



How to Submit a Dental Claim Using the AHCCCS Online Provider Portal

DFSM Provider Training Team

July 2023

About this Course

Please note that these materials are designed for Fee-for-Service programs, including the American Indian Health Program (AIHP), Tribal Regional Behavioral Health Authorities (TRBHAs), and Tribal Arizona Long Term Care Services (ALTCS).

This training presentation will cover how to submit a Dental (ADA 2012) Claim using the AHCCCS Online Provider Portal.

If you have any questions about this presentation, please email the providertrainingffs@azahcccs.gov

AHCCCS Online Provider Portal

The AHCCCS Online Provider Portal can be used for:

- Checking Member Eligibility and Enrollment
- Claim Submission, Replacements and Voids
- Checking a Claim Status
- Submitting a Prior Authorization (PA) Request and Checking a PA Status

We highly recommend using the AHCCCS Online Provider Portal for the fastest service.

AHCCCS Online Provider Portal

Providers typically register after they have received approval as an AHCCCS registered provider.

Providers must have a valid Username and Password to use the portal.

To create an account and begin using AHCCCS Online providers must go to the following web address and follow the instructions provided on the website:

- <https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f>

There is no charge for creating an account and there is no transaction charge.

Master Account Holder

When a newly registered provider registers with AHCCCS Online for the first time ***the user must request designation as the master account holder.***

Note: The master account holder is typically the first employee or agent to register an account from that provider.

However, another user can be designated as the master account holder at the provider's request.

There can be multiple master account holders.

Master Account Holder

Once the master account holder's account has been "registered", the following things occur:

1. AHCCCS sends the master account holder a temporary password.
2. The master account holder logs into the AHCCCS Online Provider Portal with that temporary password, and they change it to a new password.
3. After the master account holder is set up, other employees and agents of the newly registered provider (such as a biller) may then register for an account on AHCCCS Online.
4. At that point, **it will be the master account holder's responsibility to change that user's account settings to ensure they have been granted the appropriate access** to the subsystems that are directly related to that user's specific employment related duties.

Master Account Holder

The Master Account Holder is responsible for granting *other users within their office/hospital/clinic/provider organization* their user permissions within the AHCCCS Online Provider Portal.

Please note, that if a Master Account Holder *leaves* an organization (changes jobs, retires, resigns, etc.) that a *new* Master Account Holder needs to be designated.

- If this is not done, then new users will not have the settings they need to submit claims, prior authorizations, check eligibility status, etc.

Please keep your login information safe and remember account information may not be shared. <https://azweb.statemedicaid.us>

Dental (ADA 2012) Claim Forms

General Billing Information

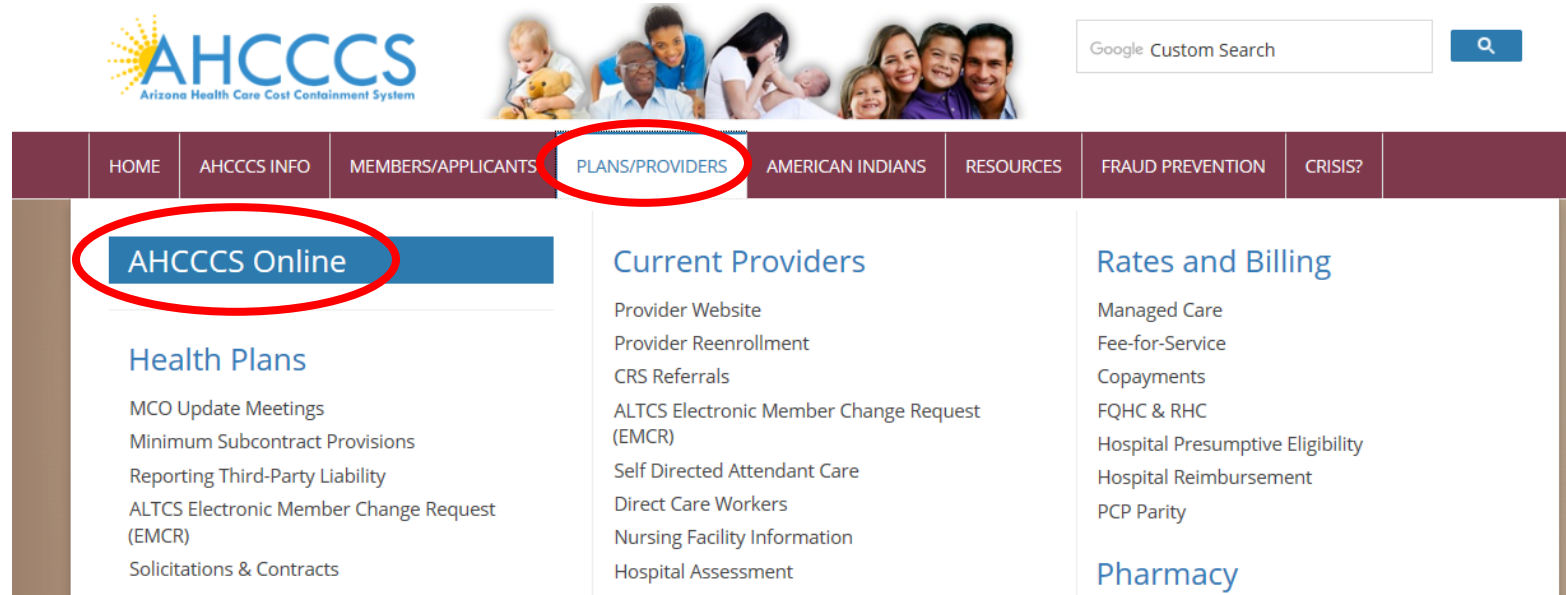
- **Claim Form:** ADA 2012 Claim Form (Dental)
- **Diagnosis Code:** ICD-10
- **CDT Codes:** Enter the appropriate procedure code from the CDT-4 Manual.
- For detailed, step-by-step instructions on how to fill out the paper ADA 2012 Claim Form please visit Chapter ,7 of the FFS Provider Billing Manual at:
 - https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap07.pdf

