

December 2018

## Covered Behavioral Health Services Guide Retirement – Important Update

In early 2019, information contained within the AHCCCS Covered Behavioral Health Services Guide (CBHSG) will be transitioned into the following areas:

- AMPM 310-B, Behavioral Health Services Benefit
- AMPM 320-T, Non-Title XIX/XXI Behavioral Health Services Benefit
  - Non-Title XIX/XXI service information will be transferred to AMPM 320-T.
- The Provider Billing Manuals
  - Billing information for Fee-For-Service providers will be transferred to the Provider Billing Manuals.
    - Chapter 19, Behavioral Health Services, of the Fee-For-Service Provider Billing Manual
    - Chapter 12, Behavioral Health Services, of the IHS/Tribal Provider Billing Manual
- Appropriate Policies as necessary.
  - i.e. Service benefit information, including transportation and transportation billing information pertinent to MCOs and FFS providers, will be transferred to AMPM 310-BB.

Once the CBHSG is retired additional information will be sent out to providers.

**Questions?** Email us at [ProviderTrainingFFS@azahcccs.gov](mailto:ProviderTrainingFFS@azahcccs.gov)

## Behavioral Health Residential Facility (BHRF) Notice

Effective **tentatively** 1/1/2019, authorization will be required for all admissions and continued stays at Behavioral Health Residential Facilities (BHRF) (Provider Type B8) for AIHP and TRBHA members. All new admissions for dates of service 1/1/2019 and later will require prior authorization.

For members currently receiving services, who were admitted prior to 1/1/19, the provider will need to get the continued stay authorized by 1/31/2019. Criteria for admission, continued stay and discharge can be found in the new policy AMPM 320-V, Behavioral Health Residential Facilities, currently posted for public comment on the AHCCCS website until 12/6/18. For specific authorization procedures and documentation requirements, please see the FFS web page. Please review training opportunities that will be available on the FFS web site. Please check for further updates.

### Q: ARE CONTRACTS NEEDED FOR FFS MEMBERS?

A: Fee-For-Service providers do not need to contract with AHCCCS AIHP, Tribal ALTCS, or a TRBHA to continue providing Medicaid Title XIX/XXI services to FFS members.

**A provider simply must be an AHCCCS registered provider.**

Providers must follow the AHCCCS Medical Policy Manual (AMPM) and Fee-for-Service Provider Billing Manual.

For information on providing services to an ACC Plan enrolled member (not a FFS member), please contact [the ACC plan](#).

### DIRECT CARE WORKER AGENCY MONITORING

Training for DCW Agencies serving Tribal ALTCS members, who live in their own home, will begin in January 2019. **Training will be by WebEx only.**

**Date:** Wednesday, Jan. 16, 2019

**Time:** 10:00 am – 11:00 am MST (GMT-07:00)

[Register for January 16th](#)

**Date:** Wednesday, Jan. 23, 2019

**Time:** 10:00 am – 11:00 am MST (Arizona, GMT-07:00)

[Register for January 23rd](#)

### CONTACT US:

If you have additional questions please outreach the DFSM Provider Training email inbox at:

[ProviderTrainingFFS@azahcccs.gov](mailto:ProviderTrainingFFS@azahcccs.gov)

## What is the Difference between AIHP and IHS?

AHCCCS often receives the question of ‘what is the difference between the American Indian Health Program (AIHP) and the Indian Health Services (IHS)?’ Many providers are under the impression that they are one and the same, and this is not the case.

The American Indian Health Program (AIHP) is a statewide health plan option for American Indians and Alaskan Natives in Arizona enrolled in AHCCCS. AIHP provides medically necessary services for enrolled members, including coverage for preventive, physical and behavioral health care services. AIHP is run by the Division of Fee-For-Service Management (DFSM) within AHCCCS. This means that when a provider submits a request for payment (claim) for services provided to an AHCCCS AIHP member, they would submit that claim to AHCCCS DFSM.

AIHP members may receive health care services from any AHCCCS registered provider that chooses to serve Fee-For-Service members. When a member enrolled in AIHP presents for a service they will show their AHCCCS AIHP membership card to their provider. The AHCCCS Medical Identification Cards will show the Health Plan Name as **AHCCCS American Indian HP**, as shown below.



