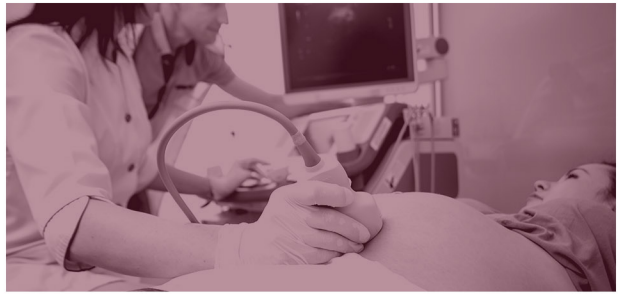





AHCCCS Claim Form Types
CMS 1500, UB-04 and ADA Dental

June 2021

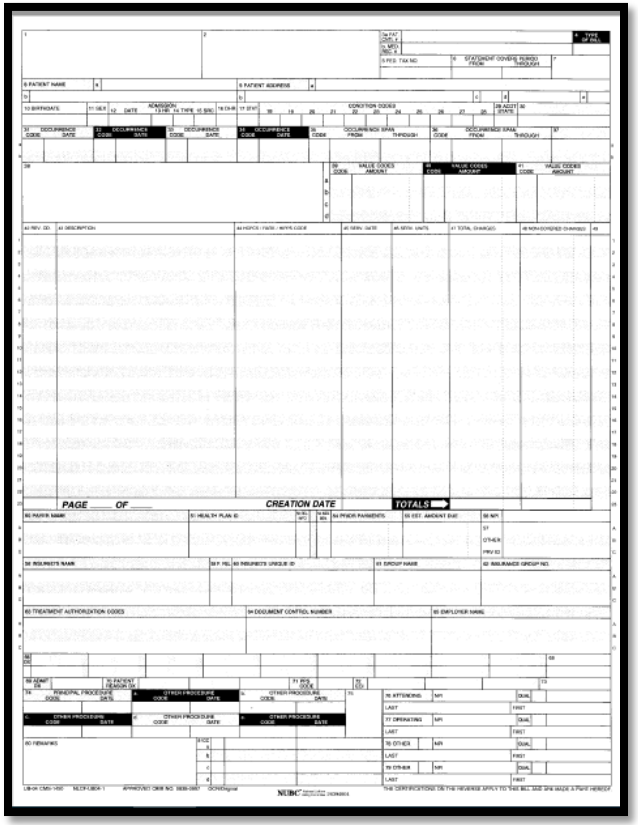
AHCCCS
Arizona Health Care Cost Containment System

Claim Forms

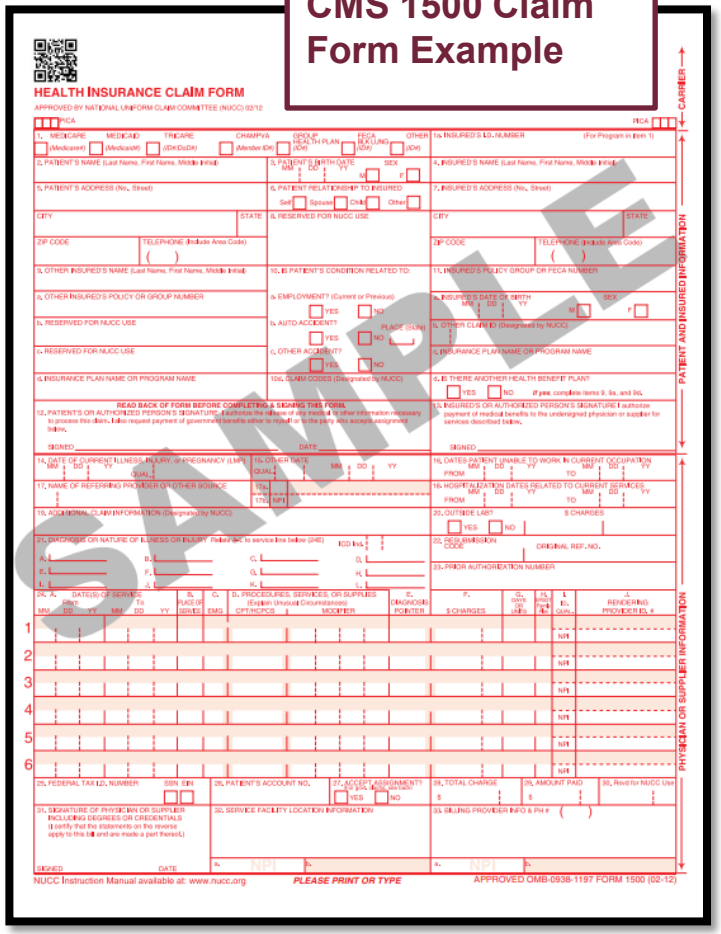
There are three types of paper claim forms accepted by AHCCCS:

- The UB-04 Claim Form for Institutional Claims
- The CMS 1500 Claim Form for Professional
- The ADA 2012 Claim Form for Dental Claims

UB-04 Claim Form Example



CMS 1500 Claim Form Example



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate A-L to service line below (24E)) ICD Ind.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ( )

SIGNED DATE

a. NPI b.

