Health Choice Provider Forum
Blue Cross® Blue Shield® of Arizona

Lazaro Torres – Network Operations
Wednesday, July 8, 2026
11:30 AM – 12:30 PM

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Provider Forum Agenda

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❖ Welcome & Introductions – Health Choice Leadership	5 mins
❖ In-Person Visits – Lazaro Torres	5 mins
❖ June Newsletter – Lazaro Torres	5 mins
❖ Provider Partnership for Healthier Kids – Lupe Campos	5 mins
❖ Happy Kids Pediatrics – Christian Leon	10 mins
❖ Provider Quality Coding Toolkit – Kyle Ayrey	5 mins
❖ Availity: 275 Attachments & 278 Authorizations – Lazaro Torres	5 mins
❖ Health Choice Provider Portal – Lazaro Torres	5 mins
❖ Cultural Competency – Jeanette Mallery	5 mins
❖ Provider Resources and Education – Holly Balderrama	5 mins
❖ Q&A	5 mins

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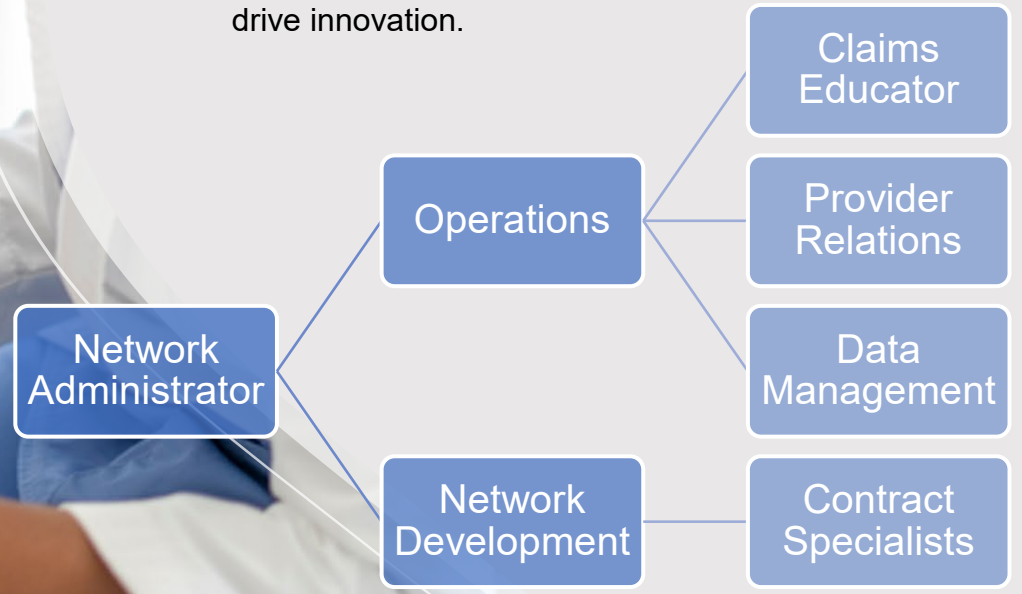
Medicaid Network Services

Diverse Professionals

Our team is composed of professionals from a broad range of backgrounds, bringing a wealth of experience and perspectives.

Dedication to Excellence

Each team member demonstrates a strong commitment to excellence within their area of expertise—consistently delivering high-quality results that ensures our collective success and drive innovation.



Staying Complaint & informed!

Provider Forum

Provider Notices

Newsletters

Provider Announcements

Provider Education

Providers Newsletters & Provider Forums

Important Links

Digital Notices

Lazaro Torres – Network Operations

5 Minutes

Health Choice Provider Newsletter – June 2026

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BlueCross BlueShield Arizona | Health Choice AZ Blue Blog NewsCenter Provid

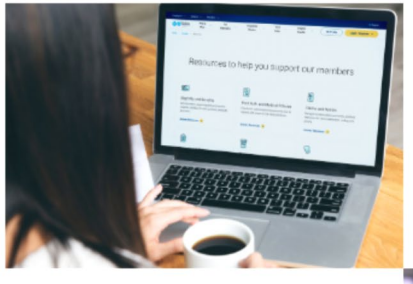
AZ Blue Health Choice Connect

Provider Newsletter

AHCCCS does not allow *incident-to billing*. Every provider must bill using their own NPI. Review the rules to prevent errors.

Read More

IN THIS ISSUE



AZ Blue Health Choice Provider Portal Made Simple

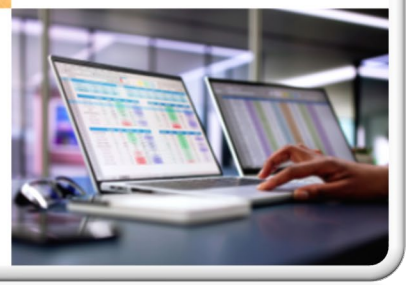
Quick tools and tips to save time every day.

Read More

New Coding Guide = Fewer Claim Issues

Get the latest AHCCCS coding updates.

Read More



Protect Patient Data: Email Rules You Must Follow

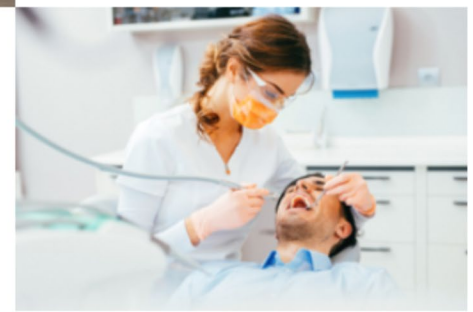
Simple steps to keep PHI safe and stay compliant.

