

Formal Provider Claim Dispute Submission of an Arizona Complete Health Medicaid Claim via Secure Portal:

The pages below outline how to submit a formal Medicaid claim dispute via our secure portal. However, we highly encourage you to use the corrected claim process and/or reconsideration process PRIOR to submitting a formal claim dispute whenever possible. When needed, the formal claim dispute process may be used to dispute (aka appeal) a claim denied partly or in whole.

1. Once you've logged on to the secure portal <https://www.azcompletehealth.com/providers/login.html>, use the Claims option to look up the claim and access its details
2. Click **Dispute**

Claim:
Status: Denied

Submitted (Green Checkmark) Denied (Red X)

Member

Member Name
Date of Birth
Member ID
Medicaid ID
Plan Type	Medicaid

Type and Dates

Type	CMS-1500
Service Dates	07/25/2023 - 07/25/2023
Received Date	07/27/2023

Payment

Billed	\$2,736.00	Check #/ EFT	080901506052
Paid	\$0	Check Date	08/01/2023
Payment Date	08/02/2023	Total Check Amount	\$136,281.20

+ COPY + VOID/RECOUP **DISPUTE**

3. Select Option 3: Formal Claim Dispute

Dispute Claim: [Close X]

DOB:

Select **Option 1: Correct the Claim**

- Most providers use this option when there is a mistake on the submitted claim

Select **Option 2: Informal Reconsideration**

- A reconsideration is an informal review performed by the claims department
- You should NOT Use this option if an authorization is not obtained and/or need to review for medical necessity
- Please utilize Option 3 to initiate a Formal Claim Dispute if a review of medical records is required.

Select **Option 3: Formal Claim Dispute**

- A formal Provider Claim Dispute (aka "post service appeal") is a formal review of your claim
- Disputes are acknowledged within 5 business days of receipt in accordance with A.A.C. R9-34-403 (Computation of Time)
- Dispute responses will be issued within 30 calendar days of submission in accordance with A.A.C. R9-34-403 (Computation of Time)
- Please refer to the [Provider Manual](#) for more information.

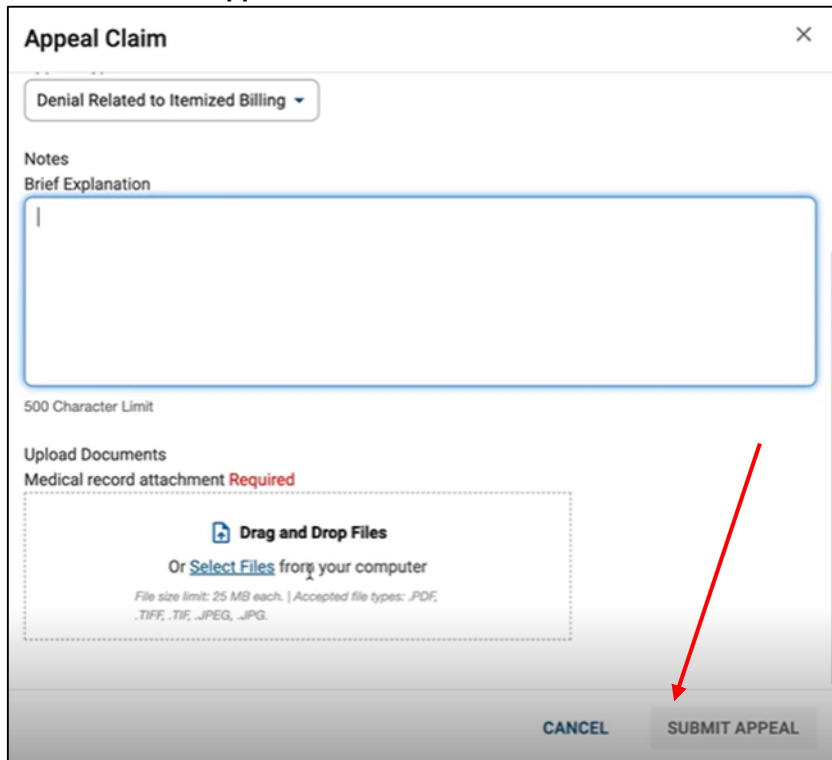
4. Select **Appeal Type** from the drop-down box (you'll be able to add details or specific comments in Step 5, for this step, simply select the appeal type that best fits your current dispute reason)