The AHCCCS Online Provider Portal

How to Submit Claims

AHCCCS Online

From the www.azahcccs.gov website click on plans and providers from the toolbar, once the drop down appears click on [AHCCCS Online](#). This link will take you to the AHCCCS Online Provider Portal.



The screenshot shows the AHCCCS website navigation menu. The 'PLANS/PROVIDERS' menu item is circled in red. Below it, the 'AHCCCS Online' link is also circled in red. The menu includes the following items: HOME, AHCCCS INFO, MEMBERS/APPLICANTS, PLANS/PROVIDERS, AMERICAN INDIANS, RESOURCES, FRAUD PREVENTION, and CRISIS?. The 'AHCCCS Online' link is highlighted in a blue box. Below the navigation menu, the 'Health Plans' section includes links for MCO Update Meetings, Minimum Subcontract Provisions, Reporting Third-Party Liability, ALTCS Electronic Member Change Request (EMCR), and Solicitations & Contracts. The 'Current Providers' section includes links for Provider Website, Provider Reenrollment, CRS Referrals, ALTCS Electronic Member Change Request (EMCR), Self Directed Attendant Care, Direct Care Workers, Nursing Facility Information, and Hospital Assessment. The 'Rates and Billing' section includes links for Managed Care, Fee-for-Service, Copayments, FQHC & RHC, Hospital Presumptive Eligibility, Hospital Reimbursement, and PCP Parity. The 'Pharmacy' section is also visible.

AHCCCS Online

[FAQ](#) | [Terms Of Use](#) | [LogIn](#) |



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 website can be terminated if the Terms of Use are violated.

TRBHA MEMBER TRANSPORT Effective 01/01/2017, 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.

ATTENTION! For information regarding the Coronavirus, please refer to the [AHCCCS COVID-19 website](#) for ADHS and CDC resources and [AHCCCS Frequently Asked Questions](#).

Attention Providers: The US Dept. of Health and Human Services made additional [COVID-19 funding available to Medicaid providers](#). Apply by July 20, 2020.

