



TOPICS:

**NEMT CLAIM SUBMISSION
UPLOADING THE DAILY TRIP
REPORT - TIBCO**

**DFSM Provider Training Team
September 24, 2019**

AHCCCS ONLINE

**CLAIM SUBMISSION
TRAINING**

NEMT PROVIDERS

Reminder: AHCCCS COVERAGE

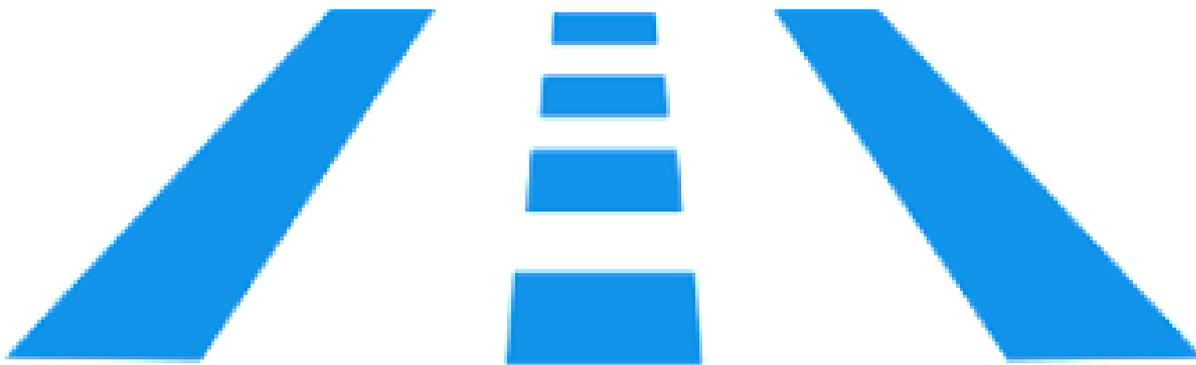
- AHCCCS covers medically necessary **non-emergency medical transportation** to and from an AHCCCS **covered** medical or behavioral health service for most recipients.
- Transportation must only be provided to transport the recipient to and from the **nearest** AHCCCS covered medical or behavioral health service.
- Tribal Business License - Effective 10/1/2014 prior authorization will be denied for transport services on Reservation if the NEMT provider ***does not*** have the corresponding Tribal Business License on file with AHCCCS Provider Registration department.

Toolbar- there are 6 Tabs that must be completed in order to submit a claim for covered NEMT services.

1. SUBMITTER
2. PROVIDERS
3. PATIENT SUBSCRIBER

4. ATTACHMENT
5. CLAIM INFORMATION
6. SERVICE LINES

GETTING STARTED



<https://azweb.statemedicaid.us>

1. Sign In: Must have a valid **username** and **password**.
2. On the Main Page - Menu– select **Claims Submission**

[Main](#) | [FAQ](#) | [Terms Of Use](#) | [LogOut](#) |

Main Page

Menu

[AIMH Services Program](#)

[Claim Status](#)

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[Prior Authorization Inquiry](#)

[Prior Authorization Submission](#)

[Provider Verification](#)

[Targeted Investments Program](#)

[Members Supplemental Data](#)

Support and Manuals

[AHCCCS Online User Manuals](#)

▲ 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.**

AIMH SERVICES PROGRAM

Pending SPA approval by CMS, AHCCCS proposes to offer services that support an American Indian Medical Home Program, including Primary Care Case Management (PCCM), diabetes education, care coordination, and promoting participation in the state Health Information Exchange, to AHCCCS AI/AN members who are enrolled in AIHP. AIMH PCCMs will be charged with addressing health disparities between American Indians and other populations in Arizona, specifically by enhancing case management and care coordination. AHCCCS registered IHS/638 facilities who meet AIMH registration criteria will be eligible for prospective per member per month payments based on the services and activities they are providing to empaneled members. For further details on the program, please click on [AIMH Home](#).

CLAIM STATUS

Claim Status allows providers to check the status of **Fee-For-Service** claims submitted to AHCCCS. If a recipient is enrolled in a capitated Health Plan, the Health Plan must be contacted for claim inquiries.

