



Claiming Procedures

April 2010

Mission

Provide, develop, and manage the best system of behavioral health care for multicultural consumers in a rural environment.



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Claiming Procedure Overview

The purpose of this manual is to explain the claiming process in detail. Other contract requirements (contract set up, client enrollment, service delivery standards, etc.) will not be included in this manual.

Many events must occur before a provider may successfully claim payment for services. The provider must be registered with AHCCCS and have a National Provider Identification number (NPI). A contract must be signed between NARBHA and the provider. The provider must also submit a W-9 form to the Accounting Unit.

If billing electronically, a provider must register and be approved by the MIS department prior to claiming. (See Provider Electronic Claiming)

In most cases, the services which the member receives must be approved in advance by the Responsible Agency or NARBHA Care Management. A Letter of Intent to Pay will be issued upon approval of these Services. (See Intent to Pay)

Once these events have occurred, claiming may begin.



Questions – Who Should I Call?

For questions regarding claims:

Claim Specialists or Claims Manager

claimsunit@narbha.org

1300 S. Yale St.

Flagstaff, AZ 86001

Ph. (928) 774-7128

For questions regarding contracts:

Senior Contract Specialist or Provider Contracts Manager

1300 S. Yale St.

Flagstaff, AZ 86001

Ph. (928) 774-7128

For questions regarding Provider electronic claiming:

Information Systems Development Manager

CIO@narbha.org

1300 S. Yale St.

Flagstaff, AZ 86001

Ph. (928) 774-7128

For questions regarding eligibility and enrollment:

Member Representatives

1300 S. Yale St.

Flagstaff, AZ 86001

Ph. (928) 774-7128

For questions regarding TPL / Co-Pay:

Financial Analyst or Financial Review Manager

1300 S. Yale St.

Flagstaff, AZ 86001

Ph. (928) 774-7128

For questions regarding Intent To Pay's:

MIS Specialist or Production Manager

1300 S. Yale St.

Flagstaff, AZ 86001

Ph. (928) 774-7128



Claiming Information

General Information

NARBHA will accept paper claims in the CMS-1500 (generally used for outpatient services) and UB-04 (generally used for inpatient services) format. Electronic submissions must be in the 837 P or 837 I format.

The filing time limits for claim submission are as follows:

Initial Submission	6 months from date of service
Resubmissions *	12 months from date of service

*If the initial submission is denied, submission of a “clean” claim must be made within 12 months of the date of service.

Providers are encouraged to submit “clean” claims after the service has been provided, upon receipt of Intent to Pay letter, and after collections of Third Party Liability (TPL) amounts are collected (If appropriate), this will ensure payments to providers in a timely manner.

CMS-1500 and 837 P are processed weekly with the cutoff being each Friday at 3:00 PM, unless announced otherwise. UB-04 and 837 I are processed twice a month with the cutoff at 3:00 PM on the 5th and the 20th of each month, unless announced otherwise.

Explanations of benefits (EOBs) are sent within five (5) days after each cutoff time for all claims which are entered prior to cutoff. For providers on a Type-of-Service 1 contract (i.e. receive payment through claims rather than “advances”) a check will be issued for “clean” claims and sent with the EOB.

Adjustments to previously paid claims must be filed if the information on the claim is determined to be inaccurate. Adjustments must be submitted on the NARBHA approved form. (See Adjustments) All adjustments over 50 claims require approval of the Claims Manager and/or the Chief Financial Officer.



Claims Help Desk

NARBHA's Claims unit provides a Help Desk to ensure resolution of Provider claim issues. The Claims Help Desk is available Monday through Friday from 8:30 AM to 4:00 PM. Providers may call or email claimsunit@narbha.org regarding issues such as:

- Completing a claiming form
- Checking status on a claim (30 days after submission of claim)
- Questions regarding payments or denials on their EOB
- Issues surrounding the Intent to Pay for service

The Help Desk responds to all inquiries within three (3) business days. Matters for which NARBHA can not make a determination within three (3) business days due to a legal or regulatory issue are referred for resolution by those legal/regulatory bodies within two (2) business days and the provider is notified of the referral.

Claim Forms

Use only alphabetical letters or whole numbers. Symbols such as \$, # and * should not be used.

All dates are to be entered in an 8-digit format WITHOUT SLASHES OR DASHES. Stay within the MMDDYYYY format. (i.e. July 1, 2010 should be entered as 07012010).

Numerals and letters must be used appropriately (the letter "O" and the numeral "0" are different) and are not interchangeable.

You must indicate the Provider Name, AHCCCS Provider ID number, National Provider Identification (NPI) number.

Member name and ID number must be exactly as it appears in the NARBHA database (generally the way it was submitted to NARBHA). NARBHA does not use the member's AHCCCS number.

You must submit a service code that is in accordance with the NARBHA contract and the ADHS Covered Behavioral Health Services Guide. If a service code requires a modifier, it must be written on the claim.

If an Intent to Pay number is required – it **must** be written on the claim or the claim will deny. Attaching the letter of Intent to Pay is not necessary. Claim information must match Letter of Intent to Pay information.



Claim Forms Cont.

Any TPL collections **must** be shown on the claim, only attaching the EOB is not correct.

You must submit all information on the claim in a way that is verifiable so that it can withstand audit.

Be sure to proof the claim before submitting it for payment. The claim must be “**clean**” – free from error and all applicable fields complete – or **it will deny**.

Attachments, such as medical records, Intent to Pay request forms, Letter of Intent to Pay, etc. are not required for claims processing and **should not** be attached to the claim. However, TPL EOBs **should** be attached to the claim.

Paper Claims – CMS-1500 or UB-04

Claims submitted on paper must be entered manually into the claims system by the NARBHA Claims staff. Paper claim volume will vary from week to week. Claims are entered in the order they are received. However, NARBHA can not guarantee that every claim received during the week will be entered for processing in that week’s cycle. NARBHA processes claims within 30 days of receipt.

NARBHA recommends the claims be typed. This ensures legibility and therefore faster processing from the NARBHA Claims Staff. If you choose to handwrite your claims, please print neatly and keep names, numbers and codes within the designated fields. Claims may not be faxed, unless asked by a member of the claims unit. Claims staff handles faxes on a case by case basis.

