



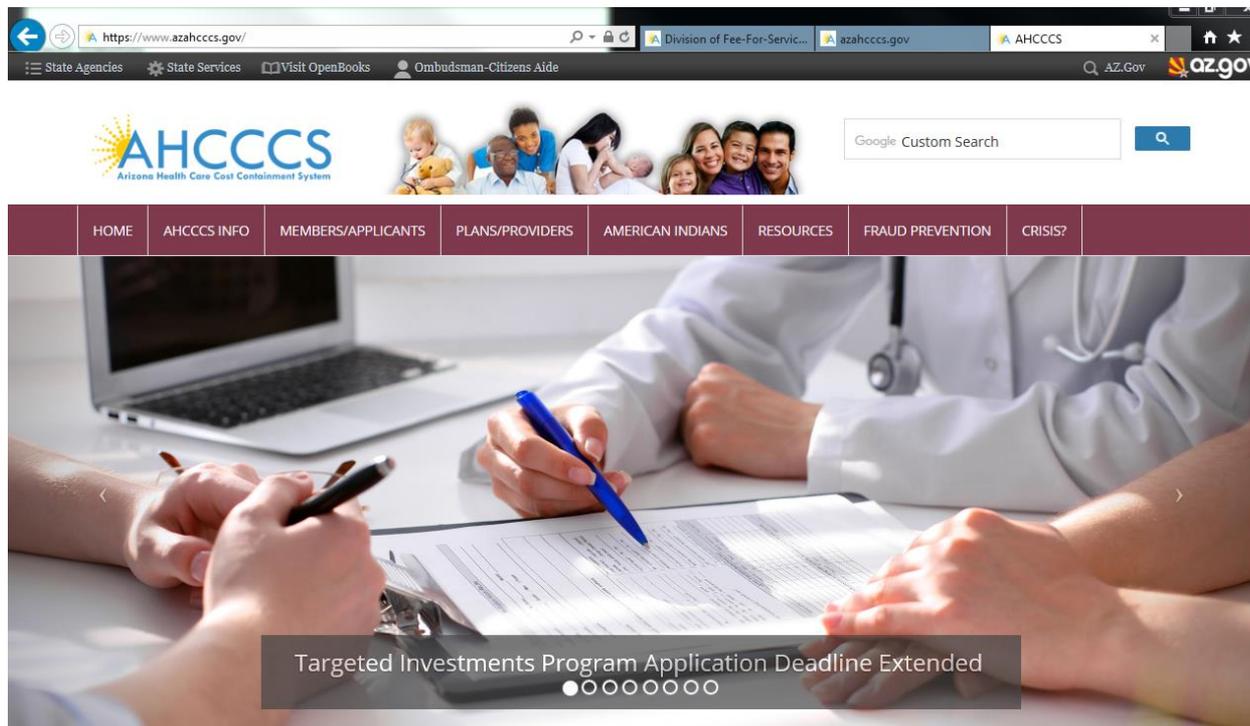
# Online Claims Submission: Professional Claim Type

February 8, 2018



# Start at the AHCCCS Website

<https://www.azahcccs.gov/>



Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid agency that offers health care programs to serve Arizona residents. Individuals must meet certain income and other requirements to obtain services.



## AHCCCS Online

### Health Plans

MCO Update Meetings  
Minimum Subcontract Provisions  
Reporting Third-Party Liability  
ALTCS Electronic Member Change Request (EMCR)  
Solicitations & Contracts

### Current Providers

Provider Website  
Provider Reenrollment  
CRS Referrals  
ALTCS Electronic Member Change Request (EMCR)  
Self Directed Attendant Care  
Direct Care Workers  
Nursing Facility Information  
Hospital Assessment

### Rates and Billing

Managed Care  
Fee-for-Service  
Copayments  
FQHC & RHC  
Hospital Presumptive Eligibility  
Hospital Reimbursement  
PCP Parity

### Pharmacy

- From the toolbar at the top of the page, click **Plans/Providers**
- Once the drop down appears, click on **AHCCCS Online**

# Log in to AHCCCS Online



**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.

### **\*\*\* ATTENTION! \*\*\***

Effective January 1, 2017, Non IHS/638 NEMT providers transporting TRBHA members over 100 miles, one way or round trip, must receive prior authorization for the transport. Behavioral health transports must be to and from a covered behavioral health service. Prior Authorization requests:

1. Must be submitted prior to service delivery in order to be considered timely.
2. Must contain a valid behavioral health diagnosis.

## AHCCCS Online User Manuals

### Sign In

Username

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.

