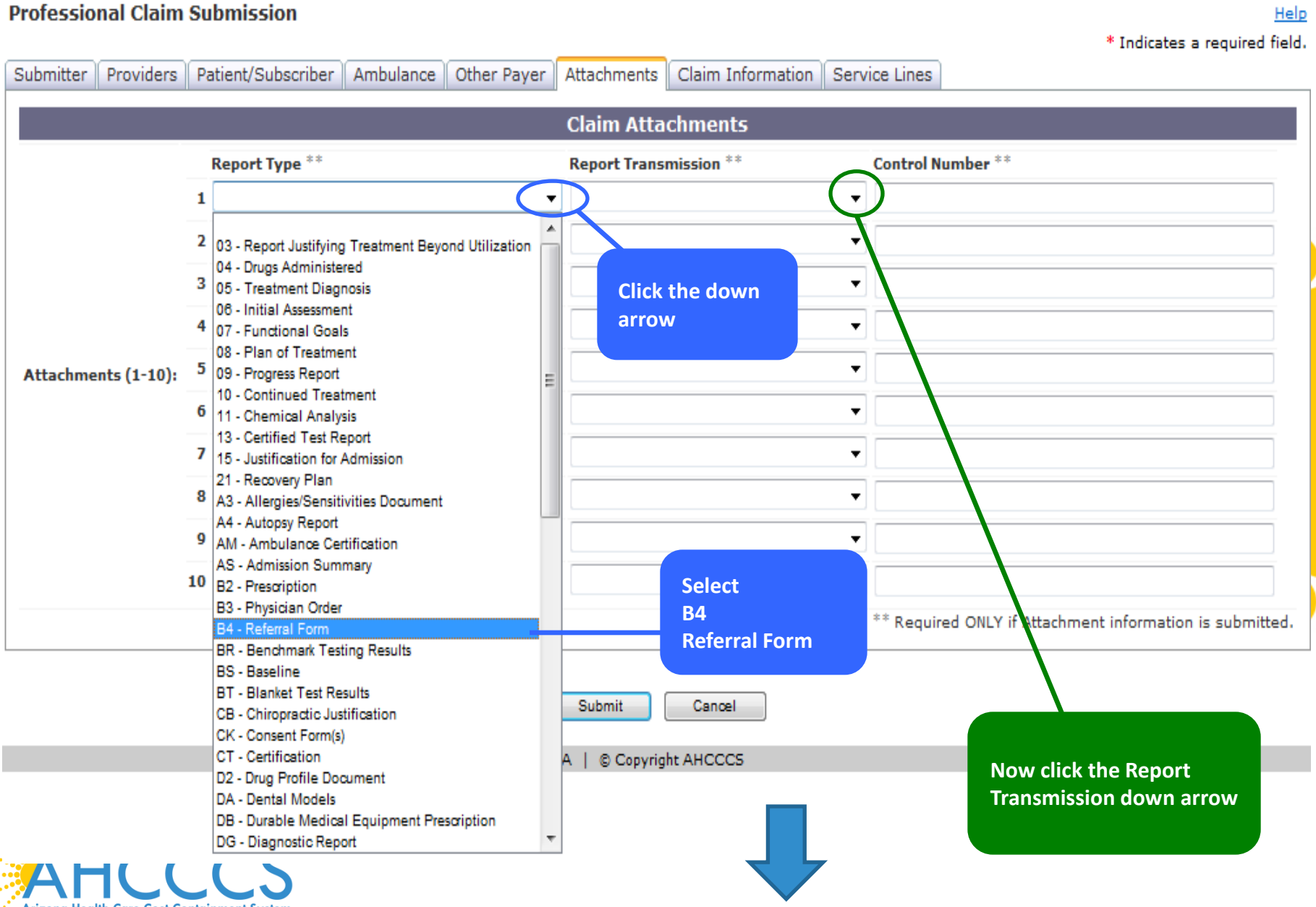

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Professional Claim Submission

Help

* Indicates a required field.

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

Claim Attachments

	Report Type **	Report Transmission **	Control Number **
1	B4 - Referral Form		
2			
3			
4			
5			
6			
7			
8			
9			
10			

Attachments (1-10):

AA - Available on Request at Provider Site
BM - By Mail
EL - Electronically Only
EM - E-Mail
FT - File Transfer
FX - By Fax

Select
EL
Electronically Only

** Required ONLY if Attachment information is submitted.

Save | Submit | Cancel

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When done entering the information click the CLAIM INFORMATION tab

Professional Claim Submission

Help

* Indicates a required field.

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

Claim Attachments

	Report Type **	Report Transmission **	Control Number **
1	B4 - Referral Form	EL - Electronically Only	A99999999061813
2			
3			
4			
5			
6			

Attachments (1-10):

This where you would enter the PWK N number

Note:
The PWK number is a unique number that you will create for each claim/document that you submit, this will allow the system to link the attachment to the correct claim. The PWK number is used only when submitting an electronic claim and attachment on the same day.

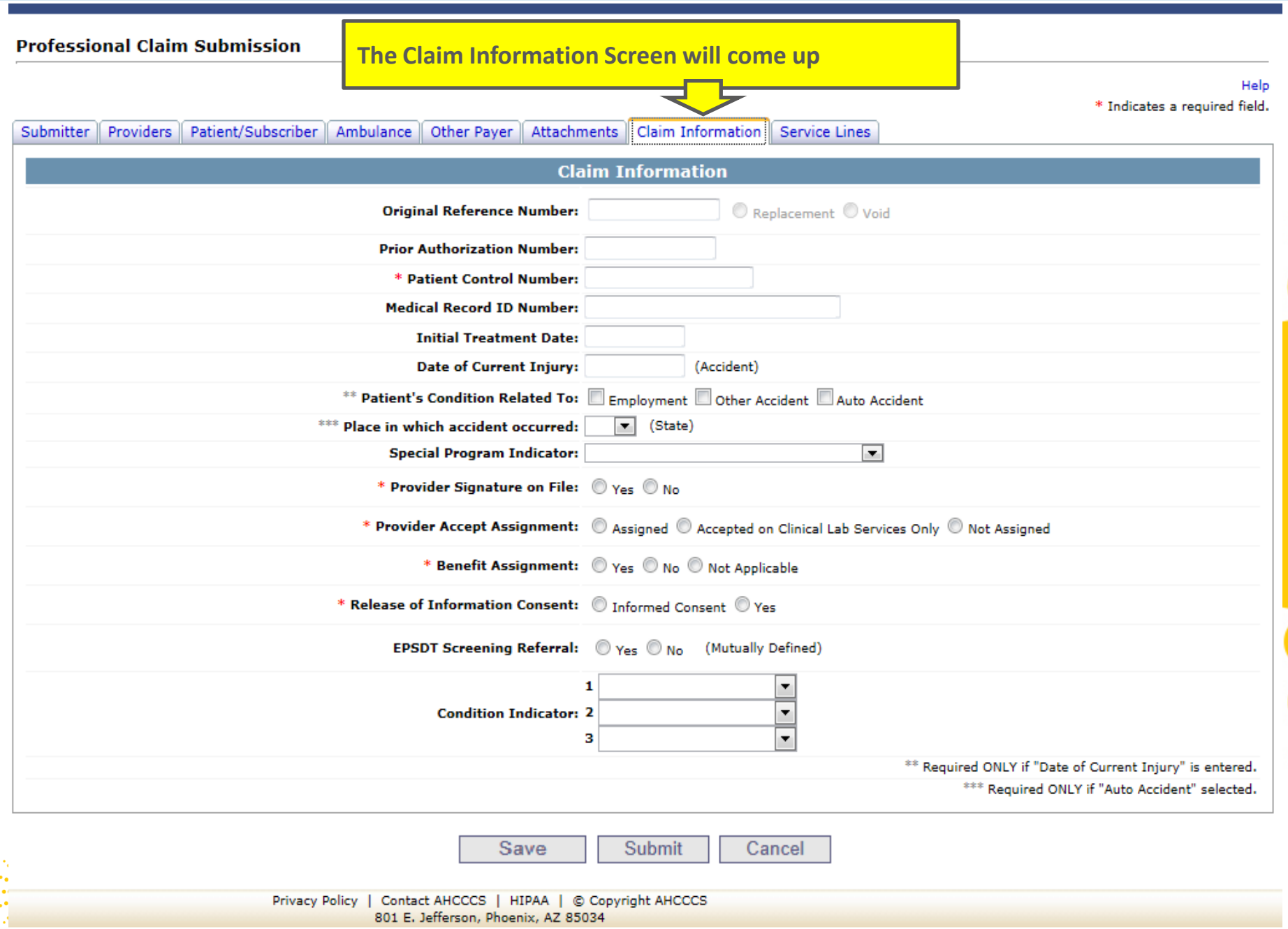
** Required ONLY if Attachment information is submitted.

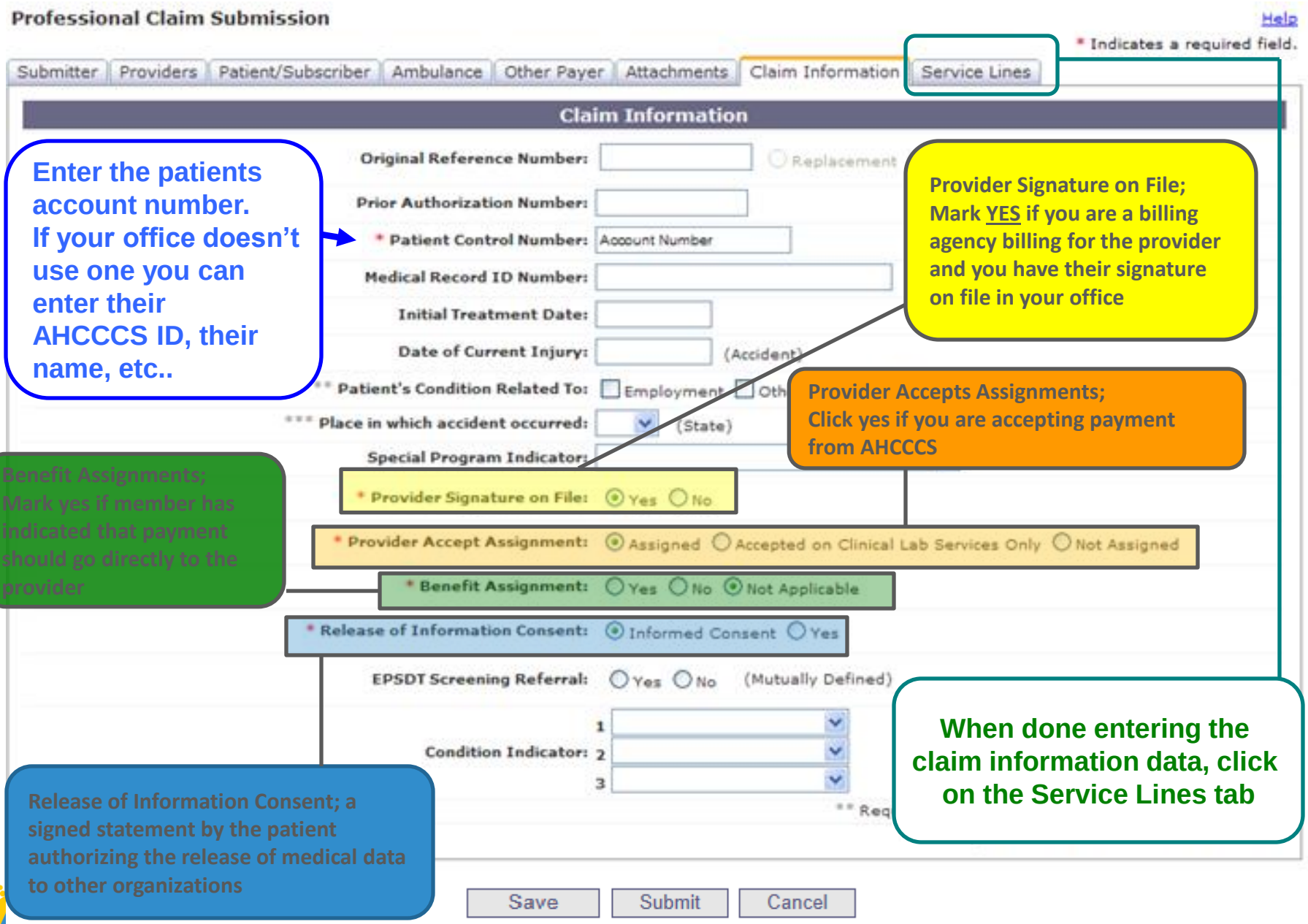
Save | Submit | Cancel

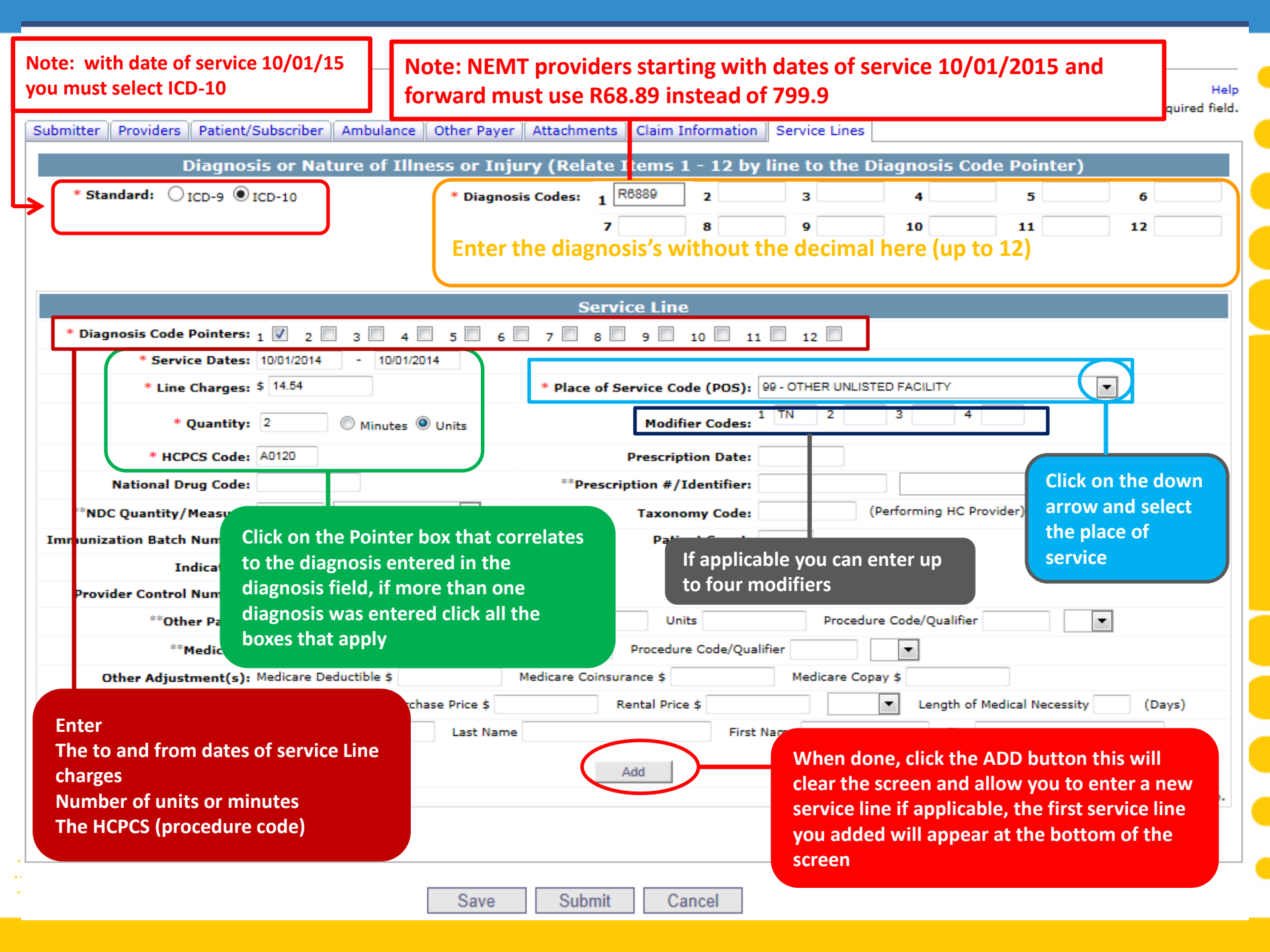
AHCCCS
Arizona Health Care Cost Containment System

Example of a PWK number using a member's AHCCCS ID and the Date of Service	
AHCCCS ID (**9-character AHCCCS ID**) The A in AHCCCSID must be in capital letter	A12345678
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**) The A in AHCCCSID must be in capital letter	A87654321
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.


Professional Claim Submission
The Claim Information Screen will come up
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Claim Information
Original Reference Number:
Replacement
Void
Prior Authorization Number:
* Patient Control Number:
Medical Record ID Number:
Initial Treatment Date:
Date of Current Injury:
(Accident)
** Patient's Condition Related To:
Employment
Other Accident
Auto Accident
*** Place in which accident occurred:
(State)
Special Program Indicator:
* Provider Signature on File:
Yes
No
* Provider Accept Assignment:
Assigned
Accepted on Clinical Lab Services Only
Not Assigned
* Benefit Assignment:
Yes
No
Not Applicable
* Release of Information Consent:
Informed Consent
Yes
EPSDT Screening Referral:
Yes
No
(Mutually Defined)
Condition Indicator:
1
2
3
** Required ONLY if "Date of Current Injury" is entered.
*** Required ONLY if "Auto Accident" selected.
Save
Submit
Cancel
Privacy Policy | Contact AHCCCS | HIPAA | © Copyright AHCCCS
801 E. Jefferson, Phoenix, AZ 85034


Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Claim Information
Original Reference Number:
Replacement
Prior Authorization Number:
* Patient Control Number:
Account Number
Medical Record ID Number:
Initial Treatment Date:
Date of Current Injury:
(Accident)
** Patient's Condition Related To:
Employment
*** Place in which accident occurred:
(State)
Special Program Indicator:
* Provider Signature on File:
Yes
No
* Provider Accept Assignment:
Assigned
Accepted on Clinical Lab Services Only
Not Assigned
* Benefit Assignment:
Yes
No
Not Applicable
* Release of Information Consent:
Informed Consent
Yes
EPSDT Screening Referral:
Yes
No
(Mutually Defined)
Condition Indicator:
1
2
3
Save
Submit
Cancel
Enter the patients account number. If your office doesn't use one you can enter their AHCCCS ID, their name, etc..
Provider Signature on File; Mark YES if you are a billing agency billing for the provider and you have their signature on file in your office
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
When done entering the claim information data, click on the Service Lines tab


Note: with date of service 10/01/15 you must select ICD-10
Note: NEMT providers starting with dates of service 10/01/2015 and forward must use R68.89 instead of 799.9
Help
quired field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
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
Enter the diagnosis's without the decimal here (up to 12)
Service Line
* Diagnosis Code Pointers: 1 2 3 4 5 6 7 8 9 10 11 12
* Service Dates: 10/01/2014 - 10/01/2014
* Line Charges: $ 14.54
* Quantity: 2 Minutes Units
* HCPCS Code: A0120
National Drug Code:
**NDC Quantity/Measu
Immunization Batch Num
Indica
Provider Control Num
**Other Pa
**Medic
* Place of Service Code (POS): 99 - OTHER UNLISTED FACILITY
Modifier Codes: 1 TN 2 3 4
Prescription Date:
**Prescription #/Identifier:
Taxonomy Code: (Performing HC Provider)
Units
Procedure Code/Qualifier
Procedure Code/Qualifier
Other Adjustment(s): Medicare Deductible $ Medicare Coinsurance $ Medicare Copay $
chase Price $ Rental Price $ Length of Medical Necessity (Days)
Last Name First Nam
Add
Click on the Pointer box that correlates to the diagnosis entered in the diagnosis field, if more than one diagnosis was entered click all the boxes that apply
If applicable you can enter up to four modifiers
Click on the down arrow and select the place of service
Enter
The to and from dates of service Line charges
Number of units or minutes
The HCPCS (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
Save
Submit
Cancel

Professional Claim Submission

Help

* 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 - 12 by line to the Diagnosis Code Pointer)

* Standard: ICD-9 ICD-10

* Diagnosis Codes: 1 7999 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

* Service Dates: -

* Line Charges: $

* Place of Service Code (POS):

* Quantity: Minutes Units

Modifier Codes: 1 2 3 4

* HCPCS Code:

National Drug Code:

**NDC Quantity/Measure:

Immunization Batch Number:

Indicators: Emergency

Provider Control Number:

**Other Payer: Primary ID

**Medicare: Paid Amount $

Other Adjustment(s): Medicare Deduc

**Durable Medical Equipment: HCPCS

**Ordering Physician: Plan ID

When you click on the Add button the first service line will appear at the bottom of the screen as line 1 and the screen will clear allowing you to add another service line if applicable, you can continue to add new service lines by clicking the ADD button after each service line you've entered

Add

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

Line No.	Begin Date	End Date	POS	HCPCS	Mod 1	Mod 2	Mod 3	Mod 4	NDC Code	NDC Units	Diag 1	Diag 2	Diag 3	Diag 4	Diag 5	Diag 6	Diag 7	Diag 8	Diag 9	Diag 10	Diag 11	Diag 12	Min./ Units	Type	Line Charges	Medicare Paid Amount	Units	Proc Code
1	10/1/2014	10/1/2014	99	A0120	TN					0	✓												2	UN	14.54		0	
																								Totals:	$14.54	$0.00		

Professional Claim Submission

Help

* 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 - 12 by line to the Diagnosis Code Pointer)

* Standard: ICD-9 ICD-10

* Diagnosis Codes: 1 7999 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

* Service Dates: 10/01/2014 - 10/01/2014

* Line Charges: $ 155.90

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

* Quantity: 101.9 Minutes Units

Modifier Codes: 1 TN 2 3 4

* HCPCS Code: S0215

Prescription Date:

National Drug Code:

**Prescription #/Identifier:

**NDC Quantity/Measure:

Taxonomy Code: (Performing HC Provider)

Immunization Batch Number:

Patient Count:

Indicators:

Provider Control Number:

Enter the information for service line 2 if applicable and click Add

**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 (Days)

**Ordering Physician: Plan ID Last Name First Name City

Add

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

Line No.	Begin Date	End Date	POS	HCPCS	Mod 1	Mod 2	Mod 3	Mod 4	NDC Code	NDC Units	Diag 1	Diag 2	Diag 3	Diag 4	Diag 5	Diag 6	Diag 7	Diag 8	Diag 9	Diag 10	Diag 11	Diag 12	Min./ Units	Type	Line Charges	Medicare Paid Amount	Units	Proc Code	Medicare Deductible Amount	Med Coinsur Am
1	10/1/2014	10/1/2014	99	A0120	TN					0	☑												2	UN	14.54			0		
																								Totals:	$14.54	$0.00			$0.00	$