Read More

Dental Code D4346: Use It The Right Way

Avoid common coding mistakes.

Read More



Partner With Us to Boost Well-Child Visits

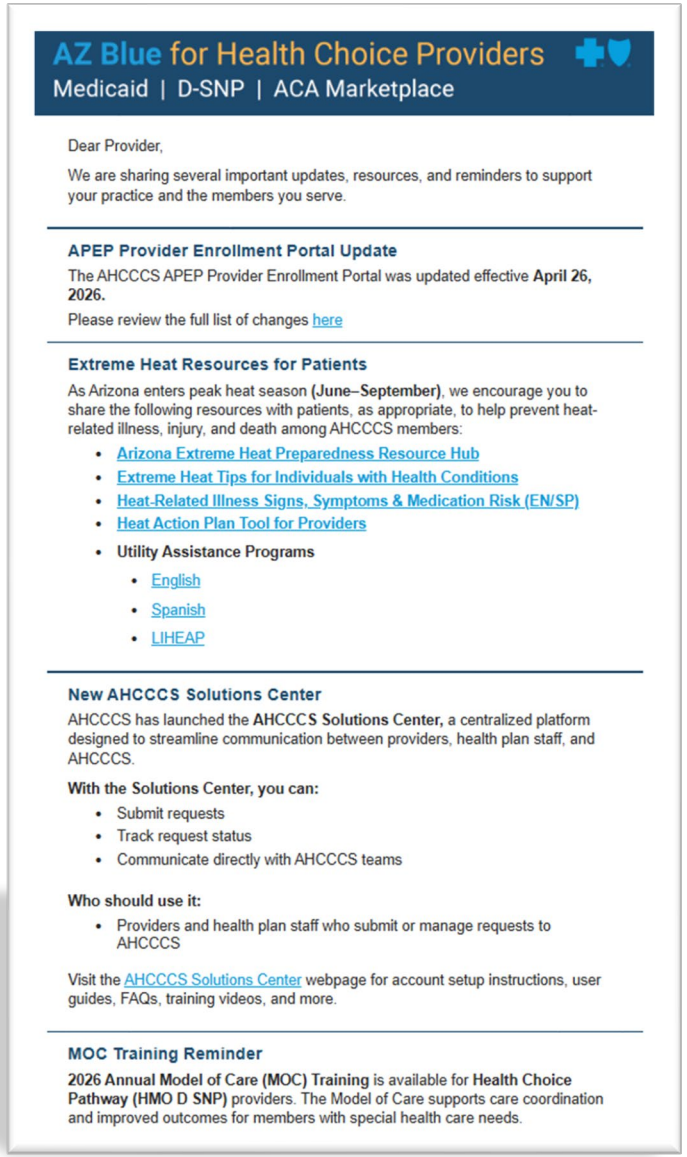
Fill schedules and connect with our team

Read More

[Subscribe Here: Health Choice Provider Newsletter]

*ProviderConnect@azblue.com

Health Choice Provider Alerts



AZ Blue for Health Choice Providers
Medicaid | D-SNP | ACA Marketplace

Dear Provider,

We are sharing several important updates, resources, and reminders to support your practice and the members you serve.

APEP Provider Enrollment Portal Update

The AHCCCS APEP Provider Enrollment Portal was updated effective **April 26, 2026.**

Please review the full list of changes here

Extreme Heat Resources for Patients

As Arizona enters peak heat season **(June–September)**, we encourage you to share the following resources with patients, as appropriate, to help prevent heat-related illness, injury, and death among AHCCCS members:

- Arizona Extreme Heat Preparedness Resource Hub
- Extreme Heat Tips for Individuals with Health Conditions
- Heat-Related Illness Signs, Symptoms & Medication Risk (EN/SP)
- Heat Action Plan Tool for Providers
- **Utility Assistance Programs**
  - English
  - Spanish
  - LIHEAP

New AHCCCS Solutions Center

AHCCCS has launched the **AHCCCS Solutions Center,** a centralized platform designed to streamline communication between providers, health plan staff, and AHCCCS.

With the Solutions Center, you can:

- Submit requests
- Track request status
- Communicate directly with AHCCCS teams

Who should use it:

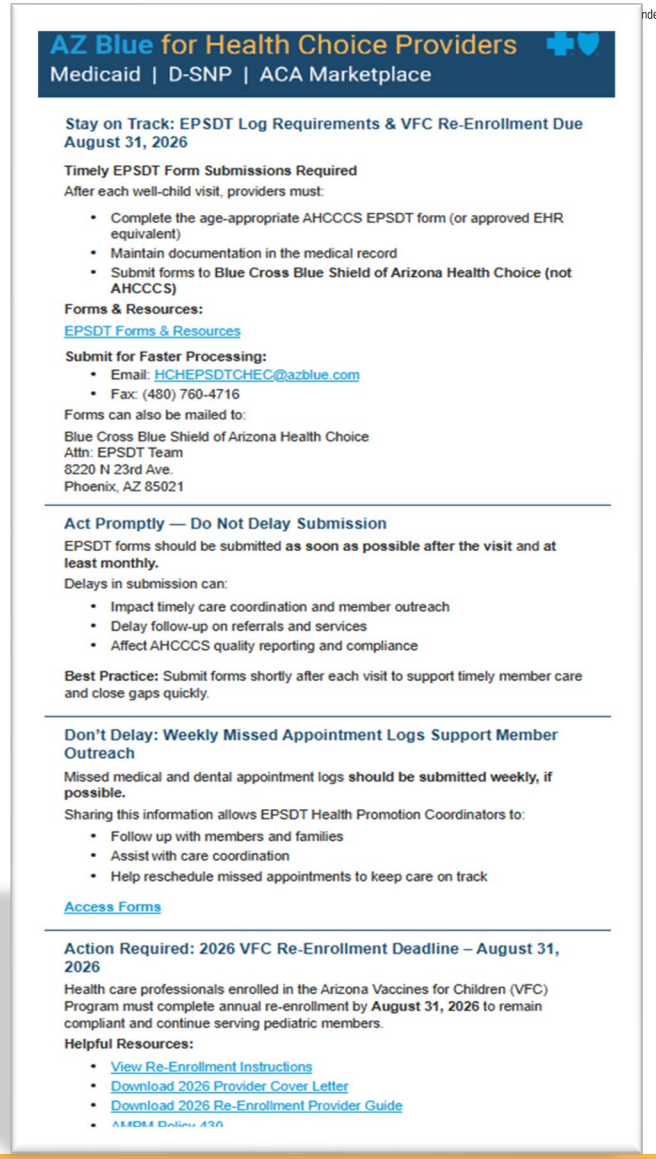
- Providers and health plan staff who submit or manage requests to AHCCCS

Visit the AHCCCS Solutions Center webpage for account setup instructions, user guides, FAQs, training videos, and more.

MOC Training Reminder

2026 Annual Model of Care (MOC) Training is available for **Health Choice Pathway (HMO D SNP)** providers. The Model of Care supports care coordination and improved outcomes for members with special health care needs.

View Provider Alert



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Stay on Track: EPSDT Log Requirements & VFC Re-Enrollment Due August 31, 2026

Timely EPSDT Form Submissions Required

After each well-child visit, providers must:

- Complete the age-appropriate AHCCCS EPSDT form (or approved EHR equivalent)
- Maintain documentation in the medical record
- Submit forms to **Blue Cross Blue Shield of Arizona Health Choice (not AHCCCS)**

Forms & Resources:

EPSDT Forms & Resources

Submit for Faster Processing:

- Email: HCHEPSDTCHEC@azblue.com
- Fax: (480) 760-4716

Forms can also be mailed to:

Blue Cross Blue Shield of Arizona Health Choice
Attn: EPSDT Team
8220 N 23rd Ave.
Phoenix, AZ 85021

Act Promptly — Do Not Delay Submission

EPSDT forms should be submitted **as soon as possible after the visit** and at **least monthly.**

Delays in submission can:

- Impact timely care coordination and member outreach
- Delay follow-up on referrals and services
- Affect AHCCCS quality reporting and compliance

Best Practice: Submit forms shortly after each visit to support timely member care and close gaps quickly.

Don't Delay: Weekly Missed Appointment Logs Support Member Outreach

Missed medical and dental appointment logs **should be submitted weekly, if possible.**

Sharing this information allows EPSDT Health Promotion Coordinators to:

- Follow up with members and families
- Assist with care coordination
- Help reschedule missed appointments to keep care on track

Access Forms

Action Required: 2026 VFC Re-Enrollment Deadline – August 31, 2026

Health care professionals enrolled in the Arizona Vaccines for Children (VFC) Program must complete annual re-enrollment by **August 31, 2026** to remain compliant and continue serving pediatric members.

Helpful Resources:

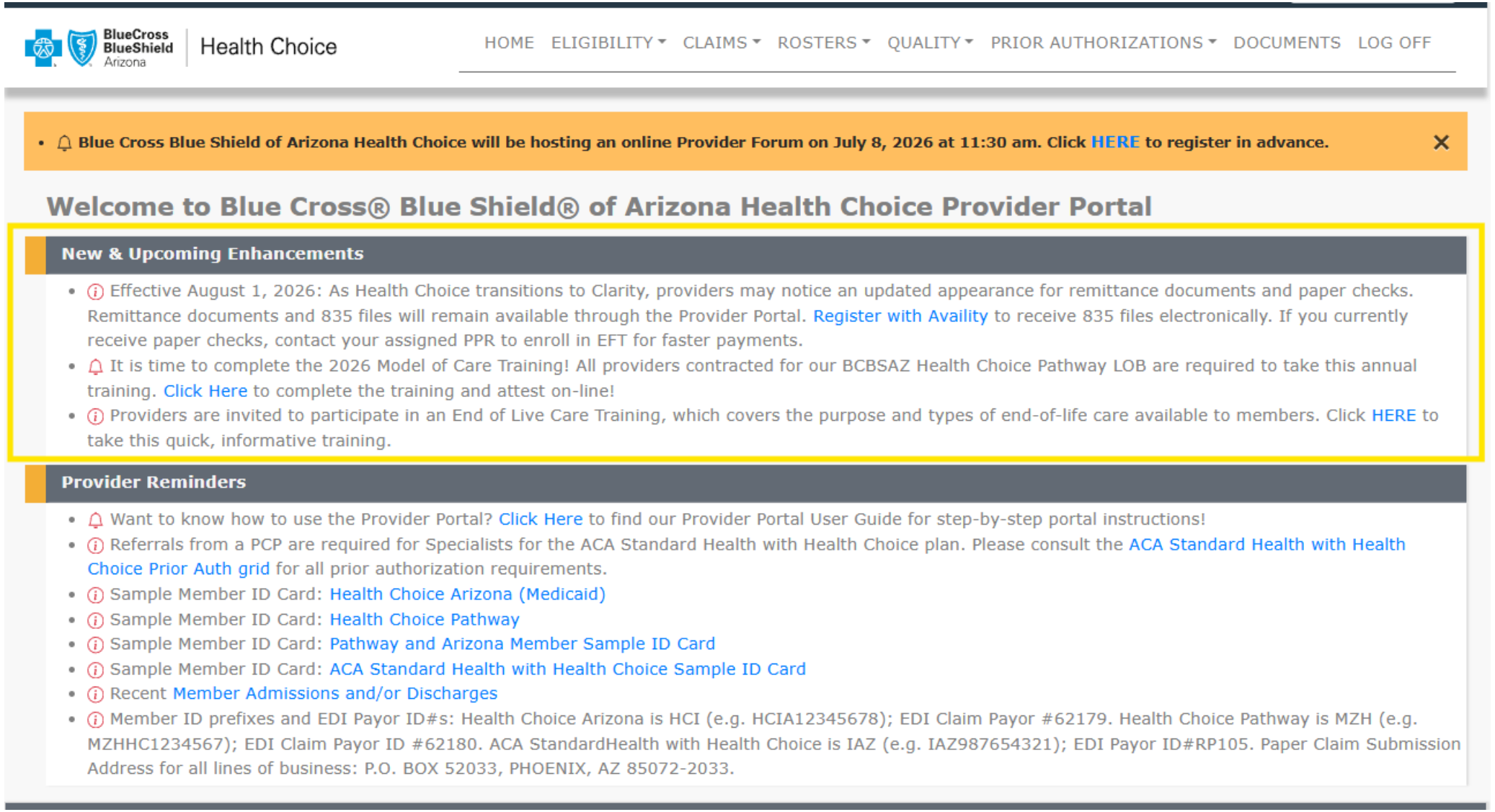
- View Re-Enrollment Instructions
- Download 2026 Provider Cover Letter
- Download 2026 Re-Enrollment Provider Guide
- AMPM Policy 430

View Provider Alert

Subscribe Here: Health Choice Digital Communication

*ProviderConnect@azblue.com

Health Choice Provider Portal Alerts



In-Person Visits

Lazaro Torres – Network Operations

2 Minutes

In-Person Engagement to Support Your Practice

What this means for your practice

- 1:1 support from your assigned Health Choice representative
- Help navigating Provider Portal tools and self-service options
- Addressing questions and concerns in real time

What to Expect

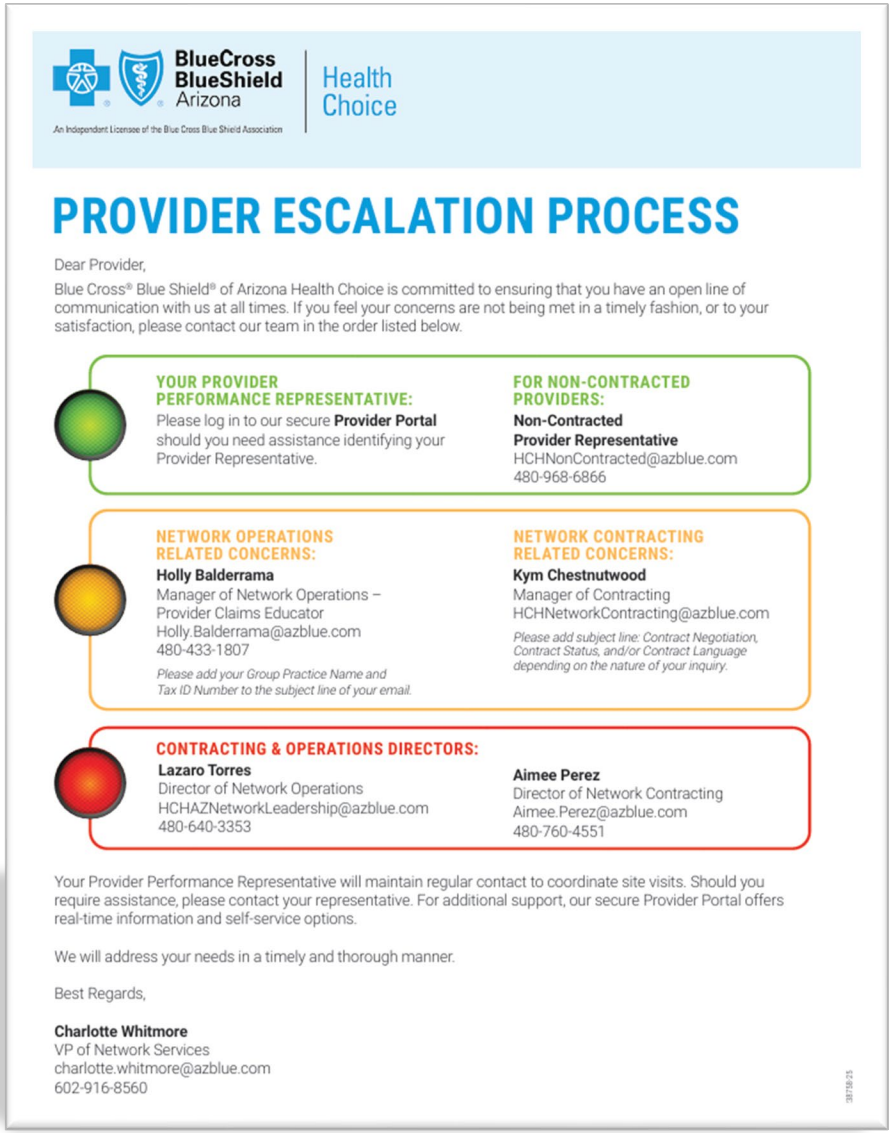
- Personalized guidance tailored to your practice workflow
- Opportunity to share feedback and improvement ideas

Interested in an in-person visit?