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

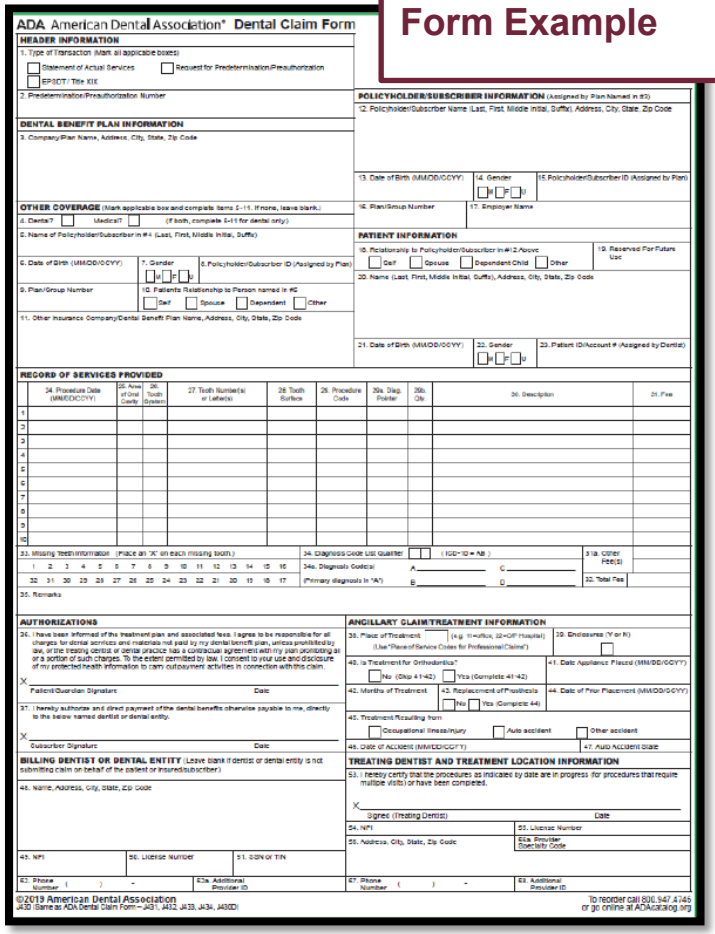
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

ADA 2012 Claim Form Example



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

Statement of Actual Services Request for Predetermination/Preauthorization

EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) 14. Gender M F 15. Policyholder/Subscriber ID (Assigned by Plan)

OTHER COVERAGE (Mark applicable box and complete items 4–11. If none, leave blank.)

4. Dental? Medical? (If both, complete 5–11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION

6. Date of Birth (MM/DD/CCYY) 7. Gender M F 8. Policyholder/Subscriber ID (Assigned by Plan)

18. Relationship to Policyholder/Subscriber in #12: Self Spouse Dependent Child Other 19. Reserved For Future Use

9. Plan/Group Number 10. Patient's Relationship to Person named in #5 Self Spouse Dependent Other

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) 22. Gender M F 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30a. Diag. Pointer	30b. Qty.	30. Description	31. Fee
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier (ICD-10 or AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A B C D

31a. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

46. Name, Address, City, State, Zip Code

43. NPI 50. License Number 51. SSN or TIN

52. Phone Number ( ) - 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=Office, 22=Off Hospital) (Use "Place of Service Codes for Professional Claims") 39. Enclosures (Y or N)

40. Is Treatment for Orthodontics? No (Skip 41-42) Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment 43. Replacement of Prosthesis No Yes (Complete 44) 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from Occupational Illness/Injury Auto accident Other accident

46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Signed (Treating Dentist) Date

54. NPI 55. License Number

56. Address, City, State, Zip Code 56a. Provider Specialty Code

57. Phone Number ( ) - 57a. Additional Provider ID

To reorder call 800.947.4746 or go online at ADAcatalog.org

What is the difference?

Type of Claim Forms

What is the CMS 1500 Claim Form? The CMS-1500 form is the standard claim form used by a non-institutional providers. AHCCCS only accepts the official red and white paper version. Providers can also submit the 837P which is electronic version of the 1500 claim form.

What is the UB-04 Claim Form? The UB-04 claim form is approved by (CMS) and the National Uniform Billing Committee (NUBC) for inpatient and outpatient paper claims billing. Providers can also submit the 837I which is the electronic version of the UB-04 claim form.

What is the ADA Dental Claim Form? The ADA Dental Claim Form is used to report dental services performed by a dentist.

Use of the UB-04 by IHS/638 and FFS Providers

Billing the All-Inclusive Rate on a UB-04 Claim Form (IHS/638 Providers)

- **Codes:** Standard revenue codes (0510-0519)
- **Reimbursement Rate:** AIR
- **Note:** IHS/638 providers are *not required* to submit CPT/HCPCS codes with the revenue code on the claim form.