Arizona Health Care Cost Containment System

Professional Claim Submission

Help

* 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 - 12 by line to the Diagnosis Code Pointer)

* Standard: ICD-9 ICD-10

* Diagnosis Codes: 1 7999 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

* Service Dates: -

* 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)

Immunization Batch Number:

Patient Count:

Indicators: Emergency EPSDT

Provider Control Number:

**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 (Days)

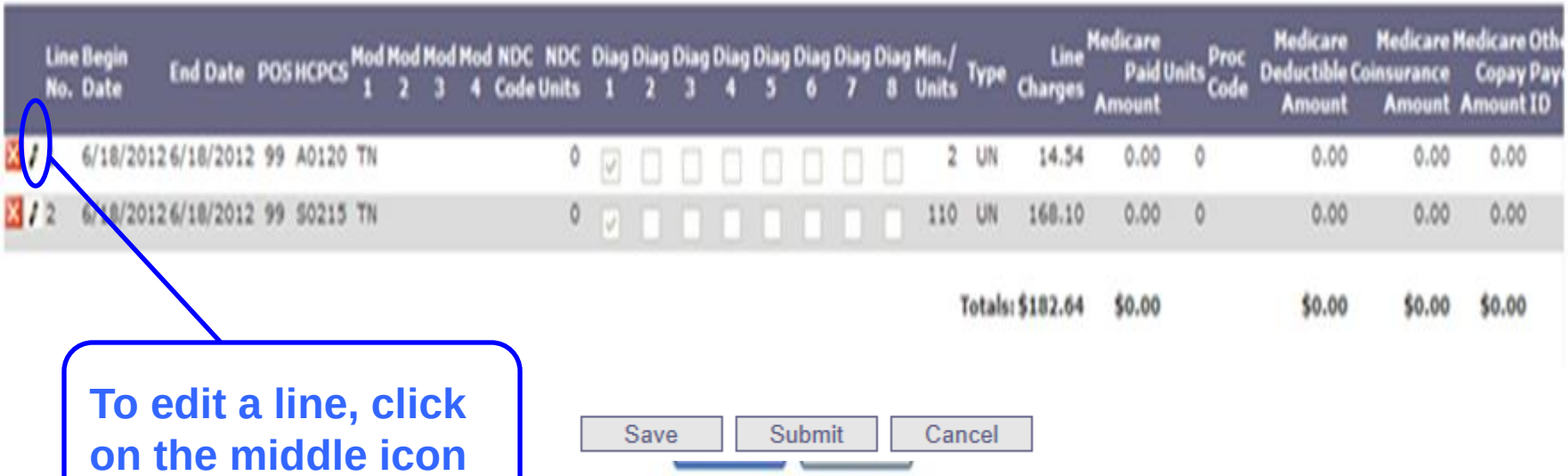
**Ordering Physician: Plan ID Last Name First Name City

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

This is how it looks with two service lines

Line No.	Begin Date	End Date	POS	HCPCS	Mod 1	Mod 2	Mod 3	Mod 4	NDC Code	NDC Units	Diag 1	Diag 2	Diag 3	Diag 4	Diag 5	Diag 6	Diag 7	Diag 8	Diag 9	Diag 10	Diag 11	Diag 12	Min./ Units	Type	Line Charges	Medicare Paid Amount	Units	Proc Code	Medicare Deductible Amount	Med Coinsur Am
1	10/1/2014	10/1/2014	99	A0120	TN					0	✓												2	UN	14.54		0			
2	10/1/2014	10/1/2014	99	S0215	TN					0	✓												101.9	UN	155.90		0			
																								Totals:	$170.44	$0.00			$0.00	$

Save Submit Cancel



To edit a line, click on the middle icon

AHCCCS
Arizona Health Care Cost Containment System

Professional Claim Submission

Help

* 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 - 12 by line to the Diagnosis Code Pointer)

* Standard: ICD-9 ICD-10

* Diagnosis Codes: 1 7999 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

* Service Dates: 10/7/2014 - 10/7/2014

* Line Charges: $ 102.00

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

* Quantity: 101.9 Minutes Units

Modifier Codes: 1 TN 2 3 4

* HCPCS Code: S0215

Prescription Date:

National Drug Code:

**Prescription #/Identifier:

**NDC Quantity/Measure:

Taxonomy Code: (Performing HC Provider)

Immunization Batch Number:

Patient Count:

Indicators: Emergency EPSDT

Provider Control Number:

**Other Payer: Primary ID

**Medicare: Paid Amount $

Other Adjustment(s): Medicare Deductible $

**Durable Medical Equipment: HCPCS Purchase Price $ Rental Price $ Length of Medical Necessity (Days)

**Ordering Physician: Plan ID Last Name First Name City

Update

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

The screen with the service line that you clicked to edit will come up, make your changes and click the update button

	Line No.	Begin Date	End Date	POS	HCPCS	Mod 1	Mod 2	Mod 3	Mod 4	NDC Code	NDC Units	Diag 1	Diag 2	Diag 3	Diag 4	Diag 5	Diag 6	Diag 7	Diag 8	Diag 9	Diag 10	Diag 11	Diag 12	Min./ Units	Type	Line Charges	Medicare Paid Amount	Units	Proc Code	Medicare Deductible Amount	Med Coinsur Am
	1	10/7/2014	10/7/2014	99	A0120	TN					0													2	UN	14.54		0			
	2	10/7/2014	10/7/2014	99	S0215	TN					0													101.9	UN	102.00		0			
																										Totals:	$116.54	$0.00		$0.00	$

Save Submit Cancel

Professional Claim Submission

Help

* 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 - 12 by line to the Diagnosis Code Pointer)

* Standard: ICD-9 ICD-10

* Diagnosis Codes: 1 7999 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

* Service Dates: -

* 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)

Immunization Batch Number:

Patient Count:

Indicators: Emergency EPSDT

Provider Control Number:

**Other Payer: Primary ID

de/Qualifier

**Medicare: Paid Amount $

Other Adjustment(s): Medicare Deductibl

**Durable Medical Equipment: HCPCS

Length of Medical Necessity (Days)

**Ordering Physician: Plan ID

City

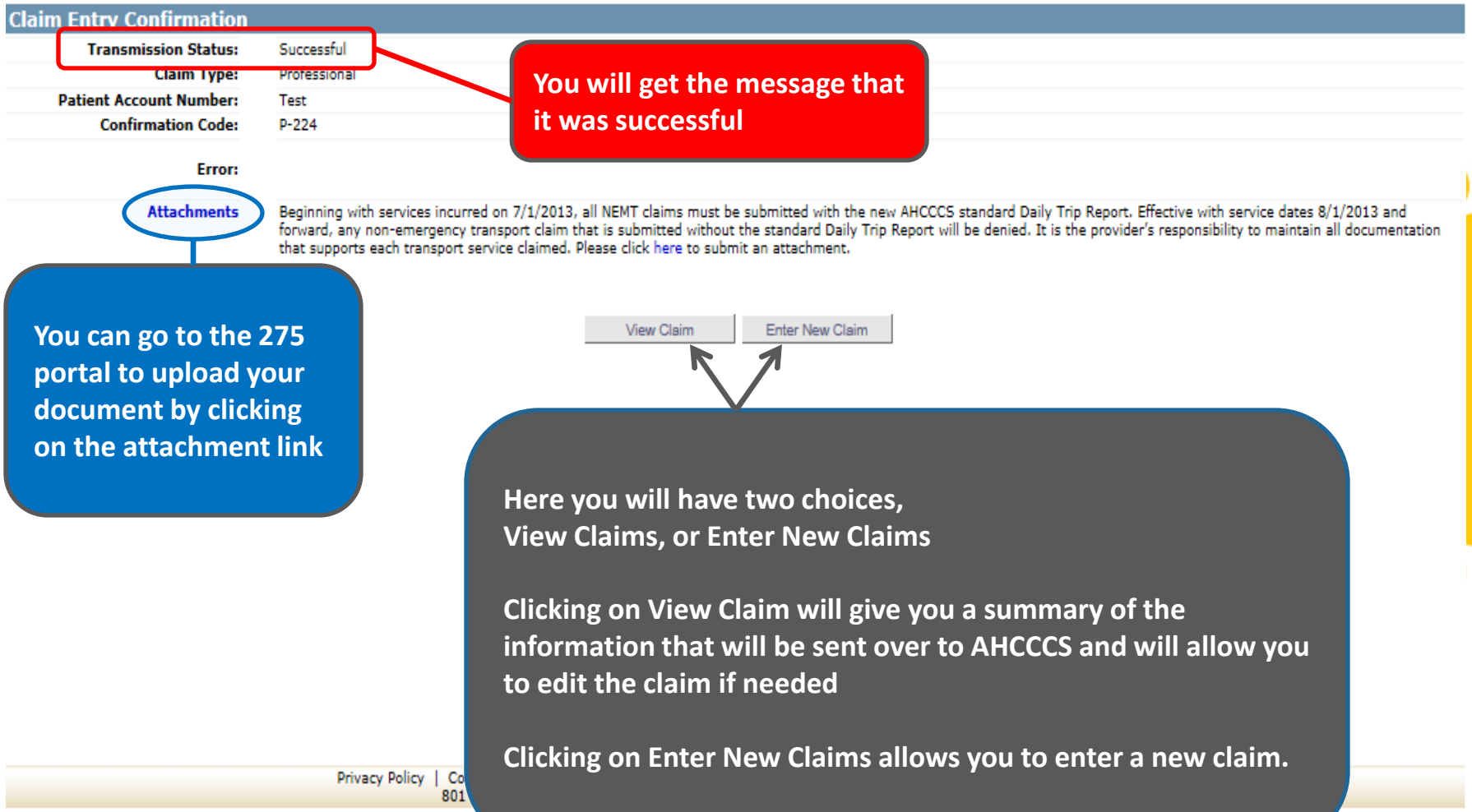
Add

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

If you are done adding or editing the claim, click the submit button

Line No.	Begin Date	End Date	POS	HCPCS	Mod 1	Mod 2	Mod 3	Mod 4	NDC Code	NDC Units	Diag 1	Diag 2	Diag 3	Diag 4	Diag 5	Diag 6	Diag 7	Diag 8	Diag 9	Diag 10	Diag 11	Diag 12	Min./ Units	Type	Line Charges	Medicare Paid Amount	Units	Proc Code	Medicare Deductible Amount	Med Coinsur Am
1	10/7/2014	10/7/2014	99	A0120	TN					0	☑												2	UN	14.54		0			
2	10/7/2014	10/7/2014	99	S0215	TN					0	☑												101.9	UN	102.00		0			
																								Totals:	$116.54	$0.00			$0.00	$

Save Submit Cancel



AHCCCS
Arizona Health Care Cost Containment System

Arizona Health Care Cost Containment System
Professional Claim Submission

Print Date: 6/19/2012 9:45:45 AM
Confirmation Code: P-30

Submitter
Organization Name: TEST/CASE
Information Contact Name: Escobedo, Albert
Information Contact Telephone #: 602-417-4562
Electronic Transmitter ID: 99222

Billing Provider
Tax ID: 123456789 (SY)
National Provider ID (NPI):
Provider Commercial Number/Name: 231725 (TEST/CASE)
Provider Taxonomy Code:
Entity Type: Person
Information Contact Name:
Information Contact Telephone #: 6024174000
Service Address: 701 E. JEFFERSON PHOENIX, AZ 85004
Pay-To Provider Address: 701 E. JEFFERSON PHOENIX, AZ 85004

Rendering Provider
Provider Commercial Number/Name: 231725 (TEST/CASE)
Entity Type: Person
National Provider ID (NPI):
Performing Provider Taxonomy Code:

Service Facility
National Provider ID (NPI):
Laboratory or Facility Name:
Address:

Referring Provider
National Provider ID (NPI):
Provider Commercial Number/Name: ()

Patient/Insured
Member ID Number/Name: A81345732 (TESTRECORD, NEW S)
Date of Birth: 01/01/1995
Gender: M
Residential Address: 801 E JEFFERSON PHX, AZ 85039
Payer Responsibility: Primary

Ambulance Information
Pick-up Address:
Drop-off Location Name:
Drop-off Address:

Attachments

	Type	Transmission	Control Number
1			
2			
3			
4			
Attachments (1-10): 5			
6			
7			
8			
9			
10			

Other Payer Information
Insured Identifier: ()
Insured/Subscriber Name: ()
Insured Address (City):
Payer Primary ID:
Payer Name:
Payer Address (City):
Responsibility:
Insured Group or Policy Number:
Insured Group Name:
Individual Relationship:
Insurance Type:
Claim Filing Indicator:
Benefit Assignment Certification:
Release of Information:
Payer Amount Paid:
Date Claim Paid:

Claim Detail
Original Reference Number:
Prior Authorization Number:
Patient's Control Number: ACCOUNT NUMBER
Medical Record ID Number:
Initial Treatment Date:
Date of Current Injury:
Patient's condition related to:
Place in which accident occurred:
Special Program Indicator:
Provider Signature on File: Yes
Provider Accept Assignment: Assigned
Benefit Assignment: Not Applicable
ase of Information Consent: Informed Consent
EPSDT Screening Referral:

Condition Indicator(s):	1	2	3	
Coding Standard: ICD-9				
Diagnosis Code(s):	1 799.9	2	3	4
	5	6	7	8

This is the summary if you click view

Service Lines

Summary

Line No.	Begin Date	End Date	POS	HCPCS	Mod 1	Mod 2	Mod 3	Mod 4	NDC Code	NDC Units	Diag 1	Diag 2	Diag 3	Diag 4	Diag 5	Diag 6	Diag 7	Diag 8	Quantity		Line Charges	Medicare Paid Amount	Medicare Deductible Amount	Medicare Coinsurance Amount	Medicare Copay Amount	Other Payer Paid Amount	EMG	EPSDT	Cor
1	06/18/2012	06/18/2012	99	A0120	TN					0.000	☑								2.000	UN	14.54	0.00	0.00	0.00	0.00	0.00			
2	06/18/2012	06/18/2012	99	S0215	TN					0.000	☑								110.000	UN	168.30	0.00	0.00	0.00	0.00	0.00			
																				Totals:	$182.84	$0.00	$0.00	$0.00	$0.00	$0.00			

Details

< Previous | Edit | Enter New Claim

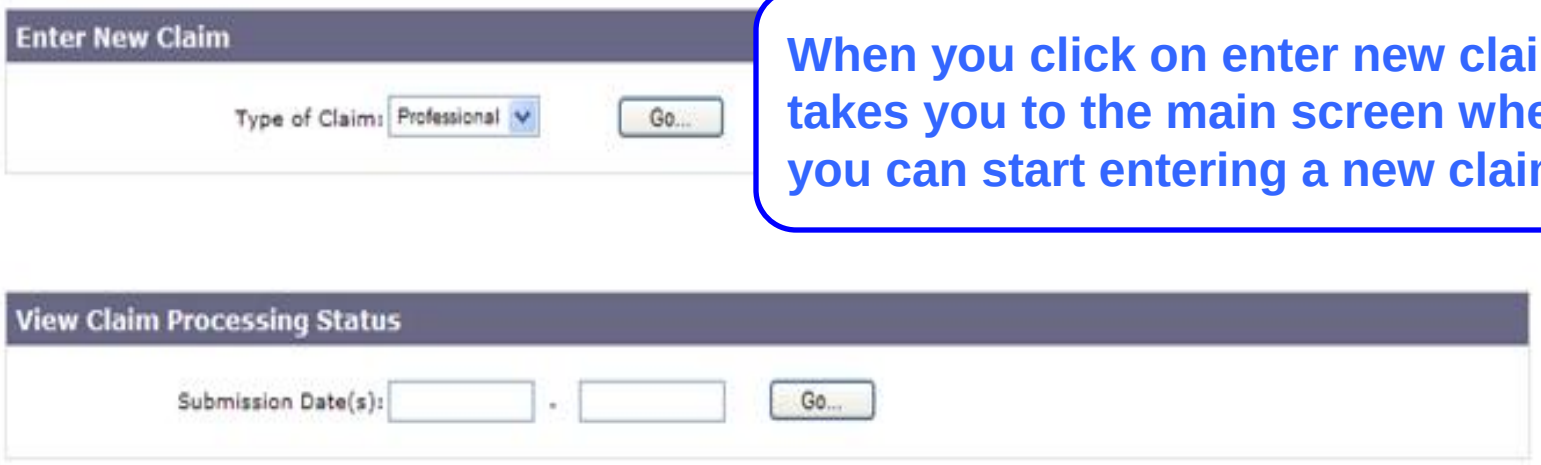
To edit the claim click on edit

Claim Submission

Claims submitted to AHCCCS prior to 4:00 PM 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.



When you click on enter new claim it takes you to the main screen where you can start entering a new claim

AHCCCS
Arizona Health Care Cost Containment System

Claim Submission

Claims submitted to AHCCCS prior to 4:00 PM 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):

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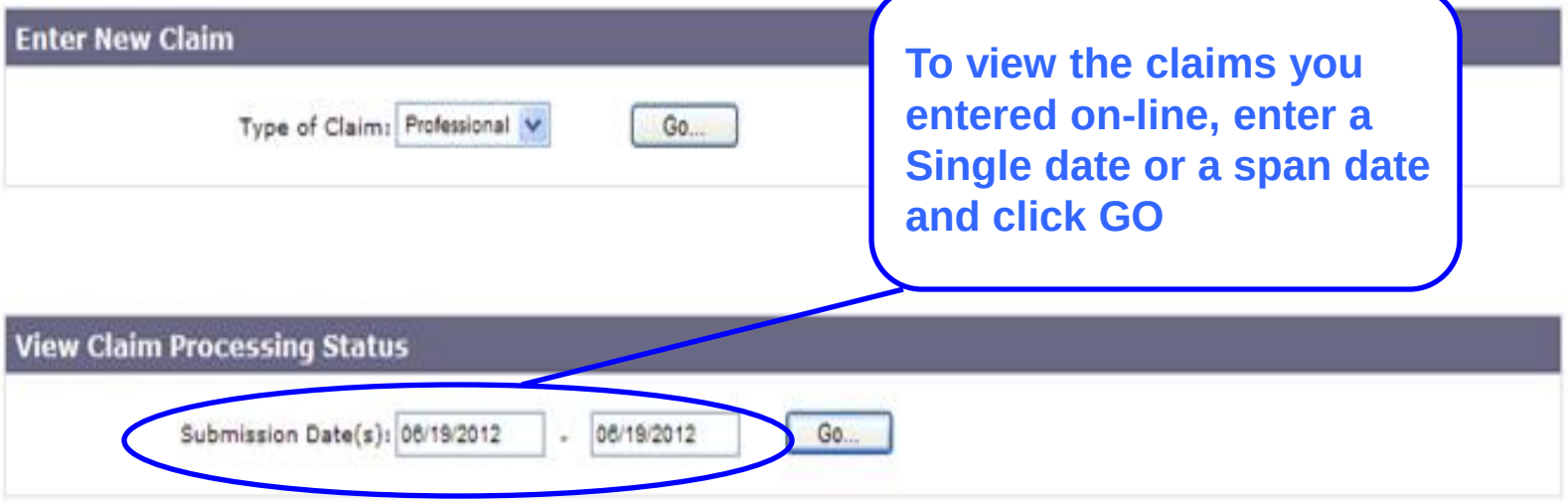


To view the claims you entered on-line, enter a Single date or a span date and click GO

AHCCCS
Arizona Health Care Cost Containment System

Claim Submission Status

Claim Type	Submission Date/Time	Patient Account #	Service Prov. NPI	Billing Prov. NPI	Date From	Date Thru	Status	Processing Date/Time	CRN	Adjudication
Professional	06/05/12 12:40 PM	ACCT # TEST REPLACE			05/15/12	05/15/12	Processed	06/05/12 04:00 PM	121575600003	Denied
Professional	06/07/12 04:58 PM	REPLACEMENT TEST			05/15/12	05/15/12	Processed	06/08/12 09:44 AM	121605600002	Denied
Professional	06/18/12 05:19 PM	ACCOUNT NUM NO TPL			06/18/12	06/18/12	Pending			
Record Count:	3									

< Previous

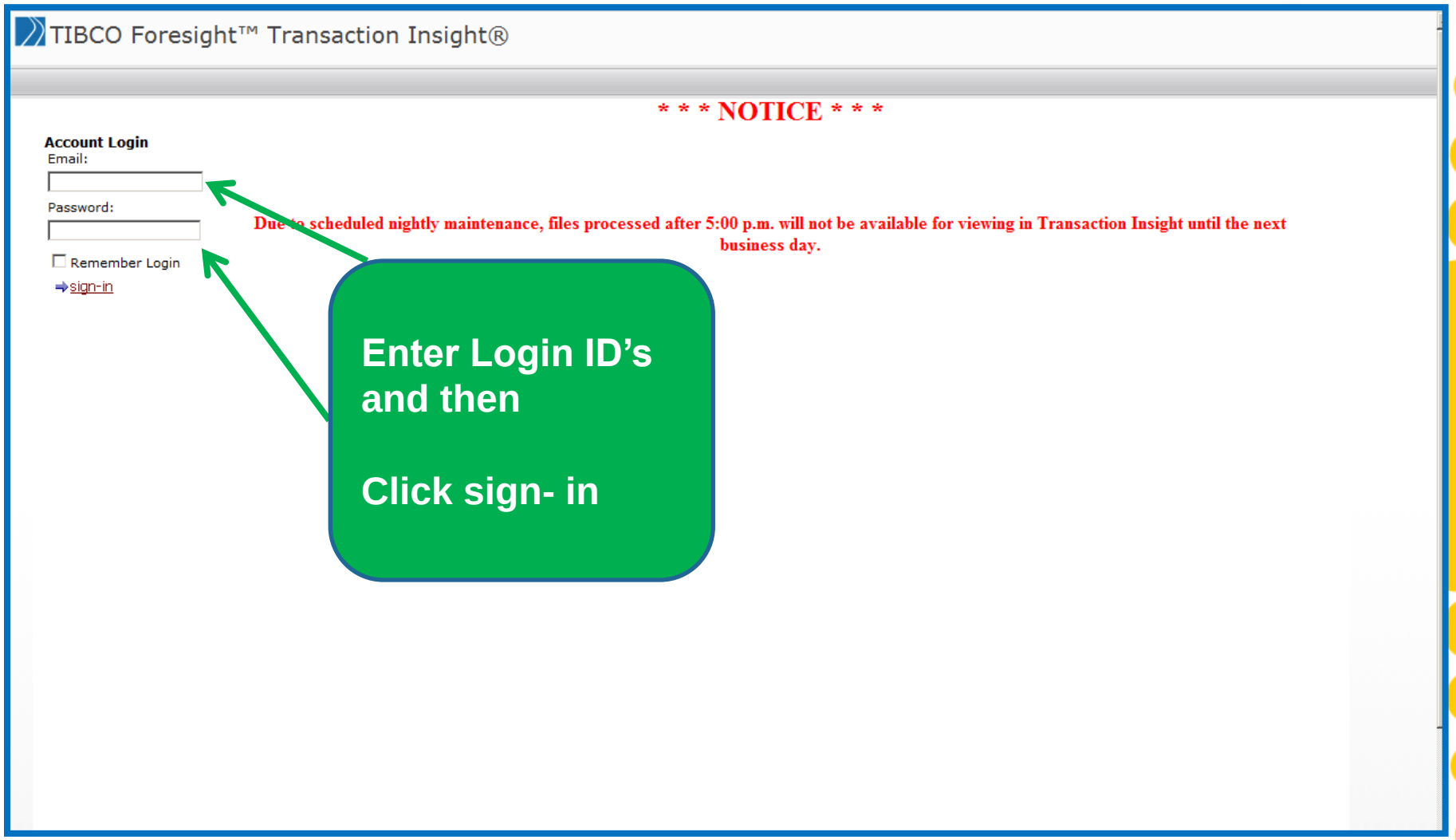
AHCCCS
Arizona Health Care Cost Containment System