- Let us know—our Provider Relations team will coordinate a visit that works for you

More than 400 in-person visits completed by Health Choice Provider Relations team in March – June 2026

Provider Escalation Process



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PROVIDER ESCALATION PROCESS

Dear Provider,

Blue Cross® Blue Shield® of Arizona Health Choice is committed to ensuring that you have an open line of communication with us at all times. If you feel your concerns are not being met in a timely fashion, or to your satisfaction, please contact our team in the order listed below.

YOUR PROVIDER PERFORMANCE REPRESENTATIVE:
Please log in to our secure **Provider Portal** should you need assistance identifying your Provider Representative.

FOR NON-CONTRACTED PROVIDERS:
Non-Contracted Provider Representative
HCHNonContracted@azblue.com
480-968-6866

NETWORK OPERATIONS RELATED CONCERNS:
Holly Balderrama
Manager of Network Operations – Provider Claims Educator
Holly.Balderrama@azblue.com
480-433-1807
Please add your Group Practice Name and Tax ID Number to the subject line of your email.

NETWORK CONTRACTING RELATED CONCERNS:
Kym Chestnutwood
Manager of Contracting
HCHNetworkContracting@azblue.com
Please add subject line: Contract Negotiation, Contract Status, and/or Contract Language depending on the nature of your inquiry.

CONTRACTING & OPERATIONS DIRECTORS:
Lazaro Torres
Director of Network Operations
HCHAZNetworkLeadership@azblue.com
480-640-3353

Aimee Perez
Director of Network Contracting
Aimee.Perez@azblue.com
480-760-4551

Your Provider Performance Representative will maintain regular contact to coordinate site visits. Should you require assistance, please contact your representative. For additional support, our secure Provider Portal offers real-time information and self-service options.

We will address your needs in a timely and thorough manner.

Best Regards,

Charlotte Whitmore
VP of Network Services
charlotte.whitmore@azblue.com
602-916-8560

Provider Escalation Process (Click Here)

Outreach Team: Provider Partnership for Healthier Kids

Lupe Campos – Manager, Consumer Outreach

5 Minutes

Working Together to Keep Children Healthy

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Let's Boost Pediatric Well-Child Visits Together!

Helping kids stay healthy starts with regular **Well-Child Visits (WCVs)**—and we're here to partner with you to make that easier.

AZ Blue Health Choice is working with providers like you to **close care gaps and improve access for pediatric members.**

Contact Lupe Campos to start now!
Guadalupe.Campos@azblue.com

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How We Support You

Our Community Outreach Team works side by side with your practice to plan events that bring families in for care.

Here's what our team can do:

- **Appointment Scheduling**
  We reach out to your assigned members and help book their Well-Child Visits
- **Event Planning Support**
  We help coordinate and organize on-site member events
- **Family Outreach**
  We connect with families to boost attendance and reduce no-shows
- **Member Incentives**
  Eligible members can earn a $25 gift card through our Healthy Rewards Program
- **On-Site Help**
  We set up an info booth, share health education, and connect members to resources
- **Giveaways**
  Swag bags and educational materials to create a great experience

Ready to Get Involved?

Feliz family care

happy kids pediatric

Health Choice Provider Meeting

July 8, 2026

Christian León

President and Chief Operating Officer

Feliz family care

happy kids pediatric

Value-Based Care Partnership Highlights

Happy Kids Pediatrics | Feliz Care Centers | Health Choice

1 Proven Pediatric Performance

- Highest performer in Arizona in EPSDT and well-child performance
- Adolescent well-care is a signature strength

2 Independent VBC Operating Model

- Not dependent on what an ACO or IPA does for us
- We invest in technology that brings payer data into our EMR workflow to identify and act on care gaps

3 Access Built Around Families

- East and West Valley clinics open Fridays and Saturdays | 8:00 AM–5:00 PM
- Approximately 85% of visits on access days are well checks
- Improves access without requiring parents to miss work or children to miss school

4 Health Choice Collaboration in Action

- Since 2022, our partnership has helped close Well-Child Visit gaps and connect more children to preventive care
- Health Choice's outreach team proactively calls members, encourages scheduling, supports families, attends events, and helps drive follow-through
- Healthy Rewards gift cards help reinforce completed well-child visits
- The outreach team is responsive, easy to work with, and a key reason the collaboration is successful
- During focused initiatives, our joint efforts can schedule approximately 90–100 patients in one day

5 Behavioral Health Integration | Roya Health

- Co-location and partnership with Roya Health strengthen our whole-person care model
- Behavioral health is a core part of our clinic model and an important component of TIP 2
- Supports access to behavioral health services in fewer than 72 hours
- Improves coordination, follow-up, and integrated care for our patients

6 TIP 1 to TIP 2

- Strong well-check and EPSDT performance helped generate strong Targeted Investments incentives in TIP 1
- The same access model, Health Choice collaboration, and behavioral health integration continue to support performance in TIP 2

Data identifies the gap. Access removes the barrier. Partnership closes the gap.

