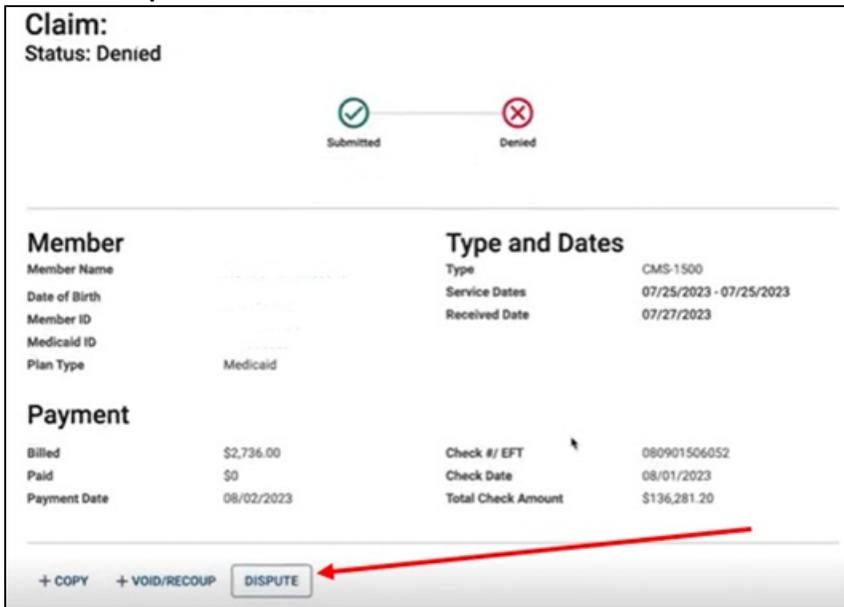


Instructions for submitting a corrected claim, an informal reconsideration request or a formal claim dispute for an Arizona Complete Health-Complete Care Plan Medicaid claim via our secure provider portal:

The pages below outline how to submit a corrected claim, an informal reconsideration request or a formal Medicaid claim dispute via our secure portal. We 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. While formal claim disputes may be submitted via the secure portal, State Fair Hearing Requests must continue to be submitted via mail as they are today.

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

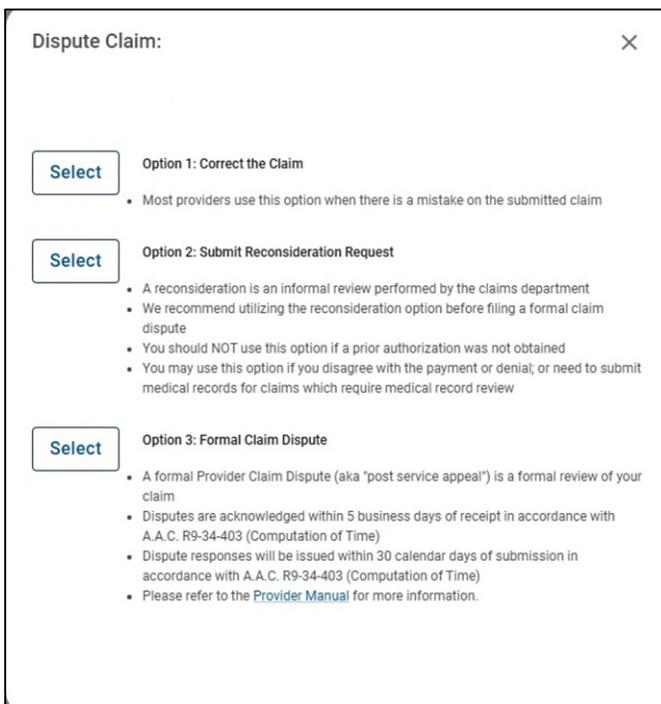
Submitted Denied

Member		Type and Dates	
Member Name	.....	Type	CMS-1500
Date of Birth	.....	Service Dates	07/25/2023 - 07/25/2023
Member ID	.....	Received Date	07/27/2023
Medicaid ID	.....	
Plan Type	Medicaid		

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 the applicable option



Dispute Claim: ×

Select Option 1: Correct the Claim

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

Select Option 2: Submit Reconsideration Request

- A reconsideration is an informal review performed by the claims department
- We recommend utilizing the reconsideration option before filing a formal claim dispute
- You should NOT use this option if a prior authorization was not obtained
- You may use this option if you disagree with the payment or denial; or need to submit medical records for claims which require medical record review

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.

Corrected Claim

1. Select **Option 1: Correct the Claim**
2. Complete the fields and resubmit

Dispute Claim: ×

Select **Option 1: Correct the Claim**

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

Select **Option 2: Submit Reconsideration Request**

- A reconsideration is an informal review performed by the claims department
- We recommend utilizing the reconsideration option before filing a formal claim dispute
- You should NOT use this option if a prior authorization was not obtained
- You may use this option if you disagree with the payment or denial, or need to submit medical records for claims which require medical record review

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.