AHCCCS Online User Manuals

Sign In

Username

1 Enter Username

Password

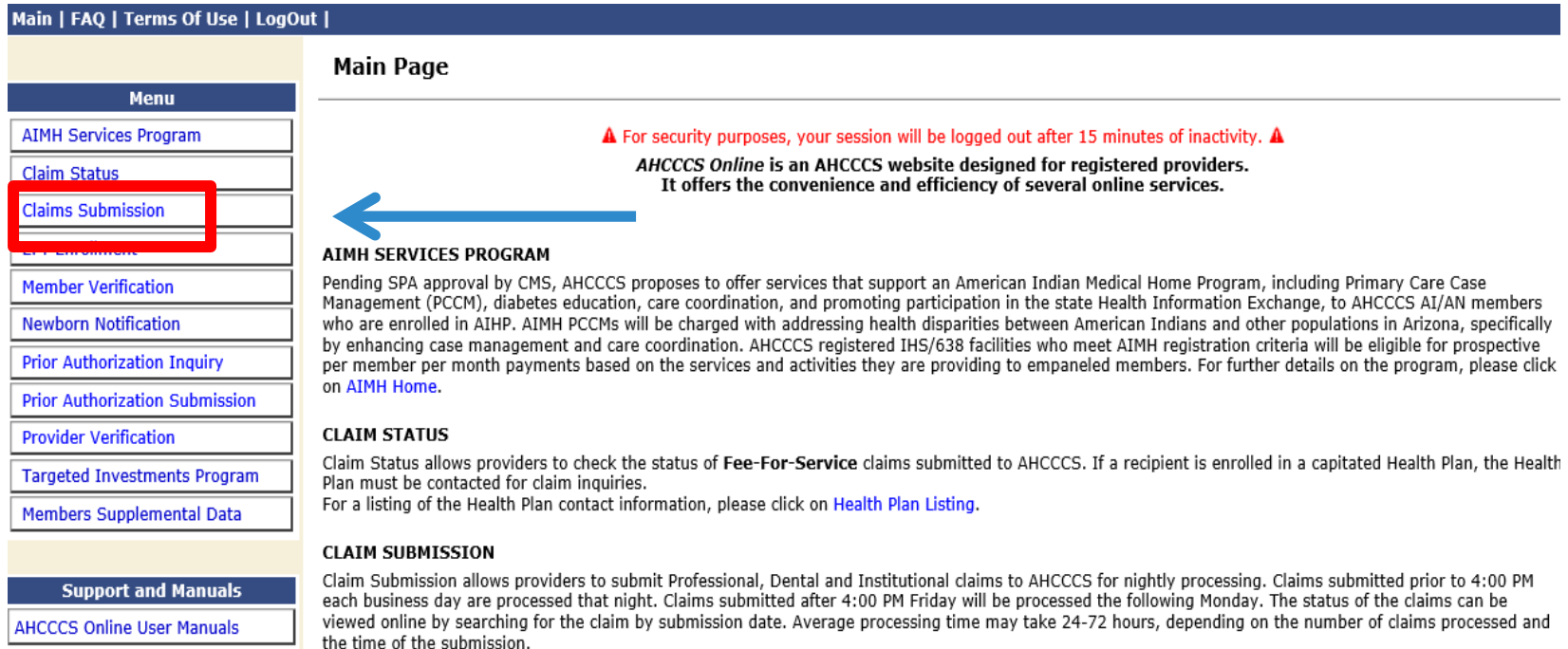
2 Enter Password

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.

Main Page

On the left-hand side of the page select “Claim Submission”.



Main | FAQ | Terms Of Use | LogOut |

Main Page

▲ 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.

Menu

- AIMH Services Program
- Claim Status
- Claims Submission**
- ET Enrollment
- Member Verification
- Newborn Notification
- Prior Authorization Inquiry
- Prior Authorization Submission
- Provider Verification
- Targeted Investments Program
- Members Supplemental Data

Support and Manuals

- AHCCCS Online User Manuals

Claim Submission Screen

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

Click “Go”

View Claim Processing Status

Submission Date(s): -

Submitter Tab

Submitter Screen

Dental Claim Submission

* Indicates a required

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
Submitter							
Organization Name: NEMT TEST							
Electronic Transmitter ID Number: 99222							
Information Contact Name: Test							
Information Contact Telephone Number: 602-555-5555							
<input type="button" value="Save"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/>							

Verify that the information is correct

Billing Provider Tab

Billing Provider Tab

- This is where you will enter the provider or group billing information.
 - In the Tax ID field enter the Billing Provider's Tax ID, if a group is billing enter the Group Biller Tax ID number.
- **Providers with a valid NPI**, will leave the provider commercial number field blank. They will then enter the 10-digit NPI in the **CMMS National Provider ID field** and click find.
- **Providers who do not have a valid NPI** will use the 6 digit AHCCCS Provider ID in the **Provider Commercial Number field**.

Billing Provider Tab

Dental Claim Submission

[Help](#)

* Indicates a required field

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	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:

Information Contact Name:

Information Contact Telephone Number:

Service Locator Code/Address:

* Pay-To Locator Code/Address:

** Required ONLY when Billing and Rendering providers are different.

Tax ID Field

Dental Claim Submission

[Help](#)

* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	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:							
Information Contact Name:							
Information Contact Telephone Number: 6024177000							
Service Locator Code/Address: <input type="text" value="01"/> <input type="button" value="v"/> 701 E JEFFERSON PHOENIX, AZ 85034							
* Pay-To Locator Code/Address: <input type="text" value="01"/> <input type="button" value="v"/> 701 E JEFFERSON PHOENIX, AZ 85034							

Enter the 9 digit TAX ID number and click on EIN

NPI or AHCCCS ID

Dental Claim Submission

[Help](#)

* Indicates a required field.

Providers **without an NPI** will use their AHCCCS 6 digit AHCCCS provider number in the Provider Commercial Number field. They will leave the NPI field blank.

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:

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

NOTE: Required fields are denoted with a red asterisk. *

Providers **WITH a valid NPI** will enter their NPI in the CMMS National Provider ID field. Click “Find” when the required fields are completed.

Entity Type Qualifier

Click your Entity Type: Person or Non-Person

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	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:							
Information Contact Name:							
Information Contact Telephone Number: 6024177000							
Service Locator Code/Address: <input type="text" value="01"/> <input type="button" value="v"/> 701 E JEFFERSON PHOENIX, AZ 85034							
* Pay-To Locator Code/Address: <input type="text" value="01"/> <input type="button" value="v"/> 701 E JEFFERSON PHOENIX, AZ 85034							

Entity Type

- Click **Person**, if the ID number comes up as a person's name.
- Click **Non-Person Entity**, if the ID comes up with a company's name.

Pay-To-Locator/Address

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	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:

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

Selecting locator code is **required** for the “Service Locator Code/Address” and the “Pay-To Locator Code/Address” fields.

The locator code determines the address to which payment is sent. The Remittance Advice will be mailed to the provider’s pay-to address if the provider is not set up for electronic remittance advices.