Enter your username & password

Click "Sign In"

## Menu

Claim Status

Claims Submission

EFT Enrollment

Member Verification

Newborn Notification

Prior Authorization Inquiry

Prior Authorization Submission

Provider Verification

Provider Re-Enrollment/Revalidation

## Support and Manuals

AHCCCS Online User Manuals

AHCCCS Online Learn More

Frequently Asked Questions

## Account Information

Username: Training01

User: Albert Escobedo

Type: Master

IP: 170.68.81.110

Provider ID: 231725

## Main Page

Click on "Claim Submission"

▲ 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 STATUS

Claim Status allows providers to check the status of **Fee-For-Service** claims submitted to AHCCCS. If a recipient is enrolled in a capitated Health Plan, the Health Plan contact information, please click on [Health Plan Listing](#).

For a listing of the Health Plan contact information, please click on [Health Plan Listing](#).

### CLAIM SUBMISSION

Claim Submission allows providers to submit Professional, Dental and Institutional claims to AHCCCS for nightly processing. Claims submitted prior to 4:00 PM 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 number. 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 Med 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 be viewed on 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 and Signatures.

For further information, please click on [AHCCCS Provider Registration](#).

### PROVIDER RE-ENROLLMENT/REVALIDATION

Provider Re-Enrollment/Revalidation allows providers to submit their re-enrollment information electronically. Providers who were registered with AHCCCS prior to 2010 must re-enroll by mail or e-mail when it is time to re-enroll. All data must be submitted by the indicated timeframe on the letter or the AHCCCS identification number will be terminated. Providers must wait to receive a re-enrollment notice. If documents are received prior to the re-enrollment notices being mailed out, the documents will be processed. Data may be submitted by authorized signers on file with AHCCCS. For further information, please click on [AHCCCS Provider Re-Enrollment/Revalidation](#).

### PRIOR AUTHORIZATION INQUIRY

# Claim Submission Screen

- Under “enter new claim”, click on the drop down and select **Professional**
- Click “Go”

## Claim Submission

Claims submitted to AHCCCS prior to 4:00 PM, Monday through Friday, will be processed within 24 to 48 hours. Once the claim has been sent for processing, it can no longer be modified via the web. After the processing deadline, corrections will need to be submitted as a **Replacement** or **Void**. The claim will not be accepted if any required data elements are missing. The claim will also be rejected if the recipient is not eligible for coverage at the time the service is rendered. Claims will be processed under the following Identification Number (Non-Person Entity):

**Payer/Receiver Electronic Transmitter Identification Number: 866004791**

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

The screenshot displays two main sections of the web interface. The top section, titled "Enter New Claim", contains a form with a "Type of Claim:" label, a dropdown menu currently set to "Professional", and a "Go..." button. A green callout box with the text "Click 'Go'" has a line pointing to the "Go..." button. The bottom section, titled "View Claim Processing Status", contains a form with a "Submission Date(s):" label, two empty date input fields separated by a hyphen, and a "Go..." button.

# Submitter Screen

## Professional Claim Submission

[Help](#)

\* Indicates a required field.

Submitter	<b>Providers</b>	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
<b>Submitter</b>							
Organization Name: NEMT TEST							
Electronic Transmitter ID Number: 99222							
Information Contact Name: Escobedo, Albert							
Information Contact Telephone Number: 602-417-4562							

Next click on the "providers"  
tab

Save Submit Cancel

Verify that the information is  
correct

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

## Professional Claim Submission

[Help](#)

\* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
Billing Provider	Rendering Provider	Referring Provider	Service Facility				

**Billing Provider**  
\* Tax ID:   SSN  EIN  
Provider Commercial Number:   
\* CMMS National Provider ID (NPI):  **Find**  
\* Entity Type:  Person  Non-Person Entity  
Health Care Provider Taxonomy Code:   
Provider Name:  
Information Contact Name:  
Information Contact Telephone Number:  
Service Locator Code/Address:  
Pay-To Locator Code/Address:

Enter the biller or the group tax ID here

When done entering all the required fields, click the "find" button

If you do not have a valid NPI # Enter your 6 digit AHCCCS provider ID here, and leave the NPI field blank

If you have a valid NPI you must enter it here and leave the provider commercial field # blank

Do not click submit

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)

# Professional Claim Submission

[Help](#)

\* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
Billing Provider	Rendering Provider	Referring Provider	Service Facility				

## Billing Provider

\* Tax ID:   SSN  EIN

Provider Commercial Number:

\* CMMS National Provider ID (NPI):

\* Entity Type:  Person  Non-Person Entity

Health Care Provider Taxonomy Code:

Provider Name: NEMT TEST

Information Contact Name:

Information Contact Telephone Number: 6024177000

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

Pay-To Locator Code/Address:  701 E JEFFERSON  
PHOENIX, AZ 85034

Your provider information should populate here

Next click on the rendering tab



Reaching across Arizona to provide comprehensive quality health care for those in need

# Rendering Provider Screen

## Professional Claim Submission

Help

\* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
Billing Provider	Rendering Provider	Referring Provider	Service Facility				
<b>Rendering Provider</b>							
If you do not have a valid NPI # Enter your 6 digit AHCCCS provider ID here, and leave the NPI field blank		Provider Commercial Number:	<input type="text" value="231725"/>	<input type="button" value="Find"/>	When done entering all the required fields, click the "find" button		
		* CMMS National Provider ID (NPI):	<input type="text"/>				
		* Entity Type:	<input checked="" type="radio"/> Person <input type="radio"/> Non-Person Entity				
		Provider Name:	<input type="text" value="TEST/CASE"/>				
		Performing Health Care Provider Taxonomy Code:	<input type="text"/>				
		<input type="button" value="Save"/>	<input type="button" value="Submit"/>	<input type="button" value="Cancel"/>			

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 all the required fields, 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)

# Professional Claim Submission

[Help](#)

\* Indicates a required field.

Submitter	Providers	<b>Patient/Subscriber</b>	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
Billing Provider	Rendering Provider	Referring Provider	Service Facility				
<b>Rendering Provider</b>							
Provider Commercial Number: <input type="text" value="231725"/>							
* CMMS National Provider ID (NPI): <input type="text" value="999999999"/> <input type="button" value="x"/> <input type="button" value="Find"/>							
* Entity Type: <input checked="" type="radio"/> Person <input type="radio"/> Non-Person Entity							
Provider Name: <input type="text" value="TEST/CASE"/>							
Performing Health Care Provider Taxonomy Code: <input type="text"/>							

After clicking the "Find" button  
The rendering provider's name will appear

Next click on the Patient/Subscriber tab

# Insured or Subscriber Screen

## Professional Claim Submission

[Help](#)

\* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
<b>Insured or Subscriber</b>							
		* Member ID Number/Date of Birth:		<input type="text"/>	<input type="text"/>	<input type="button" value="Find"/>	
Person Name:							
Gender:							
Residential Address:							
		* Payer Responsibility:		<input type="text"/>			<input type="button" value="v"/>
<small>NOTE: AHCCCS no longer accepts ADOC claims.</small>							

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

# Professional Claim Submission

[Help](#)

\* Indicates a required field.

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

## Insured or Subscriber

Enter the members AHCCCS ID and date of birth (MM/DD/YYYY)

\* Member ID Number/Date of Birth:

When done entering all the required fields, click the "find" button

Person Name:

Gender:

Residential Address:

Click on the down arrow and make your Payer Responsibility selection

\* Payer Responsibility:

NOTE: AHCCCS no longer accepts ADOC claims.

- A - Payer Responsibility Four
- B - Payer Responsibility Five
- C - Payer Responsibility Six
- D - Payer Responsibility Seven
- E - Payer Responsibility Eight
- F - Payer Responsibility Nine
- G - Payer Responsibility Ten
- H - Payer Responsibility Eleven
- P - Primary**
- S - Secondary
- T - Tertiary
- U - Unknown

# Professional Claim Submission

[Help](#)

\* Indicates a required field.

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

**Insured or Subscriber**

\* Member ID Number:  Date of Birth:

Person Name: TEST  
Gender: M  
Residential Address: 701 E Jefferson St,  
Phoenix AZ 85004  
\* Payer Responsibility:

If you want to send an attachment click the "attachments" tab

If no attachments, click "claim information" tab next

NOTE: AHCCCS no longer accepts ADOC claims.

For the purpose of this training, we will be sending an attachment

# Claim Attachments Screen

- **Report Type** – Click the drop down and select type of attachment
- **Report Transmission** – Click the drop down and select EL – Electronically Only
- **Control Number** – Enter the **PWK number**. We recommend you use the members AHCCCS ID followed by the Date of Service, making sure the “A” in the AHCCCS ID is capitalized

Claim Attachments			
	Report Type **	Report Transmission **	Control Number **
1	B4 - Referral Form	EL - Electronically Only	A88734947080117
2			
3			
4			
<b>Attachments (1-10):</b>			
5			
6			
7			
8			
9			
10			

\*\* Required ONLY if Attachment information is submitted.

Save Submit Cancel

**PWK?** The PWK is a number that you will create for each document you want to submit. This number will allow the system to link the attachment to the appropriate claim. Ensure there are no spaces and you use a capital letter.