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

CLAIM SUBMISSION

Claim Submission allows providers to submit Professional, Dental and Institutional claims to AHCCCS for nightly processing. Claims submitted prior to 4:00 PM each business day are processed that night. Claims submitted after 4:00 PM Friday will be processed the following Monday. The status of the claims can be viewed online by searching for the claim by submission date. Average processing time may take 24-72 hours, depending on the number of claims processed and the time of the submission.

Claims Submission Page

TYPE OF CLAIM – Select **PROFESSIONAL** and 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.

Enter New Claim

Type of Claim: ▾

View Claim Processing Status

Submission Date(s):

-

Professional Claim Submission

1. Confirm the Submitter information is correct.
2. Next - Select the tab **PROVIDERS**.

[Help](#)

* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
Submitter							
Organization Name: NEMT TEST							
Electronic Transmitter ID Number: 99222							
Information Contact Name: Provider, Training							
Information Contact Telephone Number: 602-417-4000							

Professional Claim Submission

Billing Provider Tab

1. Complete the **Billing Provider Information**, this will include the **TAX ID**, **National Provider ID** and **Non-Person Entity** fields.
2. If you do not have a NPI number, enter your 6 digit AHCCCS provider number in the Provider Commercial Number field.

* 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: <input type="text" value="123456789"/> <input type="radio"/> SSN <input checked="" type="radio"/> EIN							
Provider Commercial Number: <input type="text" value="007835"/>							
* CMMS National Provider ID (NPI): <input type="text"/> <input type="button" value="Find"/>							
* Entity Type: <input type="radio"/> Person <input checked="" type="radio"/> Non-Person Entity							
Health Care Provider Taxonomy Code: <input type="text"/>							
Provider Name: NEMT TEST							
Information Contact Name:							
Information Contact Telephone Number: 6024177000							
Service Locator Code/Address: <input type="text" value="01"/> 701 E JEFFERSON PHOENIX, AZ 85034							
Pay-To Locator Code/Address: <input type="text" value="01"/> 701 E JEFFERSON PHOENIX, AZ 85034							

Rendering Provider Tab

1. On the Rendering Provider tab – complete the CMMS National Provider ID field (NPI) and **Non-Person Entity field**.
2. If you do not have a NPI number, enter your 6 digit AHCCCS provider number in the **Provider Commercial Number** field, leaving the NPI number field blank.

* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
Billing Provider	Rendering Provider	Referring Provider	Service Facility				
Rendering Provider							
Provider Commercial Number:		007835					
* CMMS National Provider ID (NPI):				Find			
* Entity Type:		<input type="radio"/> Person <input checked="" type="radio"/> Non-Person Entity					
Provider Name:		NEMT TEST					
Performing Health Care Provider Taxonomy Code:							

Save Submit Cancel

Patient/Subscriber Tab

1. Enter the AHCCCS Member ID and date of birth (**MM/DD/YYYY**), and click the **FIND** button to verify the member information.
2. On the Payer Responsibility field – click the down arrow key to select payer responsibility. If AHCCCS is the primary payer, select P-Primary.

* 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: <input type="text" value="A09340007"/> <input type="text" value="03/21/1959"/> <input type="button" value="Find"/>							
Person Name: COOKIE, SUGAR							
Gender: F							
Residential Address: 4226 N LOOS CT PRESCOTT VALLEY, AZ 86314							
* Payer Responsibility: <input type="text" value="P - Primary"/> ▼							
NOTE: AHCCCS no longer accepts ADOC claims.							

ATTACHMENTS TAB

The Attachment tab is the only way to notify the AHCCCS processing system that you are submitting an Electronic attachment (Daily Trip Report) with the claim.

1. The Report Type (B4) and Report Transmission (EL) codes should be used only.
2. The **CONTROL NUMBER** field will change based on the Member ID and Date of Service.
3. The Control number entered on the Attachment tab **MUST MATCH** the control number entered In the Transaction Insight Portal (TIBCO).