**DO NOT CLICK
SAVE OR SUBMIT**

Rendering Provider Tab

Rendering Provider Tab

Dental Claim Submission

[Help](#)

* Indicates a required field

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

Rendering Provider

Provider Commercial Number:

* **CMMS National Provider ID (NPI):**

* **Entity Type:** Person Non-Person Entity

Provider Name:

** **Service Locator Code/Address:**

Performing Health Care Provider Taxonomy Code:

1. Enter the service/rendering provider NPI.
2. Entity Type – select Person

Required ONLY when Billing and Rendering providers are different, or Billing provider's service address is missing.

Rendering Provider Screen

Dental Claim Submission

Help
* Indicates a required field.

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

Rendering Provider

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:

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

* Entity Type: Person Non-Person Entity

Provider Name: TEST/CASE

Performing Health Care Provider Taxonomy Code:

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

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

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)

Save Submit Cancel

Patient/Subscriber Tab

Patient/Subscriber Tab

Enter the member's **AHCCCS ID and Date of Birth (MM/DD/YYYY)**. Click "Find" and verify that the member's information is correct.

[Help](#)

* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
Billing Provider	Rendering Provider	Referring Provider	Service Facility				
Insured or Subscriber							
* Member ID Number/Date of Birth: <input type="text" value="A10093242"/> <input type="text" value="06/23/1988"/> <input type="button" value="Find"/>							
Person Name: AHCCCS, SEDONA							
Gender: F							
Residential Address: 701 E JEFFERSON ST PHOENIX, AZ 85038							
* Payer Responsibility: <input type="text" value="P - Primary"/> <input type="button" value="v"/>							
NOTE: AHCCCS no longer accepts ADOC claims.							

Patient/Subscriber Tab

Click on the [Payer Responsibility](#) drop down. Providers must determine the AHCCCS payment after Medicare and all other first and third-party payers.

This mock claim identifies AHCCCS as the Primary Payer and highlights P-Primary.

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

Insured or Subscriber

* Member ID Number/Date of Birth:	<input type="text" value="A10093242"/>	<input type="text" value="06/23/1988"/>	<input type="button" value="Find"/>
Person Name:	AHCCCS, SEDONA		
Gender:	F		
Residential Address:	701 E JEFFERSON ST PHOENIX, AZ 85038		
* Payer Responsibility:	<input type="text" value="P - Primary"/> ▼		

NOTE: AHCCCS no longer accepts ADOC claims.

Patient/Subscriber Tab Recap

* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
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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:

* Payer Responsibility:

NOTE: AHCCCS no longer accepts ADOC claims.

Click on the down arrow and make your Payer Responsibility selection

- 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

Attachments Tab

If no attachments, click “Claim Information” tab next

The Attachments Tab (AHCCCS Online Provider Portal) & the Transaction Insight Portal

Certain types of claims require additional documentation to be submitted.

Documentation is submitted using the Transaction Insight Portal, and it links to the correct claim based on information entered into the Attachments Tab.

- In order for the **documentation (submitted through the Transaction Insight Portal)** to attach to the **claim (submitted through the AHCCCS Online Provider Portal)** it is vital that the documentation be linked to the claim.

Linking occurs by using the exact same Control/PWK Number in both the **Transaction Insight Portal** and the **AHCCCS Online Provider Portal**.

The Attachments Tab (AHCCCS Online Provider Portal) & the Transaction Insight Portal

What is the Control/PWK Number?

- It is a unique number that a provider creates for each claim/document that they submit.
- This unique number forms an electronic match between the **submitted documentation (Transaction Insight Portal)** and the **claim (AHCCCS Online Provider Portal)**.
- It allows the system to link the attachment to the correct claim.

The Control/PWK Number is entered in **twice**.

- **First**, it is entered in by the provider when they submit their claim via the **AHCCCS Online Provider Portal**; and then
- It is **entered in a second time** when they submit their documentation on the **Transaction Insight Portal**.

The Control/PWK Number and Provider Identifier

The blue circled areas must match, and the red circled areas must match.

Claim Attachments

Report Transmission **
EL - Electronically Only

Control Number **
A1234567801032018

Provider Commercial Number: 123456

* CMMS National Provider ID (NPI): Find

Provider First Name

Provider Primary Identifier Qualifier

Provider Primary Identifier

Provider Secondary Identifier 123456

Provider Address

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 P123123

Medical Record Identification Number

Claim Service Period Start Date 1/3/2018

Payer Claim Control Number or Provider Attachment Control Number A1234567801032018

Claim Status Category Code Select a value

Additional Information Request Code Select a value

Code List Qualifier Code Select a value

* - Required Fields

Submit Attachment Cancel

Information on the Transaction Insight Portal

Transaction Insight Portal

For additional information on how to submit documentation using the Transaction Insight Portal, so that the documentation matches to the correct claim, please visit the DFSM Provider Training web page at:

- https://www.azahcccs.gov/Resources/Training/DFSM_Training.html
- Trainings on the Transaction Insight Portal can be found under “Trainings by Subject” and under the Video Library.