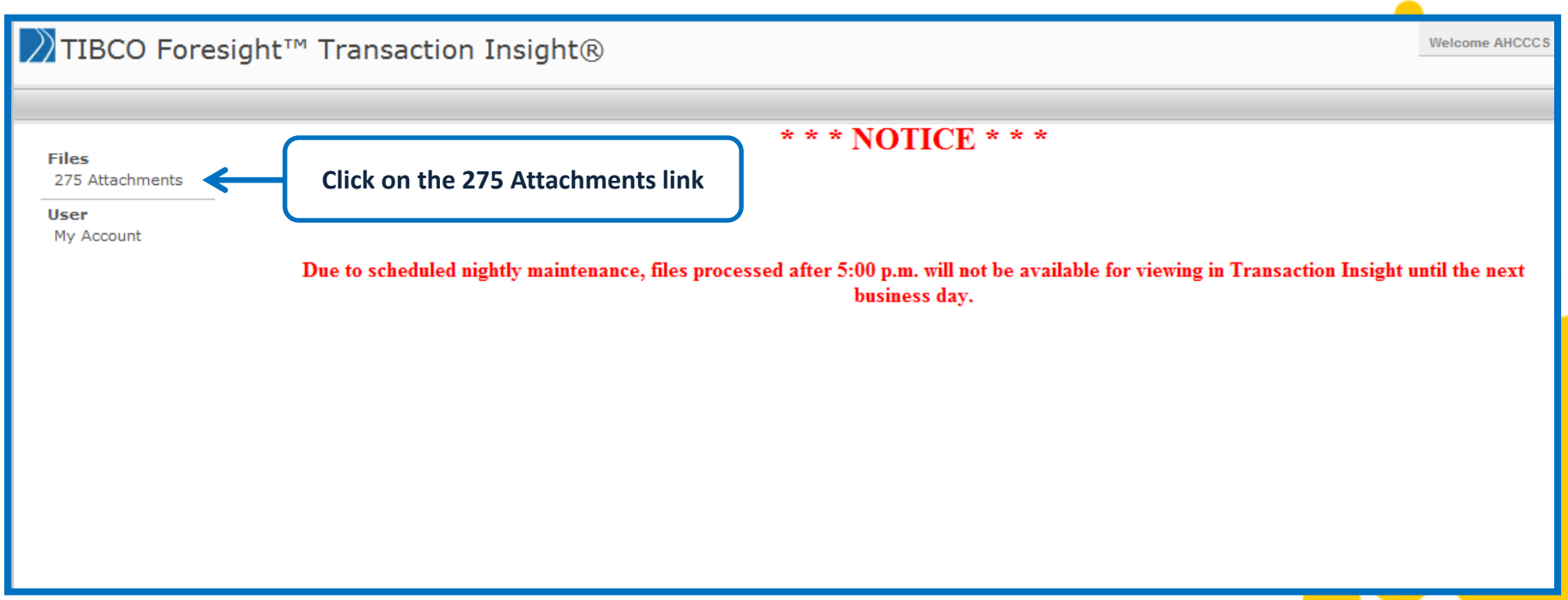
AHCCCS
Arizona Health Care Cost Containment System

Transaction Insight (TI) Portal
275 Claim Attachments
https://tiwebprd.statemedicaid.us

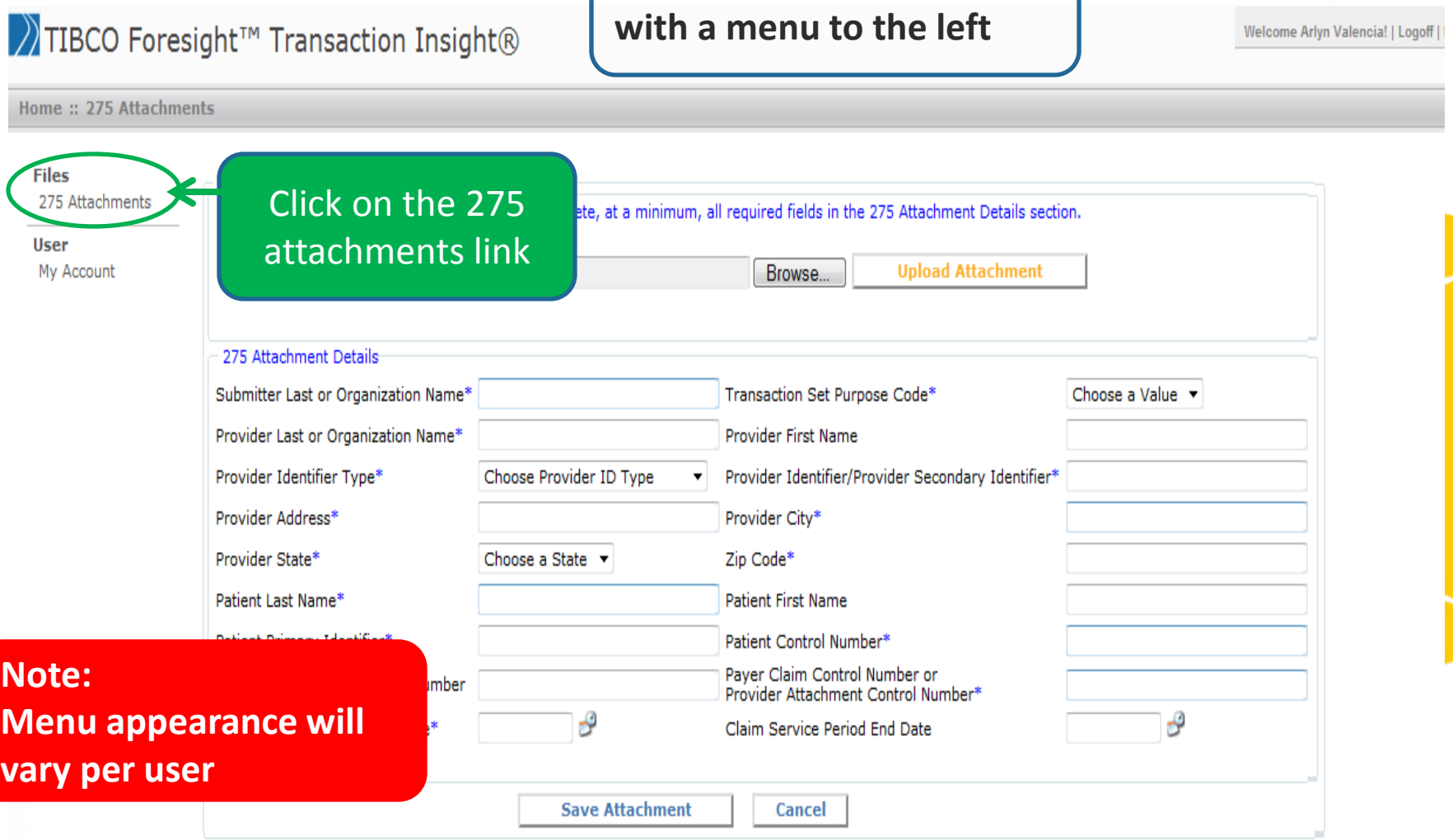
Entering Provider, Patient and Attachment Detail Information and File

Revised: 8/10/15

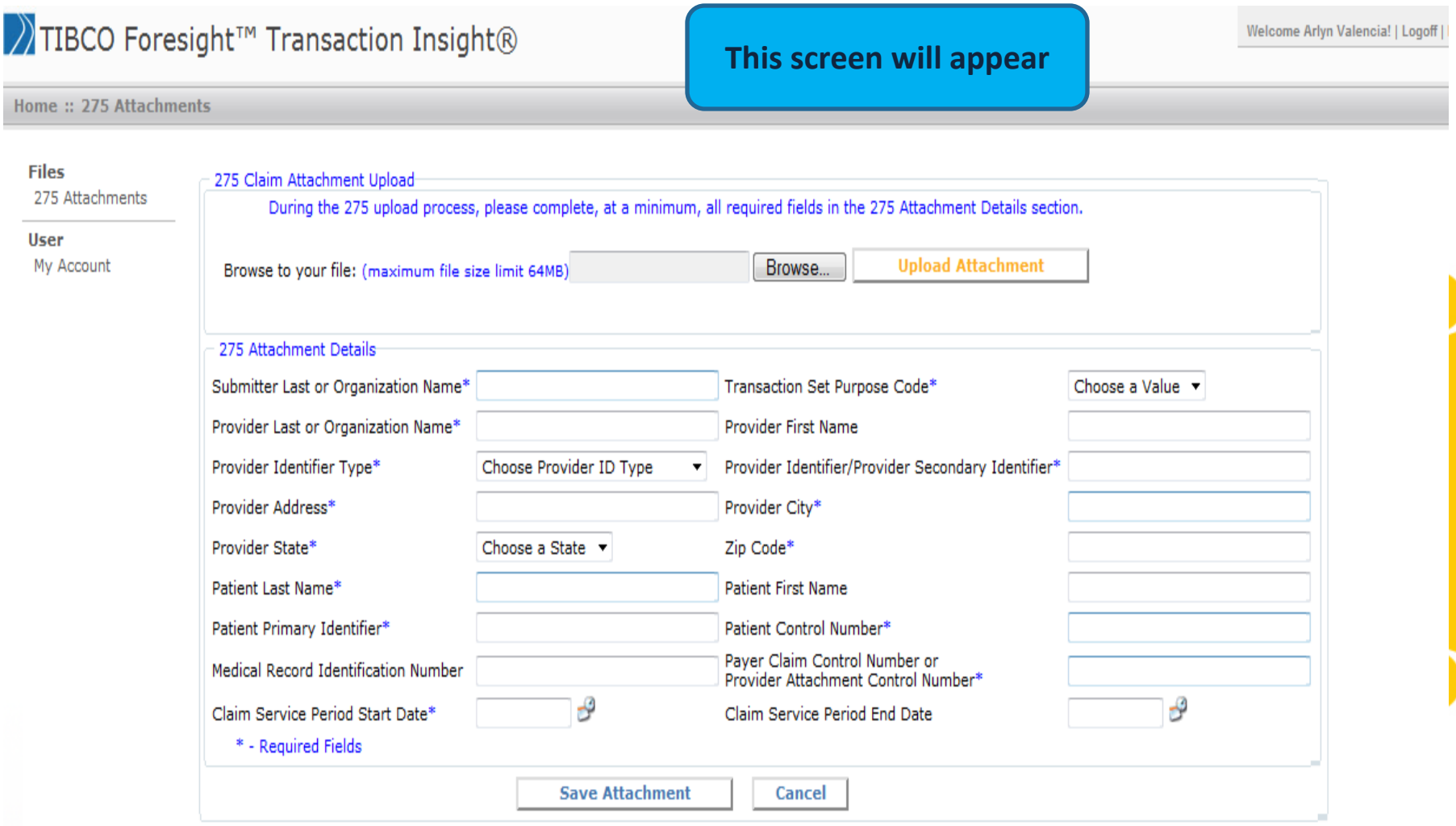

TIBCO Foresight™ Transaction Insight®
* * * NOTICE * * *
Account Login
Email:
Password:
Remember Login
sign-in
Due to scheduled nightly maintenance, files processed after 5:00 p.m. will not be available for viewing in Transaction Insight until the next business day.
Enter Login ID's and then
Click sign- in


TIBCO Foresight™ Transaction Insight®
Welcome AHCCCS
Files
275 Attachments
User
My Account
Click on the 275 Attachments link
* * * NOTICE * * *
Due to scheduled nightly maintenance, files processed after 5:00 p.m. will not be available for viewing in Transaction Insight until the next business day.

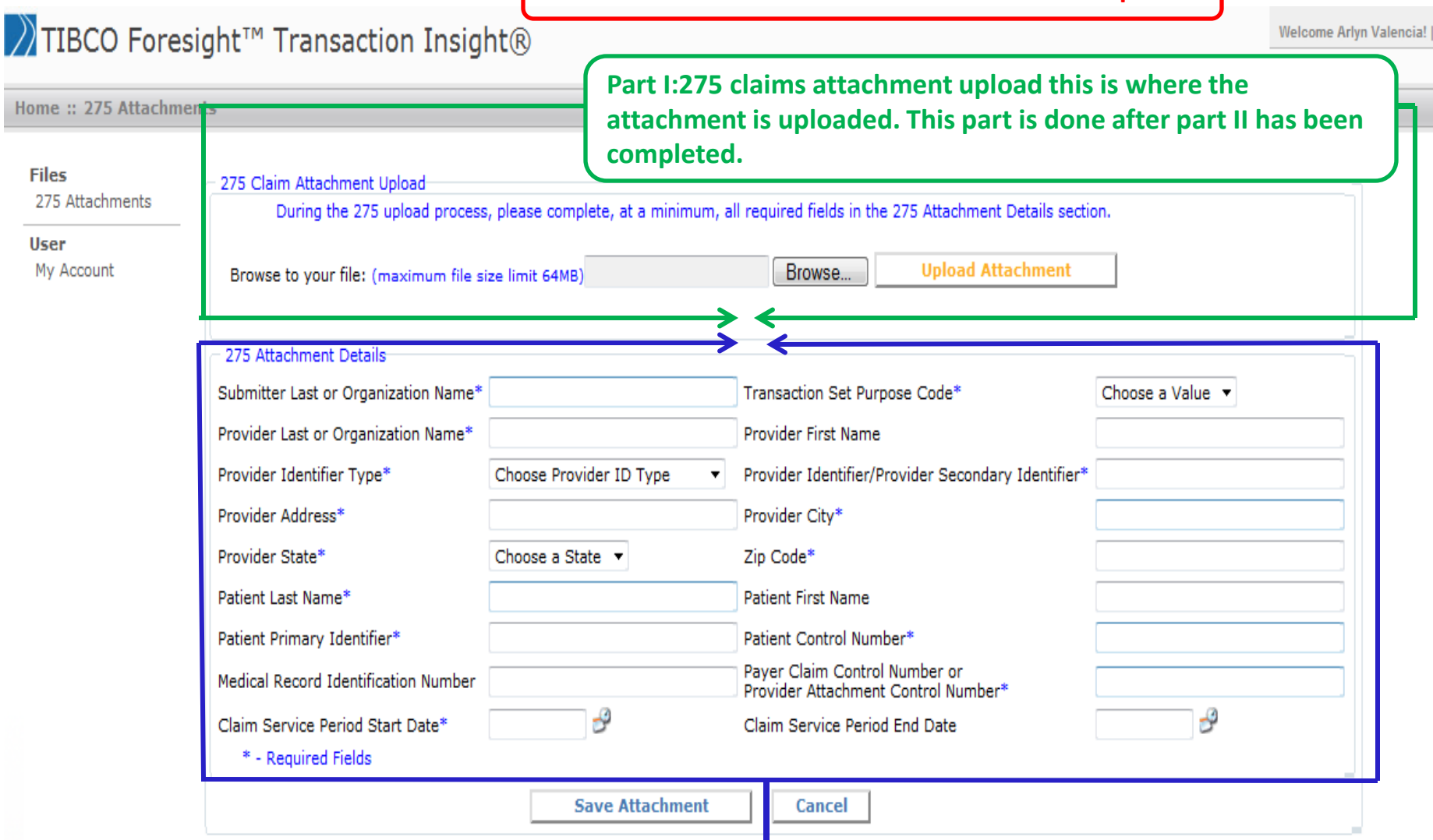
This screen will appear with a menu to the left



Note:
Menu appearance will vary per user


TIBCO Foresight™ Transaction Insight®
This screen will appear
Welcome Arlyn Valencia! | Logoff |
Home :: 275 Attachments
Files
275 Attachments
User
My Account
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
Browse to your file: (maximum file size limit 64MB)
Browse...
Upload Attachment
275 Attachment Details
Submitter Last or Organization Name*
Transaction Set Purpose Code*
Choose a Value
Provider Last or Organization Name*
Provider First Name
Provider Identifier Type*
Choose Provider ID Type
Provider Identifier/Provider Secondary Identifier*
Provider Address*
Provider City*
Provider State*
Choose a State
Zip Code*
Patient Last Name*
Patient First Name
Patient Primary Identifier*
Patient Control Number*
Medical Record Identification Number
Payer Claim Control Number or
Provider Attachment Control Number*
Claim Service Period Start Date*
Claim Service Period End Date
* - Required Fields
Save Attachment
Cancel

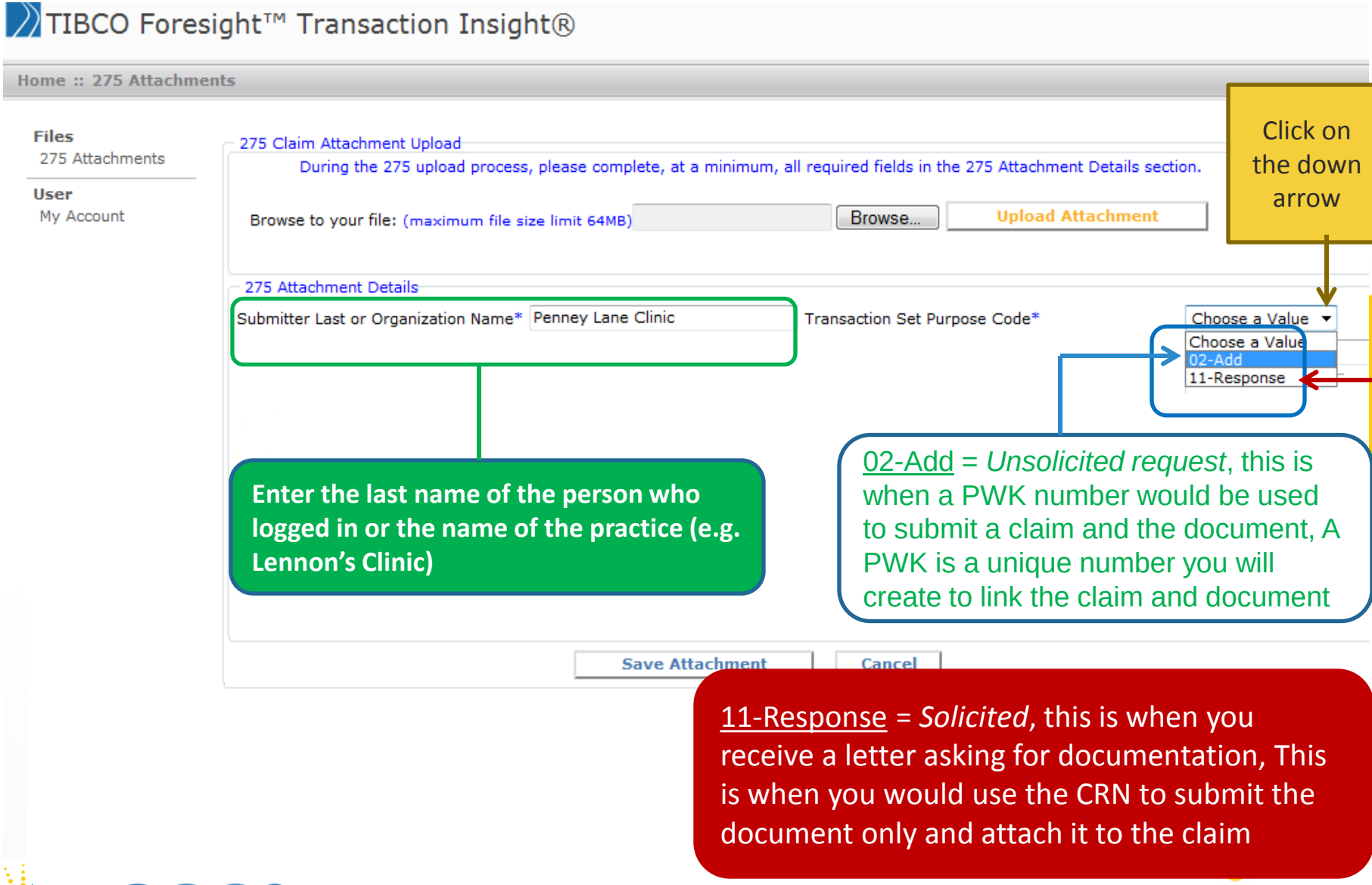
This is the main screen and it's divided into two parts

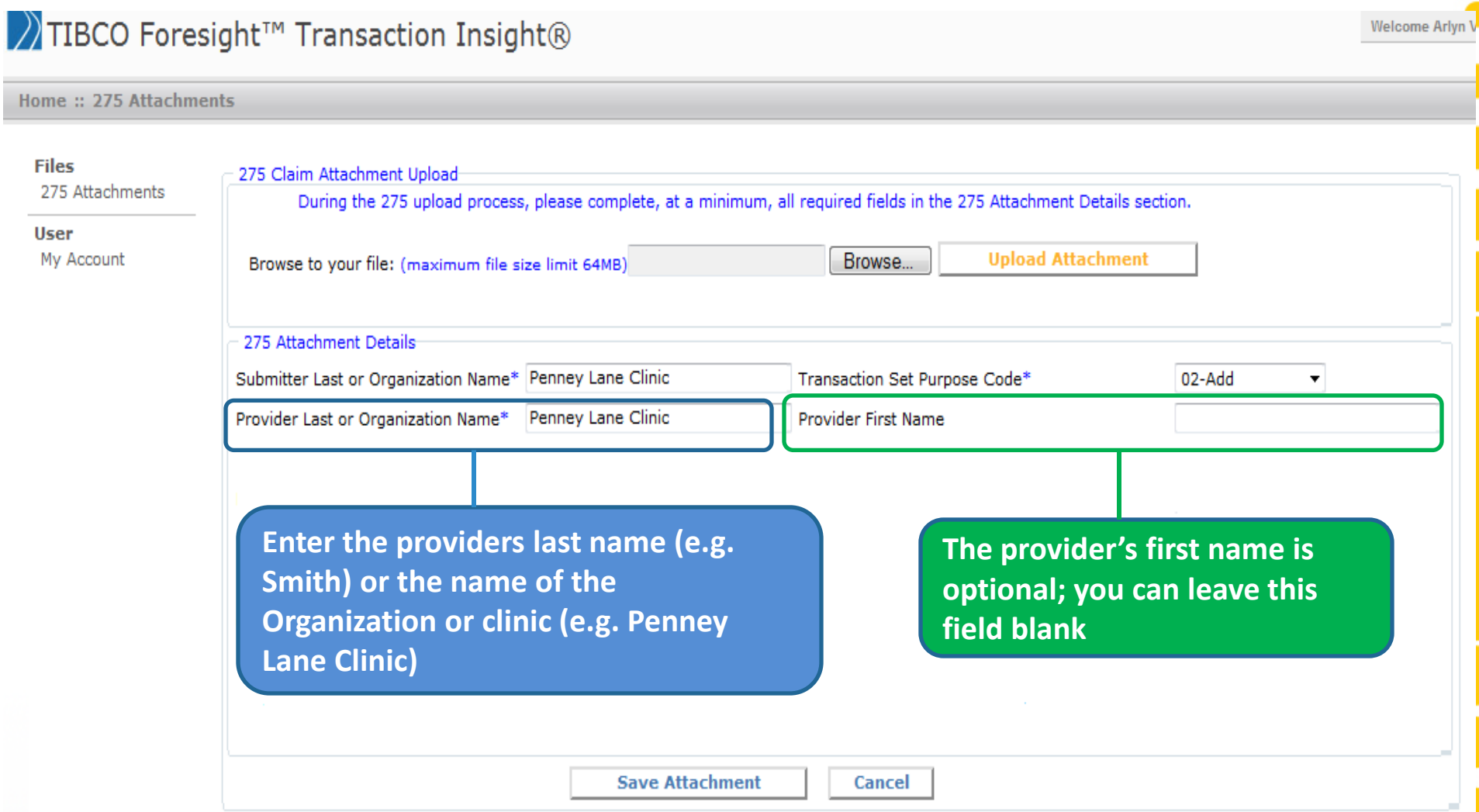


Part I:275 claims attachment upload this is where the attachment is uploaded. This part is done after part II has been completed.