All claims must include a signature. Stamps or other facsimiles are acceptable.

Electronic claims – 837 P or 837 I

All electronic claims must be submitted to the designated directory for your agency/provider. You will be given this information from NARBHA’s Network MIS staff when you start testing (Ex. \c2\provinc\xxxx\claim directory), along with a provider ID and/or abbreviation. The method for transferring files is File Transfer Protocol (FTP). If you need assistance with this application please contact NARBHA MIS.



Electronic claims – 837 P or 837 I Cont.

Claim files must also be named utilizing the following convention:

XXXX (provider ID or provider abbreviation) month month day day and the letter H for an 837 P file or the letter U for an 837 I file.

Example: 13640510HA or 13640510UA

Claim file name conventions must also match those outlined in the electronic billing instructions. Files that do not follow the required naming convention will not be processed.

Files submitted for processing are copied to the claims processing directory and a text file is generated consisting of all claim files processed. The next file is sent electronically to the provider's read directory (\2provinf\XXX\read). Providers are expected to check it against files submitted. If a claim file fails it should be corrected and resubmitted by the provider.

For information on what fields on the 837 P or the 837 I are required, please contact CIO@narbha.org

Explanation of Benefits (EOB)

NARBHA will issue an Explanation of Benefits (EOB) after each adjudication process is completed. The purpose of this is to advise the provider of the status on the claims that were submitted. If a claim is denied, this will provide information as to the problem(s) which caused such a denial. The status of a specific claim will be either Paid/Approved or Denied. NARBHA does not have a "Pended" claim status.

EOBs are organized by agency. Within each EOB, the claim payment detail is sorted by Approved or Denied, and by member name. Each line item on the EOB represents a single service code for a single member on a given date. A member total will be listed by member for each claims cycle. The EOB clearly states the reason for denial.

Electronic EOBs (835) are available upon request, for providers who bill electronically.



Data Validation and Claim Audits

Periodically NARBHA, its independent auditors, and/or its funders will audit provider claims and supporting documentation. An audit can be off-site or on-site at the provider. It is expected that all pieces of information on a claim can be substantiated in the member case file according to requirements established in contract (and other records as are deemed appropriate) or that the claim for that service has been adjusted. If claims are found to be in error, the provider is required to correct or recoup, at a minimum, those claims identified. If a pattern of errors is suspected in the larger universe of provider claims, the provider(s) may be required to research and correct any claim showing the same type of error as the sample revealed. Audits will cover, but are not limited to, the following items:

Claim Audits:

- ❖ Third Party Liability (TPL) payment amounts
- ❖ Third Party Liability (TPL) carrier information
- ❖ Co-pay amounts
- ❖ Denied claims have been “worked” and resubmitted successfully

Data Validation Audits:

- ❖ Compliance with the Covered Behavioral Health Services Guide, applicable requirements in licensure rules, contract requirements and the ADHS/DBHS/NARBHA Provider Manual
- ❖ Encounter submission timeliness, correctness and omission requirements

Errors identified through the data validation audit process are to be corrected. All corrections sent to NARBHA **must** be identified as “data validation audit”. If the provider sends an electronic file to NARBHA, this file must only contain data validation corrections. Do not mix other claims with data validation corrected claims.

NARBHA has raised the minimum standard for all data validation audits to 90% to more closely mirror the state requirement. Providers scoring 90% or higher will be successful in the audit and won’t be reviewed for a year, unless otherwise requested. Providers who score below 90% will be visited within 6 months of the original audit and another data validation audit will be performed. In addition, we have also decreased the “challenge time period” (time in which a provider has to challenge data validation findings) to 7 days in an effort to meet state requirements. The state requires that all data validation audits be completed within 21 days. Please refer to ADHS/NARBHA Provider Manual, Section 8.1 Encounter Validation Studies.



Special Billing Instructions

Duplicate Claims

When a service code is provided, more than once on the same day to the same member, by the same provider, these services must be combined when billing. Services are evaluated based on member ID, service code, modifier (if applicable) date of service, and provider AHCCCS ID number, therefore same services for a member that are provided on the same day must be submitted as one claim line. (i.e. transportation, case management, etc.)

For example, if case management was provided twice on the same day:

Member #AB123099M0
Provider #123456
Date of Service: 1/1/10
Service Code: T1016 HN
Units: 2
Time: 8:00 AM

Member # AB123099M0
Provider #123456
Date of Service: 1/1/10
Service Code: T1016 HN
Units: 2
Time: 2:00 PM

These services must be billed as follows:

1/1/10 T1016 HN 4 **units** Prov #123456

If services are billed separately, **both** services will deny as a duplicate. As a result of the denied claims, no service value and/or payment will be issued.

Modifiers / Place of Service

These are several services that can, or are required to, have modifiers and/or certain place of service. In some cases these modifiers will increase or decrease your paid amount depending on the modifier/place of service. Please refer to your contract attachment for modifiers and place of services combinations.

Date Spans / Units

In order to bill more than one date of service on a line, the services must be performed on consecutive days. When more than one date is indicated by the dates of service, the units billed must be evenly divisible by the number of days. An example of this would be July 1, 2009 to July 15, 2009 for a total of 15 days. If claims are not billed using the correct date span and number of units, the claim will be denied.



B5 Matrix

The B5 Matrix is a table found in the appendices of the ADHS/DBHS Covered Behavioral Health Service Guide. This table lists all service codes that can not be billed on the same day as another service code. Providers should have edits in place to catch these prior to submitting to NARBHA.

NARBHA Error Codes pertaining to B5 Matrix:

B5 = Service code conflicts with another service within billing file. This does not necessarily mean within the billing file from your agency that was submitted to NARBHA, it could also be from another agency that had submitted a billing file during the same adjudication process. (Both HCFA and UB).

B6 = Service code conflicts with another service code previously paid. This is caused by a service that has already been adjudicated in the NARBHA system, again not necessarily from your agency, but also from another agency. (Both HCFA and UB).