* 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	▼	A0934000709232019	
		2	▼		▼		
		3	▼		▼		
		4	▼		▼		
Attachments (1-10):	5	▼		▼			
	6	▼		▼			
	7	▼		▼			
	8	▼		▼			
	9	▼		▼			
	10	▼		▼			

** Required ONLY if Attachment information is submitted.

Save Submit Cancel

COMPLETING THE ATTACHMENT TAB

After completing the Control number field, click on the Claim Information tab to proceed with entering the claim information

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	A0934000709232019
2		
3		
4		
5		

Attachments (1-10):

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 at the same time.

Note: If entering a PWK here, the claims processing system will hold the claim for 10 days to wait for the attachment. If after 10 days the attachment has not been received the claim will Deny.

Enter the PWK number in the Control Number field. If the member ID is used make sure to use a Upper Case "A".

Control Number **
A0934000709232019

** Required ONLY if Attachment information is submitted.

Submit Cancel

CLAIM INFORMATION TAB

* Indicates a required field - Provider Signature on File, Provider Accept Assignment, Benefit Assignment and Release of Information Consent.

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
Claim Information							
Original Reference Number:		<input type="text"/>	<input type="radio"/> Replacement <input type="radio"/> Void				
Prior Authorization Number:		<input type="text"/>					
* Patient Control Number:		<input type="text" value="a09340007"/>					
Medical Record ID Number:		<input type="text"/>					
Initial Treatment Date:		<input type="text"/>					
Date of Current Injury:		<input type="text"/>	(Accident)				
** Patient's Condition Related To:		<input type="checkbox"/> Employment <input type="checkbox"/> Other Accident <input type="checkbox"/> Auto Accident					
*** Place in which accident occurred:		<input type="text" value="State"/>	(State)				
Special Program Indicator:		<input type="text"/>					
* Provider Signature on File:		<input checked="" type="radio"/> Yes <input type="radio"/> No					
* Provider Accept Assignment:		<input checked="" type="radio"/> Assigned <input type="radio"/> Accepted on Clinical Lab Services Only <input type="radio"/> Not Assigned					
* Benefit Assignment:		<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Applicable					
* Release of Information Consent:		<input checked="" type="radio"/> Informed Consent <input type="radio"/> Yes					
EPSDT Screening Referral:		<input type="radio"/> Yes <input type="radio"/> No (Mutually Defined)					
Condition Indicator:		<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>			
Additional Information:		<input type="text"/>					
		(80 character max)					

*** Required ONLY if "Date of Current Injury" is entered.
**** Required ONLY if "Auto Accident" selected.

SERVICE LINES TAB

Line #1 – Enter the Base code for the transport (ex. A0120). This example shows a round trip transport. Complete the fields and then click the **ADD** button to bring up another page to enter the miles.

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: <input type="radio"/> ICD-9 <input checked="" type="radio"/> ICD-10 * Diagnosis Codes: 1 <input type="text" value="R6889"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/>							
7 <input type="text"/> 8 <input type="text"/> 9 <input type="text"/> 10 <input type="text"/> 11 <input type="text"/> 12 <input type="text"/>							
Service Line							
* Diagnosis Code Pointers: 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/>							
* Service Dates: <input type="text" value="09/23/2019"/> - <input type="text" value="09/23/2019"/>							
* Line Charges: \$ <input type="text" value="14.54"/> * Place of Service Code (POS): <input type="text" value="99 - OTHER UNLISTED FACILITY"/>							
* Quantity: <input type="text" value="2"/> <input type="radio"/> Minutes <input checked="" type="radio"/> Units Modifier Codes: 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/>							
* HCPCS Code: <input type="text" value="A0120"/> Prescription Date: <input type="text"/>							
National Drug Code: <input type="text"/> **Prescription #/Identifier: <input type="text"/>							
**NDC Quantity/Measure: <input type="text"/>							
Immunization Batch Number: <input type="text"/> Taxonomy Code: <input type="text"/> (Performing HC Provider)							
Patient Count: <input type="text"/>							
Indicators: Emergency <input type="checkbox"/> EPSDT <input type="checkbox"/>							
Provider Control Number: <input type="text"/>							
**Other Payer: Primary ID <input type="text"/> Paid Amount \$ <input type="text"/> Units <input type="text"/> Procedure Code/Qualifier <input type="text"/>							
**Medicare: Paid Amount \$ <input type="text"/> Units <input type="text"/> Procedure Code/Qualifier <input type="text"/>							
Other Adjustment(s): Medicare Deductible \$ <input type="text"/> Medicare Coinsurance \$ <input type="text"/> Medicare Copay \$ <input type="text"/>							
***Durable Medical Equipment: HCPCS <input type="text"/> Purchase Price \$ <input type="text"/> Rental Price \$ <input type="text"/> Length of Medical Necessity <input type="text"/> (Days)							
**Ordering Physician: Plan ID <input type="text"/> Last Name <input type="text"/> First Name <input type="text"/> City <input type="text"/>							
<input type="button" value="Add"/>							