**AHCCS ID #:**

**Member Name:**

**Health Plan Name:** AHCCCS American Indian HP

**Telephone #:**

Whereas the American Indian Health Program (AIHP) is an actual Medicaid health plan managed by DFSM within AHCCCS, the Indian Health Services (IHS) is not.

Indian Health Services (IHS) is an agency within the Department of Health and Human Services, which is responsible for providing federal health services to American Indians and Alaskan Natives (AI/AN). It provides services to 2.2 million AI/ANs who belong to 573 federally recognized tribes in 37 states. Per the [Indian Health Service's web page](#), the goal of IHS is “to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.” The IHS system consists of IHS direct health care services, administered through 12 area offices and 170 IHS and tribally managed service units (638 facilities), tribally operated health care services and Urban Indian health programs.

IHS delivers health care and disease prevention services through a network of health stations, hospitals, and clinics. These facilities are managed directly by IHS, by tribes, or by tribal organizations under contract or compact with the IHS and urban Indian health programs.

IHS seeks to honor treaties between the tribes and federal government so as to provide healthcare to AI/AN people, and it draws funding from Congress. AHCCCS, in turn, acts a pass-through of funds and reimburses IHS for Medicaid services billed by IHS facilities. A list of IHS facilities can be found on the [locations page of the IHS website](#).

Thus, IHS differs from the AIHP in that AIHP is a Medicaid FFS health plan, while IHS is a federal program which funds provider networks. IHS does not directly reimburse claims for services rendered to members.

## REMINDER for NEMT Providers

As part of the registration process the owner/provider is required to disclose each employees name, employment begin date, employment end date (if applicable), and date of birth information using the [2nd page of the Provider Type Profile form](#).

Any changes to the above must be reported within 30 days. By signing the Provider Type Profile form, the owner/provider is indicating that this information will be kept on file and made available upon request.

## Direct Care Worker Agency Monitoring

In 2019, DFSM plans to conduct annual monitoring of Direct Care Service Agencies serving Tribal ALTCS members who live in their own homes. The monitoring will ensure the provision of:

- Service delivery in accordance with authorizations and the member's needs,
- Quality of care for members, and
- Training and supervision of Direct Care Workers.

Monitoring will occur at least annually via a desk level audit, and it will incorporate elements from [AMPM Chapters 900 and 1200](#).

Training on this topic for DCW agencies, supervisors and workers will be held on the following days:

**Date:** Wednesday, January 16, 2019

**Time:** 10:00 am – 11:00 am Mountain Standard Time (GMT-07:00)

**Registration Link:** Register for January 16th

**Date:** Wednesday, January 23, 2019

**Time:** 10:00 am – 11:00 am Mountain Standard Time (Arizona, GMT-07:00)

**Registration Link:** Register for January 23rd

**Training will be by WebEx only.**

If there are questions about the upcoming audit on direct care worker agencies on tribal lands, please email the following: [DCWAgencies@azahcccs.gov](mailto:DCWAgencies@azahcccs.gov).

## NEMT Reminders & Unloaded Mileage

NEMT providers are reminded that non-emergency medical transportation is a covered service only when a member is transported inside the vehicle.

Unloaded mileage, which is when transportation is performed for a member, without the member physically present within the vehicle, is not a covered service. This includes unloaded mileages associated with prescription pick-up.

A NEMT provider may not submit any claim for unloaded mileage, and a NEMT provider may not bill for picking up a member's prescription on the member's behalf. A trip to a pharmacy is a covered NEMT service if and only if the member is in the vehicle.

Per [AMPM 310-BB](#), Transportation, medically necessary non-emergency transportation furnished by a non-ambulance provider is covered when:

- a. The member shall not require medical care in route;
- b. Passenger occupancy shall not exceed the manufacturer's specified seating occupancy;
- c. Members, companions, and other passengers shall follow state laws regarding passenger restraints for adults and children;
- d. Vehicle shall be driven by a licensed driver, following applicable State laws;
- e. Vehicles shall be insured. Refer to the AHCCCS Minimum Subcontract Provisions Insurance Requirements on the AHCCCS website;
- f. Vehicles shall be in good working order;
- g. Members shall be transported inside the vehicle; and
- h. School Based providers shall follow the school based policies in effect (See AMPM Chapter 700).