B7=Override first Claim not present in database. Claims that have an override on them must always be the second claim in the NARBHA database. The first claim does not need an override and must get accepted at the State level, before the claim with the override on it can be submitted to NARBHA. (HCFA only)

Special Billing Instructions (FOR RA ONLY)

Sonora Quest Lab

- The doctor needs to write the order on a “NARBHA (Sonora Quest) lab Requisition”. The bottom copy is kept by the billing department of the RA.
- The member then goes to a draw-site and specimens are taken.
- The lab Invoices/Statements are generated at Sonora Quest.
- A Monthly Invoice/Statement is sent from Sonora Quest directly to the RA. The RA billing department reconciles the Sonora Quest Monthly Invoice with their Requisitions. The RA writes a check to Sonora Quest.
- All discrepancies are forward to Sonora Quest by the RA. All reconciliation of claims is between Sonora Quest and the RA.
- RA billing department enters the claim information into their billing system and submits these files to NARBHA for adjudication.
- Each RA has a Sonora Quest provider ID that they are to record these services under. Sonora Quest’s Provider ID with AHCCCS is 452152. Each RA has one set up using two (2) initials related to their agency, for example: Verde Valley Guidance Center would be 452152VV
- Please contact NARBHA Contract Unit regarding your agencies Sonora Quest provider number.



Special Billing Instructions (FOR RA ONLY) Cont.

Billing for Protocall delivered crisis contacts/services:

Protocall completes crisis contact sheets for calls they take.

- These Protocall crisis contact sheets make their way to the Responsible Agency that enters this information into their billing data system to track the Protocall crisis contact and bill NARBHA.
- Each RA has a Protocall provider ID that they are to record these Protocall delivered crisis services under. Protocall's Provider ID with AHCCCS is 719172. Each RA has one set up using two (2) initials related to their agency, for example: Verde Valley Guidance Center would be 719172VV
- These are adjudicated and counted as service value
- Please contact NARBHA Contract Unit regarding your agencies Protocall provider number

Third Party Liability

As guided by the DBHS/NARBHA Provider Manual (located on NARBHA's website: [www.narbha.org/for_providers/provider_resources/DBHS-NARBHA Provider Policy Manual](http://www.narbha.org/for_providers/provider_resources/DBHS-NARBHA_Provider_Policy_Manual)) Section 3.5 – “Third Party Liability and Coordination of Benefits” NARBHA is the “payer of last resort.” Pursuant to the Coordination of Benefits outlined in the provider contract, providers are expected to bill the Third Party Liability (TPL) payers prior to billing NARBHA. TPL would include, but not limited to, private health insurance, Medicare, employment related health insurance, medical support from non-custodial parents, court judgments or settlements from a liability insurer, State Worker's Compensation, first party probate-estate recoveries, long term care insurance and other Federal programs. Any and all TPL collections must be reported on the claim submitted to NARBHA. This would be recorded in the payment field on the claim. If the provider submits a paper claim to NARBHA the provider must also submit the documentation (Explanation of Benefits – EOB, etc.) demonstrating collection of TPL.

Title XIX/XXI members may also have TPL, which may require co-payment, coinsurance or deductibles. Under no circumstances shall the Provider bill or attempt to collect any TPL deductible, co-payment, or any other fee from a member whom the Provider knows to be eligible for or enrolled in the Title XIX/XXI health care entitlement system. For Medicare reporting the provider shall report zero in the responsible party field on the claim if the service provided is a Medicare covered service. If the service is not a Medicare covered service, then the payment field on the claim should be left blank.

The provider must report any and all collection of co-payment, coinsurance or deductible amounts for Non-Title XIX/XXI members who also have TPL.



Third Party Liability Cont

For Non-Title XIX/XXI member who have TPL, the collection of TPL co-payments, coinsurances, or deductibles shall be reported collectively in the TPL amount on the claim. For Non-Title XIX/XXI members who have Medicare as their TPL, the payment field will either be blank for non-covered services or the total amount collected will be reported in the TPL payment field.

If the service is necessary, the provider must ensure that its cost avoidance efforts do not prevent any person from receiving the service and that the person will not be required to pay any coinsurance or deductibles for use of the other insurer's providers.

When a response from a TPL has not been received within the timeframes established for claims submission the provider must submit the claim with a zero amount reported in the payment field and the TPL identification listed. This would include any services covered by Medicare. Once the payment from the TPL has been received the provider must adjust the previously submitted claim to reflect the payment received.

In an emergency situation, the provider must first provide any medically necessary behavioral health covered service and then coordinate payment with any potential TPL.

The provider must retain documentation verifying that a service is not covered by the TPL (i.e. case management). The provider would submit the claim to NARBHA with zero reported in the payment field and the name of the TPL identified on the claim, except for non-Medicare covered services. If submitting a paper claim, NARBHA requests the provider to highlight the payment field and the TPL's identification. With the submission of a paper claim to NARBHA, the provider must submit the TPL documentation. The documentation to demonstrate non-covered TPL service would include, but not limited to, the Explanation of Benefits (EOB) from the TPL, a denial letter from the TPL, a posted list from the TPL, HCPC Manuals – for Medicare, website postings, etc. If the service is member specific, the information shall be retained within the member's billing records. If the service is non-member specific, this may be retained in a central file for utilization for all members. The documentation must be updated every six months to be considered valid documentation.

If a service is provided to a member in which the provider is not covered by the TPL (i.e. professional level of provider is not covered in the TPL agreement) the provider may bill those services directly to NARBHA. The provider would report zero in the payment field on the claim, unless the TPL carrier is Medicare, then the payment field would be left blank. Again, the provider must retain documentation that this provider is not covered by the TPL. Valid documentation would be the same as those listed in the paragraph above.



Co-payments (Other than TPL co-payment requirements)

There are certain times when it may be necessary for members to contribute to the cost of behavioral health services. A co-payment (other than the TPL co-payment requirement) is a fixed fee for services, based on the person's ability to pay and never exceeds the actual cost of services. The DBHS/NARBHA Provider Manual, Section 3.4 "Co-payments" provides guidelines on how to assess co-payments for Title XIX/XXI and Non-Title XIX/XXI members. This manual is located on NARBHA's website for reference. [www.narbha.org/for_providers/provider_resources/DBHS-NARBHA Provider Policy Manual](http://www.narbha.org/for_providers/provider_resources/DBHS-NARBHA_Provider_Policy_Manual).