SERVICE LINES TAB

Line #2 – Enter the Miles code for the transport (ex. S0215). This example shows a round trip transport. Complete the fields and then click the **ADD** button to bring up another page.

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: <input type="radio"/> ICD-9 <input checked="" type="radio"/> ICD-10 * Diagnosis Codes: 1 <input type="text" value="R6889"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/>							
7 <input type="text"/> 8 <input type="text"/> 9 <input type="text"/> 10 <input type="text"/> 11 <input type="text"/> 12 <input type="text"/>							
Service Line							
* Diagnosis Code Pointers: 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/>							
* Service Dates: <input type="text" value="09/23/2019"/> - <input type="text" value="09/23/2019"/>							
* Line Charges: \$ <input type="text" value="300.00"/> * Place of Service Code (POS): <input type="text" value="99 - OTHER UNLISTED FACILITY"/>							
* Quantity: <input type="text" value="200"/> <input type="radio"/> Minutes <input checked="" type="radio"/> Units Modifier Codes: 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/>							
* HCPCS Code: <input type="text" value="S0215"/> Prescription Date: <input type="text"/>							
National Drug Code: <input type="text"/> ***Prescription #/Identifier: <input type="text"/>							
**NDC <input type="text"/> Taxonomy Code: <input type="text"/> (Performing HC Provider)							
Quantity/Measure: <input type="text"/>							
Immunization Batch Number: <input type="text"/> Patient Count: <input type="text"/>							
Indicators: Emergency <input type="checkbox"/> EPSDT <input type="checkbox"/>							
Provider Control Number: <input type="text"/>							
**Other Payer: Primary ID <input type="text"/> Paid Amount \$ <input type="text"/> Units <input type="text"/> Procedure Code/Qualifier <input type="text"/>							
**Medicare: Paid Amount \$ <input type="text"/> Units <input type="text"/> Procedure Code/Qualifier <input type="text"/>							
Other Adjustment(s): Medicare Deductible \$ <input type="text"/> Medicare Coinsurance \$ <input type="text"/> Medicare Copay \$ <input type="text"/>							
**Durable Medical Equipment: HCPCS <input type="text"/> Purchase Price \$ <input type="text"/> Rental Price \$ <input type="text"/> Length of Medical Necessity <input type="text"/> (Days)							
**Ordering Physician: Plan ID <input type="text"/> Last Name <input type="text"/> First Name <input type="text"/> City <input type="text"/>							
<input type="button" value="Add"/>							

uals.aspx

On this screen you will be able to verify the billing information entered and also to correct any errors before submitting the claim.

The **Pencil** icon is the edit button.

1. To make a correction, click on the pencil next to the line that you want to correct.
2. Once you are done making the correction, click the ADD button to accept the correction, then you are ready to click the **SUBMIT** button.
3. You will receive the message **“Transmission Successful”**.