## Privacy Rules and Continuity of Care

On a daily basis providers are faced with a multitude of challenges given the ever-changing landscape of the present-day healthcare system. However, one challenge they should not face entails the inability to receive vital patient information for a patient they are treating.

Continuity of care provides for this; it is concerned with the quality of a member's care over time, and by definition requires care coordination between the various practitioners participating in a member's physical and behavioral health care. In today's healthcare climate, where individuals increasingly rely upon a plethora of primary care practitioners, specialists and hospital systems, the need for continuity of care between each provider becomes all the more important. When continuity of care is done correctly, it ensures that communication occurs between all practitioners involved in a member's plan of care, so that a member's health care needs may be seamlessly met. It allows for high quality, cost-effective care, while reducing patient frustration and the potentiality of important conditions being missed.

An often-cited obstacle to ensuring this seamless continuation of care between providers is compliance with the Health Insurance Portability and Accountability Act (HIPAA). However, the HIPAA rules should not constitute an obstacle for continuity of care. Per 45 CFR 164.506, communications between covered entities, such as a health plan, a health care clearinghouse, or health care provider, may be done without the written authorization from the patient for purposes of treatment, payment, and health care operations. Continuity of care falls under the treatment provision of federal law, and is permissible without authorization from the patient so long as both providers have either a direct or indirect treatment relationship to the patient.

Providers may share information pertaining to the patient's treatment without authorization, so long as the information does not fall under one of the restricted categories, per 45 CFR 164.508 and 42 CFR Part 2:

- Psychotherapy notes, and
- Substance Use Disorder patient records,

AHCCCS supports providers in continuity of care efforts, by outlining continuity of care as a requirement in policies and contract.

AMPM 510, Primary Care Providers (PCP), lists continuity of care as a primary role and responsibility of a PCP, in addition to outlining a PCP's care coordination responsibilities. A PCP has the obligation, per AHCCCS policy, to coordinate in regards, but not limited to:

1. Referring members to providers or hospitals within the Contractor network, as appropriate, and if necessary, referring members to out-of-network specialty providers,
2. Coordinating with the Contractor in prior authorization procedures for members,
3. Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers and/or hospitals, and
4. Coordinating the medical care of the AHCCCS members assigned to them, including at a minimum:
  - a. Oversight of drug regimens to prevent negative interactive effects,
  - b. Follow-up for all emergency services,
  - c. Coordination of inpatient care,
  - d. Coordination of services provided on a referral basis, and
  - e. Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs.

In addition, AMPM 510 outlines a PCP's care coordination responsibility when they have initiated medication management services to treat a behavioral health disorder, and subsequently determined that the member should be referred to a behavioral health provider for evaluation and/or continued medication management services. Care coordination and the subsequent continuity of care can occur, while remaining in compliance with the Health Insurance Portability and Accountability Act (HIPAA) requirements (45 CFR Part 164), Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2), and the requirement to safeguard information on applicants and beneficiaries at 42 CFR 431.300 et seq.



# Claims – How to Register as a Provider and Receive Payment for Services Rendered

As an AHCCCS registered provider, providing services and submitting claims for American Indian Health Program members can be a straightforward and simple process. Allow us to show you how.

1. Provider Registration
2. Enrolling in AHCCCS Online
3. Electronic Remittance Advice Setup
4. Claim Submission
5. Documentation Submission & Enrolling for the Transaction Insight Portal
6. Payment

## 1. Provider Registration

To receive reimbursement for services rendered to AHCCCS members, all providers must be registered with AHCCCS. This requirement applies to all providers and provider types, including out-of-state providers.

Any provider or organization may participate as an AHCCCS provider if the provider or organization is qualified to render a covered service and complies with AHCCCS policies and procedures for provider participation.

**AHCCCS registered providers (also called Fee-For-Service providers) are able to provide services to American Indian Health Program (AIHP) members. FFS providers do not need a separate contract with AHCCCS AIHP, Tribal ALTCS, or a TRBHA to provide Medicaid Title XIX and XXI services to FFS members as the contractual relationship is established via the Provider Participation Agreement.**

To register with AHCCCS, a provider must:

- Meet AHCCCS requirements for professional licensure, certification or registration;
- Sign the Provider Participation Agreement (PPA);
- Complete an application;

- Complete and sign all applicable forms;
- Submit documentation of National Provider Identification (NPI) Number (if applicable); and
- Submit a Disclosure of Ownership if registering as an organization or facility.