Behavioral health providers must not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service or that services provided were not Title XIX/XXI covered services.

DBHS/NARBHA Provider Manual, Section 3.4 "Co-payments" provides guidance on those services in which a co-payment may be assessed. For multiple services received on the same day the member is only required to pay the co-payment of the most costly service.

After a co-payment has been determined the provider shall report the collection of the co-payment on the claim submission to NARBHA. This would be reported on the co-payment field.



Intent to Pay

Outpatient Services

The “Intent to Pay” (ITP) is a written notification for services delivered by a contracted FFS provider from the Responsible Agency (RA). The ITP process starts with the Responsible Agency completing the Notice of Intent to Pay form. Once treatment has been decided on at a member’s CFT/AFT meeting, the RA has three (3) business days to complete and forward this form to NARBHA.

Once the ITP information has been entered into the NARBHA tracking database, an ITP letter containing the ITP number is automatically generated. NARBHA then reviews the letter and distributes a copy of the ITP letter to the requesting Responsible Agency; with the original letter sent to the FFS provider. NARBHA has 48 hours to complete this process.

If the member requires additional services after the end date of the original ITP, the Responsible Agency must complete another Notice of Intent to Pay form with the action code of “2”; referencing the original ITP number and submitted to NARBHA. Once received by NARBHA, the same time frame is followed, as stated above.

When the FFS provider submits a claim to NARBHA for services provided, the FFS provider must reference the ITP number on the claim form in the prior authorization field. The ITP number is the six-digit number found on the lower center portion of the ITP letter. Please refer to this guide for detailed instructions to properly complete the claim form.

Non-Emergency Inpatient Services

Prior-authorizations are required for all non-emergency Level I admissions and concurrent reviews. These inpatient stays (0124, 0126) are now reviewed and authorized by the Medical Management Staff at NARBHA. Responsible Agencies should contact the Medical Management Staff when a member is admitted. It is not necessary to send a Notice of Intent to Pay form. NARBHA will review and initiate the ITP referral. Once an ITP is generated it will be sent to the Responsible Agency and the treating facility.

Bed Hold/Home Pass

Providers that are contracted to perform Bed Hold-Home Pass services are not required to obtain an Intent To Pay for these services as long as there is already a 0124 and 0126 Intent To Pay in place. This only applies to the 0183 and 0189 revenue codes.



Electronic Claims Submission (HIPAA) Institutional/Professional Claims

With the passage of the initial Health Insurance Portability and Accountability Act (HIPAA) regulation regarding Privacy it was the responsibility of all health care organizations to review their lines-of-business and determine whether these standards/regulations would apply to them. After reviewing the standards NARBHA determined that we are a covered entity under the HIPAA standards/regulations and began the steps necessary to ensure compliance with the Privacy standards and plan for compliance with future HIPAA regulations.

The Final rule for Standards for Electronic transactions was published on August 17, 2003 by the Secretary of the U.S. Department of Health and Human Services (HHS) concerning 45 C.F.R. Parts 160 and 162 under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The final rule set an implementation date of October 16, 2002. A one year extension was granted upon request and NARBHA implemented the appropriate standards on 10/03/2003 as part of this process NARBHA has successfully implemented the following transactions for our provide network:

- Health Care Claim/Institutional (HIPAA/837I)
- Health Care Claim/Professional (HIPAA/837PI)
- Health Care Claims Payment/Advice (HIPAA/835)

It is up to each health organization to determine if it able to implement, and maintain, these electronic billing transactions. This decision is critical as the HIPAA Transaction rule seems to indicate that once an agency has made the transition to electronic billing using the HIPAA transactions it may be precluded from returning to manual/hardcopy billing practices. Information on the Transaction rule can be found at:

- [Centers for Medicare and Medicaid Service - Transaction and Code Sets Standards](#)
- [Centers for Medicare and Medicaid Service - Security Standard – Regulations](#)
- [Transaction Set Final Rule - August 17, 2000](#)

Implementation guides for specific HIPAA Transactions are available through the Washington Publishing Company web site at <http://www.wpc-edi.com>. There may be costs involved for these resources.



Claim Formats - NARBHA will allow the submission of claims data electronically using the HIPAA standard transactions defined above.

These electronic claims submission transactions must adhere to the Electronic Data Interchanges standards defined in the HIPAA regulations with the minor changes necessary to satisfy the business needs of NARBHA and our payor, the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS). **These are the only formats that NARBHA can accept for submission of electronic claim data. No non-HIPAA/proprietary formats for billing can be accepted.**

For a provider to submit claims to NARBHA electronically the following conditions must be satisfied

- Provider must be able to prepare claim files meeting the HIPAA transaction standards as implemented at NARBHA.
- Provider must be able to make the minor modification to the HIPAA 837/P and HIPAA 837/I transactions that will satisfy the needs of NARBHA and out payor, DBHS.

NARBHA Certification for 837 Claims Step-By-Step Process

Item	Description	Comments
1.	Provider submits a formal request to NARBHA's Claims Unit to implement electronic claim submission.	
2.	NARBHA sends to Provider: <ul style="list-style-type: none"> a. New process testing procedures for certification. b. VFP connection executable. c. FTP userID/password and IP Address. 	
3.	Site establishes connection to the FTP point via VPN then FTP client	
4.	Site submits a small set of 837 claims to the test system for a format check.	The test file should have a minimum of 90 items or a pre-negotiated amount The acceptance rate must be 90% or greater.
5.	Provider passes format check	



6.	<p>Provider submits a small set of 837 claims to the test system.</p> <ol style="list-style-type: none"> a. Site passed format check. b. NARBHA submits to adjudication. c. Provider passes adjudication. d. Site receives 835 remittance advice and .pdf EOB and is able to accept and process. 	<p>The test file should have a minimum of 90 items or a pre-negotiated amount</p> <p>The acceptance rate must be 90% or greater.</p>
7.	<p>Provider submits 2 volume tests to the test system. The volume will be determined by NARBHA and agreed on by the provider.</p> <ol style="list-style-type: none"> a. Site passed format check. b. NARBHA submits to adjudication. c. Site passes adjudication. d. Site receives 835 remittance advice and .pdf EOB and is able to accept and process. 	<p>The volume amount will be determined by NARBHA and agreed on by the provider.</p> <p>The acceptance rate must be 90% or greater.</p>
8.	<p>Provider is certified to submit claims to NARBHA.</p>	
9.	<p>The Provider is responsible for all errors and correction submissions. The provider will work directly with the NARBHA claims staff to rectify problems.</p>	