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 U Amount
1	9/23/2019	9/23/2019	99	A0120						0	<input checked="" type="checkbox"/>	<input type="checkbox"/>	2	UN	14.54											
2	9/23/2019	9/23/2019	99	S0215						0	<input checked="" type="checkbox"/>	<input type="checkbox"/>	200	UN	300.00											
																							Totals:	\$314.54	\$0.00	

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



TRANSACTION INSIGHT PORTAL

TIBCO – UPLOADING THE DAILY TRIP REPORT



TRANSACTION INSIGHT PORTAL (TIBCO)

275 ATTACHMENTS PAGE

Home : 275 Attachments

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... **Part 1**

Part 2

Transaction Set Purpose Code	Select a value
Submitter Last or Organization Name	<input type="text"/>
Provider Entity Type Qualifier	<input type="radio"/> Person (1) <input checked="" type="radio"/> Non-Person Entity (2)
Provider Last or Organization Name	<input type="text"/>
Provider First Name	<input type="text"/>
Provider Primary Identifier Qualifier	Select a value
Provider Primary Identifier	<input type="text"/>
Provider Secondary Identifier	<input type="text"/>
Provider Address	<input type="text"/>
Provider City	<input type="text"/>
Provider State	Select a value
Provider Zip Code	<input type="text"/>
Patient Last Name	<input type="text"/>
Patient First Name	<input type="text"/>
Patient Primary Identifier	<input type="text"/>
Patient Control Number	<input type="text"/>
Medical Record Identification Number	<input type="text"/>
Claim Service Period Start Date	<input type="text"/>
Claim Service Period End Date	<input type="text"/>
Payer Claim Control Number or Provider Attachment Control Number	<input type="text"/>
Claim Status Category Code	Select a value
Additional Information Request Code	Select a value
Code List Qualifier Code	Select a value

* - Required Fields

Part 3

The 275 Attachments page have three parts:

- Part 1: Upload Attachment
- Part 2: Details
- Part 3: Save Attachment

* Required Fields

NOTE:
Provider Primary or Secondary Identifier/Qualifier are also required fields.

**Response Type is - 02 – Add (unsolicited).
The PWK number must be entered in the Provider Attachment Control Number field.**

Transaction Set Purpose Code	02- ADD	▼	*
Submitter Last or Organization Name	IHS Shiprock		*
Provider Entity Type Qualifier	<input type="radio"/> Person (1) <input checked="" type="radio"/> Non-Person Entity (2)		*
Provider Last or Organization Name	IHS Shiprock		*
Provider First Name			
Provider Primary Identifier Qualifier	XX-NPI	▼	
Provider Primary Identifier	Enter the Provider NPI		
Provider Secondary Identifier			
Provider Address	801 EAST JEFFERSON		*
Provider City	PHOENIX		*
Provider State	AZ - Arizona	▼	*
Provider Zip Code	85034		*
Patient Last Name	DOE		*
Patient First Name	JANE		*
Patient Primary Identifier	A12345678		*
Patient Control Number	Q-12345		*
Medical Record Identification Number			
Claim Service Period Start Date	09/01/2019	🔗 *	
Claim Service Period End Date		🔗	
Payer Claim Control Number or Provider Attachment Control Number	A1234567809012019		*
Claim Status Category Code	Select a value	▼	
Additional Information Request Code	Select a value	▼	
Code List Qualifier Code	Select a value	▼	

*** These 3 fields can stay at "Select a value" no action required.**

* - Required Fields

Claim Screen and TI Attachment Screen Match

CLAIM SUBMISSION ATTACHMENT PAGE		
CLAIM ATTACHMENTS		
Report Type	Report Transmission	Control Number
B4- Referral Form	EL - Electronically Only	A1234567809012019

TRANSACTION INSIGHT PORTAL PAGE	
Payer Claim Control Number or Provider Attachment Control Number	<input type="text" value="A1234567809012019"/>
Claim Status Category Code	Select a value <input type="button" value="v"/>
Additional Information Request Code	Select a value <input type="button" value="v"/>
Code List Qualifier Code	Select a value <input type="button" value="v"/>

Required Fields

Response Type - 11-Response (solicited) → (AHCCCS requested the documentation)
The AHCCCS 12 digit CRN must be entered in the Provider Attachment Control Number.