Note: Please note that institutions (organizations/facilities) are required to pay an [enrollment fee](#), effective January 1, 2012. Specific provider types will require an OIG site visit prior to enrollment, and are subject to unannounced post enrollment site visits ([Required Fee and-or Site Visit by Provider Type](#)).

Information and registration materials may be obtained by calling the AHCCCS Provider Registration Unit at:

Phoenix area: (602) 417-7670 (Option 5)

In-state: 1-800-794-6862 (Option 5)

Out of state: 1-800-523-0231 Ext. 77670

[AHCCCS Provider Registration materials](#) are also available on the AHCCCS website.

## 2. Enrolling in AHCCCS Online

FFS Providers can take advantage of the [AHCCCS Online Provider Portal](#), which offers a quick and easy way to submit claims and prior authorization requests online. In addition, a provider can check a member's eligibility and for the status of their claims and prior authorization requests all in this one easy location.

AHCCCS *highly* encourages providers to sign up for the AHCCCS Online Provider Portal, due to its ease of use. Registering is free and there are no transaction charges.

To register click on the 'Register for an AHCCCS Online account' option in the left hand column. You will need either your NPI (or AHCCCS ID number if you do not have an NPI) and your Tax ID number.

The Division of Fee-For-Service Management (DFSM) has a [training page](#) with a number of trainings on AHCCCS Online.

## Claims – How to Continued

- [Verifying Member Eligibility Online](#)
- [Online Prior Authorization Submission](#)
- [Online Behavioral Health Prior Authorization Submission](#)
- [Online Claim Submission: Dental Claim ADA Type \(ADA-2012 equivalent\)](#)
- [Online Claim Submission: Institutional Claim Type \(UB-04 equivalent\)](#)
- [Online Claim Submission: Professional Claim Type \(CMS-1500 equivalent\)](#)

Please see Chapter 3, Provider Records and Registration, of the [IHS/Tribal Provider Billing Manual](#).

### 3. Electronic Remittance Advice (ERA/835) Setup

1. Did you know that you can receive the Remittance Advice electronically? To sign up submit an inquiry to AHCCCS by emailing [EDICustomerSupport@azahcccs.gov](mailto:EDICustomerSupport@azahcccs.gov) or calling (602) 417-4451, between 7:00 AM and 5:00 PM (Arizona Time), Monday through Friday.

### 4. Claim Submission

Claims can be submitted to AHCCCS in a variety of ways:

- HIPAA-Compliant 837 Electronic Transaction Process (**recommended**)
- AHCCCS Online Provider Portal
- By Mail

#### HIPAA-Compliant 837 Electronic Transaction Process

- If a provider is interested in being set up to submit claims via the HIPAA-compliant 837 Electronic Transaction Process, please email [EDICustomerSupport@azahcccs.gov](mailto:EDICustomerSupport@azahcccs.gov) and request to become an AHCCCS Trading Partner. They will then be provided with additional information.

#### AHCCCS Online Provider Portal

- Trainings with screen shots can be found for each claim type:
  - [Online Claim Submission: Dental Claim ADA Type \(ADA-2012 equivalent\)](#)
  - [Online Claim Submission: Institutional Claim Type \(UB-04 equivalent\)](#)
  - [Online Claim Submission: Professional Claim Type \(CMS-1500 equivalent\)](#)

#### Mail - Paper Claims

- All paper claims should be mailed, with adequate postage, to:
  - AHCCCS Claims
  - P.O. Box 1700
  - Phoenix, AZ 85002-1700

After a claim is submitted it is sent through the FFS claims processing cycle, where the FFS business rules are applied. Our processing cycle reviews each field to ensure that data is not missing, incorrect, or invalid.