Other caveats and criteria:

- The Provider must have access to the Internet to allow them to be able to submit/retrieve claims information. Secure processes adhering to the NARBHA implementation of the HIPAA Security guidelines will be set up between the provider and NARBHA to allow for this claim information to be exchanged.
- The Provider may, at any time, be asked to re-test/re-certify their claim submission formats/process if their acceptance rates consistently fall below the 90% acceptance level or, in the opinion of NARBHA staff, re-testing/re-certification is necessary.
- Violation of NARBHA System Security Requirements will be a basis for immediate suspension of the provider's ability to submit claims electronically.



CMS-1500 Claim Form

The CMS-1500 Claim Form is completed by outpatient providers to bill for covered services.

Step-by-step instructions for completing this form begin on the page following the CMS-1500 Claim Form/Image. These instructions are numbered according to the order of field names on the CMS-1500 Claim Form.

It is not necessary to fill out the complete form. Fields that must be completed in order to receive payment are marked as “required”. Those fields marked “not required” are not applicable to behavioral health claims processing and may be left blank.



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY; 22. MEDICAID RESUBMISSION CODE; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; B. PLACE OF SERVICE; C. EMG; D. PROCEDURES, SERVICES, OR SUPPLIES; E. DIAGNOSIS POINTER; F. \$ CHARGES; G. DAYS OR UNITS; H. ICD-9-CM; I. ID. QUAL; J. RENDERING PROVIDER ID #; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE
Printed on Recycled Paper

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)



CMS-1500 Procedures

1. Not Required

1a. INSURED'S ID NUMBER

Required

Enter the unique 10-digit member ID in this field. The last two digits of the ID will always have an M or F followed by a numeric character. If you are unsure of the Member ID, contact **NARBHA's member services**.

Providers should always use the ID number indicated on the Letter of Intent to Pay. If an invalid member ID number is used, the claim will deny.

Incorrect Examples:

AB12345610 (Old BHMIS#)

A123456789 (AHCCCS #)

123-45-6789 (SSN)

Correct Example:

AB123456M0

AB123456F0

2. PATIENT'S NAME

Required

Enter the member's name in the following order: Last name, First Name and Middle Initial. The name must be the same as on the member intake.

3. PATIENT'S BIRTH DATE AND SEX

Required

Enter the member's Date of Birth. Enter "M" for male or "F" for female.

4. Not Required

5. Not Required

6. Not Required

7. Not Required

8. Not Required

9. Not Required

10. Not Required

11. Not Required

11a. Not Required

11b. Not Required

11c. INSURANCE PLAN NAME

Required, if applicable

Enter the name of the Third Party Liability payer. Highlighted if possible.

11d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

Required, if applicable

Check the appropriate box to indicate other TPL coverage.



- 12. **Not Required**
- 13. **Not Required**
- 14. **Not Required**
- 15. **Not Required**
- 16. **Not Required**
- 17. **Not Required**

18. HOSPITAL ADMIT DATE

Required

Enter the date the member was admitted. If billing for service with a Place of Service 21, 51, 52, 55, 56 you must have a hospital admit date.

- 19. **Not Required**

- 20. **Not Required**

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

Required

Enter the member's behavioral health ICD-9 diagnosis code. You must enter at least one primary diagnosis. Secondary, third and fourth diagnosis is optional. Only valid ICD-9 diagnosis codes are acceptable for claims submission. Enter the appropriate code that best describes the diagnosis for the member. **All codes must be coded to the highest specificity (i.e. add 4th and 5th digit).**

- 22. **Not Required**

23. PRIOR AUTHORIZATION NUMBER

Required, if applicable

Enter the six-digit Service Intent to Pay number on the claim. Intent to Pay number must be written on the claim or the claim will be denied. (Attaching the letter of Intent to pay is not necessary and will not be looked at) If more than one service is on the claim, use box 24J to show corresponding Intent to Pay number for each service. **The number of units, dates and provider number must match the Intent to Pay or the claim will deny.** The Intent to Pay Number can be found on the lower center portion of the Letter of Intent to Pay.

24a. DATE OF SERVICE

Required

Enter the member's date of service. The date of service should be completed in a 6-digit format, MMDDYY. The "From" box should be the first date of service and the "To" date the last date of service. In order to bill more than one date of service on a line, the services must be performed on consecutive days.



24b. PLACE OF SERVICE

Required

Enter the appropriate place of service code that describes where the service was rendered.

11 = Office

41 = Ambulance – Land

12 = Home

42 = Ambulance – Air or Water

21 = Inpatient Hospital

51 = Level I Behavioral Health Facility

22 = Outpatient Hospital

52 = Psychiatric Facility Partial Hospitalization

23 = Emergency Room – Hospital

56 = Psychiatric Residential Treatment Center

99 = Other

*2**Use 99 for Prevention and Early Intervention

24c. EMG

Required -NARBHA uses this field to indicate type of service

Enter one of the choices below to indicate the method of payment for the service(s):

1 = Fee-For-Service – this service is to be reimbursed by filing the claim. If a “clean” claim is submitted with correct information and there are no outstanding balances to be applied, a check will be issued.

2 = Advance/Block Purchase – the provider has been pre-paid for these services; filing of the claim is to record encounter data for Value of Services. No check will be issued by NARBHA at time of adjudication.

24d. PROCEDURES AND MODIFIERS

Required

Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the *same date of service*, enter the procedure only once. Use the units field (24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the Covered service Guide B-2 matrix.

Note: Some codes require modifiers.

MODIFIER

Required, if applicable

Enter the appropriate modifier that best describes the services rendered.

Note: Some modifiers may have an impact on rate payable for a service.