2026 Performance Measure Provider Toolkit

Kyle Ayrey – Quality Improvement Program Manager

5 Minutes

New Format – 2026

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2026 Physician's Quality Toolkit

AHCCCS and CMS Performance Metrics
Quality Improvement Specialist (QIS) Program

Blue Cross® Blue Shield® of Arizona (BCBSAZ)/Health Choice employs a team of quality experts called Quality Improvement Specialists. They will work with your practice and consider your unique needs to help your performance on AHCCCS and CMS Quality Measures. If your practice already has an assigned QIS, reach out to them anytime with questions. If you do not have a QIS and are interested in learning more about the program and how it may benefit your practice, please email PerformanceImprovement@azblue.com.

Child and Adolescent Performance Metrics

Pediatric Well-Care Visits (WCV)

Age: Birth to 21

Frequency: 6 visits by 15 months, 2 visits between 15 and 30 months, then annually ages 3 to 21

Qualifying CPT Codes:
New patient well visit: **99381-99385**
Established patient well visit: **99391-99395**
***NOTE:** Well visits can be scheduled at any time during the year; BCBSAZ Health Choice does not impose restrictions around timing of well visits. Per measure specifications, a minimum of 2 weeks between visit dates is required for well-care visit measures to be included in the related quality measure. Telehealth well visits, which were permitted during COVID, are no longer acceptable for well child visit HEDIS measures in 2025

Developmental Screening in the First Three Years of Life (DEV-CH)

Description: Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday

Qualifying Codes: CPT 96110 combined with **ICD-10 Code Z13.42** Encounter for Screening of Global Developmental Delays (Milestones)

Child and Adolescent Recommended Immunization Schedule*

For the latest immunization recommendations please refer to: **https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html**
To assist with accurate data collection, have parents/guardians correct names with AHCCCS when applicable (Example Baby Girl Smith).
*Note: All immunizations must be logged in ASIIS

Annual Dental Visits, Fluoride Varnish, and Dental Sealants

Oral Evaluation, Dental Services (OED): Members under 21 years who received a comprehensive or periodic oral evaluation with a dental provider

Topical Fluoride for Children (2 measures reported):
TFL-CH, dental (DQA) measure: The percentage of children ages 1 - 21 years who received at least two topical fluoride applications within the reporting year
TFC, HEDIS measure: Medicaid members 1-4 years of age who received at least 2 fluoride varnish applications
Qualifying CPT Codes: 99188 (PCP), D1206, D1208

AHCCCS covers dental screening and treatment for members under age 21. A formal referral is not necessary but may facilitate a dental visit

You can help your patients find a contracted Dental Provider on the Health Choice website: **https://providerdirectory.healthchoiceaz.com**

Lead Screening in Children (LSC)

The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday

Childhood Immunization Combo 3

Description: Children who turned two years of age during the measurement period who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); on or before their second birthday

Child/Adolescent/Adult Performance Metrics

Asthma Medication Ratio

Age: 5–64

Description: The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Members qualify for this measure with any of the following during the measurement year:
- An ER or inpatient stay with a primary diagnosis of asthma OR
- Four outpatient visits with an asthma diagnosis AND two asthma medication fills OR
- Four asthma medication fills

Controller medications include:
- Inhaled steroids and inhaled steroid combinations
- Long-acting beta agonists
- Long-acting muscarinic agonists
- Leukotriene modifiers
- Antibody inhibitors
- Anti-interleukin 4 or 5

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Age: 12+

Description: The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care within 30 days. **Note** – capture of depression screening comes through LOINC codes through EMR data sharing or supplemental data files

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

Ages: 18+

Description: Members with 2 or more of the following conditions who receive a follow-up visit within 7 days of an ER visit for any diagnosis:
- COPD/Asthma or unspecified bronchitis
- Alzheimer's disease or dementia related disorder
- Chronic kidney disease
- Depression
- Congestive heart failure
- Myocardial infaction (new or old)
- Atrial fibrillaion
- Stroke or TIA

Timely Prenatal and Postpartum Visits; Postpartum Depression Screening

Prenatal Visits: Pregnant patients should receive at least one prenatal care visit during the first trimester; care may be with PCP or OB and include initial visits for pregnancy testing and OB referral. Make sure to include the diagnosis of pregnancy in the claim when pregnancy testing is positive.
Qualifying Codes:T1015, 99201-99205, 99211-99215, 99241-99245, 0502F ; ICD-10 diagnosis code of pregnancy (Z32.x, Z33.x or Z34.x) must be submitted with EM codes

Postpartum Visits: Patients who give birth should receive a postpartum visit between 7 and 84 days post-delivery; postpartum visits may be completed with a PCP or OB. In addition to traditional PP visits, visits addressing items such as weight, contraception, breastfeeding, PP depression, C-section/wound check count for this measure.
Qualifying Services: Postpartum office visit, IUD insertion, Pap exam
Qualifying Codes for Postpartum Visit: 57170, 58300, 59430, 99501, 0503F, G0101, Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

Postpartum Depression Screening (PDS-E)
The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. Two rates are reported:
1. **Depression Screening:** The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period.
2. **Follow-Up on Positive Screen:** The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

Data collection: Screenings are captured with LOINC codes and follow up with Care Management and visit codes.

