Claims and Payments

For our delegated health plans, please submit claims directly to Arizona Priority Care in order to expedite your payment. We encourage provider offices to consider submitting claims electronically.

The advantages to Electronic Claims Submission are:

1. Claims are usually received within 1-2 days.
2. You are able to verify receipt of claims by payer within two business days. (Identify missing claims earlier).
3. Claims that are submitted with errors can be identified and corrected within 24 hours, rather than waiting for a payer to deny for additional information up to 45 days later.
4. Since claims are received electronically into the claims processing system, they are processed faster because no data entry source is required.
5. When you utilize AZ Connect, you are able to verify receipt as well as claim status without having to make a phone call. To request access, please email ProviderRelations@AZPriorityCare.com.

Electronic Claims Submission Options –

To Enroll in Change Healthcare:

1. Call Change Healthcare (formerly Emdeon) at (866) 858-8938
2. Sign-up online at www.changehealthcare.com (**Payor ID is 27154**)

To Enroll in Office Ally (for professional claims only)**:**

1. Call Office Ally at (866) 575-4120, then select "Enrollment"
2. Sign-up online at www.cms.officeally.com, click on "Start Today", (Payor ID is AZPCP)

Send Paper and/or Corrected Claim Submissions to:

Arizona Priority Care
ATTN: Claims Department
585 North Juniper Drive, Suite 150
Chandler, AZ 85226

PAYMENTS

AZPC processes claims once a week; checks are mailed every Friday and Electronic Funds Transfers (EFT) are processed every Wednesday. Electronic Remittance Advices (ERA) are available through our EZ-Net system in the format of a standard 835 file. If you would like to enroll in EFT/ERA or request access to the EZ-Net system, please email ProviderRelations@AZPriorityCare.com.

PROVIDER CLAIMS DISPUTES

If a participating contracted provider disagrees with an Arizona Priority Care claim determination, a dispute may be requested. Arizona Priority Care recommends that providers submit dispute requests on the Provider Dispute Resolution Request (PDR) form. To access the PDR form and instructions, please visit AZ Connect Provider Portal at https://azconnect.azprioritycare.com/production/default.asp

Compliance with the following is required to file a Dispute:

1. The provider who rendered the service must submit the dispute request with all necessary information, including new information that was not originally submitted, documenting the reason for the appeal request, the original claim, Explanation of Benefits (EOB), prior authorization letter or form, and supporting medical records to the Arizona Priority Care Provider Dispute Department as documented on the EOB.
2. Dispute requests must be received by Arizona Priority Care within 365 calendar days of the Explanation of Benefits (EOB) determination unless the Provider Participation Agreement (PPA) states otherwise.
3. The reason for the dispute must be clearly stated.
4. The disputed amount for each claim must be clearly stated.

Upon receipt of the dispute, the Provider Dispute Department reviews the dispute and approves or denies it within 30 calendar days of receipt of the request based upon the information submitted. If a dispute is denied based on failure to comply with the dispute submission requirements, including those listed above and timeliness requirements, the underlying claims may be denied.

If denied, they are treated as a non-reimbursable service and cannot be billed to the member.

Please submit your provider dispute in writing to the address below:

Arizona Priority Care
585 North Juniper Drive, Suite 150
Chandler, AZ 85226
ATTN: PDR Specialist

If you have questions regarding our Provider Dispute Resolution Process, please call:

Claims Provider Services
(480) 499-8700, Select 3, then Option 3
(855) 706-8388, Select 3, then Option 3

To ensure we resolve your claims issues, we will:

- Gladly accept additional documentation for reconsideration of your claim, i.e. medical documentation, chart notes, authorization information
- Reprocess claims as appropriate
- Answer your questions when you are unsure how your claim was processed