24e. Not Required



24f. CHARGES

Required

Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at \$10.00 and three (3) units were provided, enter \$30.00 here and three units in box 24g. NARBHA will not do the calculation for you, and claims will be paid at the lesser amount.

24 g. UNITS

Required

Enter the units of services provided on the date(s) in box 24a. Bill all units of service provided on a given date on one line. Fractional units are not acceptable, and will cause the claim to deny. When more than one date is indicated by the dates of service, the units billed must be evenly divisible by the number of days.

24h. EPSDT Family Plan

Required, if applicable-NARBHA uses this as an override field

Enter the "F" override code. If claims can be overridden according to the B5 matrix, override indicator will need to be used here.

24i. Not Required

24j. RENDERING PROVIDER ID #

Required, if applicable- NARBHA uses this field for corresponding ITP numbers when billing more than one service on a claim

Enter the ITP Number that matches the service being billed on each line. If more than one service is on the claim, use box 24J to show corresponding Intent to Pay number for each service per line.

25. FEDERAL TAX ID NUMBER

Required

Enter either the Provider's Federal Tax ID Number (EIN) or, if an individual, the Social Security Number (SSN). Place a check in the appropriate box. This number must match the number listed on your W-9 form. If number is missing or invalid, it will cause the claim to deny.

26. PATIENT'S ACCOUNT NUMBER

Optional

Enter your internal account number here. This field may be used by providers to track members by placing an internal account number in this field.

27. Not Required



- 28. TOTAL CHARGE**
Required
Enter the total for all charges for all lines on the claim.
- 29. AMOUNT PAID**
Required, if applicable
Enter the total amount of the TPL collections. EOB must be attached to claim.
- 30. BALANCE DUE**
Required
Enter the amount that is to be considered for payment. Calculate this by subtracting the amount paid (box 29) from the total charge (box 28).
- 31. SIGNATURE**
Required
The claim must be signed by the provider submitting the claim form or by an authorized representative. Stamps or other facsimiles are acceptable.
- DATE**
Required
Enter the date on which the claim was signed. The signature date cannot be prior to the date(s) of service.
- 32. SERVICE FACILITY LOCATION**
Required, if applicable
Enter the name and address of the facility where services were rendered.
- 32a. NPI NUMBER**
Required, if applicable
Enter the 10 digit NPI number.
- 32b. AHCCCS ID NUMBER**
Required, if applicable
Enter the 6-digit AHCCCS Provider Number.
- 33. BILLING PROVIDER INFO AND PHONE NUMBER**
Required
Enter the Provider's name, address, zip code, and phone number.
- 33a. NPI NUMBER**
Required
Enter the 10 digit number that is assigned to the provider submitting the bill. This number must match the given provider number in box 33b.



33b. AHCCCS ID NUMBER

Required

Enter the 6-digit AHCCCS Provider Number. This number **MUST** match the Provider ID number on file with DBHS and NARBHA or the claim will deny.

Send completed claims to:

**NARBHA
Claims Unit
1300 South Yale Street
Flagstaff, AZ 86001**

**Please do not fax claims as it is hard to read and may
cause claims to fail.**



UB-04 Claim Form

The UB-04 Claim Form is used to bill for services such as inpatient stays, bed hold/pass days, and outpatient facility usage, i.e. ECT charges. Other professional services provided during an inpatient stay must be billed separately on a CMS-1500 Claim Form.

Step-by-step instructions for completing this form begin on the page following UB-04 Claim Form image. These instructions are numbered according to the order of the field names on the UB-04 Claim Form.

It is not necessary to fill out the entire form. Fields that must be completed in order to receive payment are marked “required”. Those fields marked “not required” are not applicable to behavioral health claims processing and may be left blank.



UB-04 Procedures

1. **PROVIDER NAME AND ADDRESS**
Required
Enter the name and address of the facility **providing** the service.
2. **Not Required**
- 3a. **PATIENT CONTROL NUMBER**
Optional
Enter your internal account number. Use this field to record any internal billing/identification number the member may have.
- 3b. **Not Required**
4. **TYPE OF BILL**
Required
Enter the three-digit code that best describes the type of bill being submitted. The valid types of bill codes are:
111 = Admission through discharge Claim
112 = Interim Billing (First Claim)
113 = Interim Billing (Continuing Claim)
114 = Interim Billing (Final Claim)
131 = Outpatient Facility Charge (for ECT ONLY)
5. **FEDERAL TAX ID NUMBER**
Required
Enter the facility's Federal Tax ID Number
6. **STATEMENT COVERS PERIOD**
Required
Enter the beginning service date and ending service date for this bill. All dates should be entered in the MMDDYY format.
7. **Not Required**
8. **PATIENT'S NAME**
Required
Enter the member's last name, first name, and middle initial.
9. **Not Required**
10. **BIRTH DATE**
Required
Enter the member's birth date in the MMDDYYYY format.



11. SEX

Required

Enter "M" (male) or "F" (female).

12. ADMISSION DATE

Required

Enter the date of admission. Date must be entered in a 6-digit format.

Do not use slashes or dashes!

Example: June 3, 2010 = 060310

13. ADMISSION HOUR

Required

Enter the two-digit code from the list below that corresponds to the member's time of admission:

AM

00 = 12:00 – 12:59 (Midnight)

01 = 01:00 - 01:59

02 = 02:00 – 02:59

03 = 03:00 – 03:59

04 = 04:00 – 04:59

05 = 05:00 – 05:59

06 = 06:00 – 06:59

07 = 07:00 – 07:59

08 = 08:00 – 08:59

09 = 09:00 – 09:59

10 = 10:00 – 10:59

11 = 11:00 – 11:59

PM

12 = 12:00 – 12:59 (Noon)

13 = 01:00 – 01:59

14 = 02:00 – 02:59

15 = 03:00 – 03:59

16 = 04:00 – 04:59

17 = 05:00 – 05:59

18 = 06:00 – 06:59

19 = 07:00 – 07:59

20 = 08:00 – 08:59

21 = 09:00 – 09:59

22 = 10:00 – 10:59

23 = 11:00 – 11:59

14. ADMISSION TYPE

Required

Enter the code from the following list that best describes the reason for the member's admission:

1 = Emergency

Member requires medical care for severe, life threatening, or disabling conditions.