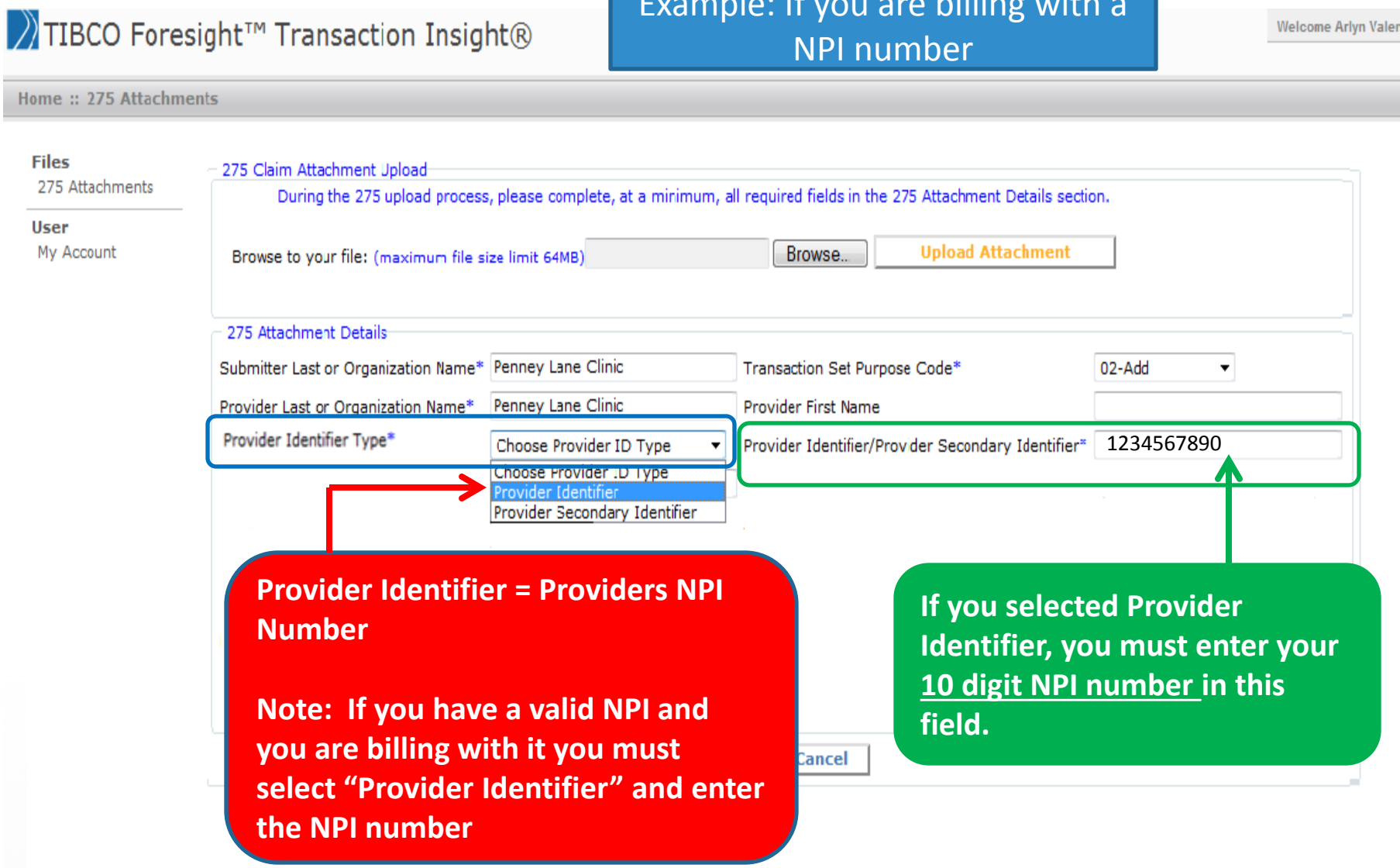
Part II: ***275 Attachment Details*** *(Provider and member information is entered here.)*
Part II Must be completed before processing to Part I.

AHCCCS
Arizona Health Care Cost Containment System


TIBCO Foresight™ Transaction Insight®
Home :: 275 Attachments
Files
275 Attachments
User
My Account
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
Browse to your file: (maximum file size limit 64MB)
Browse...
Upload Attachment
275 Attachment Details
Submitter Last or Organization Name*
Penney Lane Clinic
Transaction Set Purpose Code*
Choose a Value
Choose a Value
02-Add
11-Response
Save Attachment
Cancel
Click on the down arrow
Enter the last name of the person who logged in or the name of the practice (e.g. Lennon's Clinic)
02-Add = Unsolicited request, this is when a PWK number would be used to submit a claim and the document, A PWK is a unique number you will create to link the claim and document
11-Response = Solicited, this is when you receive a letter asking for documentation, This is when you would use the CRN to submit the document only and attach it to the claim


TIBCO Foresight™ Transaction Insight®
Welcome Arlyn
Home :: 275 Attachments
Files
275 Attachments
User
My Account
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
Browse to your file: (maximum file size limit 64MB)
Browse...
Upload Attachment
275 Attachment Details
Submitter Last or Organization Name*
Penney Lane Clinic
Transaction Set Purpose Code*
02-Add
Provider Last or Organization Name*
Penney Lane Clinic
Provider First Name
Enter the providers last name (e.g. Smith) or the name of the Organization or clinic (e.g. Penney Lane Clinic)
The provider's first name is optional; you can leave this field blank
Save Attachment
Cancel

Example: If you are billing with a NPI number

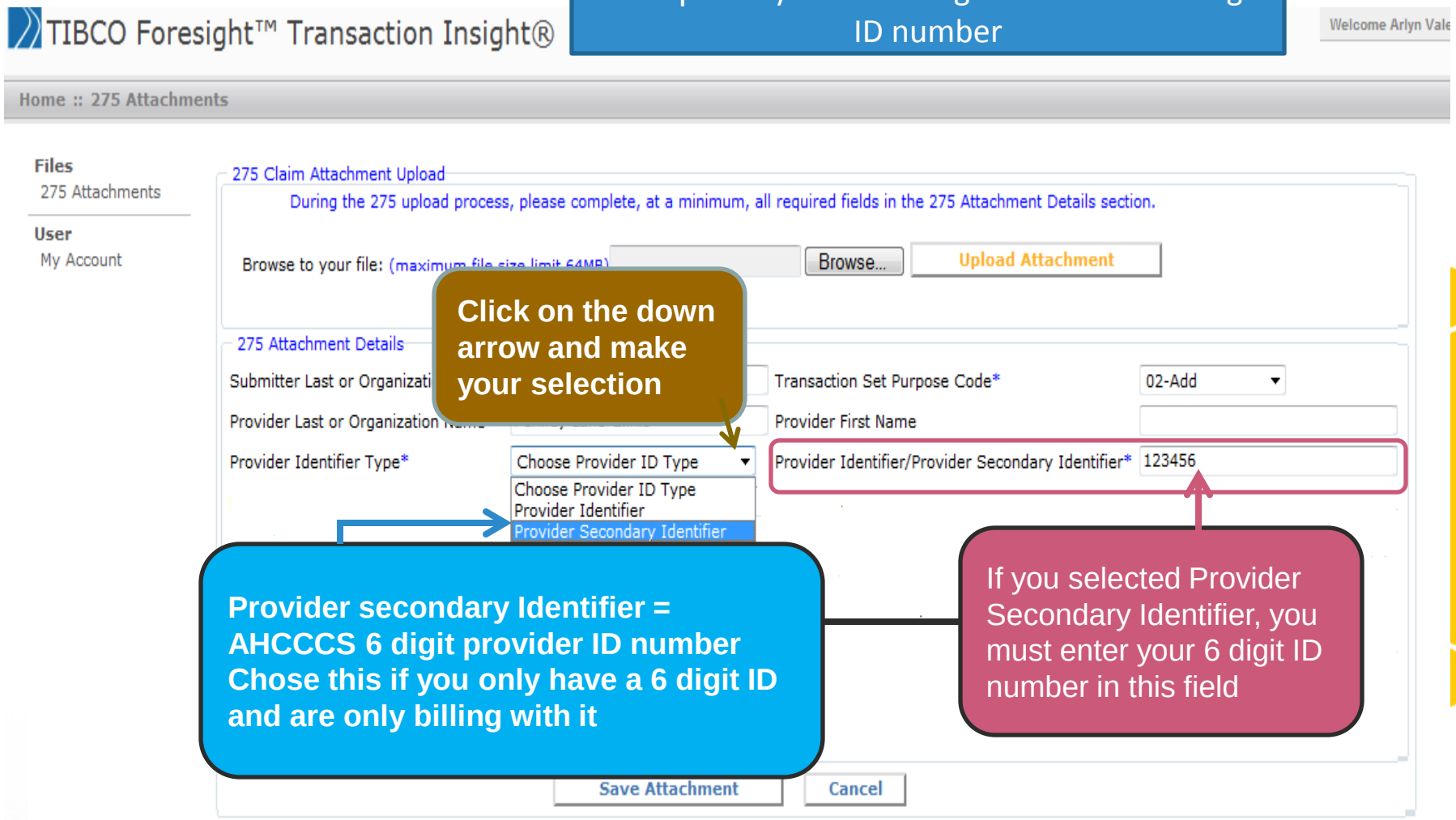


Provider Identifier = Providers NPI Number

Note: If you have a valid NPI and you are billing with it you must select "Provider Identifier" and enter the NPI number

If you selected Provider Identifier, you must enter your 10 digit NPI number in this field.

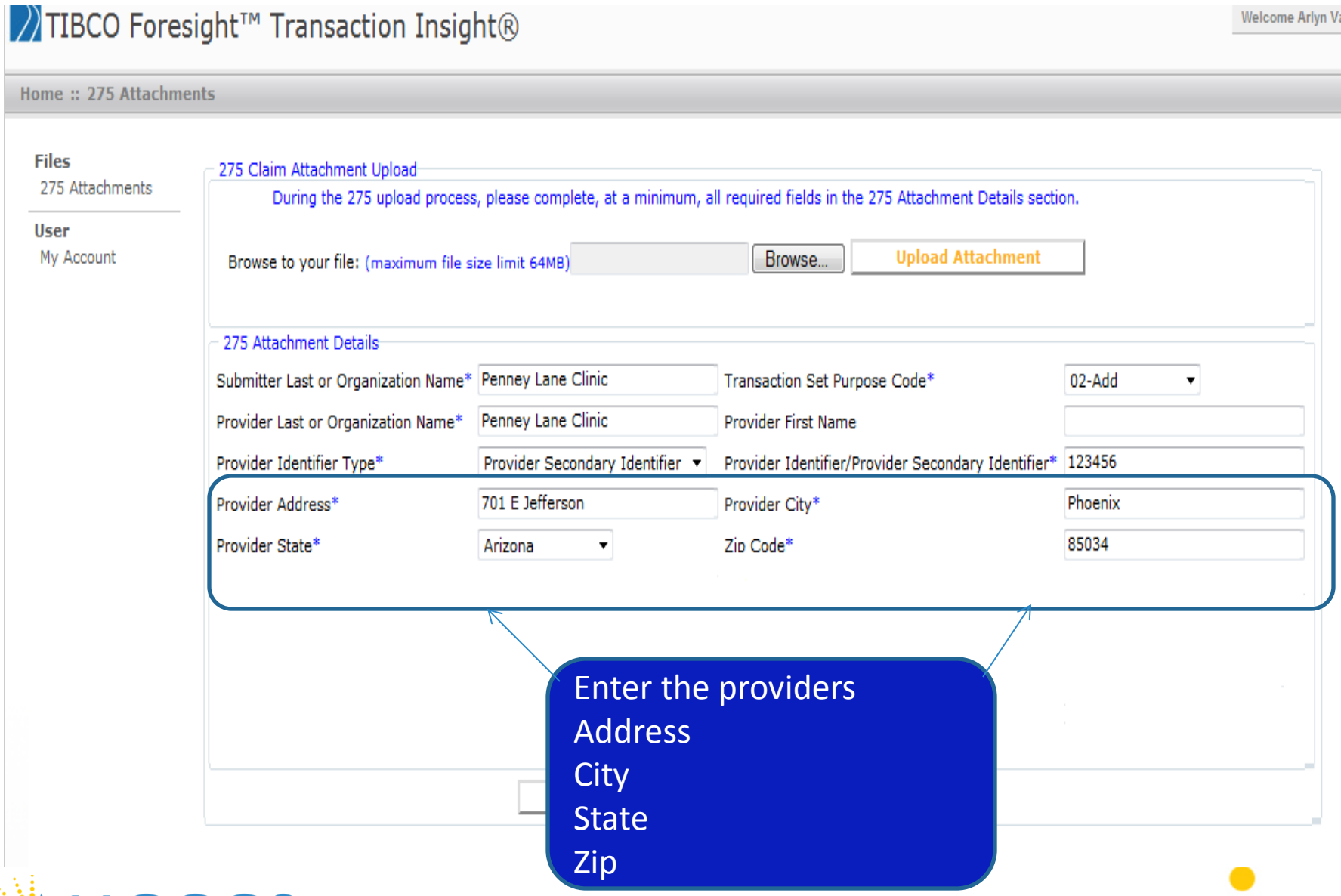
Example: If you are billing with a Ahcccs 6 digit ID number

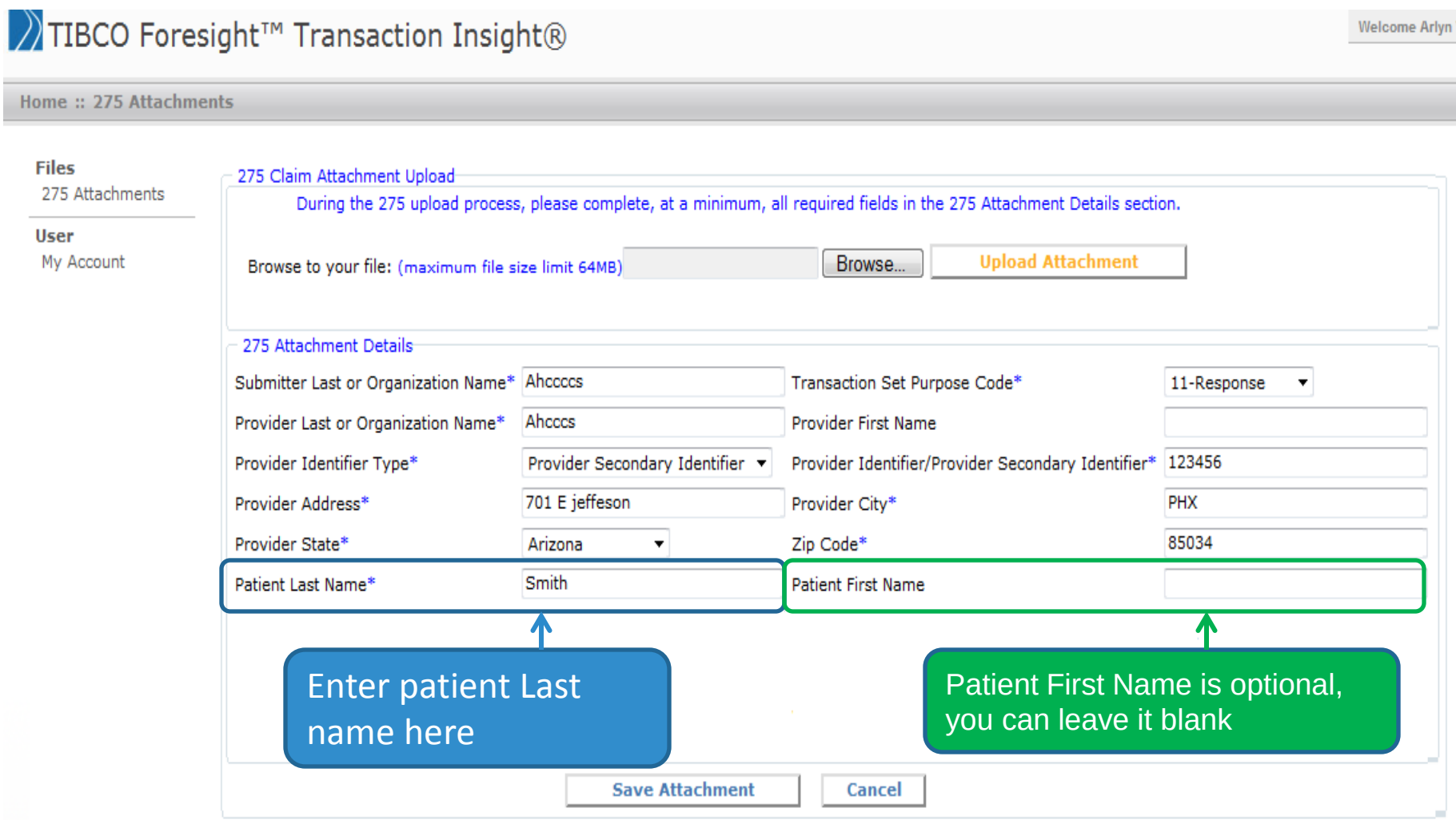


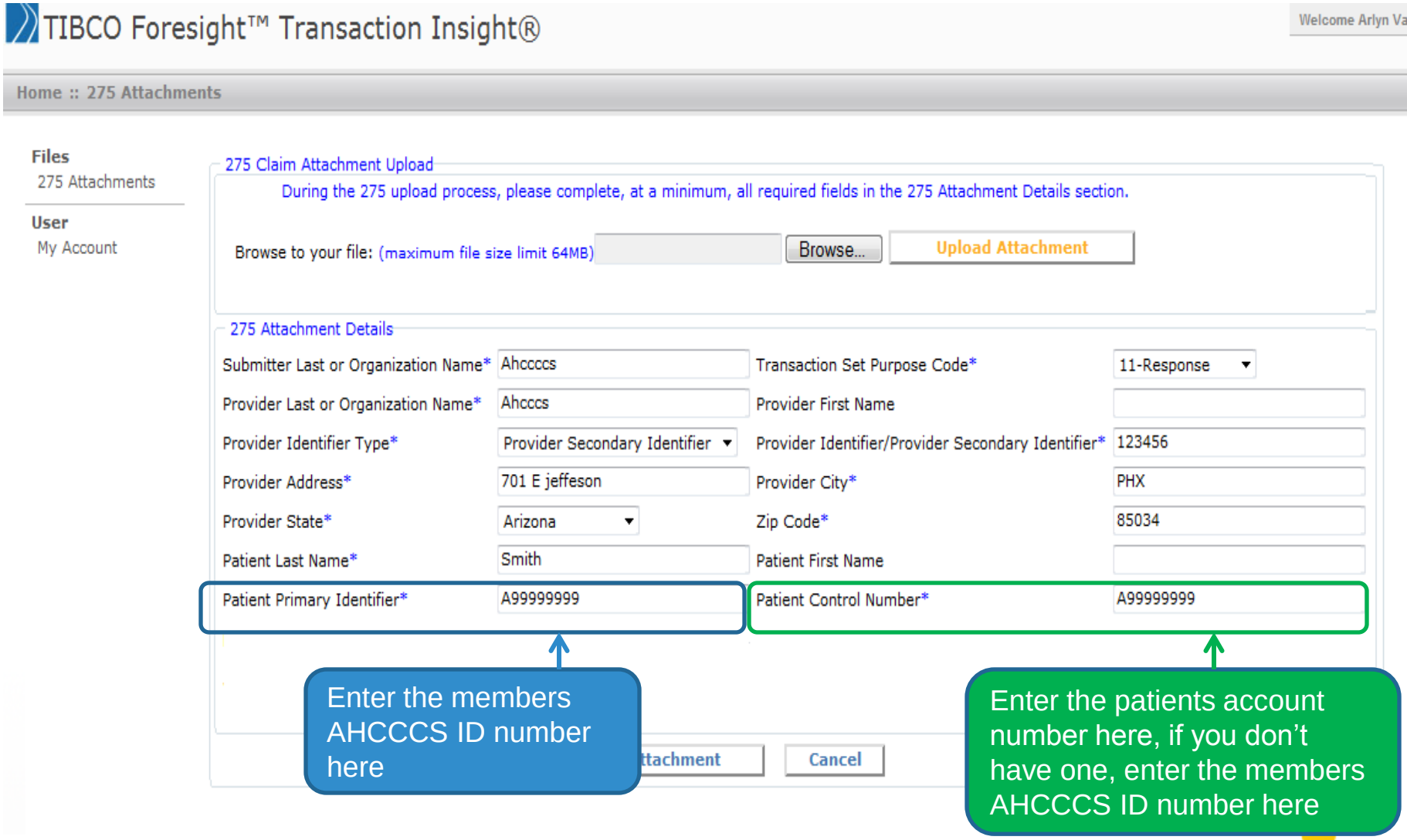
Click on the down arrow and make your selection