Reconsideration

1. Select **Option 2: Informal Reconsideration**

Dispute Claim: ✕

Select Option 1: Correct the Claim

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

Select Option 2: Submit Reconsideration Request 

- A reconsideration is an informal review performed by the claims department
- We recommend utilizing the reconsideration option before filing a formal claim dispute
- You should NOT use this option if a prior authorization was not obtained
- You may use this option if you disagree with the payment or denial; or need to submit medical records for claims which require medical record review

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.

2. Select Reconsideration Type from the drop-down box

Reconsider Claim ✕

Claim No.
Member Name
DOB

 **For Reconsideration Only!**
Not for appeals. Example: If an authorization was not obtained and/or you need to review for medical necessity, submit an appeal. Any submission on this form will be treated as a reconsideration. Please refer to your Provider Manual.

Select Reconsideration Type 

- Denied for a Global/Unbundled Procedure
- Denied for Untimely Filing
- Denial Related to an Authorization
- Claim Paid at the Incorrect Amount
- Coordination of Benefits (COB)
- Co-insurance/Co-pay/Deductible Applied Incorrectly
- Emergency Department Services

CANCEL **SUBMIT RECONSIDERATION**

Associated Documents
Attachment1

Enter the reason for your reconsideration request including pertinent facts and data that support it. There is a 500-character limit, so this should be a summary

3. Scroll down to Upload Documents. Drag and drop files or select files from your computer to upload your medical records, and/or other supporting documentation
4. Check the box at the bottom of the screen to receive email status updates and then click SUBMIT RECONSIDERATION

The screenshot shows a web form titled "Reconsider Claim" with a close button (X) in the top right corner. The form is divided into several sections:

- Notes:** A section labeled "Brief Explanation" with a text area containing the text "The claim was submitted timely as demonstrated by the attached documentation". A red arrow points to the "Brief Explanation" label.
- Character Limit:** Below the text area, it says "500 Character Limit".
- Upload Documents:** A section titled "Upload Documents" with a sub-label "Proof of timely filing attachment Required". It features a dashed border box containing:
 - A "Drag and Drop Files" button with a folder icon. A red arrow points to this button.
 - Text: "Or [Select Files](#) from your computer".
 - Text: "File size limit: 25 MB each. | Accepted file types: .PDF, .TIFF, .TIF, .JPEG, .JPG".A red arrow points to the bottom of this dashed box.
- Email Updates:** A checkbox with the text "Check here to receive email status updates for this reconsideration." A red arrow points to the checkbox.
- Buttons:** At the bottom, there are two buttons: "CANCEL" and "SUBMIT RECONSIDERATION". A red arrow points to the "SUBMIT RECONSIDERATION" button.

5. Reconsiderations may be submitted within 12 months of the date of service. Reconsiderations are reviewed within 60 days of receipt. If the claim is overturned, you'll receive an updated remittance advice. If the original processing is upheld, and the reconsideration was submitted by mail, you'll receive a determination letter outlining the decision. If the reconsideration is submitted via the secure portal, the portal will reflect the upheld decision in the claim details

Claim Dispute

1. Select **Option3: Formal Claim Dispute**

Dispute Claim: ✕

Select Option 1: Correct the Claim

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

Select Option 2: Submit Reconsideration Request

- A reconsideration is an informal review performed by the claims department
- We recommend utilizing the reconsideration option before filing a formal claim dispute
- You should NOT use this option if a prior authorization was not obtained
- You may use this option if you disagree with the payment or denial; or need to submit medical records for claims which require medical record review

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.

2. 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)

Appeal Claim ✕

Claim No.
Member Name
DOB

 **For Appeals Only!**
Not for reconsiderations. Please refer to your Provider Manual.

Select Appeal Type 

- Denied for a Global/Unbundled Procedure
- Denied for Untimely Filing** 
- Denial Related to an Authorization
- Claim Paid at the Incorrect Amount
- Coordination of Benefits (COB)

CANCEL **SUBMIT APPEAL**

Check Date 08/01/2023
Total Check Amount \$136,281.20

25/2023

3. 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 must also complete the Claim Dispute Form (available on our website on the Medicaid Provider Claim Resolution Process page) and upload it along with pertinent medical records and/or other supporting documents in Step 4**
4. Scroll down to Upload Documents. Drag and drop files or select files from your computer to upload your Claim Dispute Form, medical records, and/or other supporting documentation and click SUBMIT APPEAL

Appeal Claim [Close]

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

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

Most Recent Payment details do not show final claim status until a payment date is available. Check back before your timely filing deadline.

✓ Success
Your Appeal request #X257AZW36019 has been submitted successfully.

Claim: Status: Denied

Submitted Denied

6. Within five 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)
7. Claim dispute decisions are issued with 30 calendar days of submission in accordance with A.A.C. R9-34-403 (Computation of Time)
8. 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

For general assistance on the grievance and appeal system, visit the Grievance and Appeal System and the Medicaid Provider Claim Resolution Process pages on our website:

- a. <https://www.azcompletehealth.com/providers/resources/grievance-process.html>
- b. <https://www.azcompletehealth.com/providers/resources/grievance-process/provider-claim-disputes.html>

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