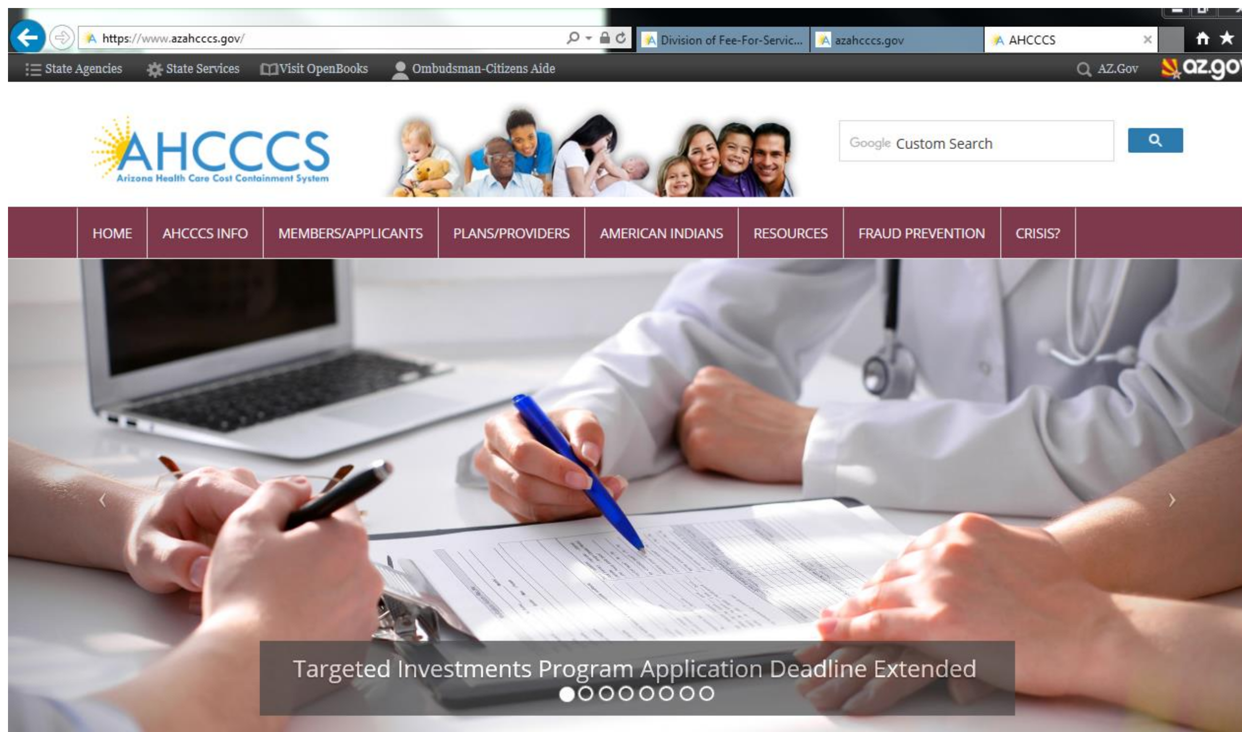
Online Claims Submission: Institutional Claim Type

February 22, 2018

Start at the AHCCCS Website

https://www.azahcccs.gov/



AHCCCS
Arizona Health Care Cost Containment System

Search

1. Click Plans/Providers

HOME | AHCCCS INFO | MEMBERS/APPLICANTS | PLANS/PROVIDERS | AMERICAN INDIANS | RESOURCES | FRAUD PREVENTION | CRISIS?

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

Sign In

Enter your username & password

Click "Sign In"

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.

Main Page

Click on "Claim Submission"

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

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 He
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
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
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 subm
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
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 prio
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 terr
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 pro
system requirements. Data may be submitted by authorized signers on file with AHCCCS. For further information, please click on AHCCCS Provider Re-Enrollm

PRIOR AUTHORIZATION INQUIRY

Claim Submission Screen

- Under “enter new claim”, click on the drop down and select **Institutional**
- 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: Institutional Go...

Click “Go”

View Claim Processing Status

Submission Date(s): - Go...

Submitter Screen

Institutional Claim Submission

Help

* Indicates a required field.

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

Submitter

Organization Name:	NEMT TEST
Electronic Transmitter ID Number:	99222
Information Contact Name:	Escobedo, Albert
Information Contact Telephone Number:	602-417-4562

Save | Submit | Cancel

Next click on the “providers” tab

Verify that the information is correct

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

Institutional Claim Submission

Help

* Indicates a required field.

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

Billing Provider | Referring Provider | Service Facility | Attending Provider | Operating Provider

Billing Provider

Enter the biller or the group tax ID here

* 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:

Save | Submit | 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

Do not click submit

This will automatically populate to non-person entity

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Institutional Claim Submission

Help

* Indicates a required field.