* Indicates a required f

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
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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:

NOTE: AHCCCS no longer accepts ADOC clai

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

If no attachments, click "tooth status" tab next

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

Attachments Tab

- 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

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		
The Report Type (B4) and Report Transmission (EL) codes should be used only.							
Attachments (1-10):	5	▼		▼			
	6	▼		▼			
	7	▼		▼			
	8	▼		▼			
	9	▼		▼			
	10	▼		▼			

Attachments Tab

The control number is also referred to as the PWK number. A PWK number is a unique number that the provider creates for each claim/document they submit. It allows the system to link the attachment to the correct claim.

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		x
2		▼					
3		▼					
4		▼					
5		▼					
6		▼					
7		▼					
8		▼					
9		▼					
10		▼					

Attachments (1-10):

Enter the PWK number, it is recommend to use:
Members AHCCCS ID followed by the date of service.
AXXXXXXXXXMMDDYYYY

Attachments Tab

The Attachment tab is the only way to notify the AHCCCS processing system that the provider is submitting an Electronic Attachment with the claim. From the time of claim submission, providers have [15 days](#) to upload attachments using the Transaction Insight Portal.

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		▼		▼			

Control Number (PWK number)

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

AHCCCS ID (9-character AHCCCS ID)

A12345678

The A in AHCCCSID must be in uppercase

Date of Service

01/03/18

PWK for Claim 1, Document 1

A1234567801032018

Different AHCCCS ID member with the Same Date of Services

AHCCCS ID (9-character AHCCCS ID)

A87654321

The A in AHCCCSID must be in uppercase

Date of Service

01/03/18

PWK for Claim 2, Document 2

A8765432101032018

The combination of the member's AHCCCS ID and the Date of Service is what makes the PWK number unique to each claim.

Tooth Status Tab

Tooth Status Tab

Dental Claim Submission

[Help](#)

* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
Tooth Status							
Tooth Number/Status **		Tooth Number/Status **		Tooth Number/Status **			
1	<input type="text"/> <input type="text"/> <input type="text"/>	2	<input type="text"/> <input type="text"/> <input type="text"/>	3	<input type="text"/> <input type="text"/> <input type="text"/>		
4	<input type="text"/> <input type="text"/> <input type="text"/>	5	<input type="text"/> <input type="text"/> <input type="text"/>	6	<input type="text"/> <input type="text"/> <input type="text"/>		
7	<input type="text"/> <input type="text"/> <input type="text"/>	8	<input type="text"/> <input type="text"/> <input type="text"/>	9	<input type="text"/> <input type="text"/> <input type="text"/>		
10	<input type="text"/> <input type="text"/> <input type="text"/>	11	<input type="text"/> <input type="text"/> <input type="text"/>	12	<input type="text"/> <input type="text"/> <input type="text"/>		
13	<input type="text"/> <input type="text"/> <input type="text"/>	14	<input type="text"/> <input type="text"/> <input type="text"/>	15	<input type="text"/> <input type="text"/> <input type="text"/>		
16	<input type="text"/> <input type="text"/> <input type="text"/>	17	<input type="text"/> <input type="text"/> <input type="text"/>	18	<input type="text"/> <input type="text"/> <input type="text"/>		

Claim Information Tab

Claim Information Screen

Dental Claim Submission

Help

* Indicates a required field.

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

Claim Information

Original Reference Number: Replacement Void

Prior Authorization Number:

* Patient Control Number:

* Place of Service:

Date of Current Injury: (Accident)

** Patient's Condition Related To: Employment Other Accident Auto Accident

*** Place in which Accident Occurred: (State)

* Provider Signature on File: Yes No

* Provider Accept Assignment: Assigned Not Assigned

* Benefit Assignment: Yes No Not Applicable

* Release of Information Consent: Informed Consent Yes

Special Program Code:

Service Date:

Save Submit Cancel

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

Service Lines Tab

On the left side click the radio dial next to ICD-10.

- **NOTE: Effective 10/01/15, you must select ICD-10**

Dental Service Line

To the right side of the screen, you will see the Diagnosis Codes field.

- Enter the DX codes. **Do not include the decimal point** when entering the DX codes (ex. correct format (R6889) incorrect format (R68.89)).
- Up to 12 DX codes can be entered **WITHOUT the decimal.**

Submitter Providers Patient/Subscriber

Diagnosis Codes(Relate Items Principal, 1, 2, or 3 by line to the Diagnosis Code Pointer)

*** Standard ICD-9 ICD-10 Principal Diagnosis Code: Other Diagnosis Codes: 1 2 3

Universal National Tooth Designation System

Service Line

* Service Date: *** Diagnosis Code Pointers: Principal 1 2 3

* Fee: \$ Place of Service:

* ADA Procedure Code: Line Item Control Number:

ADA Modifier Codes: 1 2 3 4 Oral Cavity Designation Codes: 1 2 3 4 5

Procedure Count:

Tooth Number:

Tooth Surface (1-5): 1 2 3 4 5

**Other Payer: Primary ID Paid Amount \$ Units Procedure Code/Qualifier

**Medicare: Paid Amount \$ Units Procedure Code/Qualifier

Enter the following:

- Diagnosis Code Pointers
- Service Date
- Fee
- ADA Procedure Code
- ADA Modifier Codes
- Procedure Count
- Tooth Number
- Tooth Surface
- Place of Service
- And all other applicable fields

Dental Service Line

Help

* Indicates a required field.

Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
-------------	-------------	--------------	-------------------	---------------

(Relate Items Principal, 1, 2, or 3 by line to the Diagnosis Code Pointer)

Principal Diagnosis Code: Other Diagnosis Codes: 1 2 3

Service Line

* Service Date:	<input type="text" value="10/02/2020"/>	*** Diagnosis Code Pointers:	Principal <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>				
* Fee:	\$ <input type="text" value="100.00"/>	Place of Service:	<input type="text" value=""/>							
* ADA Procedure Code:	<input type="text" value="D0150"/>	Line Item Control Number:	<input type="text" value=""/>							
ADA Modifier Codes:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	Oral Cavity Designation Codes:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Procedure Count:	<input type="text" value=""/>									
Tooth Number:	<input type="text" value=""/>									
Tooth Surface (1-5):	1 <input type="text" value=""/>	2 <input type="text" value=""/>	3 <input type="text" value=""/>	4 <input type="text" value=""/>	5 <input type="text" value=""/>					
**Other Payer:	Primary ID <input type="text" value=""/>	Paid Amount \$	<input type="text" value=""/>	Units	<input type="text" value=""/>	Procedure Code/Qualifier	<input type="text" value=""/>	<input type="text" value=""/>		
**Medicare:	Paid Amount \$	<input type="text" value=""/>	Units	<input type="text" value=""/>	Procedure Code/Qualifier	<input type="text" value=""/>	<input type="text" value=""/>			

Dental Service Line

Dental Claim Submission

Help

* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
Diagnosis Codes(Relate Items Principal, 1, 2, or 3 by line to the Diagnosis Code Pointer)							
*** Standard: <input type="radio"/> ICD-9 <input checked="" type="radio"/> ICD-10		Principal Diagnosis Code: <input type="text"/>		Other Diagnosis Codes: 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/>			
Universal National Tooth Designation System							
Service Line							
* Service Date: <input type="text" value="10/02/2020"/>		*** Diagnosis Code Pointers: Principal <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>					
* Fee: \$ <input type="text" value="100.00"/>		Place of Service: <input type="text"/>					
* ADA Procedure Code: <input type="text" value="D0150"/>		Line Item Control Number: <input type="text"/>					
ADA Modifier Codes: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>		Oral Cavity Designation Codes: 1 <input type="text"/>					
Procedure Count: <input type="text"/>							
Tooth Number: <input type="text"/>							
Tooth Surface (1-5): 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/>							
**Other Payer: Primary ID <input type="text"/>		Paid Amount \$ <input type="text"/>		Units <input type="text"/>		Pro <input type="text"/>	
**Medicare: Paid Amount \$ <input type="text"/>		Units <input type="text"/>		Procedure Code/Qualifier <input type="text"/>			

Diagnosis Code Pointers

- Click the corresponding pointer to each diagnosis code.
- If more than one diagnosis code is entered be sure to click all the boxes that apply.

Dental Service Line

Dental Claim Submission

[Help](#)

* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments	Tooth Status	Claim Information	Service Lines
Diagnosis Codes(Relate Items Principal, 1, 2, or 3 by line to the Diagnosis Code Pointer)							
*** Standard: <input type="radio"/> ICD-9 <input checked="" type="radio"/> ICD-10		Principal Diagnosis Code: <input type="text"/>		Other Diagnosis Codes: 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/>			
Universal National Tooth Designation System							
Service Line							
* Service Date: <input type="text" value="10/02/2020"/>		*** Diagnosis Code Pointers: Principal <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>					
* Fee: \$ <input type="text" value="100.00"/>		Place of Service: <input type="text" value=""/>					
* ADA Procedure Code: <input type="text" value="D0150"/>		Line Item Control Number: <input type="text"/>					
ADA Modifier Codes: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>		Oral Cavity Designation Codes: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>					
Procedure Count: <input type="text"/>							
Tooth Number: <input type="text"/>							
Tooth Surface (1-5): 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <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"/> <input type="text"/>	
**Medicare: Paid Amount \$ <input type="text"/>		Units <input type="text"/>		Procedure Code/Qualifier <input type="text"/>		<input type="text"/>	

Click the down arrow and select POS

Dental Service Line

Submitter	Providers	Patient/Subscriber	Other Payer	Attachments
Diagnosis Codes(Relate Items Principal, 1, 2				
*** Standard: <input type="radio"/> ICD-9 <input checked="" type="radio"/> ICD-10		Principal Diagnosis Code: <input type="text"/>		
Universal National Tooth Designation System				
Service				
* Service Date:	<input type="text" value="10/02/2020"/>	*** Diagnos		
* Fee:	\$ <input type="text" value="50.00"/>			
* ADA Procedure Code:	<input type="text" value="D1120"/>	Line Item		
ADA Modifier Codes:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	Oral Cavity De		
Procedure Count:	<input type="text"/>			
Tooth Number:	<input type="text"/>			
Tooth Surface (1-5):	1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <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"/> <input type="text"/>			
**Medicare:	Paid Amount \$ <input type="text"/> Units <input type="text"/> Procedure Code/Qualifier <input type="text"/> <input type="text"/>			
Other Adjustment(s):	Medicare Deductible \$ <input type="text"/> Medicare Coinsurance \$ <input type="text"/>			
Date Claim Paid:	Other Payer <input type="text"/> Medicare <input type="text"/> Other Adjustments <input type="text"/>			
**Rendering Provider:	Taxonomy Code <input type="text"/> Last/Organization Name <input type="text"/> <input type="text"/>			
First Name	<input type="text"/> NPI <input type="text"/> Commercial # <input type="text"/>			
<input type="button" value="Add"/>				