Billing on a UB-04 Claim Form (FFS Providers)

- **Codes:** All applicable Revenue Codes, CPT/HCPCS codes and modifiers
- **Reimbursement Rate:** Capped FFS rate or DRG.
- **Note:** FFS Providers *must* include the revenue code *and* all applicable CPT/HCPCS codes *and* (when needed) modifiers to receive the correct reimbursement.

Use of the CMS 1500 by IHS/638 and FFS Providers

Billing on a CMS 1500 Claim Form (IHS/638 Providers)

- **Codes:** CPT/HCPCS codes and modifiers
- **Reimbursement Rate:** Capped FFS Rate
- **Note:** IHS/638 providers use the CMS 1500 Claim Form for KidsCare Outpatient Services, individual practitioner services, and outpatient services that cannot be billed at the AIR. (Including all services listed under the FFS provider section)

Billing on a CMS 1500 Claim Form (FFS Providers)

- **Codes:** CPT/HCPCS codes and modifiers
- **Reimbursement Rate:** Capped FFS Rate
- **Note:** Emergency and non-emergency transportation services, FQHC services, ambulatory surgical centers, independent laboratories, durable medical equipment, individual practitioner services, and KidsCare outpatient services.

Examples of Provider Types that bill using the UB-04 (Institutional)

Provider types that can submit their services using the UB-04 claim form include:

- Free-Standing Dialysis Facility (41)
- Free-Standing Birthing Center
- Hospitals (02)
- Hospice Facility (35)
- IHS/638 Hospitals (02)
- Skilled Nursing Facility (22)

Some examples of provider types that bill using the CMS 1500 (Professional)

Provider types that can submit their services using the CMS 1500 claim form include:

- Emergency Transportation (06)
- Assisted Living Facilities (36)
- Treat & Refer Providers (TR)
- Ambulatory Surgery Centers (43)
- Durable Medical Equipment Suppliers (30)
- Federally Qualified Health Centers (FQHC) and (C2) Community Rural Health Centers (RHC) (29)
- Home Attendant Care Agencies (40) and Home Health Agencies (23)
- NEMT (28)
- Medical Practitioners, Anesthesiologist, Physician Assistants, Physical, Speech and Occupational Therapists, Pathology, Laboratory, and Radiology

Examples of Mental Health Provider types that bill using the CMS 1500 Claim FORM

Provider types that can submit their services using the CMS 1500 claim form include:

- Behavioral Health Outpatient Clinic (77)
- Behavioral Health Residential Facility (B8)

Provider Type that billing using the ADA Dental Claim Form

Provider types that can submit their services using the ADA 2012 claim form include:

- Dentists (07) (including dental anesthesiology services)


DFSM Provider Education and Training Unit

AHCCCS
Arizona Health Care Cost Containment System

DFSM Provider Training

The DFSM Provider Education and Training Unit can assist providers with the following:

- How to submit and status claims or prior authorization requests through the AHCCCS Online Provider Portal (FFS programs, including AIHP, TRBHAs and Tribal ALTCS).
- Submission of documentation using the Transaction Insight Portal (i.e. the AHCCCS Daily Trip report, requested medical records, etc.).

Additionally, the DFSM Provider Training unit offers trainings with informational updates to program changes, system updates, and changes to the AHCCCS policy, AHCCCS guides and manuals.

Education and Training Questions?

The DFSM Provider Education and Training Unit does not instruct providers on how to code or bill for a particular service.

For additional information on rates and coding please follow the below guidelines:

- Rates - Questions on AHCCCS FFS rates should be directed to the rates team at FFSRates@azahcccs.gov
- Coding - Questions on AHCCCS Coding should be directed to the coding team at CodingPolicyQuestions@azahcccs.gov
  - NOTE: The Coding team cannot instruct providers on how to code or bill for a particular service. Those questions should be directed to the provider's professional coder/biller.
- ACC Plan Claims - Questions regarding the submission of claims to an AHCCCS Complete Care (ACC) Health Plan should be directed to the appropriate ACC Health Plan.

The DFSM Provider Training Team can be reached at ProviderTrainingFFS@azahcccs.gov

Technical Questions?

For technical assistance with the AHCCCS Online Provider Portal, please call:

- AHCCCS ISD Customer Support Desk at 602-417-4451 or ISDCustomerSupport@azahcccs.gov

Claims Questions?

For claims questions that cannot be resolved on the portal, please outreach the Claims Customer Service team at:

- Phone: (602) 417-7670 – Select Option 4
- From: Monday – Friday from 7:30am – 4:00pm (Phoenix Time).

The Claims Customer Service team can assist with the following items:

- Details regarding a claim status that cannot be answered on the AHCCCS Online Provider Portal;
- Providing denial codes and general information regarding denied claims; and
- Providing general information about approved and pended claims.

NOTE: Providers should not call the Claims Customer Service team if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, the address a check was mailed to, and payment details for approved claims.

Policy Information

AHCCCS FFS Provider Billing Manual:

- https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

AHCCCS IHS/Tribal Provider Billing Manual:

- https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.html

AHCCCS Medical Policy Manual

- https://www.azahcccs.gov/shared/MedicalPolicyManual/

Thank You.