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

Billing Provider | Referring Provider | Service Facility | Attending Provider | Operating Provider

Billing Provider

* Tax ID: 123456789 ( ) SSN (•) EIN

Provider Commercial Number: 007835

* CMMS National Provider ID (NPI): [ ] Find

* 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: 01 701 E JEFFERSON PHOENIX, AZ 85034

Pay-To Locator Code/Address: 01 701 E JEFFERSON PHOENIX, AZ 85034

Save Submit Cancel

Your provider information should populate here

Next click on the Service Facility tab

Institutional Claim Submission

Help

* Indicates a required field.

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

Billing Provider	Referring Provider	Service Facility	Attending Provider	Operating Provider

Service Location (Non-Person Entity)

CMMS National Provider ID (NPI): 9999999999 Find

Laboratory or Facility Name:

Service Location Number/Address:

Save Submit Cancel

Enter the attending provider information by clicking the "attending provider" tab.

Click the "find" button

Enter facility NPI number here

Next click on the patient/subscriber tab

Insured or Subscriber Screen

Institutional Claim Submission

Help

* Indicates a required field.

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

Insured or Subscriber

* **Member ID Number/Date of Birth:**	Find
Person Name:	
Gender:	
Residential Address:	
* **Payer Responsibility:**	

NOTE: AHCCCS no longer accepts ADOC claims.

Save | Submit | Cancel

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

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Arizona Health Care Cost Containment System

Institutional Claim Submission

Help

* Indicates a required field.

Submitter | Providers | Patient/Subscriber | Other Payer | Codes/Values | 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: A12345678 01/01/1995 Find

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

Person Name:

Gender:

Residential Address:

* Payer Responsibility: P - Primary

NOTE: AHCCCS no longer accepts ADOC claims.

Click on the down arrow and make your Payer Responsibility selection

Save Submit Cancel

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

Institutional Claim Submission

Help

* Indicates a required field.

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

Insured or Subscriber

* **Member ID Number/Date of Birth:**	A12345678 · 01/01/1995 · Find
Person Name:	TEST
Gender:	M
Residential Address:	701 E Jefferson St, Phoenix AZ 85004
* **Payer Responsibility:**	P - Primary

Save | Submit | Cancel

Click on the “Codes/Values” tab next

The members information will populate here

Institutional Claim Submission

Help

* Indicates a required field.

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

Procedure Codes | Diagnosis Codes | Condition Codes | Occurrence Codes | Value Codes

To enter the diagnosis click the diagnosis tab

Procedure Information

** Principal Code/Date:

Other Procedures (1-24):

	Code	Date **		Code	Date **		Code	Date **
1			2			3		
4			5			6		
7			8			9		
10			11			12		
13			14			15		
16			17			18		
19			20			21		
22			23			24		

** Required ONLY if Procedure Code is submitted.

If billing for inpatient, enter procedure code(s) and date

Do not enter the diagnosis codes here, those will be entered in the "Diagnosis Codes" tab

Save | Submit | Cancel

Institutional Claim Submission

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

If no attachments, click "claim information" tab next

Help

* Indicates a required field.

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

Procedure Codes | Diagnosis Codes | Condition Codes | Occurrence Codes | Value Codes

If applicable enter the Condition, Occurrence, And Value codes here on their corresponding tabs

Diagnosis Information

* Principal Diagnosis Code: ______ Present on Admission: ______

Enter the primary diagnosis here

Admitting Diagnosis Code: ______

Enter Admitting diagnosis here

External Cause of Injury Codes (1-12): 1 2 3 4 5 6 7 8 9 10 11 12

	Code	Present on Admission		Code	Present on Admission		Code	Present on Admission
1			2			3		
4			5			6		
7			8			9		
10			11			12		
13			14			15		
16			17			18		
19			20			21		
22			23			24		

Other Diagnosis (1-24):

Other diagnosis's in particular for inpatient claims can be entered here

Save | Submit | Cancel

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

Attachments (1-10):

	Report Type **	Report Transmission **	Control Number **
1	B4 - Referral Form	EL - Electronically Only	A98734947080117
2			
3			
4			
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) *Note: The A in AHCCCS ID must be a 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) *Note: The A in AHCCCS ID must be a 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.

Institutional Claim Submission

Make your Assignment selection

Click on the down arrow and make your selection

When done click on the Service Lines tab

* Indicates a required field.

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

Claim Information

* Provider Accept Assignment: (•) Assigned ( ) Accepted on Clinical Lab Services Only ( ) Not Assigned
* Benefit Assignment: ( ) Yes ( ) No (•) Not Applicable
* Release of Information: (•) Informed Consent ( ) Yes
* Patient Control Number: Account number
* Patient Status: 01 - DISCHARGED TO HOME OR SELF CARE
Admission Source:
Delay Reason Code
* Total Claim Charge Amount $ 289 (Total for all service lines)
* Facility Type Code: 08 - TRIBAL 638 PROVIDER-BASED FACILITY
* Standard: ( ) ICD-9 (•) ICD-10

Patient's Reason(s) for Visit: 1 / 2 / 3

Diagnosis Related Group (DRG) Code:

...es ( ) No (Mutually Defined)

Admission Type:
* Admission Date: 10/01/2017
Admission Time: (HHMM)
Discharge Time: (HHMM)
* Statement From/To Date: 10/01/2017 - 10/01/2017
* Claim Form Bill Type: 131 (Original)
Medical Record ID #:
Original Reference #:
Prior Authorization #:
Location:
Additional Information: (80 char...)