Adult Performance Metrics

Medicare Annual Wellness Visits (AWV) / Comprehensive Health Evaluation (CHE)

Age: All patients covered by Medicare (Traditional, Dual/Special Needs, and Advantage plans)

Description: A yearly "Wellness" visit to develop or update a personalized plan to help prevent disease and disability, based on current health and risk factors. The yearly "Wellness" visit isn't a physical exam.

Qualifying CPT Codes: G0438/G0439/G0468 ONLY
***NOTE:** 99499 may be used in addition to G Codes for patients with 12+ diagnoses.
Health Choice Pathway recommends one AWV per calendar year (no minimum required time between AWVs as with traditional Medicare).
www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

Breast Cancer Screening (BCS-E)

Age: 40–74*

Description: Women 40–74 years of age must have a mammogram to screen for breast cancer every two years.

*Note updated age range
EXCLUSION Z90.13 History of bilateral mastectomy

Cervical Cancer Screening

Age: 21–64

Frequency: Age 21–64, cervical cytology every 3 years
Age 30–64, cervical cytology + HPV test every 5 years

Description: The percentage of women 21–64 years of age who were screened for cervical cancer in the previous 3–5 years

Qualifying CPT if performed in-office: Q0091
EXCLUSION Z90.710 Acquired absence of both cervix and uterus
When documenting hysterectomy in the chart, be specific. Acceptable documentation for exclusion: Total, vaginal, complete, or radical hysterectomy. Hysterectomy with documentation that a member no longer needs Pap testing/cervical cancer screening is also acceptable.

Colorectal Cancer Screening (COL-E)

Age: 45–75

Description: Individuals 45–75 years screened for colorectal cancer

Frequency: Varies based on screening type:
- FOBT/FIT Kit: Every year
- Sigmoidoscopy: Every 5 years
- Colonoscopy: Every 10 years
- FIT DNA/Cologuard®: Every 3 years
- CT Colonography: Every 5 years

CPT-II code to help in collecting data from prior year screening results when applicable: 3017F Colorectal cancer screening results documented and reviewed

Diabetes Care: Glycemic Status Assessment for Patients with Diabetes (GSD), BP Control, Eye Exam, and Kidney Health
Blood Pressure Control for patients with hypertension (BPC-E)

Age: 18–75

Description: Diabetic patients (type 1 and type 2) 18–75 years of age should receive each of the following every year:
- Hemoglobin A1c (HbA1c) test or glucose management indicator
- Retinal eye exam
- BP measurement and treatment if 140/90 or higher

*Two measures are reported for GSD: Members with A1c 8 or less and members with A1c >9. Poor control is considered 9.1 and higher.

Frequency: Every year

CPT and CPT-II Codes for A1c Control:
83036 Hemoglobin; glycosylated (A1C) test
3044F Most recent HbA1c < 7.0%
3051F Most recent HbA1c ≥ 7.0% and < 8.0%
3046F Most recent HbA1c > 9.0%
3052F Most recent HbA1c ≥ 8.0% < or = 9.0%

Blood Pressure Control: BDP (Controlling Blood Pressure in Diabetes) and BCP-E (Blood Pressure Control) – patients 18–75 with a diagnosis of hypertension and/or a diagnosis of diabetes meet the measure(s) when their most recent blood pressure reading is <140/90.

CPT-II codes for BDP and BPC-E:
3074F Most recent systolic blood pressure < 130 mm Hg
3075F Most recent systolic blood pressure 130-139 mm Hg
3077F Most recent systolic blood pressure > 140 mm Hg
3078F Most recent diastolic blood pressure < 80 mm Hg
3079F Most recent diastolic blood pressure 80-89 mm Hg
3080F Most recent diastolic blood pressure > 90 mm Hg

Diabetic Eye Exams: Current year dilated retinal screening w/ evidence of retinopathy: **CPT-II: 2022F, 2024F, 2026F**
Current year dilated retinal screening w/o evidence of retinopathy: **CPT-II: 2023F, 2025F, 2033F**
Prior year dilated negative retinal screening: **CPT-II: 3072F**

Kidney Health Evaluation for Patients with Diabetes (KED):
Diabetic patients aged 18–85.
The measure evaluates adults who have received an annual kidney health evaluation by an estimated glomerular filtration rate (eGFR) **AND** a urine albumin-creatinine ratio (uACR) during the measurement year.

Care for Older Adults (COA) Medication Review, Functional Status Assessment

Age: 66 years and older

Frequency: Every year

Functional Status Assessment: An individual's functional status should be assessed using ADLs, IADLs, or other standardized tool
Qualifying CPT-II Codes: 1170F Functional Status Assessed

Medication Review: At least one medication review by a prescribing practitioner or clinical pharmacist during the measurement year.
BOTH documentation of the medication list and documented review by a prescriber must be present.
Qualifying CPT-II Codes (both required to satisfy the measure):
1159F Medication list documented in medical record **AND**
1160F Review of all medications by a prescribing practitioner

Social Need Screening and Intervention (SNS-E)

Age: All

Description: Members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive.