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

AHCCCS ID ( 9 – character AHCCCS ID)	A12345678
<i>Note: The A in AHCCCS ID must be a capital letter</i>	
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)	A87654321
<i>Note: The A in AHCCCS ID must be a capital letter</i>	
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.

# Claim Information Screen

## 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  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

Save

Submit

Cancel

Enter the patients account number. If your office doesn't use one you can enter their AHCCCS ID, their name, etc..

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.

Provider Signature on File

Provider Accepts Assignments; Click yes if you are accepting payment from AHCCCS

When done entering the claim information data, click on the Service Lines tab

# Service Line Screen

## Professional Claim Submission

**Note: Effective 10/1/15, you must select ICD-10**

Enter the diagnosis without the decimal here (up to 12)

\* 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  2  3  4  5  6   
7  8  9  10  11  12

### Service Line

If applicable, you can enter up to four modifiers

\* 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:

Specialty Code:  (Performing HC Provider)

Immunization Batch Number:

Patient Count:

Indicators: Emergency  EPSDT

Provider Control Number:

TPL payer information is entered here.

Click on the dropdown and select the place of service

\*\*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

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

Enter the following:

- Diagnosis Code Pointers
- To & From dates of service line charges
- Number of units or minutes
- The HCPCS (procedure code)

Save

Submit

Cancel

# Service Lines Add and Updates

The service line will allow you to continue to “ADD” more lines, unless you click edit or remove buttons.

**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	Pro Cod
1	1/1/2017	1/1/2017	99	A0120	TN	-	-	-	-	0.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>	2.000	UN	14.54	-	0.00											
2	1/31/2017	1/31/2017	99	S0215	TN					0.000	<input checked="" type="checkbox"/>	<input type="checkbox"/>	100.000	UN	150.00		0.000											
																								<b>Totals: \$164.54</b>		<b>\$0.00</b>		

**Update**

\*\* 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	Pro Cod
1	01/01/2017	01/01/2017	99	A0120	TN	-	-	-	-	0.000	<input checked="" type="checkbox"/>	<input type="checkbox"/>	2.000	UN	14.54	-	0.000											
2	01/31/2017	01/31/2017	99	S0215	TN					0.000	<input checked="" type="checkbox"/>	<input type="checkbox"/>	100.000	UN	150.00		0.000											
																								<b>Totals: \$164.54</b>		<b>\$0.00</b>		

Once you’ve entered all services lines (edited or removed), you will have the option to update the changes.

# Submit

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  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: \$

\* Quantity:   Minutes  Units

\* HCPCS Code:

National Drug Code:

\*\*NDC Quantity/Measure:

Immunization Batch Number:

Indicators: Emergency  EPSDT

Provider Control Number:

\*\*Other Payer: Primary ID

\*\*Medicare: Paid Amount \$

Other Adjustment(s): Medicare Deductible \$

\*\*Durable Medical Equipment: HCPCS  Pu

\*\*Ordering Physician: Plan ID

\* Place of Service Code (POS):

Modifier Codes: 1  2  3  4

Prescription Date:

\*\*Prescription #/Identifier:

Taxonomy Code:  (Performing HC Provider)

Patient Count:

Procedure Code/Qualifier:

Copay \$

Length of Medical Necessity  (Days)

City:

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

Once you've completed entering all the relevant claim(s) information, click "Submit"

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	6/1/2016	6/1/2016	32	97001						0	<input checked="" type="checkbox"/>	<input type="checkbox"/>	1	UN	65.02		0											
																								<b>Totals:</b>	<b>\$65.02</b>	<b>\$0.00</b>		

Save   **Submit**   Cancel

# Claim Entry Confirmation Screen

## Claim Entry Confirmation

**Transmission Status:** Successful

**Claim Type:** Professional

**Patient Account Number:** A98734947

**Confirmation Code:** P-269

You will receive a message that it was successful

Error:

Attachments

Beginning with services incurred on 7/1/2013, all NEMT claims must be submitted with the new AHCCCS standard Daily Trip Report. Effective with service dates 8/1/2013 and forward, any non-emergency transport claim that is submitted without the standard Daily Trip Report will be denied. It is the provider's responsibility to maintain all documentation that supports each transport service claimed. Please click [here](#) to submit an attachment.

You can go to the 275 portal to upload your document by clicking on the attachment link

View Claim

Enter New Claim

Here you will have two choices:  
View Claims or Enter New Claims

Clicking on View Claim will give you a summary of the information that will be sent over to AHCCCS and will allow you to edit the claim if needed

Clicking on Enter New Claims allows you to enter a new claim.

Please send your questions  
regarding this training to:

[ProviderTrainingFFS@azahcccs.gov](mailto:ProviderTrainingFFS@azahcccs.gov)



# Thank you!