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

Enter the bill type here

Enter the span date, if only one Date enter that date twice

Enter the date the member Was Admitted/Seen

Save | Submit | Cancel

Institutional Claim Submission

Enter the unit for the line you are billing

Help

* Indicates a required field.

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

Service Line

* Service Dates: 10/01/2017 - 10/01/2017

* Service Unit Count: 1 ○ Days ◉ Units

** Revenue Code: 0519 — Enter the revenue code

* Line Item Charge Amount: $ 294

** HCPCS:

Non-Covered Charge Amount: $

National Drug Code (5-4-2 Format):

Medicare Deductible/Quantity: $

NDC Quantity/Measurement:

Medicare Copayment/Quantity $

Procedure Modifiers: 1 2 3 4

Medicare Coinsurance/Quantity: $

Provider Control Number:

Date Claim Paid:

Prescription Number/Reference ID:

Add

** Either Revenue Code or HCPCS Code required for the service line.

Enter the Date of Service for the service line you are billing

If only billing for one date enter that date twice

Enter HCPCS if required

When done, click the add button, this will bring up a blank screen so that you can enter another line

Enter the billed charge for the line you are billing

Click on Days or Units Which ever you are billing for

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 grou

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	✓												2.000	UN	14.54	-	0	
2	1/31/2017	1/31/2017	99	S0215	TN					0.000	✓												100.000	UN	150.00		0.000	
																								Totals:	$164.54	$0.00		

Update

** All or none of the information is required for the line or gro

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
1	01/01/2017	01/01/2017	99	A0120	TN	-	-	-	-	0.000	✓												2.000	UN	14.54		0.000
2	01/31/2017	01/31/2017	99	S0215	TN					0.000	✓												100.000	UN	150.00		0.000
																								Totals:	$164.54	$0.00	

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

Submit

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

Claim Entry Confirmation Screen

Claim Entry Confirmation

Transmission Status: Successful

Claim Type: Institutional

Patient Account Number: 9999999999

Confirmation Code: I-90

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 will receive a message that it was successful

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.

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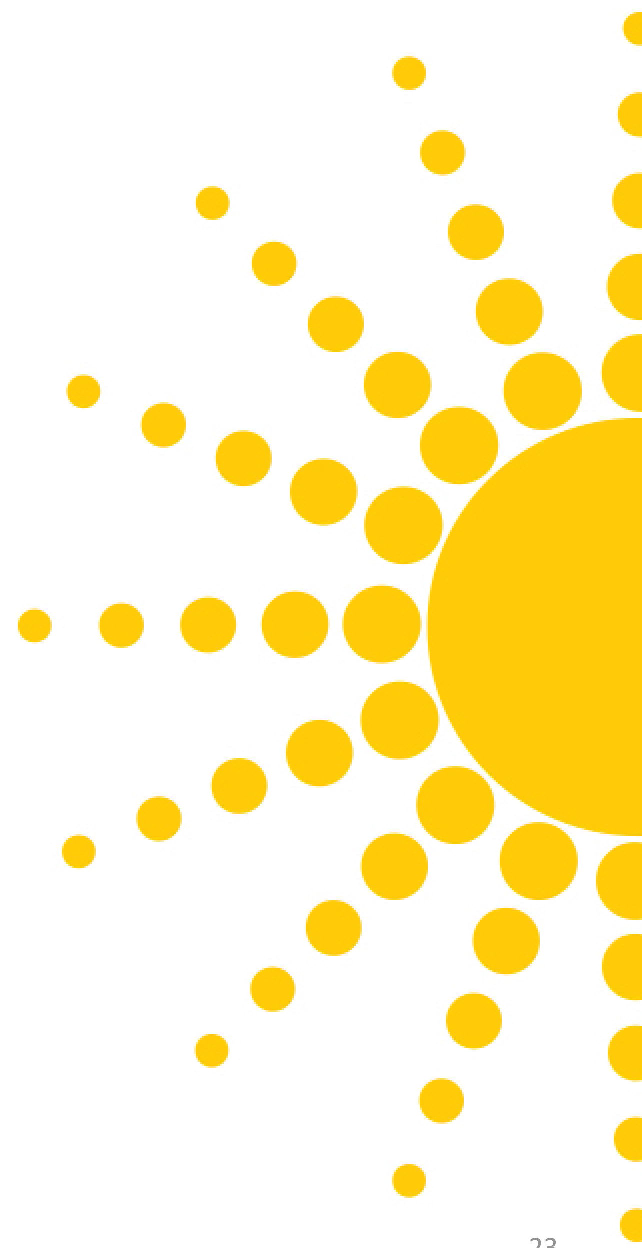
Arizona Health Care Cost Containment System

Please send your questions regarding this training to:

ProviderTrainingFFS@azahcccs.gov



Thank you!