The screenshot shows the 'Appeal Claim' form with a dropdown menu open for 'Select Appeal Type'. The menu options are: 'Denied for a Global/Unbundled Procedure', 'Denied for Untimely Filing' (highlighted with a mouse cursor), 'Denial Related to an Authorization', 'Claim Paid at the Incorrect Amount', and 'Coordination of Benefits (COB)'. A red arrow points to the dropdown menu. A yellow warning box at the top states: 'For Appeals Only! Not for reconsiderations. Please refer to your Provider Manual.' The form also displays 'Check Date: 08/01/2023' and 'Total Check Amount: \$136,281.20'. Buttons for 'CANCEL' and 'SUBMIT APPEAL' are visible.

5. Enter the reason for your claim dispute including pertinent facts and data that supports your request for payment/additional payment. There is a 500-character limit, so this should be a summary. You can upload a dispute letter and any medical records or other supporting documents in Step 6
6. Drag and drop files or select files from your computer to upload your dispute letter, medical records, and/or other supporting documentation

The screenshot shows the 'Appeal Claim' form with the 'Denial Related to Itemized Billing' dropdown selected. The 'Notes' section has a 'Brief Explanation' text area with a 500-character limit. A red arrow points to this text area. The 'Upload Documents' section includes a 'Medical record attachment Required' label and a dashed box for file uploads. The upload area contains the text: 'Drag and Drop Files' with a file icon, 'Or Select Files from your computer', and 'File size limit: 25 MB each. | Accepted file types: .PDF, .TIFF, .TIF, .JPEG, .JPG.' A red arrow points to the dashed box. 'CANCEL' and 'SUBMIT APPEAL' buttons are at the bottom.

7. Click **Submit Appeal** button



Appeal Claim

Denial Related to Itemized Billing

Notes

Brief Explanation

500 Character Limit

Upload Documents

Medical record attachment **Required**

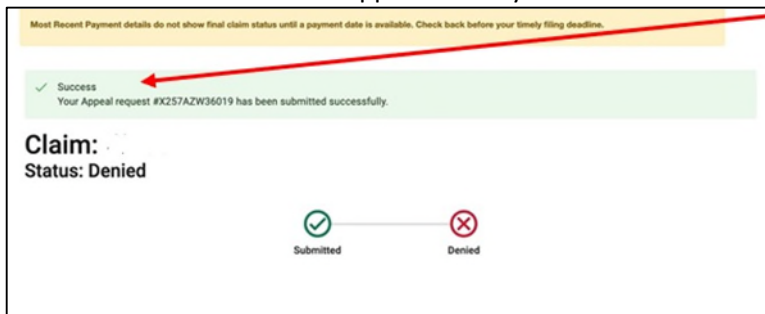
Drag and Drop Files

Or **Select Files** from your computer

File size limit: 25 MB each. | Accepted file types: .PDF, .TIFF, .TIF, .JPEG, .JPG.

CANCEL SUBMIT APPEAL

8. A “Success” notification appears once you’ve submitted the dispute



9. Within five (5) business days of your successful Claim Dispute submission, an acknowledgment letter is mailed to the address listed on your uploaded claim dispute documentation in accordance with A.A.C. R9-34-403 (Computation of Time)
10. Claim dispute decisions are issued with 30 calendar days of submission in accordance with A.A.C. R9-34-403 (Computation of Time)
11. If you need status of a successfully submitted claim dispute *and it has been over 30 calendar days* since your submission, you may email an inquiry to the Arizona Complete Health Grievance and Appeals Department at AzCHGrievanceAndAppeals@azcompletehealth.com
12. For general assistance on the grievance and appeal system, please visit the Grievance and Appeal System page and the Claim Dispute page on our website:
 - o <https://www.azcompletehealth.com/providers/resources/grievance-process.html>
 - o <https://www.azcompletehealth.com/providers/resources/grievance-process/provider-claim-disputes.html>
13. If you require assistance with our secure provider portal, please contact your Provider Engagement representative for assistance. If you need your assigned Provider Engagement Specialist’s contact information, please email AzCHProviderEngagement@azcompletehealth.com