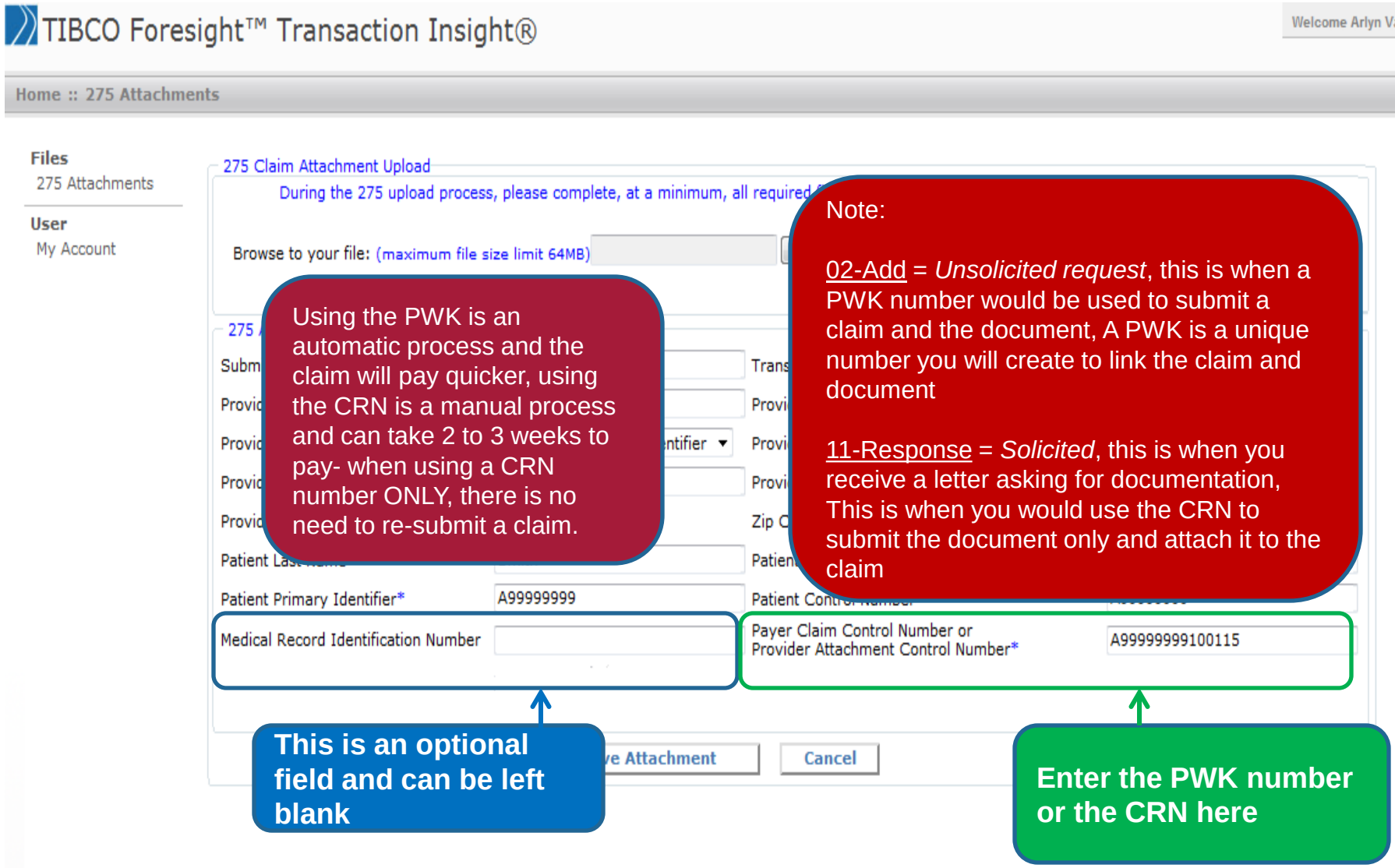
Provider secondary Identifier = AHCCCS 6 digit provider ID number Chose this if you only have a 6 digit ID and are only billing with it

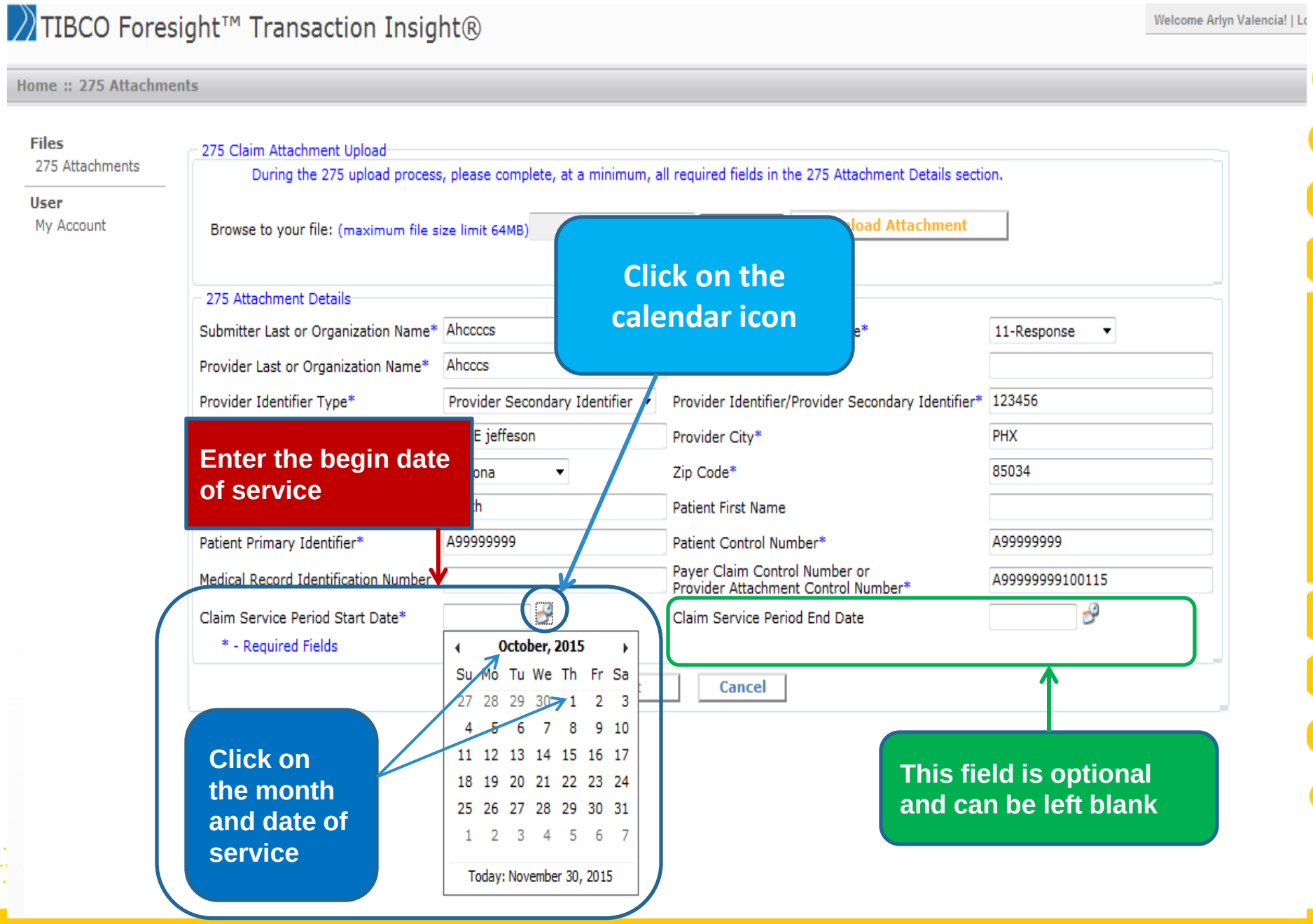
If you selected Provider Secondary Identifier, you must enter your 6 digit ID number in this field

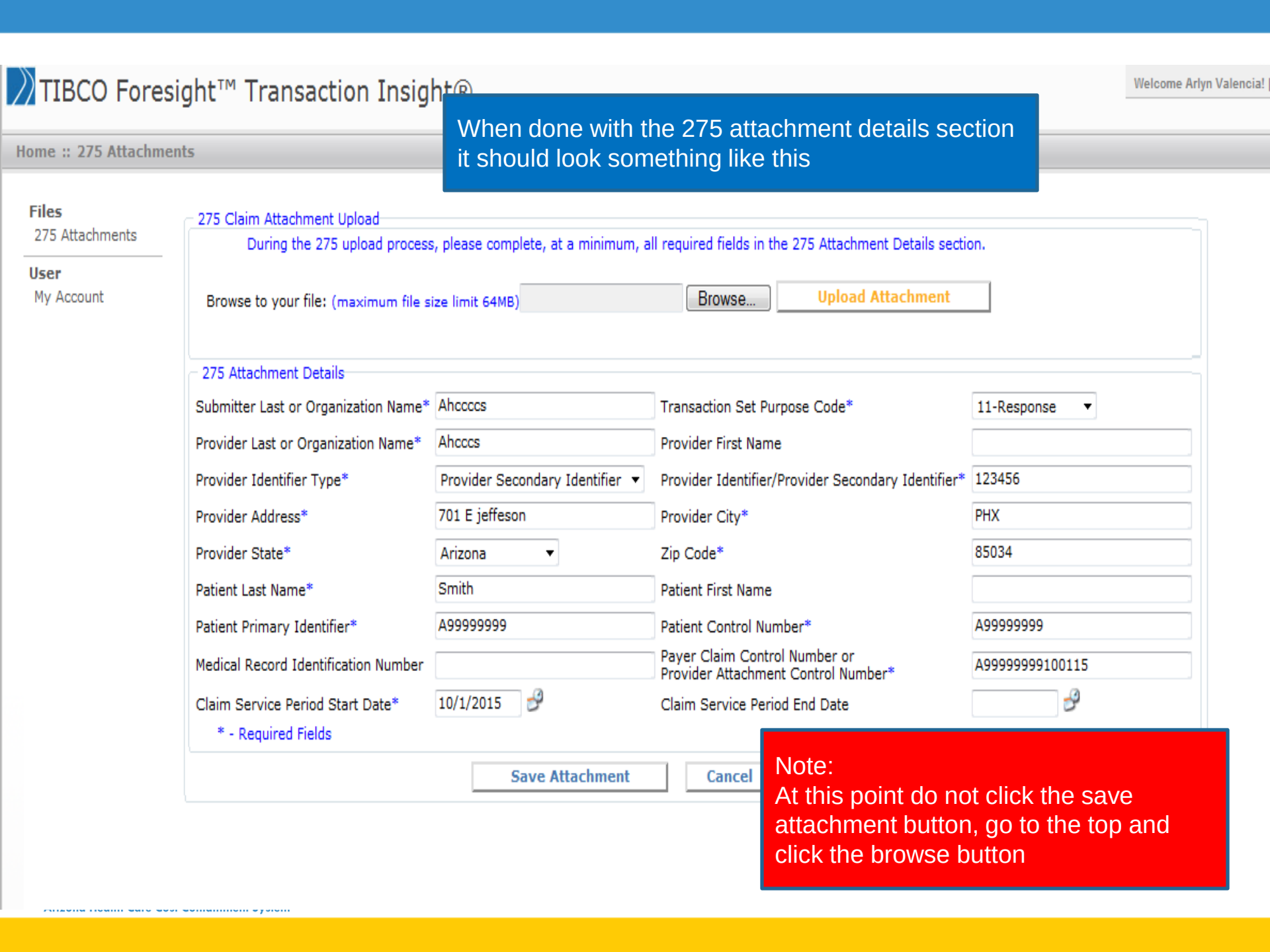

TIBCO Foresight™ Transaction Insight®
Welcome Arlyn Valencia
Home :: 275 Attachments
Files
275 Attachments
User
My Account
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
Browse to your file: (maximum file size limit 64MB)
Browse...
Upload Attachment
275 Attachment Details
Submitter Last or Organization Name* Penney Lane Clinic
Transaction Set Purpose Code* 02-Add
Provider Last or Organization Name* Penney Lane Clinic
Provider First Name
Provider Identifier Type* Provider Secondary Identifier
Provider Identifier/Provider Secondary Identifier* 123456
Provider Address* 701 E Jefferson
Provider City* Phoenix
Provider State* Arizona
Zip Code* 85034
Enter the providers
Address
City
State
Zip

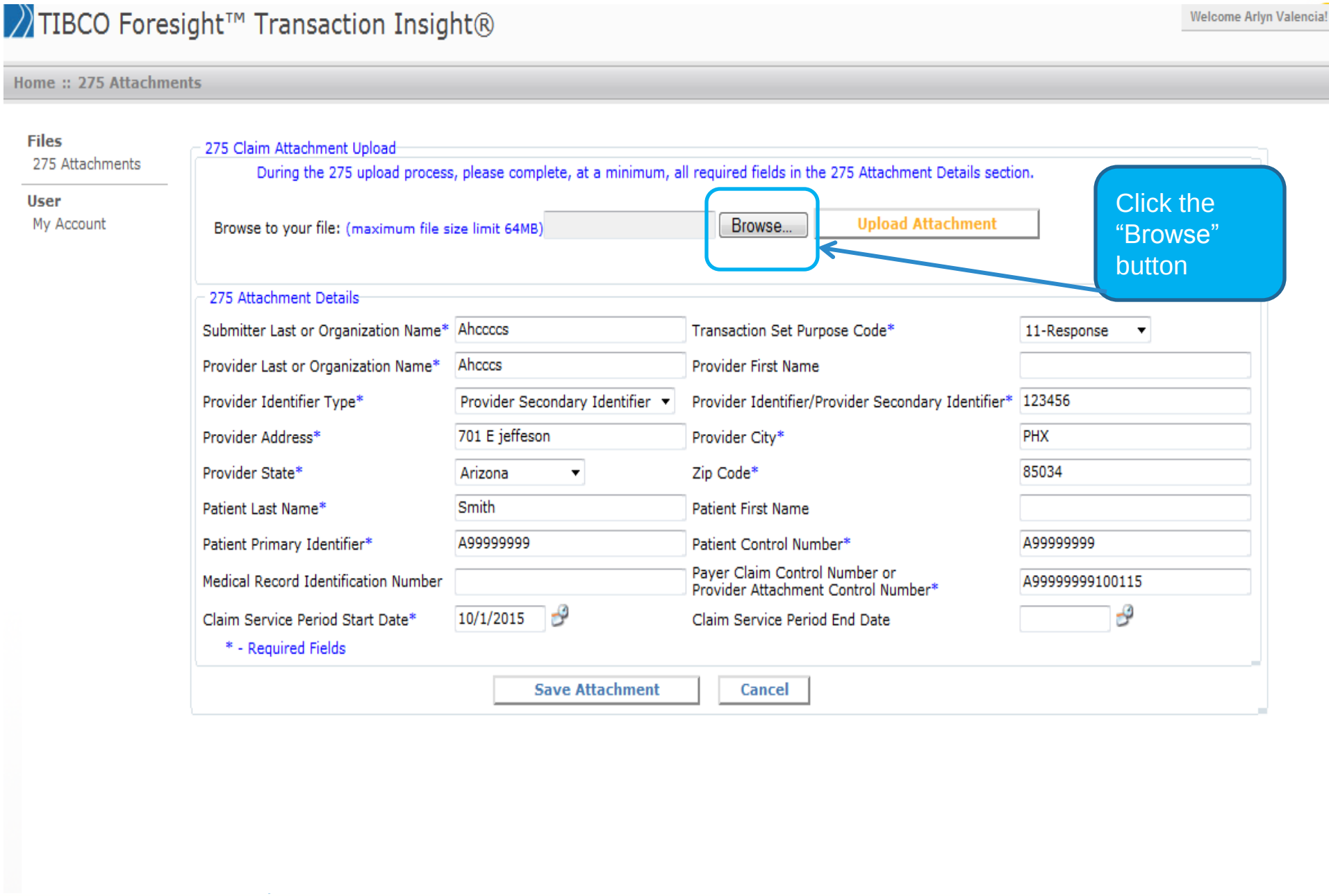

TIBCO Foresight™ Transaction Insight®
Welcome Arlyn Valencia! |
Home :: 275 Attachments
Files
275 Attachments
User
My Account
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
Browse to your file: (maximum file size limit 64MB)
Browse...
Upload Attachment
275 Attachment Details
Submitter Last or Organization Name* Ahccccs
Transaction Set Purpose Code* 11-Response
Provider Last or Organization Name* Ahcccs
Provider First Name
Provider Identifier Type* Provider Secondary Identifier
Provider Identifier/Provider Secondary Identifier* 123456
Provider Address* 701 E jeffeson
Provider City* PHX
Provider State* Arizona
Zip Code* 85034
Patient Last Name* Smith
Patient First Name
Enter patient Last name here
Patient First Name is optional, you can leave it blank
Save Attachment
Cancel


TIBCO Foresight™ Transaction Insight®
Welcome Arlyn Valencia
Home :: 275 Attachments
Files
275 Attachments
User
My Account
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
Browse to your file: (maximum file size limit 64MB)
Browse...
Upload Attachment
275 Attachment Details
Submitter Last or Organization Name* Ahccccs
Transaction Set Purpose Code* 11-Response
Provider Last or Organization Name* Ahcccs
Provider First Name
Provider Identifier Type* Provider Secondary Identifier
Provider Identifier/Provider Secondary Identifier* 123456
Provider Address* 701 E jeffeson
Provider City* PHX
Provider State* Arizona
Zip Code* 85034
Patient Last Name* Smith
Patient First Name
Patient Primary Identifier* A99999999
Patient Control Number* A99999999
ttachment
Cancel
Enter the members AHCCCS ID number here
Enter the patients account number here, if you don't have one, enter the members AHCCCS ID number here

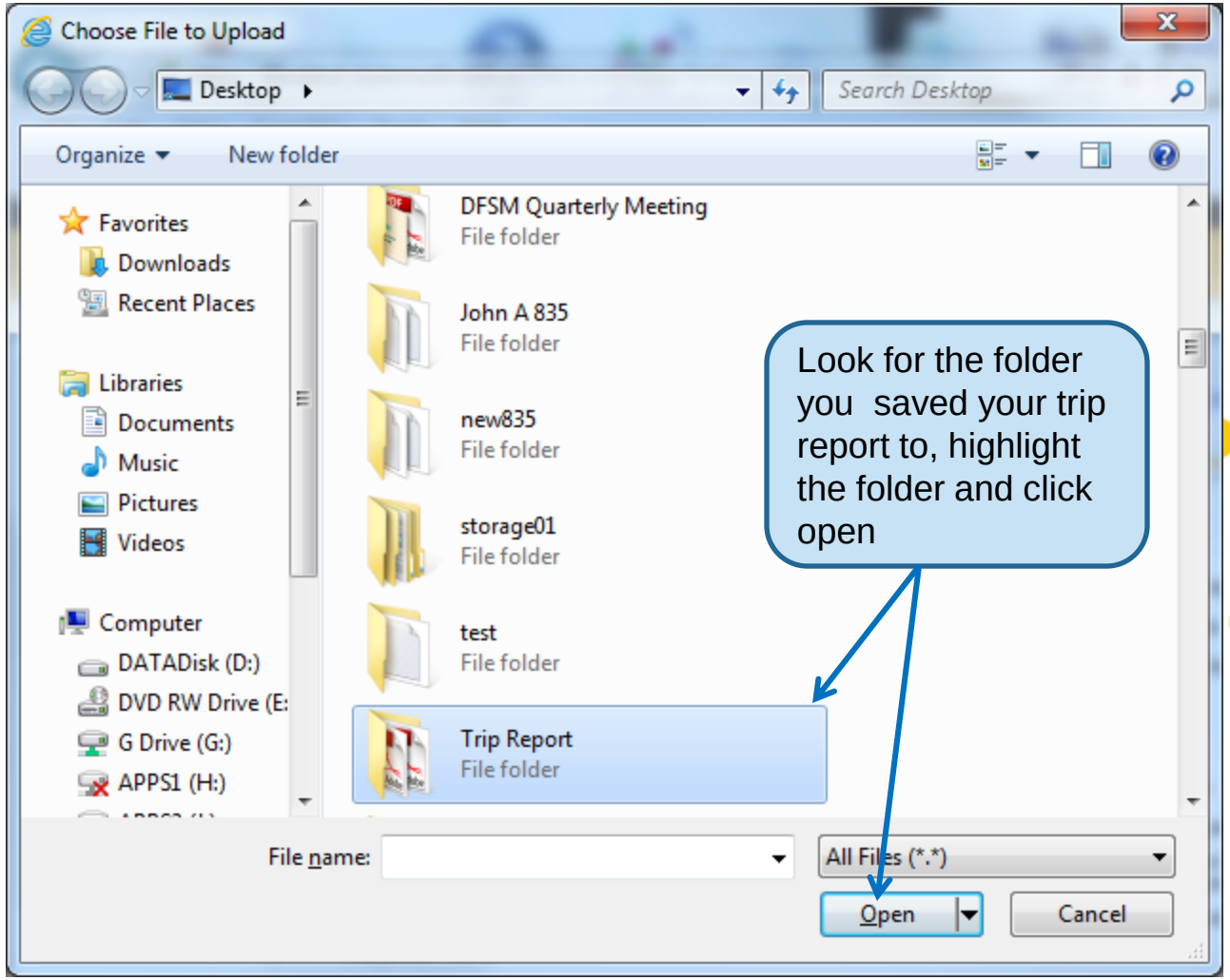

TIBCO Foresight™ Transaction Insight®
Welcome Arlyn Valencia
Home :: 275 Attachments
Files
275 Attachments
User
My Account
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required
Browse to your file: (maximum file size limit 64MB)
Patient Primary Identifier*
A99999999
Medical Record Identification Number
Payer Claim Control Number or
Provider Attachment Control Number*
A99999999100115
Cancel
Using the PWK is an automatic process and the claim will pay quicker, using the CRN is a manual process and can take 2 to 3 weeks to pay- when using a CRN number ONLY, there is no need to re-submit a claim.
Note:
02-Add = Unsolicited request, this is when a PWK number would be used to submit a claim and the document, A PWK is a unique number you will create to link the claim and document
11-Response = Solicited, this is when you receive a letter asking for documentation, This is when you would use the CRN to submit the document only and attach it to the claim
This is an optional field and can be left blank
Enter the PWK number or the CRN here