2 = Urgent

The member requires immediate attention.

3 = Elective

The member's condition permits time to schedule services.



15. ADMISSION SOURCE

Required

Enter the code from the following list that best describes the source of admission:

- 1 = Physician Referral
- 2 = Clinic Referral
- 3 = Health Plan Referral
- 4 = Transfer from Hospital
- 5 = Transfer from Skilled Nursing Home
- 6 = Transfer from another type of Health Care Facility
- 7 = Emergency Room
- 8 = Courts or Law Enforcement
- 9 = Information not Available
- A = Transfer from a Critical Access Hospital
- B = Transfer From another Home Health Agency
- C = Readmission to Same Home Health Agency
- D = Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claims to the Payer

16. DISCHARGE HOUR

Required

Enter the code that represents the hour of discharge. Use the codes from the following list:

AM

- | | |
|-------------------------------|--------------------|
| 00 = 12:00 – 12:59 (Midnight) | 06 = 06:00 – 06:59 |
| 01 = 01:00 – 01:59 | 07 = 07:00 – 07:59 |
| 02 = 02:00 – 02:59 | 08 = 08:00 - 08:59 |
| 03 = 03:00 – 03:59 | 09 = 09:00 – 09:59 |
| 04 = 04:00 – 04:59 | 10 = 10:00 – 10:59 |
| 05 = 05:00 – 05:59 | 11 = 11:00 – 11:59 |

PM

- | | |
|---------------------------|--------------------|
| 12 = 12:00 – 12:59 (Noon) | 18 = 06:00 – 06:59 |
| 13 = 01:00 – 01:59 | 19 = 07:00 – 07:59 |
| 14 = 02:00 – 02:59 | 20 = 08:00 – 08:59 |
| 15 = 03:00 – 03:59 | 21 = 09:00 – 09:59 |
| 16 = 04:00 – 04:59 | 22 = 10:00 – 10:59 |
| 17 = 05:00 = 05:59 | 23 = 11:00 – 11:59 |



17. PATIENT STATUS

Required

Enter the code from the list below that best describes the member's status:

- 01 = Discharges to Home or Self Care
- 02 = Transferred to Another Short Term general Hospital
- 03 = Transferred to a Skilled Nursing Facility
- 04 = Transferred to an Intermediate Care Facility
- 05 = Transferred to Another Type of Institution
- 06 = Discharged to Home Under Care of Organized Home Health Service Organization
- 07 = Left Against Medical Advice
- 20 = Expired
- 30 = Still a Patient
- 65= Discharge/transferred to a Psychiatric Hospital

The following illustrates the correct correlation between Patient Status and Type of Bill:

Type of Bill	Patient Status Code
111	01 – 20 and 65
112	30 Only
113	30 Only
114	01 – 20 and 65
131	01 Only

- 18. Not Required
- 19. Not Required
- 20. Not Required
- 21. Not Required
- 22. Not Required
- 23. Not Required
- 24. Not Required
- 25. Not Required
- 26. Not Required
- 27. Not Required.
- 28. Not Required
- 29. Not Required
- 30. Not Required
- 31. Not Required
- 32. Not Required
- 33. Not Required
- 34. Not Required
- 35. Not Required
- 36. Not Required
- 37. Not Required
- 38. Not Required



- 39. **Not Required**
- 40. **Not Required**
- 41. **Not Required**

42. **REVENUE CODE**
Required

Enter the 4-digit Revenue Code(s) for the service(s) provided. The Revenue Code must match the Letter of Intent to Pay.

**Some provider types also require that a 4-digit Revenue Code(s) be provided for any Ancillary Services.

43. **REVENUE CODE DESCRIPTION**
Required

Enter the description of the revenue code billed in field 42.

44. **HCPS/RATES**
Required

Enter the Usual and Customary rate for each revenue code billed in field 42.

45. **SERVICE DATE**
Required

Enter the first date the service was provided in the MMDDYY format.

46. **SERVICE UNITS**
Required

Enter the number of units/days services were provided for the revenue code. If billing an interim claim, the units should equal the number of days for the dates of service entered. If billing a discharge claim, deduct one unit. NARBHA will pay date of admit but not date of discharge.

47. **TOTAL CHARGES**
Required

Enter the total charges for each ancillary revenue code. Multiply your "Usual and Customary" rate for the revenue code by the number of service units/days.

- 48. **Not Required**
- 49. **Not Required**

50. **PAYER NAME**
Required, if member has TPL
Enter name of TPL provider

- 51. **Not Required**
- 52. **Not Required**



- 53. Not Required**
- 54. PRIOR PAYMENTS**
Required, if applicable
 Enter the TPL amount received by the provider from the EOB. EOB must be attached to claim.
- 55. EST AMOUNT DUE**
Required, if applicable
 Enter the amount that is to be considered for payment. Calculate this by subtracting the amount paid from the total charges.
- 56. NPI# NATIONAL PROVIDER ID**
Required
 The number assigned to the provider submitting the bill. This is a 10-digit number. Must match the given provider number in #57.
- 57. PROVIDER ID**
Required
 Enter the 6-digit AHCCCS Provider Number. This number MUST match the Provider ID Number on file with DBHS and NARBHA or the claim will deny.
- 58. Not Required**
- 59. Not Required**
- 60. INSURED'S ID NUMBER**
Required
 Enter the unique 10-digit Member ID in this field. The last two digits of the ID will always have and M or F followed by a numeric character. If you are unsure of the Member ID, please contact NARBHA's member services.
- Providers should always use the Member ID# indicated on the Letter of Intent to Pay. If an invalid Member ID is used, the claim will deny.
- | | |
|-------------------------|------------------|
| Incorrect Examples: | Correct Example: |
| AB12345610 (Old BHMIS#) | AB123456M0 |
| 123456789 (AHCCCS#) | AB123456F0 |
| 123-45-6789 (SSN) | |
- 61. Not Required**
- 62. Not Required**



63. TREATMENT AUTHORIZATION CODES

Required

Enter the 6-digit Service Intent to Pay Number. This number must match the number printed on the Letter of Intent to Pay. The number of units, dates, and provider number must match the Intent to Pay or the claim will deny.