When done, click the ADD button.

1. This will clear the screen and allow you to enter a new service line if needed.
2. This newly added service line will appear at the *bottom* of the screen.
3. The service line tab will allow you to add more service lines (each new one appearing at the bottom of the screen) until you proceed with the submission of the claim.

Summary Line

*** Required ONLY if diagnosis codes are entered.

Line No.	Service Date	ADA Proc Code	Mod 1	Mod 2	Mod 3	Mod 4	Tooth #	Surface 1	Surface 2	Surface 3	Surface 4	Surface 5	Other Fee ID	Payer Paid Amount	Procedure Code	Units	Medicare Paid Amount	Procedure Code	Units	Medicare Deductible Amount	Medicare Coinsurance Amount	Pn 1
1	10/02/20	D0150												100.00		0			0			
Totals:													\$100.00	\$0.00		\$0.00		\$0.00	\$0.00			

The service line entered will then appear at the bottom of the page.

As each new line is added, a blank Service Line section will appear.

- New Service Lines may be entered here.
- Click “Add” to add new service lines.

Other Payer Attachments Tooth Status Claim Information Service Lines

Sickness or Injury (Relate Items 1 - 12 by line to the Diagnosis Code Pointer)

* **Diagnosis Codes:** 1 2 3 4 5 6
7 8 9 10 11 12

Service Line

*** **Diagnosis Code Pointers:** Principal 1 2 3

Place of Service:

Line Item Control Number:

Oral Cavity Designation Codes: 1 2 3 4 5

ADA Modifier Codes: 1 2 3 4

Procedure Count:

Tooth Number:

Tooth Surface (1-5): 1 2

****Other Payer:** Primary ID

****Medicare:** Paid Amount \$

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

Code/Qualifier

(ys)

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	Proc Code										
1				D0150						0	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	UN	65.02		0											
																								Totals:	\$65.02	\$0.00												

Entered lines will appear at the bottom of the Service Lines tab, as shown here.

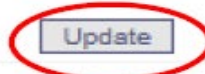
Service Lines Add and Updates

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



Line No.	Service Date	ADA Proc Code	Mod 1	Mod 2	Mod 3	Mod 4	Tooth #	Surface 1	Surface 2	Surface 3	Surface 4	Surface 5	Other Fee Payer ID	Payer Paid Amount	Procedure Code	Units	Medicare Paid Amount	Procedure Code	Units	Medicare Deductible Amount	Medicare Coinsurance Amount
1	01/01/18	D0150												65.00		0			0		
Totals: \$65.00														\$0.00	\$0.00	\$0.00	\$0.00	\$0.00			

Line No.	Service Date	ADA Proc Code	Mod 1	Mod 2	Mod 3	Mod 4	Tooth #	Surface 1	Surface 2	Surface 3	Surface 4	Surface 5	Other Fee Payer ID	Payer Paid Amount	Procedure Code	Units	Medicare Paid Amount	Procedure Code	Units	Medicare Deductible Amount	Medicare Coinsurance Amount
1	01/01/18	D0150	-	-	-	-	-	-	-	-	-	-		65.00	--	-	0	--	-	0	-
Totals: \$65.00														\$0.00	\$0.00	\$0.00	\$0.00	\$0.00			



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

Updated Summary Lines

*** Required ONLY if diagnosis codes are entered.

Line No.	Service Date	ADA Proc Code	Mod 1	Mod 2	Mod 3	Mod 4	Tooth #	Surface 1	Surface 2	Surface 3	Surface 4	Surface 5	Other Fee ID	Payer Paid Amount	Procedure Code	Units	Medicare Paid Amount	Procedure Code	Units	Medicare Deductible Amount	Medicare Coinsurance Amount	Print	
1	10/02/20	D0150											100.00			0			0			<input type="checkbox"/>	
2	10/02/20	D1120											50.00			0			0			<input type="checkbox"/>	
Totals:													\$150.00	\$0.00		\$0.00		\$0.00	\$0.00		\$0.00	\$0.00	

After all services lines are entered, review the claim information, if okay, Click the "Submit" Button.