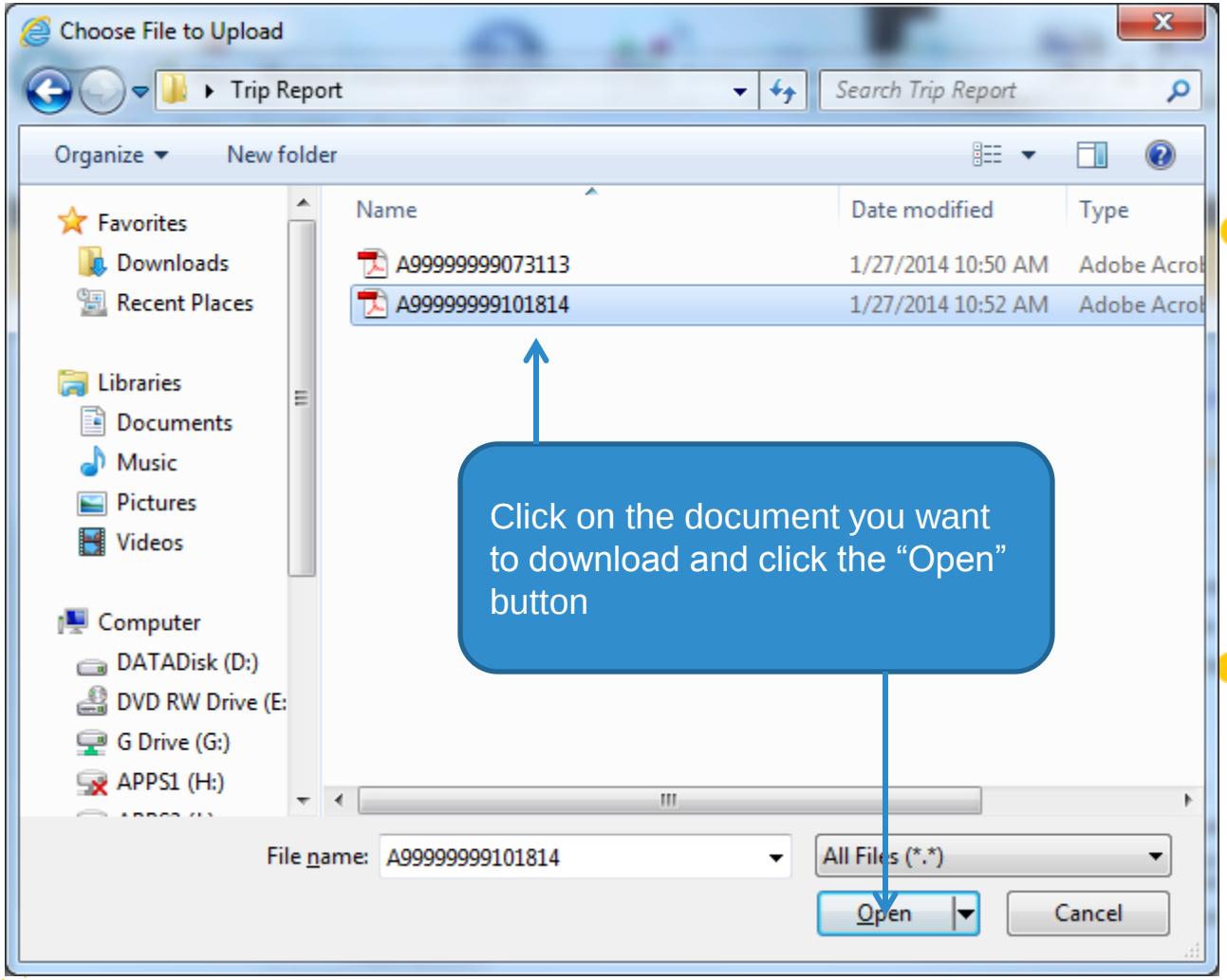

TIBCO Foresight™ Transaction Insight®
Welcome Arlyn Valencia! | Lo
Home :: 275 Attachments
Files
275 Attachments
User
My Account
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
Browse to your file: (maximum file size limit 64MB)
load Attachment
275 Attachment Details
Submitter Last or Organization Name*
Ahccccs
Provider Last or Organization Name*
Ahcccs
Provider Identifier Type*
Provider Secondary Identifier
Provider Identifier/Provider Secondary Identifier*
123456
Provider City*
PHX
Zip Code*
85034
Patient First Name
Patient Primary Identifier*
A99999999
Patient Control Number*
A99999999
Medical Record Identification Number
Payer Claim Control Number or
Provider Attachment Control Number*
A99999999100115
Claim Service Period Start Date*
Claim Service Period End Date
* - Required Fields
Cancel
October, 2015
Su Mo Tu We Th Fr Sa
27 28 29 30 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
1 2 3 4 5 6 7
Today: November 30, 2015
Click on the calendar icon
Enter the begin date of service
Click on the month and date of service
This field is optional and can be left blank

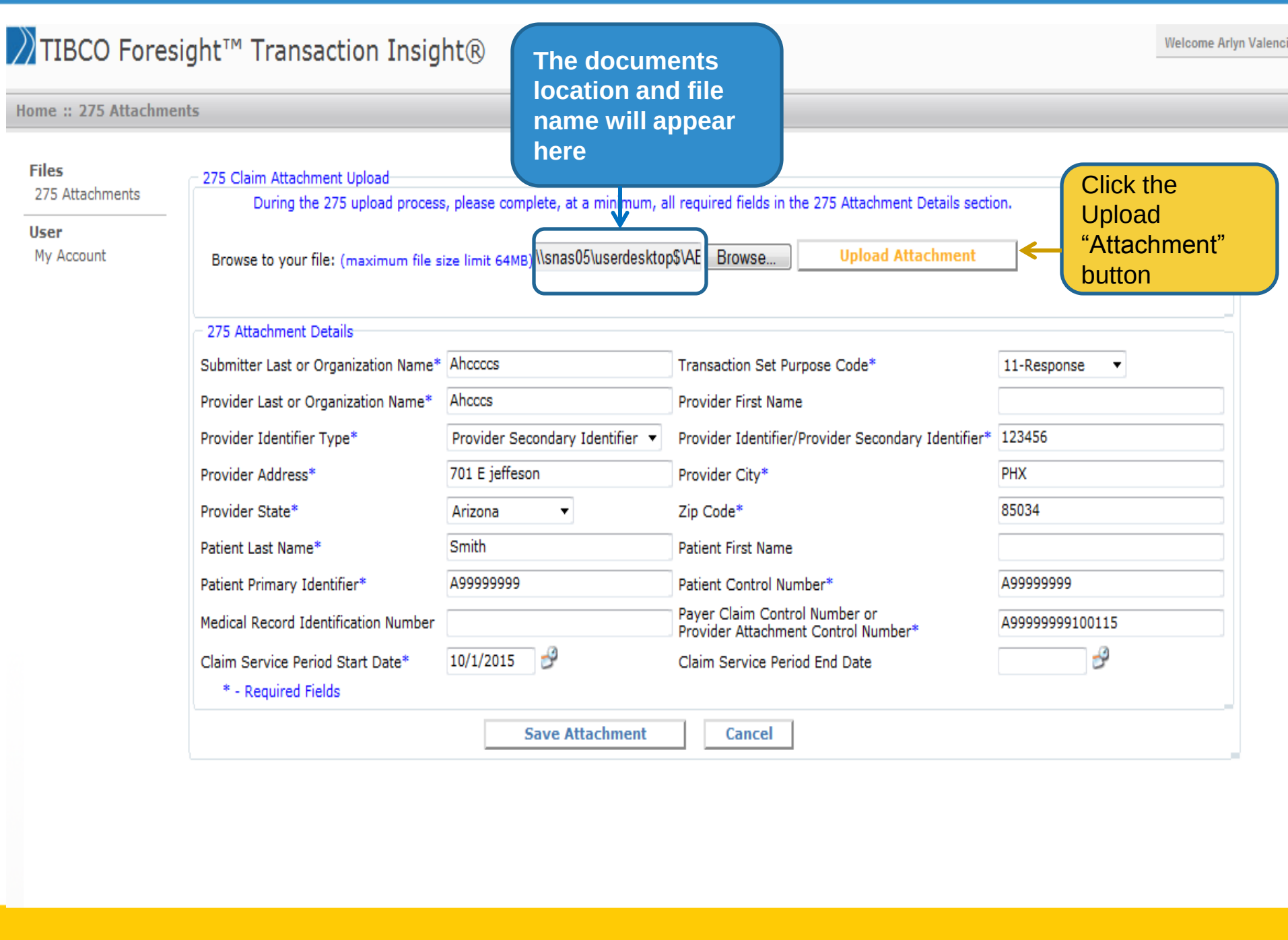

TIBCO Foresight™ Transaction Insight®
Welcome Arlyn Valencia!
When done with the 275 attachment details section it should look something like this
Home :: 275 Attachments
Files
275 Attachments
User
My Account
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
Browse to your file: (maximum file size limit 64MB)
Browse...
Upload Attachment
275 Attachment Details
Submitter Last or Organization Name* Ahccccs
Transaction Set Purpose Code* 11-Response
Provider Last or Organization Name* Ahcccs
Provider First Name
Provider Identifier Type* Provider Secondary Identifier
Provider Identifier/Provider Secondary Identifier* 123456
Provider Address* 701 E jeffeson
Provider City* PHX
Provider State* Arizona
Zip Code* 85034
Patient Last Name* Smith
Patient First Name
Patient Primary Identifier* A99999999
Patient Control Number* A99999999
Medical Record Identification Number
Payer Claim Control Number or Provider Attachment Control Number* A99999999100115
Claim Service Period Start Date* 10/1/2015
Claim Service Period End Date
* - Required Fields
Save Attachment
Cancel
Note:
At this point do not click the save attachment button, go to the top and click the browse button

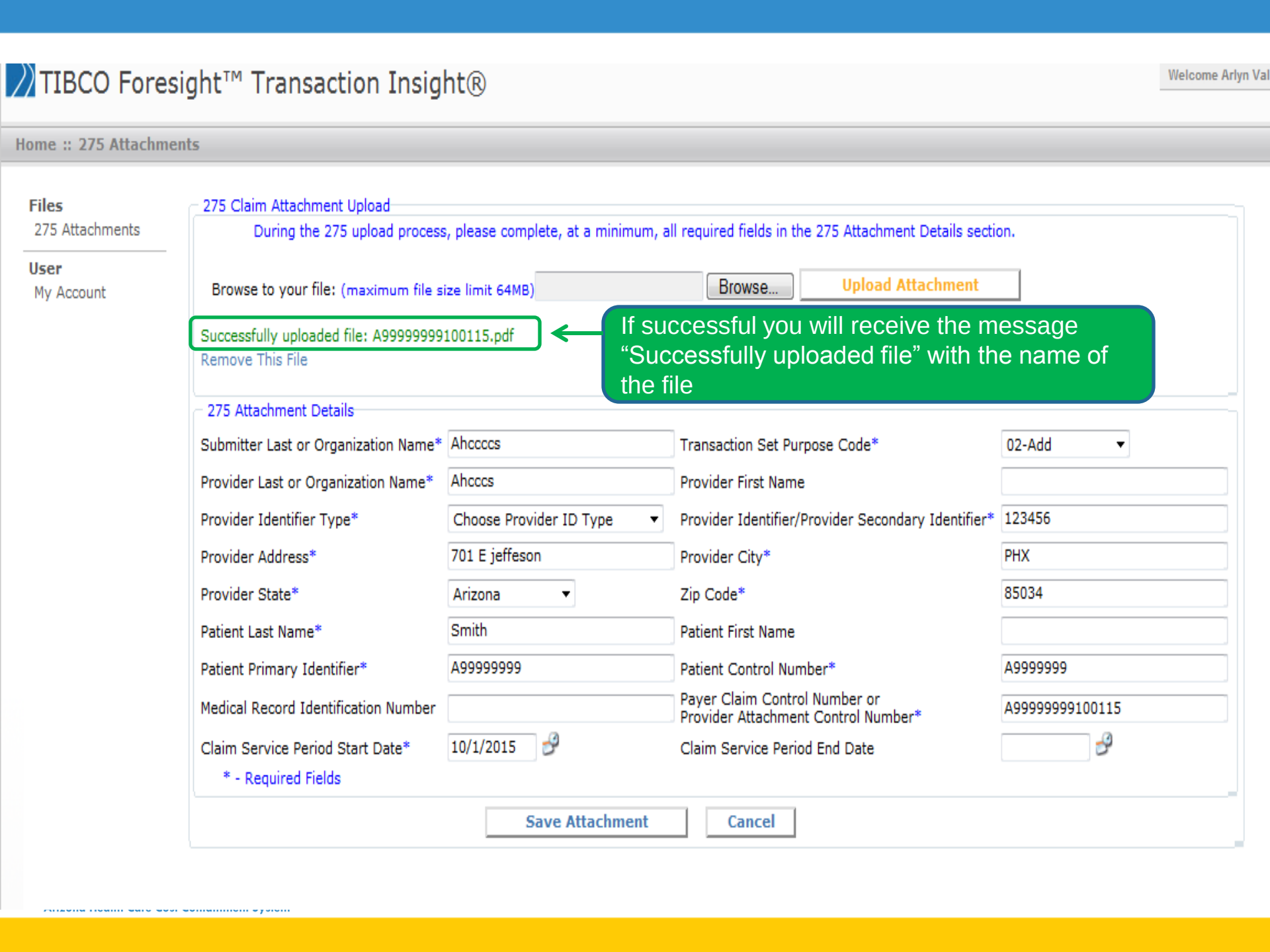

TIBCO Foresight™ Transaction Insight®
Welcome Arlyn Valencia!
Home :: 275 Attachments
Files
275 Attachments
User
My Account
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
Browse to your file: (maximum file size limit 64MB)
Browse...
Upload Attachment
Click the "Browse" button
275 Attachment Details
Submitter Last or Organization Name* Ahccccs
Transaction Set Purpose Code* 11-Response
Provider Last or Organization Name* Ahcccs
Provider First Name
Provider Identifier Type* Provider Secondary Identifier
Provider Identifier/Provider Secondary Identifier* 123456
Provider Address* 701 E jeffeson
Provider City* PHX
Provider State* Arizona
Zip Code* 85034
Patient Last Name* Smith
Patient First Name
Patient Primary Identifier* A99999999
Patient Control Number* A99999999
Medical Record Identification Number
Payer Claim Control Number or Provider Attachment Control Number* A99999999100115
Claim Service Period Start Date* 10/1/2015
Claim Service Period End Date
* - Required Fields
Save Attachment
Cancel