Transaction Set Purpose Code	11 - RESPONSE	*
Submitter Last or Organization Name	IHS Shiprock	*
Provider Entity Type Qualifier	<input type="radio"/> Person (1) <input checked="" type="radio"/> Non-Person Entity (2)	*
Provider Last or Organization Name	IHS Shiprock	*
Provider First Name		
Provider Primary Identifier Qualifier	XX-NPI	*
Provider Primary Identifier	Enter Provider NPI	*
Provider Secondary Identifier		
Provider Address	801 EAST JEFFERSON	*
Provider City	PHOENIX	*
Provider State	AZ - Arizona	*
Provider Zip Code	85034	*
Patient Last Name	DOE	*
Patient First Name	JANE	*
Patient Primary Identifier	A12345678	*
Patient Control Number	Q-12345	*
Medical Record Identification Number		
Claim Service Period Start Date	09/01/2019	*
Claim Service Period End Date		
Payer Claim Control Number or Provider Attachment Control Number	Enter the 12 digit AHCCCS Claim Reference Number	*
Claim Status Category Code	R4- Documentation Request	*
Additional Information Request Code	11503-0	*
Code List Qualifier Code	LOI-LOINC Codes	*

When using the 11-Response make sure to select "R4 Documentation Request" prompt. The Request code and Qualifier code fields leave as shown.

* - Required Fields

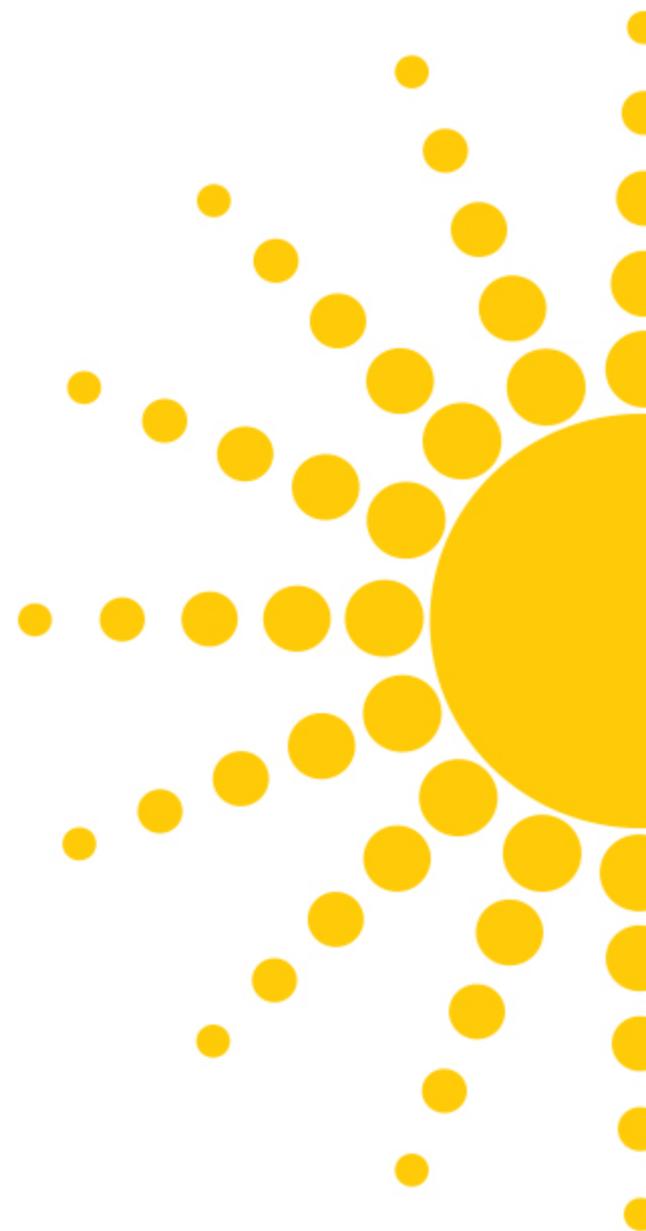
Submit Attachment Cancel

Important Tips:

1. The PWK number must begin with a upper case "A".
2. Do not use a lower case "a", this is not a match.
3. Make sure the PWK number that is entered on the claim attachment tab is entered in the same format in TIBCO.

Correct Format	Incorrect Format
CRN 192016589012	01920165890212#
PWK A1234567809052019	a12345678090519

Video Trainings: Claim Submission TIBCO Submission



Thank You!