Finalizing the Claim

Line No.	Service Date	ADA Proc Code	Mod 1	Mod 2	Mod 3	Mod 4	Tooth #	Surface 1	Surface 2	Surface 3	Surface 4	Surface 5	Other Fee Payer ID	Payer Paid Amount	Procedure Code	Units	Medicare Paid Amount	Procedure Code	Units	Medicare Deductible Amount	Medicare Coinsurance Amount	Pn 1
1	10/02/20	D0150												100.00		0			0			
2	10/02/20	D1120												50.00		0			0			
Totals:													\$150.00	\$0.00			\$0.00			\$0.00	\$0.00	

Save Submit Cancel

Additional Help - Online Error Messages

Message from webpage



ATTENTION! Please correct the following item(s):

--- BILLING PROVIDER ---

- Missing Tax ID.
- Missing Tax ID Type (SSN or EIN).
- Missing Provider Commercial Number or NPI.
- Missing Entity Type (Person or Non-Person).
- Missing Provider Name.
- Missing Pay-To Locator Code/Address.

--- RENDERING PROVIDER ---

- Missing Provider Commercial Number or NPI.
- Missing Entity Type (Person or Non-Person).
- Missing Provider Name.

--- PATIENT/SUBSCRIBER ---

- Missing Member ID Number.
- Missing Member Date of Birth.
- Missing Payer Responsibility.

--- CLAIM INFORMATION ---

- Missing Patient Control Number.
- Missing Provider Signature on File.
- Missing Provider Accept Assignment.
- Missing Benefit Assignment.
- Missing Release of Information Consent.

If a required field is missing information, the Online system will identify the fields that have an error. Make the necessary correction(s) and proceed with the claim submission.

OK

Claim Entry Confirmation Screen

Claim Entry Confirmation

Transmission Status: Successful
Claim Type: Dental
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.

Service Line Screen Overview

Enter the diagnosis without the decimal here

Dental Claim Submission

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

Help
* Indicates a required field.

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

Diagnosis Codes(Relate Items Principal, 1, 2, or 3 by line to the Diagnosis Code Pointer)

*** Standard: ICD-9 ICD-10

Principal Diagnosis Code: Other Diagnosis Codes: 1 2 3

Universal National Tooth Designation System

Service Line

* Service Date:

* Fee: \$

* ADA Procedure Code:

ADA Modifier Codes: 1 2 3 4

Procedure Count:

Tooth Number:

Tooth Surface (1-5): 1 2 3 4 5

**Other Payer: Primary ID Paid Amount \$ Units Procedure Code/Qualifier

**Medicare: Paid Amount \$ Units Procedure Code/Qualifier

Other Adjustment(s): Medicare Deductible \$ Medicare Coinsurance \$

Date Claim Paid: Other Payer Medicare Other Adjustments

**Rendering Provider: Taxonomy Code Last/Organization Name

First Name NPI Commercial #

Add

** All or none of the information is required for the line or group.
*** Required ONLY if diagnosis codes are entered.

Enter the following:

- Service Date
- Fee
- ADA Procedure Code

TPL payer information is entered here.

Click on the dropdown and select the place of service

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

Save

Submit

Cancel



DFSM Provider Education and Training Unit

DFSM Provider Education and Training

The AHCCCS Provider Training Unit can assist providers with the following:

- AHCCCS Online Provider Portal Training:
 - How to submit and status claims and prior authorization using the AHCCCS Online Provider Portal;
- How to use the Transaction Insight Portal (for the submission of accompanying documentation);
- Provide clarification on AHCCCS policies and system updates;
- Changes to the program; and
- Other details.

For training requests please contact the DFSM Provider Training Team at

ProviderTrainingFFS@azahcccs.gov

DFSM Provider Education and Training

Note: The provider training and medical coding teams cannot instruct providers on how to code or bill for a particular service. For example, questions regarding the use of modifiers, billing combination of codes, place of service etc., should be directed to your organization's coder/biller for guidance.

Note: Questions regarding the processing of claims by the AHCCCS Complete Care (ACC) Health Plans should be directed to the appropriate ACC Health Plan.

Who to contact?

- Questions on AHCCCS Fee-for-Service rates email FFSRates@azahcccs.gov
- Questions on AHCCCS Coding email: CodingPolicyQuestions@azahcccs.gov

Need Help!

If you need assistance with the following:

Questions about warrants, paper EOBs, or EFTs please contact the Division of Business & Finance (DBF) at ahcccswarrantinquiries@azahcccs.gov or call **(602) 417-5500**. Hours: **10:00 AM – 4:00 PM Arizona Time**.

To check the status of your EFT, please email the Division of Business & Finance (DBF) at ahcccsfinanceeft@azahcccs.gov

Questions related to electronic transactions or to request an ERA transaction setup email servicedesk@azahcccs.gov or contact **(602) 417-4451**. Hours: **7:00 AM – 5:00 PM Arizona Time**.

Providers should use the AHCCCS Online website as the first step in checking the status of the prior authorizations and claims. Our Provider Services representatives are skilled to provide help to many *basic* prior authorization and claims questions. To reach **Provider Services call (602) 417-7670**.

Provider Services Call Center Operation Hours: **Monday-Friday from 7:30 A.M. - 5:00 P.M.**

Providers should not call the Provider Services 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. Providers should refer to the AHCCCS Website Plans/Providers for more information.

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.