1. If data is missing, incorrect, or invalid (i.e. a letter is listed instead of a number) in a **required field** the claim may not make it all the way through the processing cycle. In these cases the claim will **stop** and be sent back to the provider for correction.
2. It is up to the provider to fill in the missing, incorrect or invalid data and to resubmit before further processing/review can occur.
3. If there is no missing, incorrect, or invalid data in fields, the claim will make it through the processing cycle. At this point the claim will be, based on the information entered on the claim:
  - Approved,
  - Denied, or
  - Held for additional review by adjudication or medical review.
4. When a claim is held for review by adjudication or medical review, AHCCCS will either choose

## Claims – How to Continued

to approve or deny the claim based on the information submitted, or may determine that additional information is needed and request documentation. The ultimate outcome of adjudication and medical review is approval or denial of the claim.

5. When a claim is denied a correspondence is generated for the provider, which explains why the claim was denied. This is called the Remittance Advice or Electronic Remittance Advice (ERA). This will be sent to the provider, and it is up to the provider to make corrections to the claim and to resubmit it to AHCCCS for reprocessing (this is called 'replacing a claim' because it is replacing a previously submitted claim).
6. Approved claims go to finance, where funds are either transferred via direct deposit to the provider or a check is printed.

For additional information please visit the following chapters in our Provider Billing Manuals:

- [Chapter 4, General Billing Rules](#)
- [Chapter 5, Claim Form Requirements](#)
- [Chapter 16, Claims Processing](#)
- [Claims Errors](#)
- [Chapter 18, Understanding the Remittance Advice](#)

### 5. Documentation Submission & Enrolling for the Transaction Insight Portal

Did you know that you not only can submit your claims online, but you can submit your documentation online? Trip reports, discharge summaries, and other medical documentations can all be submitted online to AHCCCS using the [Transaction Insight Portal](#).

To learn more about the Transaction Insight Portal

and how to submit documentation through it please visit our step-by-step training (with screenshots) at: [Transaction Insight \(TI\) Portal Web Upload Attachment Guide](#)

### 6. Payment

Payment for paid claims can be received in two ways:

- Direct Deposit
- Vendor Check (also called Vendor Warrant)

#### Direct Deposit

- Providers can sign up for direct deposit of checks using the Automated Clearing House (ACH). This eliminates the need to wait for checks to arrive in the mail. To register for direct deposit, providers simply need to sign up for [Electronic Funds Transfer \(EFT\) payments](#).

Benefits of Receiving Payments Electronically:

- Immediate availability of funds;
- Fully traceable payments;
- Elimination of mail and deposit delays;
- Elimination of lost, stolen, or misplaced checks; and
- Elimination of stale checks to be recovered from Unclaimed Property.

If you have questions on how to enroll for EFT payments, and you are in the Metro Phoenix area codes of 602, 480, or 623, you can call us at 602-417-5500. Otherwise, the toll free number is 877-500-7010.

#### Vendor Checks/Vendor Warrants

- Effective 11/5/18, Vendor Checks are mailed on Fridays.

## Field 43 and Reporting the Medicaid Drug Rebate Data (NDC Number)

Providers are reminded that, when reporting the NDC number on the UB-04 form, to use the following format:

### 1. NDC Qualifier

To indicate that it is an NDC Number being reported, enter the NDC Qualifier of N4 in the first 2 positions on the left side of the field.

Example:

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278ML10.000	J1642	2.00
2				
3				

### 2. NDC Number

The next 11 positions immediately following “N4” are the NDC Number of the drug in 5-4-2 format **with no hyphens**.

**NOTE:** The NDC Number is an 11-digit numeric code, without hyphens or spaces.

Example 1 (incorrect example):

A provider enters in this:

**N412345-6789-01 GR 30 000**

To correct the above example, the provider would enter:

**N412345678901GR30.000** or **N412345678901GR30**

Example 2

(correct example):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278ML10.000	J1642	2.00
2				
3				

### 3. Unit Qualifier

The next two positions immediately following the NDC Number are the Unit Qualifier.

The NDC Unit of Measurement Qualifier\*

- i. UN = Unit
- ii. ML = Milliliters
- iii. GR = Gram
- iv. F2 = International Unit



## Field 43 and Reporting the Medicaid Drug Rebate Data (NDC Number) Continued

Example (correct example):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278ML10.000	J1642	2.00
2				
3				

### 4. Unit Quantity

The Unit Quantity will immediately follow the last digit of the Unit Qualifier.

