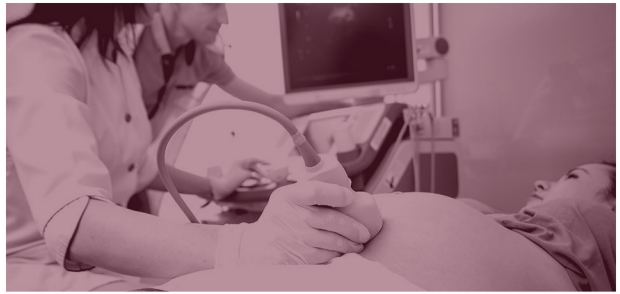





Paper Claim Submission Requirements

CMS 1500, UB-04, and the ADA 2012 Claim Form Tips

June 2021

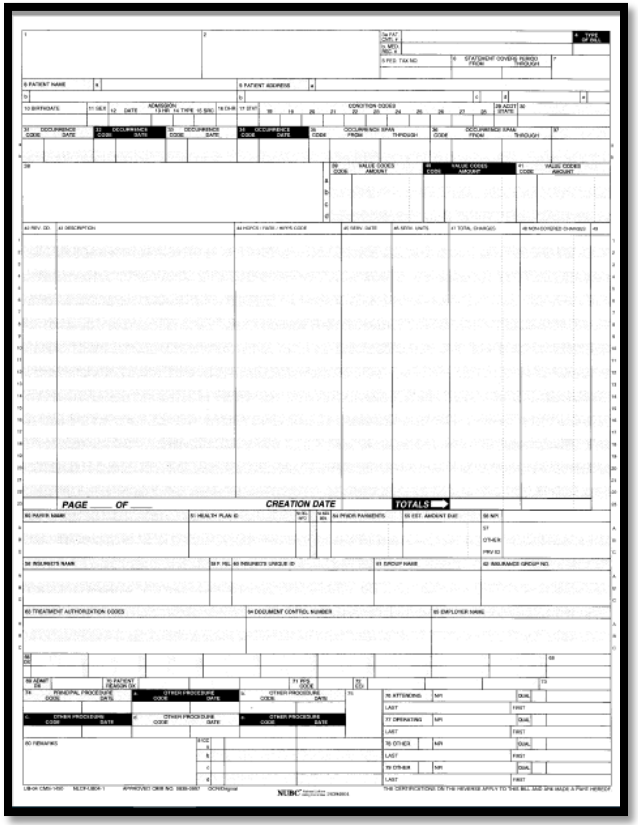
AHCCCS
Arizona Health Care Cost Containment System

Claim Forms

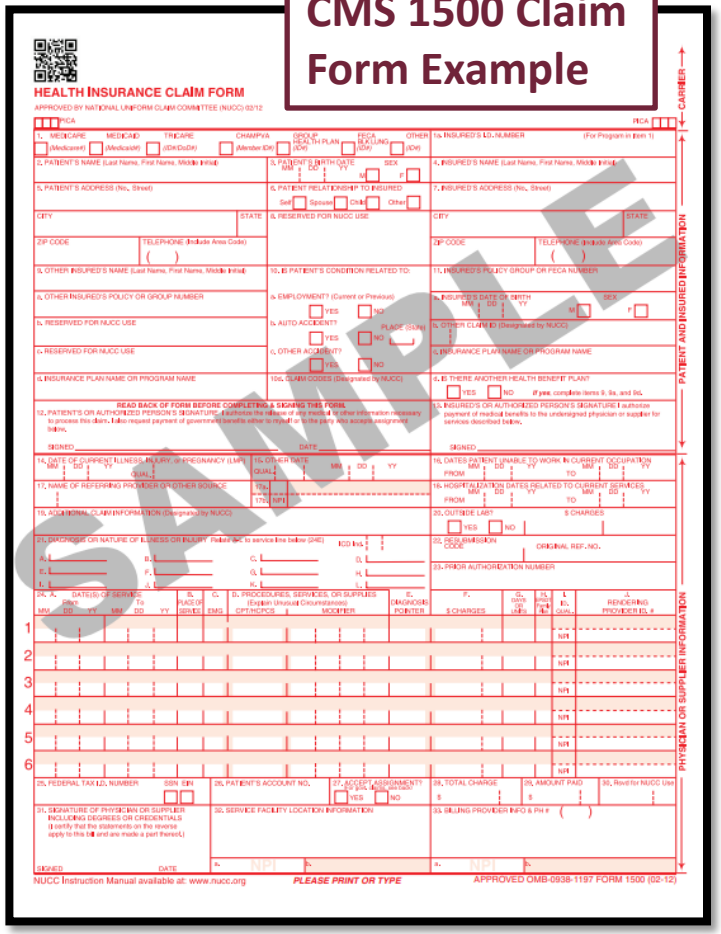
There are three types of paper claim forms accepted by AHCCCS:

- 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 MM DD YY QUAL.

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

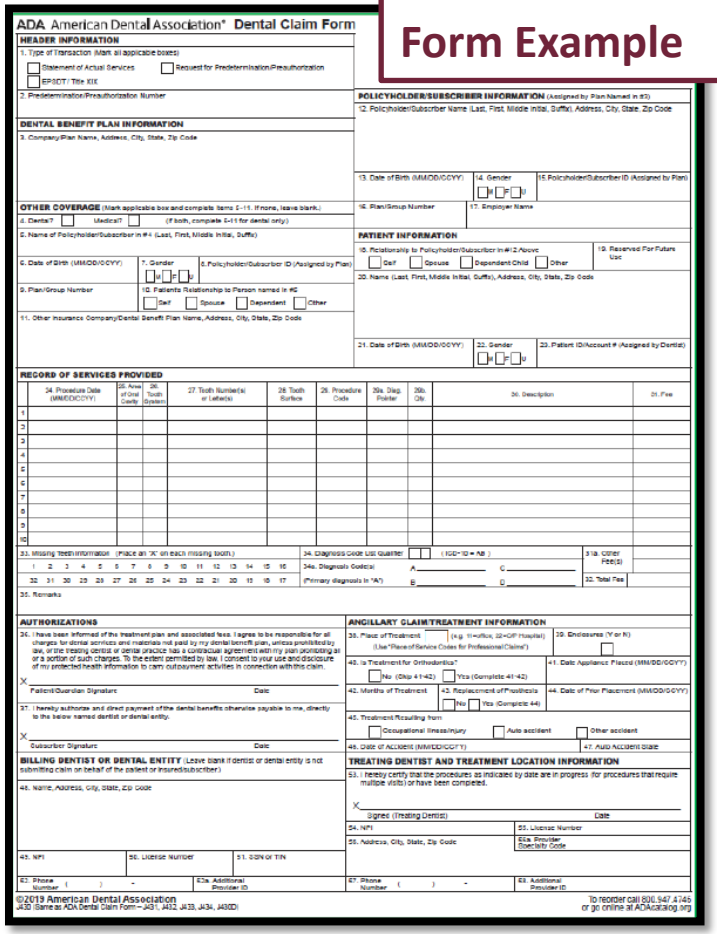
CARRIER

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 = AB)

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

31a. Other Fee(s)

32. 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

General Information

Claims for services must be submitted to the AHCCCS Administration on the correct claim form for the type of service being billed.

- NOTE: The preferred method of claims submission remains the ***HIPAA-compliant 837D transaction process***.
- If a provider is not set up to perform the 837D transaction process, then submission of a claim via the AHCCCS Online Provider Portal is the preferred method of claim submission.

For information on how to submit claims using the HIPAA-compliant 837D transaction process or via the AHCCCS Online Provider Portal please refer to Chapter 4, General Billing Rules, of the Fee-For-Service Provider Billing Manual and the appropriate implementation guides.

