













#### **Paper Claim Submission Requirements**

CMS 1500, UB-04, and the ADA 2012 Claim Form Tips July 2023



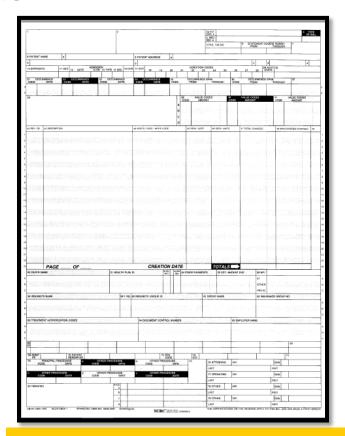
#### Claim Forms

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

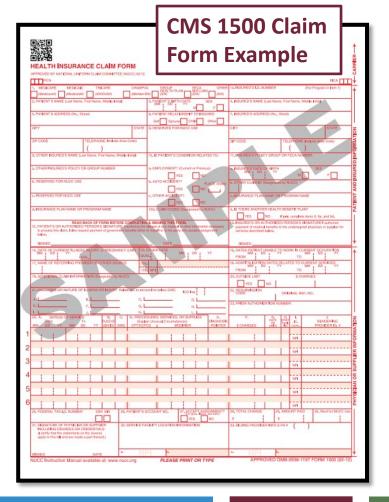
- The UB-04 Claim Form for Institutional Claims
- The CMS 1500 Claim Form for Professional
- The ADA 2012 Claim Form for Dental Claims

**UB-04 Claim Form Example** 









## ADA 2012 Claim Form Example

ADA American Dental Association* Dental Claim For	
HEADER INFORMATION	Form Example
Type of Transaction (Mark all applicable boxes)	I OIIII EXAMPLE
Statement of Actual Services Request for Predetermination Preauthorization	· ·
EPSOT/ Title XIX	
Predetermination/Preauthorization Number	POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #2)
	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
DENTAL BENEFIT PLAN INFORMATION	
2. Company Plan Name, Address, City, State, Zip Code	
	13. Date of Rith (MM/DD/CCVV) 14. Geoder 15 Policyholder Dubscriber ID (Assigned by Plan)
	DI FOU
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)	15. Flan/Strup Number 17. Employer Name
Denta?	T. Happy I. A.
S. Name of Policyholder/Subscriber in #4 (Last, First, Niddle Initial, Suffix)	PATIENT INFORMATION
	15. Relationship to Policyholder/Subscriber in #12 Above 19. Reserved For Future
Date of BHH (MMOD/CCYY)     7. Gender     6. Policyholder/Dubscriber ID (Assigned by Plan	C C C Uas
□v□=□v	20. Name (Last, First, Middle Initial, Ouffis), Address, City, Otats, Zip Code
9. Plan/Group Number 10. Patients Relationship to Person named in #5	
Self Spouse Dependent Cther	
11. Other insurance Company/Dental Benefit Flan Name, Address, City, Otats, Zip Code	1
	21. Date of Birth (MMOD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist)
	□×□⊧□□□
RECORD OF SERVICES PROVIDED	
24. Procedure Date of Oral Tooth 27. Teath Number(s) 28 Tooth 29. Procedure Date	
(MMICDICCYY) Conty Option of Lebel(s) Surface Call	Pointer Oty. St. Description St. Pee
1	
2	
>	
4	
5	
c	
7	
10	
	Code List Quarter (100-10 = AB ) 518, Other
31. Missing Teeth Information (Place an 'X' on each missing born.) 34. Diagnosis 1 2 3 4 5 5 7 6 9 10 11 12 13 14 15 16 34e. Diagnosis	Fee(s)
32 31 30 25 26 27 26 25 24 23 22 21 20 13 16 17 (Primary day	
35. Remarks	D
as normana	
AUTHORIZATIONS	ANGILLARY GLAIM/TREATMENT INFORMATION
34. I have been informed of the treatment plan and associated fees. I agree to be responsible for all	35. Place of Treatment (e.g. 11+office, 12+OF Hospital) 39. Enclosures (Yor N)
charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentals or dental practice has a contractual agreement with my plan portioniting all or a sortion of such charges. To the extent permitted by law, I consent to your use and disclosure	(Use "Place of Service Codes for Professional Claims")
or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry outpayment activities in connection with this claim.	43. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY)
X	No (Ohip 41:42) Yea (Complete 41:42)
Palenti Ouerdan Dignature Date	42. Months of Treatment 42. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/GCYY)
27. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly	No Yes (Complete 44)
to the below named dentist or dental entity.	45. Treatment Resulting from
x	Occupational lineasinjury Auto accident Other accident
Gubscriber Olgnature Date	46. Date of Accident (MM/DDIGGTY) 47. Auto Accident State
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insuredisubscriber)	TREATING DENTIST AND TREATMENT LOCATION INFORMATION
	<ol> <li>I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.</li> </ol>
48. Name, Address, City, State, Zp Code	The state of the s
	X Sones (Treating Dentist) Date
	Signed (Treating Dentist) Date  54. NPI 55. License Number
	54. NPI 55. License Number 55. Address, City, State, Zip Gode Boeclaty Gode
43. NFI St. Literse Number 51, 33N of TIN	Specialty Code
St. Diese number St. confortin	
E2. Phose ( ) - E2a. Additional	67. Phone ( ) - ER Additional
	Number Provider ID
© 2019 American Dental Association #30 (Same as ADA Dental Claim Form – #31, #32, #33, #34, #30D)	To reorder call 800.947.4746 or go online at ADAcatalog.org



#### **General Information**

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

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

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



#### Basic Formatting for All Claim Form Types

To ensure the successful processing of a paper claim form:

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



#### Stamps

To ensure the successful processing of a paper claim form:

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



#### Multiple Pages

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

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



#### Multiple Pages

To ensure the successful processing of a paper claim form with <u>multiple</u> pages (continued):

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



## **Resubmitting Paper Claims**

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

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

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

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



## Resubmitting Paper Claims

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

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

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

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



## Resources for Paper Claim Submission

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

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

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

• <a href="https://www.azahcccs.gov/PlansProviders/Downloads/IHS-TribalManual/IHS-Chap05ClmFormRequire.pdf">https://www.azahcccs.gov/PlansProviders/Downloads/IHS-TribalManual/IHS-Chap05ClmFormRequire.pdf</a>

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

 https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/claimsclue s.html











# 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 <u>FFSRates@azahcccs.gov</u>
- Questions on AHCCCS Coding email: <u>CodingPolicyQuestions@azahcccs.gov</u>



### 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 <a href="mailto:ahcccs.gov">ahcccs.gov</a> 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 <a href="mailto:servicedesk@azahcccs.gov">servicedesk@azahcccs.gov</a> 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:

• <a href="https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStriba">https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStriba</a> <a href="libillingManual.html">lbillingManual.html</a>

#### **AHCCCS Medical Policy Manual**

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



## Thank You.