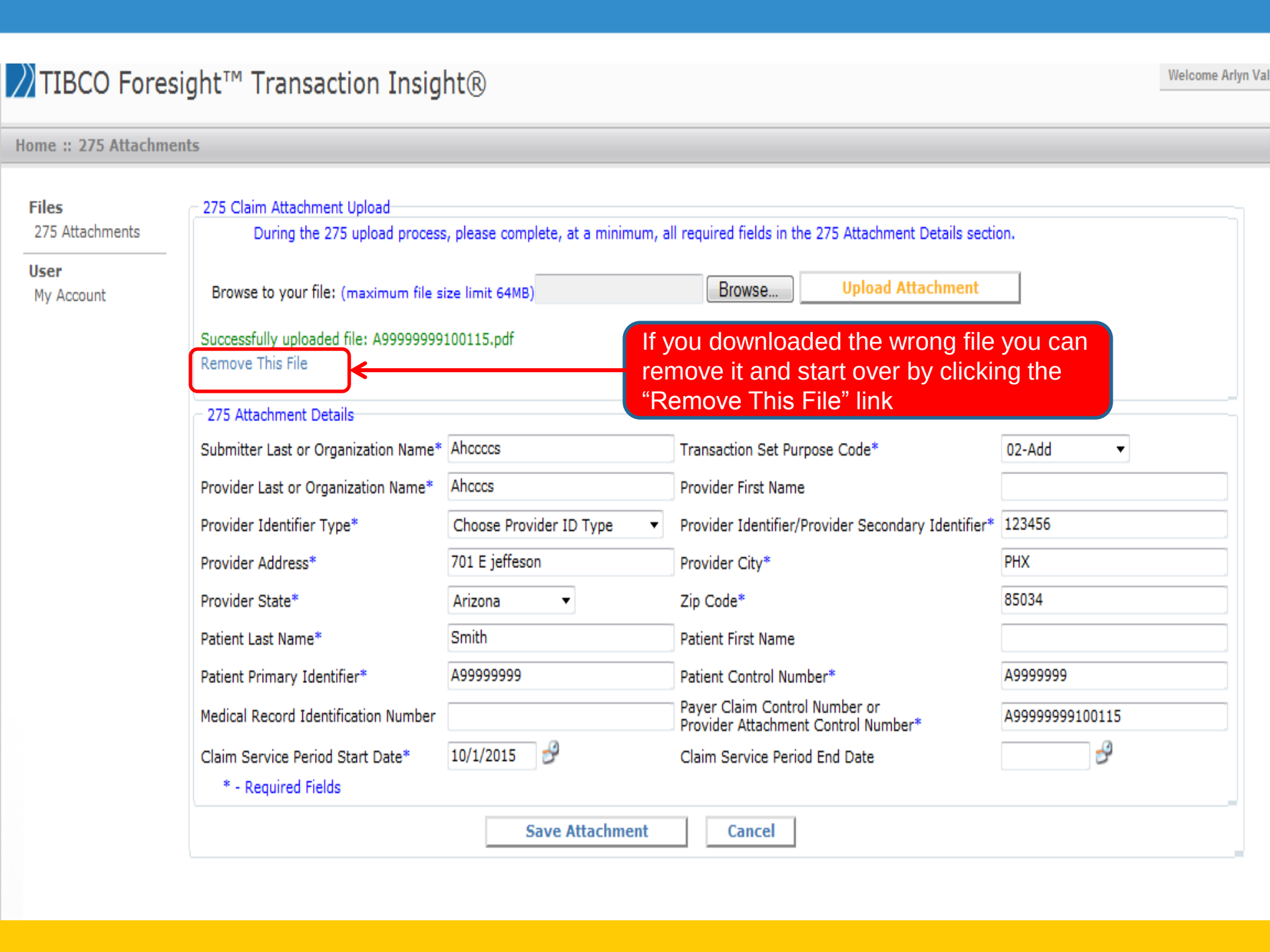
The file search window will come up

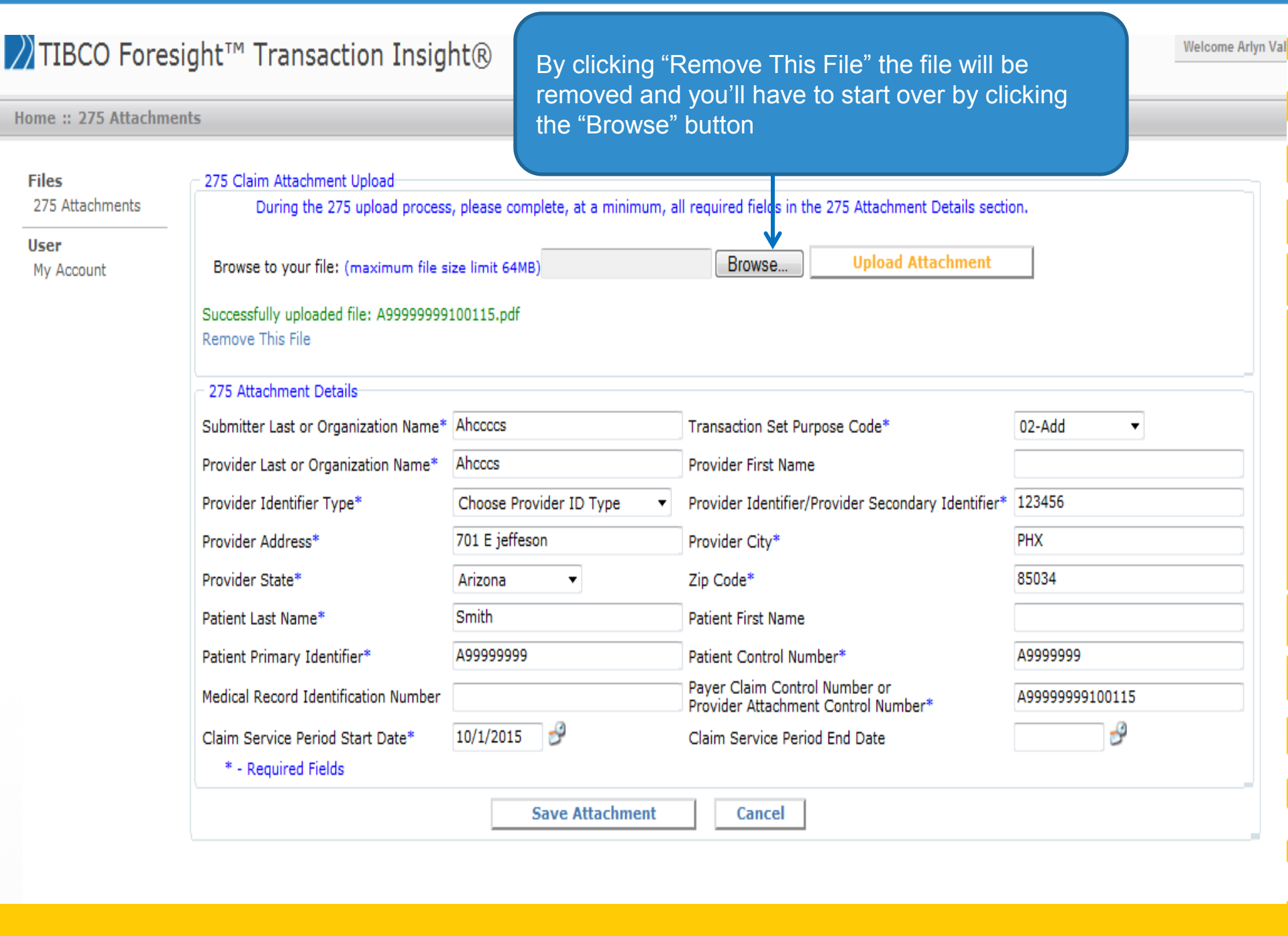


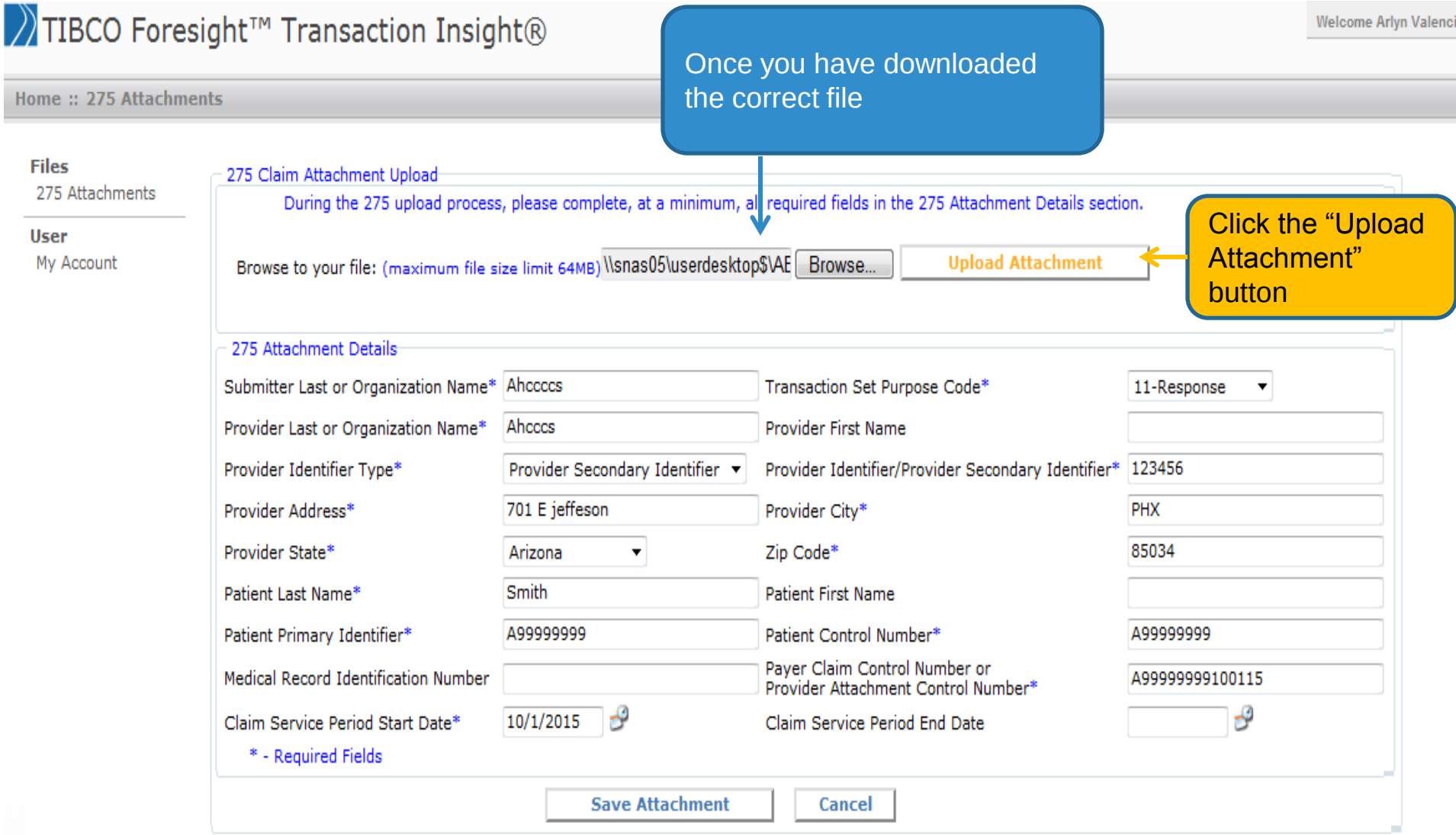

Choose File to Upload
Trip Report
Search Trip Report
Organize
New folder
Favorites
Downloads
Recent Places
Libraries
Documents
Music
Pictures
Videos
Computer
DATADisk (D:)
DVD RW Drive (E:
G Drive (G:)
APPS1 (H:)
Name
Date modified
Type
A99999999073113
1/27/2014 10:50 AM
Adobe Acrol
A99999999101814
1/27/2014 10:52 AM
Adobe Acrol
Click on the document you want to download and click the “Open” button
File name:
A99999999101814
All Files (*.*)
Open
Cancel

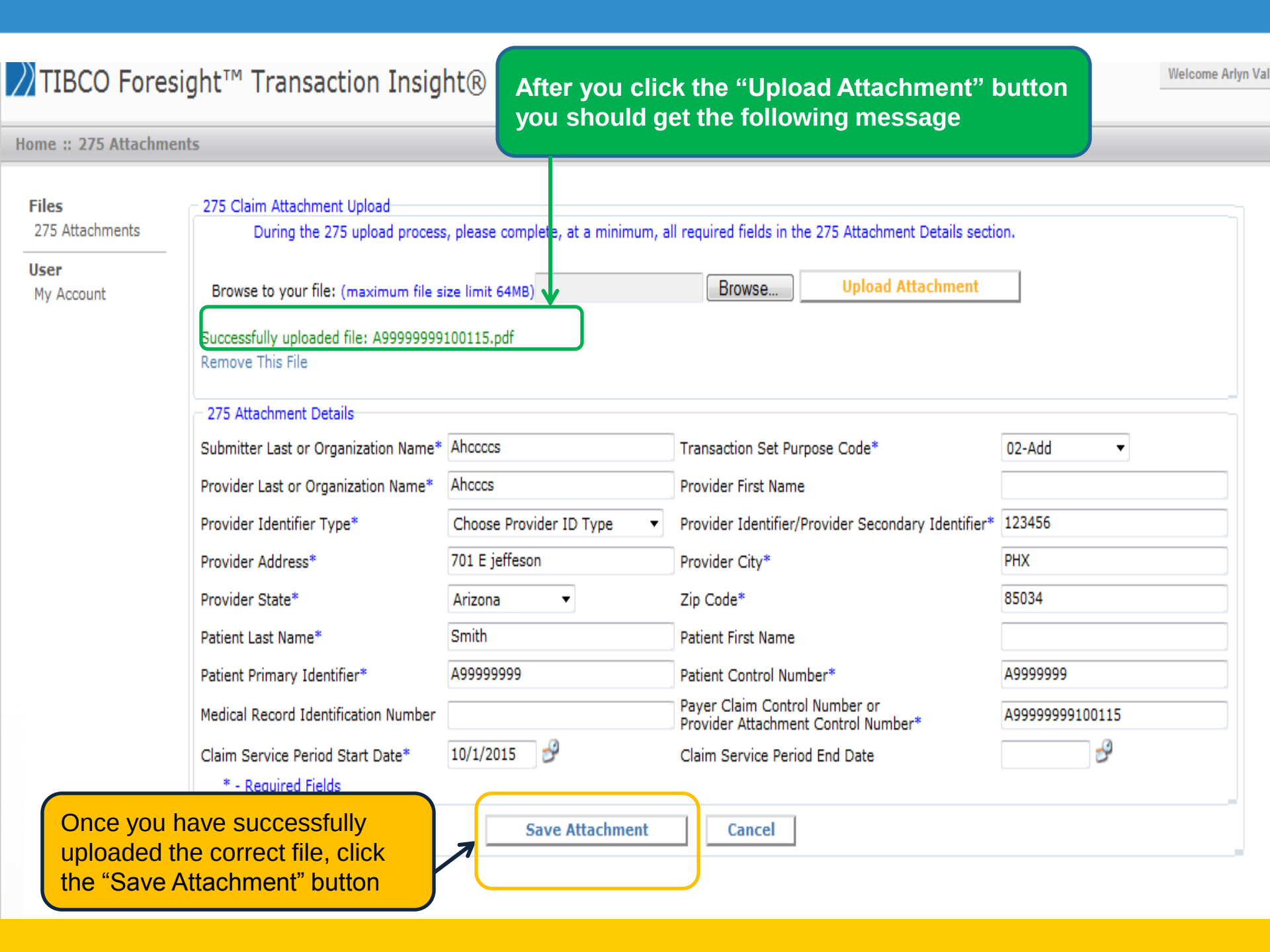

TIBCO Foresight™ Transaction Insight®
Welcome Arlyn Valenci
Home :: 275 Attachments
The documents location and file name will appear here
Files
275 Attachments
User
My Account
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
Browse to your file: (maximum file size limit 64MB)
\\snas05\userdesktop$\AE
Browse...
Upload Attachment
Click the Upload "Attachment" button
275 Attachment Details
Submitter Last or Organization Name* Ahccccs
Transaction Set Purpose Code* 11-Response
Provider Last or Organization Name* Ahcccs
Provider First Name
Provider Identifier Type* Provider Secondary Identifier
Provider Identifier/Provider Secondary Identifier* 123456
Provider Address* 701 E jeffeson
Provider City* PHX
Provider State* Arizona
Zip Code* 85034
Patient Last Name* Smith
Patient First Name
Patient Primary Identifier* A99999999
Patient Control Number* A99999999
Medical Record Identification Number
Payer Claim Control Number or Provider Attachment Control Number* A99999999100115
Claim Service Period Start Date* 10/1/2015
Claim Service Period End Date
* - Required Fields
Save Attachment
Cancel

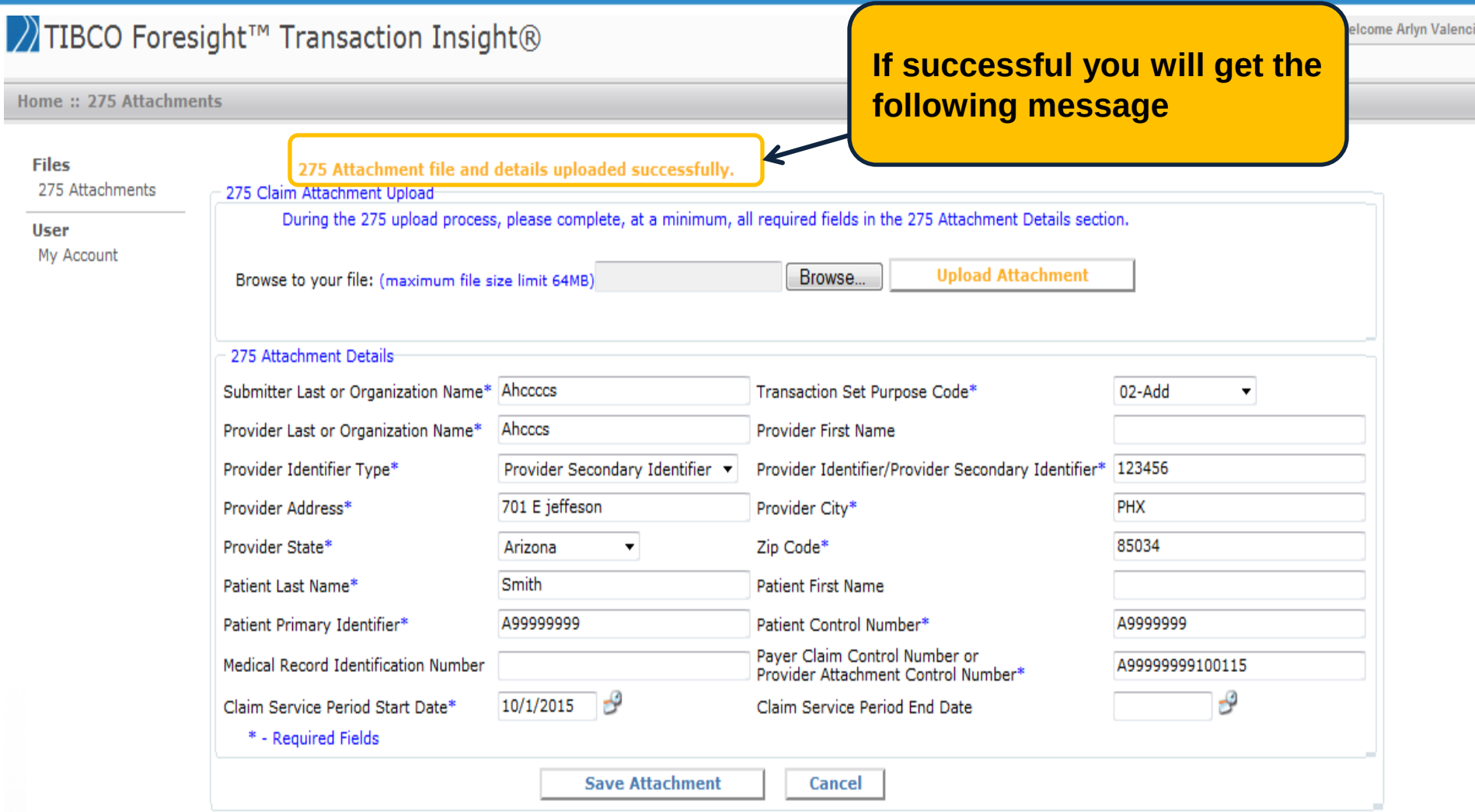

TIBCO Foresight™ Transaction Insight®
Welcome Arlyn Val
Home :: 275 Attachments
Files
275 Attachments
User
My Account
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
Browse to your file: (maximum file size limit 64MB)
Browse...
Upload Attachment
Successfully uploaded file: A99999999100115.pdf
Remove This File
If successful you will receive the message "Successfully uploaded file" with the name of the file
275 Attachment Details
Submitter Last or Organization Name* Ahccccs
Transaction Set Purpose Code* 02-Add
Provider Last or Organization Name* Ahcccs
Provider First Name
Provider Identifier Type* Choose Provider ID Type
Provider Identifier/Provider Secondary Identifier* 123456
Provider Address* 701 E jeffeson
Provider City* PHX
Provider State* Arizona
Zip Code* 85034
Patient Last Name* Smith
Patient First Name
Patient Primary Identifier* A99999999
Patient Control Number* A9999999
Medical Record Identification Number
Payer Claim Control Number or Provider Attachment Control Number* A99999999100115
Claim Service Period Start Date* 10/1/2015
Claim Service Period End Date
* - Required Fields
Save Attachment
Cancel


TIBCO Foresight™ Transaction Insight®
Welcome Arlyn Val
Home :: 275 Attachments
Files
275 Attachments
User
My Account
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
Browse to your file: (maximum file size limit 64MB)
Browse...
Upload Attachment
Successfully uploaded file: A99999999100115.pdf
Remove This File
If you downloaded the wrong file you can remove it and start over by clicking the "Remove This File" link
275 Attachment Details
Submitter Last or Organization Name* Ahccccs
Transaction Set Purpose Code* 02-Add
Provider Last or Organization Name* Ahcccs
Provider First Name
Provider Identifier Type* Choose Provider ID Type
Provider Identifier/Provider Secondary Identifier* 123456
Provider Address* 701 E jeffeson
Provider City* PHX
Provider State* Arizona
Zip Code* 85034
Patient Last Name* Smith
Patient First Name
Patient Primary Identifier* A99999999
Patient Control Number* A9999999
Medical Record Identification Number
Payer Claim Control Number or Provider Attachment Control Number* A99999999100115
Claim Service Period Start Date* 10/1/2015
Claim Service Period End Date
* - Required Fields
Save Attachment
Cancel


TIBCO Foresight™ Transaction Insight®
Welcome Arlyn Val
By clicking “Remove This File” the file will be removed and you’ll have to start over by clicking the “Browse” button
Home :: 275 Attachments
Files
275 Attachments
User
My Account
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
Browse to your file: (maximum file size limit 64MB)
Browse...
Upload Attachment
Successfully uploaded file: A99999999100115.pdf
Remove This File
275 Attachment Details
Submitter Last or Organization Name* Ahccccs
Transaction Set Purpose Code* 02-Add
Provider Last or Organization Name* Ahcccs
Provider First Name
Provider Identifier Type* Choose Provider ID Type
Provider Identifier/Provider Secondary Identifier* 123456
Provider Address* 701 E jeffeson
Provider City* PHX
Provider State* Arizona
Zip Code* 85034
Patient Last Name* Smith
Patient First Name
Patient Primary Identifier* A99999999
Patient Control Number* A9999999
Medical Record Identification Number
Payer Claim Control Number or Provider Attachment Control Number* A99999999100115
Claim Service Period Start Date* 10/1/2015
Claim Service Period End Date
* - Required Fields
Save Attachment
Cancel


TIBCO Foresight™ Transaction Insight®
Welcome Arlyn Valenci
Home :: 275 Attachments
Once you have downloaded the correct file
Files
275 Attachments
User
My Account
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
Browse to your file: (maximum file size limit 64MB) \\snas05\userdesktop$\AE
Browse...
Upload Attachment
Click the "Upload Attachment" button
275 Attachment Details
Submitter Last or Organization Name* Ahccccs
Transaction Set Purpose Code* 11-Response
Provider Last or Organization Name* Ahcccs
Provider First Name
Provider Identifier Type* Provider Secondary Identifier
Provider Identifier/Provider Secondary Identifier* 123456
Provider Address* 701 E jeffeson
Provider City* PHX
Provider State* Arizona
Zip Code* 85034
Patient Last Name* Smith
Patient First Name
Patient Primary Identifier* A99999999
Patient Control Number* A99999999
Medical Record Identification Number
Payer Claim Control Number or Provider Attachment Control Number* A99999999100115
Claim Service Period Start Date* 10/1/2015
Claim Service Period End Date
* - Required Fields
Save Attachment
Cancel


TIBCO Foresight™ Transaction Insight®
Welcome Arlyn Val
Home :: 275 Attachments
After you click the “Upload Attachment” button you should get the following message
Files
275 Attachments
User
My Account
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
Browse to your file: (maximum file size limit 64MB)
Browse...
Upload Attachment
Successfully uploaded file: A99999999100115.pdf
Remove This File
275 Attachment Details
Submitter Last or Organization Name* Ahccccs
Transaction Set Purpose Code* 02-Add
Provider Last or Organization Name* Ahcccs
Provider First Name
Provider Identifier Type* Choose Provider ID Type
Provider Identifier/Provider Secondary Identifier* 123456
Provider Address* 701 E jeffeson
Provider City* PHX
Provider State* Arizona
Zip Code* 85034
Patient Last Name* Smith
Patient First Name
Patient Primary Identifier* A99999999
Patient Control Number* A9999999
Medical Record Identification Number
Payer Claim Control Number or Provider Attachment Control Number* A99999999100115
Claim Service Period Start Date* 10/1/2015
Claim Service Period End Date
* - Required Fields
Once you have successfully uploaded the correct file, click the “Save Attachment” button
Save Attachment
Cancel

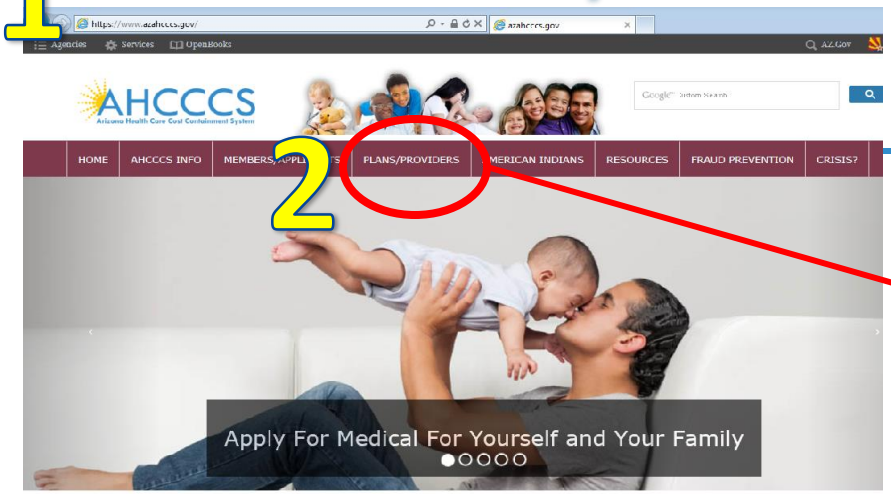

TIBCO Foresight™ Transaction Insight®
elcome Arlyn Valencia
Home :: 275 Attachments
If successful you will get the following message
Files
275 Attachments
User
My Account
275 Attachment file and details uploaded successfully.
275 Claim Attachment Upload
During the 275 upload process, please complete, at a minimum, all required fields in the 275 Attachment Details section.
Browse to your file: (maximum file size limit 64MB)
Browse...
Upload Attachment
275 Attachment Details
Submitter Last or Organization Name* Ahccccs
Transaction Set Purpose Code* 02-Add
Provider Last or Organization Name* Ahcccs
Provider First Name
Provider Identifier Type* Provider Secondary Identifier
Provider Identifier/Provider Secondary Identifier* 123456
Provider Address* 701 E jeffeson
Provider City* PHX
Provider State* Arizona
Zip Code* 85034
Patient Last Name* Smith
Patient First Name
Patient Primary Identifier* A99999999
Patient Control Number* A9999999
Medical Record Identification Number
Payer Claim Control Number or Provider Attachment Control Number* A99999999100115
Claim Service Period Start Date* 10/1/2015
Claim Service Period End Date
* - Required Fields
Save Attachment
Cancel

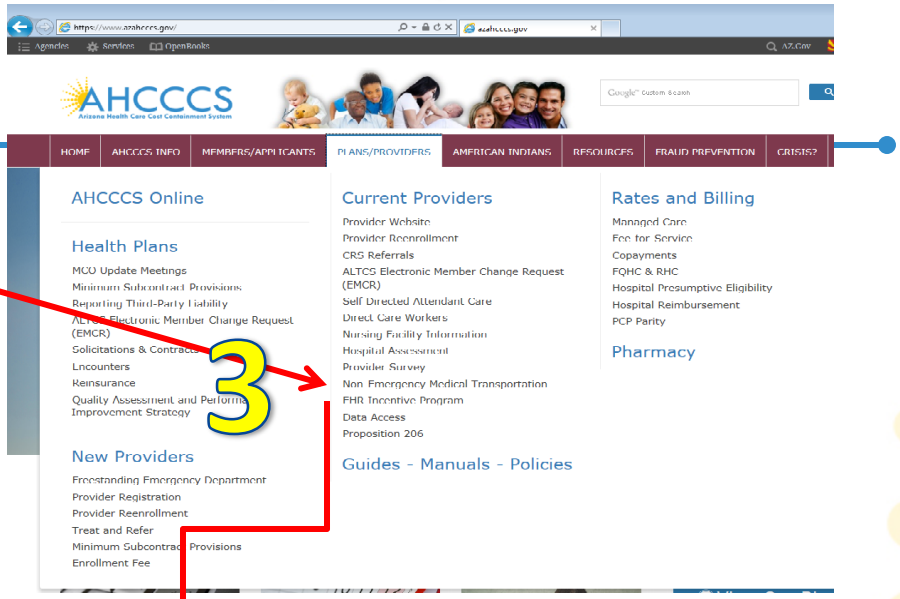
AHCCCS
Arizona Health Care Cost Containment System

How to fill out daily trip reports?