The NDC Unit Quantity is the amount of medication administered. **If** it includes a decimal point, a decimal point **must** be used and a blank space cannot be left in place of the decimal point. There is a **limit** of 3 characters to the right of the decimal point. (i.e. 1234.456). Any unused spaces are left blank.

**IMPORTANT NOTE:** If the NDC Unit Quantity has a space in it, it can result in errors.

Example 1 (incorrect example):

A provider is attempting to bill for 20 milliliters, and enters the following on their claim.

**N412345678901ML20 500**

This would be read as **20500.000** and not as **20.500**

To correct the above example, the provider would enter: **N412345678901ML20.500**

Example 2 (incorrect example):

A provider is attempting to bill for 1 unit, and enters the following on their claim.

**N412345678901ML1 000**

This would be read as **1000.000** and not as **1.000**

To correct the above example, the provider would enter: **N412345678901ML1.000** or **N412345678901ML1**

Example 3 (incorrect example):

A provider is attempting to bill for 50 milliliters, and enters the following on their claim:

**N412345678901ML50 000**

This would be read as **50000.000** and not as **50.000**

To correct the above example, the provider would enter: **N412345678901ML50.000** or **N412345678901ML50**

## Field 43 and Reporting the Medicaid Drug Rebate Data (NDC Number) Continued

Example 4 (correct example):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278ML10.000	J1642	2.00
2				
3				

Example 5 (correct example):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278ML10	J1642	2.00
2				
3				

## CMS 1500 Claim Form Updates

The following updates have been made to Chapter 5, Billing on the CMS 1500 Claim Form, of the Fee-For-Service Provider Billing Manual, and to Chapter 5, Claim Form Requirements, of the IHS/Tribal Provider Billing Manual.

- Previously the shaded section of Field 24J was used to report Medicare and/or other insurance information. This does not need to be reported on the CMS 1500. Instead, always attach a copy of the Medicare or other insurer’s EOB to the claim. Please report the Rendering Provider’s Taxonomy Code, if applicable, in this field.
- When reporting the Rendering Provider’s Taxonomy Code in Field 24J, please make sure to put the indicator “ZZ” in Field 24I, as shown below.
- Field 33b has been updated to be the Billing Provider’s Taxonomy Code.

**24I. ID Qualifier**

**Required**

Enter in the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24J in the shaded area. ZZ should be entered to indicate a Taxonomy Code.

E DIAGNOSIS POINTER	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID#
				<b>ZZ</b>	Taxonomy Code
					<b>NPI</b> Rendering Provider NPI ID#

**24J. Rendering Provider ID # (SHADED AREA) – Use for Taxonomy Code Reporting** **Required if applicable**

Use this SHADED field to report the provider’s 10 digit alpha-numeric Taxonomy Number.

NOTE: Previously this section was used to report Medicare and/or other insurance information. This does not need to be reported on the CMS 1500. Instead, always attach a copy of the Medicare or other insurer’s EOB to the claim.

See Chapter 9, Medicare/Other Insurance Liability, of the Fee-For-Service Provider Billing Manual for details on billing claims with Medicare and other insurance.

E DIAGNOSIS POINTER	F \$ CHARGES		G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID#
					ZZ	Taxonomy Code
						NPI Rendering Provider NPI ID#

**24J. Rendering Provider ID # (NON SHADED AREA) – RENDERING PROVIDER ID #** **Required**

The Rendering Provider’s 10 digit NPI is required for all providers that are mandated to maintain an NPI #.

For atypical provider types, the AHCCCS ID must be used unless the provider has chosen to obtain an NPI and has provided this NPI to AHCCCS.

E DIAGNOSIS POINTER	F \$ CHARGES		G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID#
					ZZ	Taxonomy Code
					NPI	0000000000

**33a Billing Provider NPI #** **Required if applicable**

**33b. Other ID – AHCCCS ID # (Shaded Area)** **Required if applicable**

33. PHYSICIAN’S, SUPPLIER’S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Doc Holliday  
123 OK Corral Drive  
Tombstone, AZ 85XXX

a. NPI	b. Taxonomy Code
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For provider training questions please outreach the Provider Training Division of DFSSM at [ProviderTrainingFFS@azahcccs.gov](mailto:ProviderTrainingFFS@azahcccs.gov).