Basic Formatting for All Claim Form Types

To ensure the successful processing of a paper claim form:

- The printed information **must be aligned correctly** with the appropriate section/box on the form. If a claim is not aligned correctly, it may cause the OCR system to read the data incorrectly and the claim will reject.
- The preferred font for claims submission is **Lucinda Console** and the **preferred font size is 10**.
- Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system.
- Liquid paper correction fluid ("White Out") may not be used. Correction tape may not be used.
- Original claim forms **must be used** for any paper claims submitted to AHCCCS.
    - NOTE: The OCR system **cannot read "copies"** that are made from the original claim form.

Stamps

To ensure the successful processing of a paper claim form:

- Claim forms with labels and stamps will not be accepted, as that is considered an alteration of the claim.
  - **NOTE:** The only exception to this is in regards to stamped provider signatures. Stamped provider signatures will be accepted only in certain fields as shown below:
    - CMS-1500 - Field 31
    - UB-04 - Field 53
    - ADA 2012 - Field 53

Multiple Pages

To ensure the successful processing of a paper claim form with ***multiple pages:***

- Please do not submit double-sided, multiple page claims. Each claim page must be submitted on a separate piece of paper, with the pages numbered (e.g., 1 of 3, 2 of 3, 3 of 3, etc.).
- To ensure that all pages of a multiple-page claim are processed as a single claim, the pages must be numbered.
- Keep all pages together, back-to-back. All pages should be paper-clipped or rubber-banded together. ***Do not staple.***
- Totals should not be carried forward onto each page, and each page can be treated as a single page. ***The total should be entered on the last page only.***

Multiple Pages

To ensure the successful processing of a paper claim form with ***multiple pages (continued):***

- All service lines must be completed on the first page before proceeding to the second page of the claim. All lines on page 1 **must** be filled in, prior to proceeding to the second page of the claim form.
  - CMS 1500 - All lines (1-6) under field 24 (A-J)
  - UB-04 - All lines (1-22) under fields 42-48
  - ADA 2012 - All lines (1-10) under fields 24-31
- Please note that only the required fields on all lines will need to be filled in.

Resubmitting Paper Claims

AHCCCS retains a permanent electronic image of all paper claims submitted, in accordance with state retention record requirements, ***requiring providers to file clear and legible claim forms.***

Claims for services must be legible and submitted on the correct claim form (UB-04, CMS 1500, or ADA 2012) for the type of service(s) billed.

Claims that are not legible or that are not submitted on the correct form will be returned to providers without being processed.

- If a claim is returned, you must resubmit the claim on the correct type of claim form, submit it within the required time frame (following timely filing guidelines) and ensure that it is legible.

Resubmitting Paper Claims

A resubmitted claim form cannot be a black and white copy of the previously submitted claim.

- For example, when using the CMS 1500 Claim Form, the resubmitted claim form must be submitted on a new, red claim form.

Documentation is required when resubmitting claims, even if the documentation was submitted with an earlier version of the claim and the claim number is referenced on the resubmitted claim. **Documentation must be resubmitted.**

- Each claims must stand on its own, as the system is unable to pull documentation from a previously submitted claim. Any documentation submitted with a claim is imaged and linked to the claim.

Resources for Paper Claim Submission

Chapter 4, General Billing Rules, of the IHS/Tribal Provider Billing Manual:

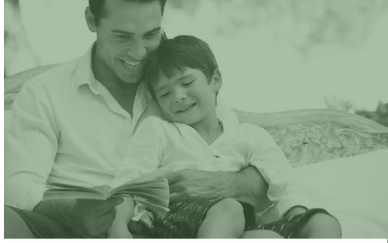
- https://www.azahcccs.gov/PlansProviders/Downloads/IHS-TribalManual/IHS-Chap04GenBillRules.pdf

Chapter 5, Claim Form Requirements, of the IHS/Tribal Provider Billing Manual:

- https://www.azahcccs.gov/PlansProviders/Downloads/IHS-TribalManual/IHS-Chap05ClmFormRequire.pdf

Claims Clues articles can be found on the AHCCCS website at:

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

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.