64. Not Required

65. Not Required

66. DIAGNOSIS CODE

Required

Enter the member's behavioral health ICD-9 diagnosis code. You must enter at least one primary diagnosis in the range of 290.00 to 316.99. Although a patient may have other diagnosis codes (e.g., a "V" code or other ICD-9 diagnostic code outside this range), a claim for an inpatient psychiatric service must indicate a valid mental health or substance abuse diagnosis in the above range as primary. Only valid ICD-9 diagnosis codes are acceptable for claims submission. **All codes must be coded to the highest specificity (i.e. add 4th and 5th digit)**

67. Not Required

68. Not Required

69. ADMIT DIAGNOSIS

Required

Enter the ICD-9 code for the admitting diagnosis. You must enter at least one primary diagnosis in the range of 290.00 to 316.99. Although a patient may have other diagnosis codes (e.g., a "V" code or other ICD-9 diagnostic code outside this range), a claim for an inpatient psychiatric service must indicate a valid mental health or substance abuse diagnosis in the above range as primary. Only valid ICD-9 diagnosis codes are acceptable for claims submission. **All codes must be coded to the highest specificity (i.e. add 4th and 5th digit)**

70. Not Required

71. Not Required

72. Not Required

73. Not Required

74. Not Required

75. Not Required

76. ATTENDING PROVIDER NAME AND IDENTIFIERS

Required

Enter the attending Physicians name and NPI number. Omitting this information from your claim will cause it to deny.



- 77. Not Required**
- 78. Not Required**
- 79. Not Required**
- 80. Not Required**
- 81. Not Required**

Send completed claims to:

**NARBHA
Claims Unit
1300 South Yale Street
Flagstaff, AZ 86001**

**Please do not fax claims as it is hard to read and may
cause claims to fail.**



Electronic Claim Adjustment Procedure

Claims previously submitted by a provider and approved/paid by NARBHA may require an adjustment in certain circumstances. Usually this is the result of provider billing errors, enrollment, authorization, claims processing problems, or changes to information about amounts of Third Party Liability collected. The result of these conditions can be either an overpayment or underpayment. Denied claims DO NOT need to be adjusted. Denied claims just need to be resubmitted with corrections.

Provider-originated adjustments can **only** be submitted via the NARBHA approved electronic spreadsheet. Providers do not need to submit copies of the EOB with this format, but if invalid ICN number(s) are used on the spreadsheet, the entire spreadsheet will be returned for corrections. Providers can contact the Claims Help Desk for a copy of the approved spreadsheet.

The full original claim paid amount will be recouped and a recoupment invoice will be sent to the provider confirming when adjustments are complete. For services which were a payback to NARBHA, no action is required by the provider. This payback amount will be deducted from your next EOB.

For provider originated adjustments, services needing additional payment or correction to a payment, the provider must resubmit a corrected claim. Adjustment requests received without a corrected claim will be recouped but will not be repaid until a clean corrected claim is received. Correct claims should be mailed the same day the spreadsheet was submitted with a copy of the email attached to the corrected claim(s).

In circumstances where mass claims need to be adjusted (50 or more), the provider must request, in **writing**, permission to submit mass adjustments. This will be reviewed by the Claiming Manager and/or the Chief Financial Officer at NARBHA, and a decision will be made to approve the mass adjustments or deny the request. Each request is handled by a case by case situation.

Adjustment must adhere to the same time frames as the time frames for original claims or they will be denied.

NARBHA originated adjustments require no action on the part of the provider. The provider will be notified via a recoupment invoice and/or an EOB that their claim(s) has been adjusted.



The instructions below correspond to the fields on the Electronic Claim Adjustment Request Form. Please use the NARBHA approved **electronic spreadsheet**. After you have completed this spreadsheet electronically, and have sent an email, please print the email and/or the spreadsheet and attach it to the correct claims to be mailed. The claims should be in the mail the same day that the spreadsheet was emailed.

❖ **PROVIDER NAME**

Enter your Provider Name as it appears on the Explanation of Benefits (EOB).

❖ **PROVIDER NUMBER**

Enter the complete Provider AHCCCS ID Number as it appears on the EOB.

❖ **ADJUSTMENT REASON**

Enter a full description of the reason for filing this adjustment, please explain to the fullest. Example: Billing error due to missing documentation.

❖ **ADJUSTMENT AMOUNT**

Enter the total dollar amount for the adjusted claims listed on the spread sheet.

❖ **COUNT OF ADJUSTED CLAIMS**

Enter the number of claims that you would like adjusted on the spread sheet.

❖ **INTERNAL CONTROL NUMBER (ICN)**

Enter the Internal Control Number (ICN) as it appears on the EOB. If this number is invalid or incorrect for any reason, the ENTIRE spread sheet will be returned for corrections. This must be in column "A", and must include the leading zero.

❖ **CLIENT ID**

Enter the member's ID number

❖ **DATE OF SERVICE**

Enter the date of service as it appears on the EOB.

❖ **EOB DATE**

Enter the EOB date that you will be adjusting the claim from. This date is located in the upper left corner of the EOB.



❖ **UNITS**

Enter the number of units as it appears on the EOB.

❖ **PAID AMOUNT TO BE ADJUSTED**

Enter the total amount paid on the EOB. This has to be the total amount paid, NARBHA does not recoup partial payment amounts.

AT NO TIME CAN THE ATTACHED SPREADSHEET BE CHANGED FOR ANY REASON. THE SHEET NEEDS TO STAY THE WAY IT WAS SENT TO YOU. IF THE SPREADSHEET IS CHANGED FOR ANY REASON, IT WILL BE RETURNED TO YOU FOR CORRECTIONS.

If you have any questions or need assistance in completion of the adjustment form please call the NARBHA Claims Help Desk @ (928) 774-7128, or email claimsunit@narbha.org

Please email your completed Adjustment Request form to:

Cheri.Burian@narbha.org

And also CC in the email:

Rebecca.Weinberg@narbha.org

Please remember to print a copy of your email and/or spreadsheet to send with your correct claims.