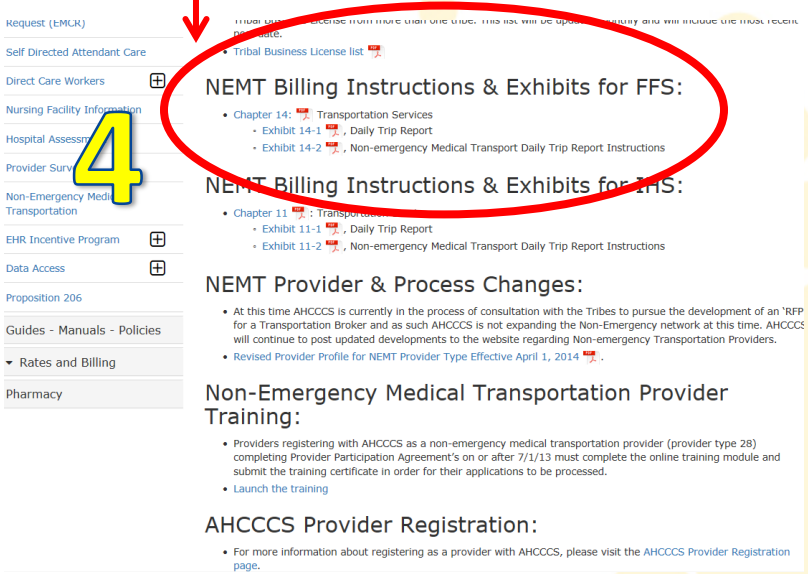
- One ways
- Round trips
- Multi-trips

Where can you find the trip reports?





1. AHCCCS Online
2. Plans/Providers
3. Current Providers
   - Non-Emergency Medical Transportation
4. NEMT Billing Instructions for FFS (exhibit 14-1)



AHCCCS
Arizona Health Care Cost Containment System

Exhibit 14-2

Non-emergency Medical Transport Daily Trip Report Instructions

Effective 7/1/2013 AHCCCS requires the use of this standard Daily Trip Report format. The upper left area of the form is for the Provider's name and demographic information.

The drivers must print clearly. Illegible Daily Trip Reports may result in audit error and recoupment.

Original Daily Trip Reports must be completed in pen. If an error is made, draw a single line through the error and print the correct information.

If a recipient's transport has more than one "stop" or destination, then each trip must be fully documented.

For example:

Recipient is picked up at home and transported to the doctor's office (1st trip).
The doctor gives the recipient a prescription for medication.
The recipient is transported from the doctor's office to Walgreen Pharmacy (2nd trip)
Recipient is returned home (3rd trip)

The Daily Trip Report would have 3 trips documented as indicated.

Letterhead box: must have provider's complete information
Driver name: print full name
Date: indicate the day of the week (Sa Su M T W Th F) and the month/day/year
Vehicle #: license plate # and state (If Provider requires make/model/color details, use space below)
NOTE: if driver uses a 2nd vehicle for same date of service use a new Daily Trip Report and indicate (at the bottom right) the page number detail. All pages become the *complete* Daily Trip Report for the transport services, for that recipient, on that service date.
Name: print the AHCCCS recipient's full name
Pick-up time: clock time including the AM/PM indicator (example: 4:12 AM)
Pick-up Odometer: document the actual odometer reading at the pick-up location
Drop-off time: clock time including the AM/PM indicator (example: 4:46 AM)
Drop-off Odometer: document the actual odometer reading at the drop-off location
Trip miles: subtract the pick-up odometer reading from the drop-off odometer reading= trip miles
Pick-up physical address: full address or detailed directions, including name of the village/town
Drop-off physical address: full name and address, including name of village/town
Type of trip: check the appropriate type
AHCCCS ID#: the recipient's ID number
Mailing address: recipient's full mailing address
Reason for Visit: only as much information as the recipient is willing to share
Name of Escort: if recipient is traveling with a parent/guardian or attendant, print their full name
Relationship: indicate the Escort's relationship to the recipient
Driver's Signature: each page must be signed and dated
Page ___ of ___: indicate each page number and the total number of pages used to document all transports for this driver, this service date.

Important to know about trip reports?

1. Effective 7/1/13 – AHCCCS requires the use of this standard Daily Trip Report format.

2. The letter box in the upper left corner area must have the Provider's name and demographic information.

3. Driver must enter in their information and vehicle license plate. Enter the day and date of service.

4. The form must be filled out legibly.
   - Errors can be corrected by drawing one line through the mistake and writing the correct information above it.
5. Hand written in PEN (Black or Blue)

AHCCCS
Arizona Health Care Cost Containment System

This is the letter box where the Provider's name and demographic information is entered.

Exh 14-1 **DAILY TRIP REPORT**

Driver Name: _____

Date: _____

Vehicle #_____ type_____

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Pick up location & address						
Drop off location & address						

Round Trip ___ One Way ___ Mult stops_____

AHCCCS #: _____ Mailing Address: _____

Date of Birth:_____

Reason for Visit e specific): _____

Name of Escort: _____ Relationship: _____

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Pick up location & address						
Drop off location & address						

Round Trip ___ One Way ___ Mult stops_____

AHCCCS #: _____ Mailing Address: _____

Date of Birth:_____

Reason for Visit _____

Name of Escort: _____ Relationship: _____

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Pick up location & address						
Drop off location & address						

Round Trip ___ One Way ___ Mult stops_____

AHCCCS #: _____ Mailing Address: _____

Date of Birth:_____

Reason for Visit _____

Name of Escort: _____ Relationship: _____

This is to certify that the information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Standard Daily Trip Report

Exh 14-1 **DAILY TRIP REPORT**

Driver Name: _____

Date: _____

Vehicle #_____ type_____

Driver name: print full name
Date: indicate the day of the week (Sa Su M T W Th F) and the month/day/year
Vehicle #: license plate # and state (If Provider requires make/model/color details, use space below)
NOTE: if driver uses a 2nd vehicle for same date of service, use a new Daily Trip Report and indicate (at the bottom right) the page number detail. All pages become the *complete* Daily Trip Report for the driver on that service date.

NEMT Test Provider
701 E Jefferson
Phoenix, AZ 85034

Exh 14-1 **DAILY TRIP REPORT**

Driver Name: *John Doe*

Date: *W 07/31/13*

Vehicle # AZ000000 type VAN

The upper left area of the form is for the provider's name and demographic information.

NEMT Test Provider
701 E Jefferson
Phoenix, AZ 85034

Ex: ROUND TRIP
Same driver

Exh 14-1 **DAILY TRIP REPORT**

AHCCCS
Arizona Health Care Cost Containment System

Driver Name: John Doe

Date: W 07/31/13

Vehicle # AZ000000 Type VAN

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Jane Smith	9:00am	0001	9:30am	0009	Jane Smith	8
Jane Smith	10:00am	0009	10:30am	0017	Jane Smith	8
Pick up location & address	Safeway store, Sacaton, AZ					
Drop off location & address	Doctor John, 2345 S Strawberry Fields, Phoenix, AZ 89999					

Round Trip ___√___ One Way _____ Mult Stops _____

AHCCCS #: A99999999 Mailing Address: PO Box 1234, Sacaton, AZ 89999
Date of Birth: 10/10/10
Reason for Visit: Pain in the arm after a fall
Name of Escort: _____ Relationship: _____

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Pick up location & address						
Drop off location & address						

Round Trip _____ One Way _____ Mult Stops _____

AHCCCS #: _____ Mailing Address: _____
Date of Birth: _____
Reason for Visit/Diagnosis (Be specific): _____
Name of Escort: _____ Relationship: _____

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Pick up location & address						
Drop off location & address						

AHCCCS #: _____ Mailing Address: _____
Date of Birth: _____
Reason for Visit/Diagnosis (Be specific): _____
Name of Escort: _____

This is to certify that the information is true, and complete. I und... Federal and State funds, and that any false claims, statements or documents, or concealment o... a material fact, may be prosecuted under applicable ...deral of State laws.

Driver Signature John Doe Date 07/31/13 Page 1 of 1

REMEMBER:
Driver's Signature: each page must be signed and dated
Page ___ of ___: all transports per driver with date of service.

NEMT Test Provide
701 E Jefferson
Phoenix, AZ 85034

Ex: ROUND TRIP
2 different drivers

Exh 14-1 **DAILY TRIP REPORT**

Driver Name: John Doe

Date: W 07/31/13

Vehicle # AZ000000 Type VAN

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Jane Smith	9:00am	0001	9:30am	0009	Jane Smith	8
Pick up location & address	Safeway store, Sacaton, AZ					
Drop off location & address	Doctor John, 2345 S Strawberry Fields, Phoenix, AZ 89999					

Round Trip _____ One Way √ Mult Stops _____

AHCCCS #: A99999999 Mailing Address: PO Box 1234, Sacaton, AZ 89999
Date of Birth: 10/10/10
Reason for Visit: Pain in the arm after a fall
Name of Escort: _____ Relationship: _____

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Pick up location & address						
Drop off location & address						

Round Trip _____ One Way _____ Mult Stops _____

AHCCCS #: _____ Mailing Address: _____
Date of Birth: _____
Reason for Visit: _____
Name of Escort: _____ Relationship: _____

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Pick up location & address						
Drop off location & address						

Round Trip _____ One Way _____ Mult Stops _____

AHCCCS #: _____ Mailing Address: _____
Date of Birth: _____
Reason for Visit: _____
Name of Escort: _____ Relationship: _____

This is to certify that the information is true, and complete. I understand that payment and satis
Federal and State funds, and that any false claims, statements or documents, or concealment of
prosecuted under applicable Federal of State laws.

Driver Signature John Doe Date 07/31/13 Page 1 of 2

1st page – driver one

NEMT Test Provider
701 E Jefferson
Phoenix, AZ 85034

Ex: ROUND TRIP
2 different drivers

Exh 14-1 **DAILY TRIP REPORT**

AHCCCS
Arizona Health Care Cost Containment System

Driver Name: Leroy Doe
Date: W 7/31/13
Vehicle # AZ000000 Type VAN

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Jane Smith	10:00am	0011	10:30am	0019	Jane Smith	8
Pick up location & address	Doctor John, 2345 S Strawberry Fields, Phoenix, AZ 89999					
Drop off location & address	Safeway store, Sacaton, AZ					

Round Trip _____ One Way √ Mult Stops _____

AHCCCS #: A99999999 Mailing Address: PO Box 1234, Sacaton, AZ 89999
Date of Birth: 10/10/10
Reason for Visit Pain in the arm after a fall
Name of Escort: _____ Relationship: _____

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Pick up location & address						
Drop off location & address						

Round Trip _____ One Way _____ Mult Stops _____

AHCCCS #: _____ Mailing Address: _____
Date of Birth: _____
Reason for Visit _____
Name of Escort: _____ Relationship: _____

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Pick up location & address						
Drop off location & address						

Round Trip _____ One Way _____ Mult Stops _____

AHCCCS #: _____ Mailing Address: _____
Date of Birth: _____
Reason for Visit _____
Name of Escort: _____ Relationship: _____

This is to certify that the information is true, and complete. I understand that payment and sat
Federal and State funds, and that any false claims, statements or documents, or concealment o
prosecuted under applicable Federal of State laws.

Driver Signature Leroy Doe Date 07/31/13

Page 2 of 2

2nd page – driver two

NEMT Test Provide
701 E Jefferson
Phoenix, AZ 85034

Ex: MULTI - TRIP
Same day, driver, & member.

Exh 14-1 **DAILY TRIP REPORT**

Driver Name: John Doe

Date: S 08/31/13

Vehicle # AZ000000 Type VAN

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Jane Smith	9:00am	0001	9:30am	0009	Jane Smith	8
Pick up location & address	Safeway store, Sacaton, AZ					
Drop off location & address	Doctor John, 2345 S Strawberry Fields, Phoenix, AZ 89999					

Round Trip _____ One Way _____ Mult Stops ___√___

AHCCCS #: ___ Mailing Address: PO Box 1234, Sacaton, AZ 89999

Date of Birth: _____

Reason for Visit/Diagnosis (Be specific): Pain in the arm after a fall

Name of Escort: _____ Relationship: _____

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Jane Smith	10:00am	0009	10:30am	0014	Jane Smith	5
Pick up location & address	Doctor John, 2345 S Strawberry Fields, Phoenix, AZ 89999					
Drop off location & address	X-ray United, 2222 E X-ray Rd, Phoenix, AZ 89999					

Round Trip _____ One Way _____ Mult Stops ___√___

AHCCCS #: _____ Mailing Address: _____

Date of Birth: _____

Reason for Visit/Diagnosis (Be specific): Pain in the arm after a fall

Name of Escort: _____ Relationship: _____

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Jane Smith	11:00am	0014	11:30am	0019	Jane Smith	5
Pick up location & address	X-ray United, 2222 E X-ray Rd, Phoenix, AZ 89999					
Drop off location & address	Doctor John, 2345 S Strawberry Fields, Phoenix, AZ 89999					

Round Trip _____ One Way _____ Mult Stops √_____

AHCCCS #: ___ Mailing Address: _____

Date of Birth: _____

Reason for Visit/Diagnosis (Be specific): Pain in the arm after a fall

Name of Escort: _____ Relationship: _____

This is to certify that the information is true, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal of State laws.

Driver Signature John Doe Date 08/31/13

NEMT Test Provid
701 E Jefferson
Phoenix, AZ 8503

Ex: MULTI - TRIP
Same day, driver, & member.

Exh 14-1 **DAILY TRIP REPORT**

Driver Name: John Doe

Date: W 08/31/13

Vehicle # AZ000000 Type VAN

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Jane Smith	12:00pm	0019	12:30pm	0027	Jane Smith	8
Pick up location & address	Doctor John, 2345 S Strawberry Fields, Phoenix, AZ 89999					
Drop off location & address	Safeway store, Sacaton, AZ					

Round Trip _____ One Way _____ Mult Stops ✓

AHCCCS #: A99999999 Mailing Address: PO Box 1234, Sacaton, AZ 89999
Date of Birth: 10/10/10
Reason for Visit/Diagnosis (Be specific): Pain in the arm after a fall
Name of Escort: _____ Relationship: _____

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Pick up location & address						
Drop off location & address						

Round Trip _____ One Way _____ Mult Stops _____

AHCCCS #: _____ Mailing Address: _____
Date of Birth: _____
Reason for Visit/Diagnosis (Be specific): _____
Name of Escort: _____ Relationship: _____

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Jane Smith						
Pick up location & address						
Drop off location & address						

Round Trip _____ One Way _____ Mult Stops _____

AHCCCS #: _____ Mailing Address: _____
Date of Birth: _____
Reason for Visit/Diagnosis (Be specific): _____
Name of Escort: _____ Relationship: _____

This is to certify that the information is true, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal of State laws.

Driver Signature John Doe Date 08/31/13

NEMT Test Provide
701 E Jefferson
Phoenix, AZ 85034

Another Ex: MULTI - TRIP
Same day, driver, & member.

Exh 14-1 **DAILY TRIP REPORT**

Driver Name: John Doe

Date: W 07/31/13

Vehicle # AZ000000 Type VAN

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Jane Smith	9:00am	0001	9:30am	0009	Jane Smith	8
Jane Smith	10:00am	0009	10:30am	0017	Jane Smith	8
Pick up location & address	Safeway Store, Sacaton, AZ					
Drop off location & address	Doctor John, 2345 S Strawberry Fields, Phoenix, AZ 89999					

Round Trip ___√___ One Way _____ Mult Stops _____

AHCCCS #: A99999999 Mailing Address: PO Box 1234, Sacaton, AZ 89999
Date of Birth: 10/10/10
Reason for Visit, Pain in the arm after a fall
Name of Escort: _____ Relationship: _____

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Jane Smith	1:00pm	0020	1:30pm	0030	Jane Smith	10
Pick up location & address	Safeway Store, Sacaton, Az					
Drop off location & address	Casa Grande ER					

Round Trip _____ One Way _√___ Mult Stops _____

AHCCCS #: A99999999 Mailing Address: _____
Date of Birth: 10/10/10
Reason for Visi Chest pain
Name of Escort: _____ Relationship: _____

Name of Recipient	Pick up time	Pick up odometer	Drop off time	Drop off odometer	Recipient Signature	Trip miles
Pick up location & address						
Drop off location & address						

Round Trip _____ One Way _____ Mult Stops _____

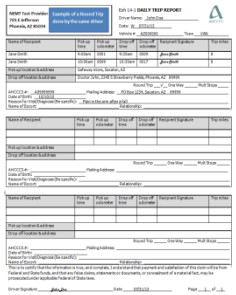
AHCCCS #: _____ Mailing Address: _____
Date of Birth: _____
Reason for Visit, _____
Name of Escort: _____ Relationship: _____

This is to certify that the information is true, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal of State laws.

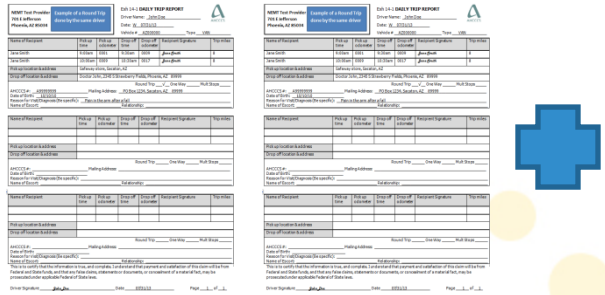
Driver Signature John Doe Date 07/31/13

Quick Review – Trip Reports

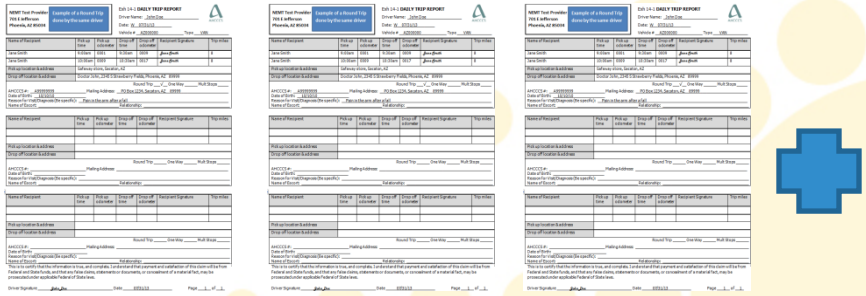
R/T or O/W or Multi-trip



R/T-2 drivers Multi-trips



Multi-trips



AHCCCS
Arizona Health Care Cost Containment System

FAQS

Q: Can you use lower case alpha on a PWK number?

A: If you are using the AHCCCS ID in your PWK number, make sure the A is in upper case. For example: A99999999082713

Q: If I have a valid NPI number (10 digit ID) do I have to use it or can I use my 6 digit AHCCCS Provider ID?

A: If you have a valid NPI number you must use it when billing the claim and on the 275 attachment TI portal.
If you use your NPI in your claim and use your 6 digit Provider ID in the 275 TI Portal, the attachment will not link and will result in a denied claim.

Q: Can I make correction to the trip report?

A: Original Trip Report must be completed in pen. If an error is made, draw a single line through the error and rescan the trip report.

Q: Is there a file size limitation on the 275 claim attachments?

A: There is a 64 MB file size limit.

Q: Can multiple attachments be loaded at one time?

A: No. You can only upload one attachment/file a time. However, you can scan multiple pages of trip reports and save this as one file.

Q: How do I reset my password?

A: You can call AHCCCS ISD Customer Support at 602.417.4451 to get your TI Portal password reset.

Q: How do I add other user(s)?

A: Email a request for TI account setup to EDICustomerSupport@azahcccs.gov and required to provide the following:
6 digit AHCCCS Provider ID or 10 digit NPI, Full Name and correct email address.

Q: What size should the document be?

A: 8 ½ by 11

Q: Can you upload color documents?

A: The documents should be in black and white

Q: What should the DPI (resolution) be?

A: They should be 300 DPI

REMINDERS/COMMON ERRORS

- **NEVER SHARE YOUR TI PORTAL USERNAME AND PASSWORD. Doing so is a security violation.**
  - Any user/staff that will be uploading to TI Portal must email a request for TI account setup to EDICustomerSupport@azahcccs.gov and required to provide the following:
    6 digit AHCCCS Provider ID or 10 digit NPI, Full Name and correct email address
- Provider Identifier Type:
  - Provider Identifier MUST be the 10 digit NPI Number
  - Provider Secondary Identifier MUST be the 6 digit AHCCCS Provider ID
- 9-character AHCCCS ID, beginning with an A, for example, A12345678
- The PWK submitted in your claim (837) or through AHCCCS Online must be the same PWK (Payer Claim Control Number) entered in TI Upload. **This will cause your claim to be denied due to this mismatch of PWK.**
- Always verify your data before you click on Save Attachment.
- Always verify that the correct attachment has been selected before you click on Upload Attachment.
- Leave the fields blank if they are not required
- Please be careful when tabbing through the field and make sure you didn't accidentally hit the space bar. The cursor should always be in the first entry when entering data 
- Make sure you subscribe to the 275 Claims Attachment and TI Users Listserv in order to receive important notification pertaining to the 275 process or TI Portal
  - Go to: http://listserv.azahcccs.gov
  - Select the name of the list serv you would like to subscribe to:
    - ISD-275-CLAIMS-ATTACHMENT-L and ISD-EDI-TI-USERS-L (for 275 TI Portal users/info on TI Portal)
    - FFS-ALL-PROVIDERS-L (info from DFSM regarding Claims Processing, Updates, etc)
  - In the menu on the right, select "Join or Leave ListServ name".
  - Complete the Name and Email address fields and select "Subscribe ListServ name". An email will be sent to the user to confirm the subscription request. Users wanting to unsubscribe from a particular list can do so by selecting the "Unsubscribe ListServ name" option.

Questions?

Thank You.