Related codes: G0136 Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment;
96160, Administration of patient-focused health risk assessment instrument with scoring and documentation, per standardized instrument;
96161, Administration of caregiver-focused health risk assessment instrument for the benefit of the patient, with scoring and documentation, per standardized instrument.
LOINC and SNOMED codes (from EMR data)

Plan All-Cause Readmissions (PCR)

Description: The rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge. The observed rate and predicted probability is used to calculate a calibrated observed-to-expected ratio.
Two Proven Strategies to Reduce Readmissions:
1. Follow-up phone call after discharge
2. Follow-up appointment within 7 days of discharge

Care Management

BCBSAZ Health Choice Pathway Care Managers assist members to obtain resources and healthcare services to meet member needs. By supporting members, they support you, the primary care provider.
Care Managers educate members on the importance of the treatment plan you developed and the importance of the preventive and treatment services you ordered such as labs, imaging studies, medications.
Please contact Care Management when you need that extra support to close quality and preventive service care gaps. **HCHHCACaseManagement@azblue.com** or **480-350-2232**

Adult Immunization Status (AIS-E)

Age 19+

Percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster, and pneumococcal.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

Adults 18 years of age and older who have schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

[2026 Physician's Quality Toolkit]

Covered Measures

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Child and Adolescent Measures

- Child and Adolescent Well Visits (WCV)
- Developmental Screening in the First Three Years of Life (DEV-CH)
- Oral Evaluation and Dental Services (OED)
- Topical Fluoride for Children (TFC-CH)
- Lead Screening in Children (LSC)
- Childhood Immunization Status Combo 3 (CIS)

Maternal Measures

- Timeliness of Prenatal Care (PPC)
- Postpartum Care (PPC)
- Postpartum Depression Screening (PDS-E)

Child/Adolescent/Adult Measures

- Asthma Medication Ratio (AMR)
- Depression Screening and Follow-Up (DSF-E)
- Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)

Covered Measures (cont.)

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Diabetes Care Measures

- Glycemic Status Assessment for Patients with Diabetes (GSD),
- Blood Pressure Control (BPD)
- Eye Exam, and Kidney Health
- Blood Pressure Control for patients with hypertension (BPC-E)

Adult Measures

- Medicare Annual Wellness Visits (AWV)
- Comprehensive Health Evaluation (CHE)
- Breast Cancer Screening (BCS-E)
- Cervical Cancer Screening (CCS)
- Colorectal Cancer Screening (COL-E)
- Social Needs Screening (SNS-E)
- Plan All Cause Readmissions (PCR)
- Adult Immunization Status (AIS-E)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

Significant Notes

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

- Per AMPM 430, AHCCCS requires that suicide and depression screenings begin at 10 years of age and adolescent substance use disorder (SUD) screenings begin at 12 years of age.

Kidney Health Evaluation for Patients with Diabetes (KED):

- The measure evaluates adults who have received an annual kidney health evaluation by an estimated glomerular filtration rate (eGFR) **AND** a urine albumin creatinine ratio (uACR) during the measurement year.
- uACR must be identified by one of the following:
  - Both a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) and a urine creatinine test (Urine Creatinine Lab Test Value Set) with service dates **four days or less apart**.
  - A uACR (Urine Albumin Creatinine Ratio Lab Test Value Set).

Availity

Lazaro Torres – Network Operations

5 Minutes

New Transactions with Availity

275 – Attachments

- Submit required documentation electronically. (e.g., medical records, attachments).
- Streamlines medical records and attachments submissions

278 – Authorization Requests & Status

- Submit and track prior authorization requests electronically.
- Faster approvals & real-time status updates

Electronic Transactions Made Easy

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

Transactions

- 835 Electronic Remittance
- 837 Institutional, Professional & Dental
- 270/271 Eligibility
- 275 Attachments
- 276/277 Claim Status
- 278 Authorization

Payer IDs

- Health Choice Arizona: **62179**
- Health Choice Pathway: **62180**
- ACA Standard Health w/ Health Choice: **RP105**

Why Switch to Electronic Transactions?

- Real-time claim + eligibility responses
- Auto-posting with 835 ERA improves efficiency
- Less paperwork with 275 & 278 transactions

Getting Started (3 Steps)

1. Register with Availity Essentials
2. Set up EDI connections with your PM/EHR or clearinghouse to enable X12 Transactions
3. Test and go live. Enable ERAs (835) for automated posting.

Support Contact: Availity Client Services at 800-282-4548

Resources

BlueCross BlueShield Arizona
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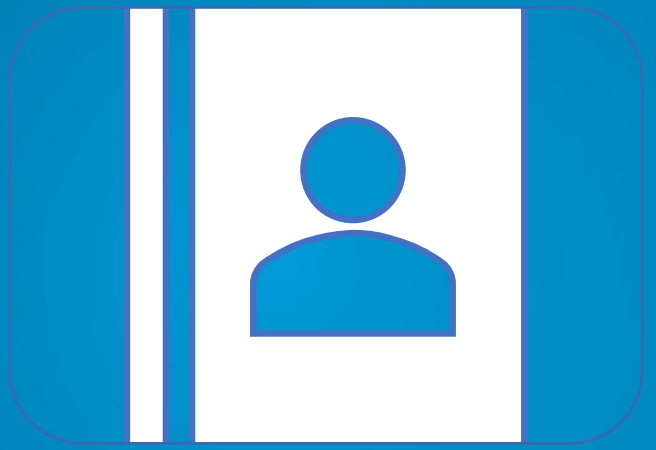
Health Choice

Availity EDI Connection Guide



Availity EDI Companion Guide

For questions or assistance, contact HCEDIGroup@azblue.com

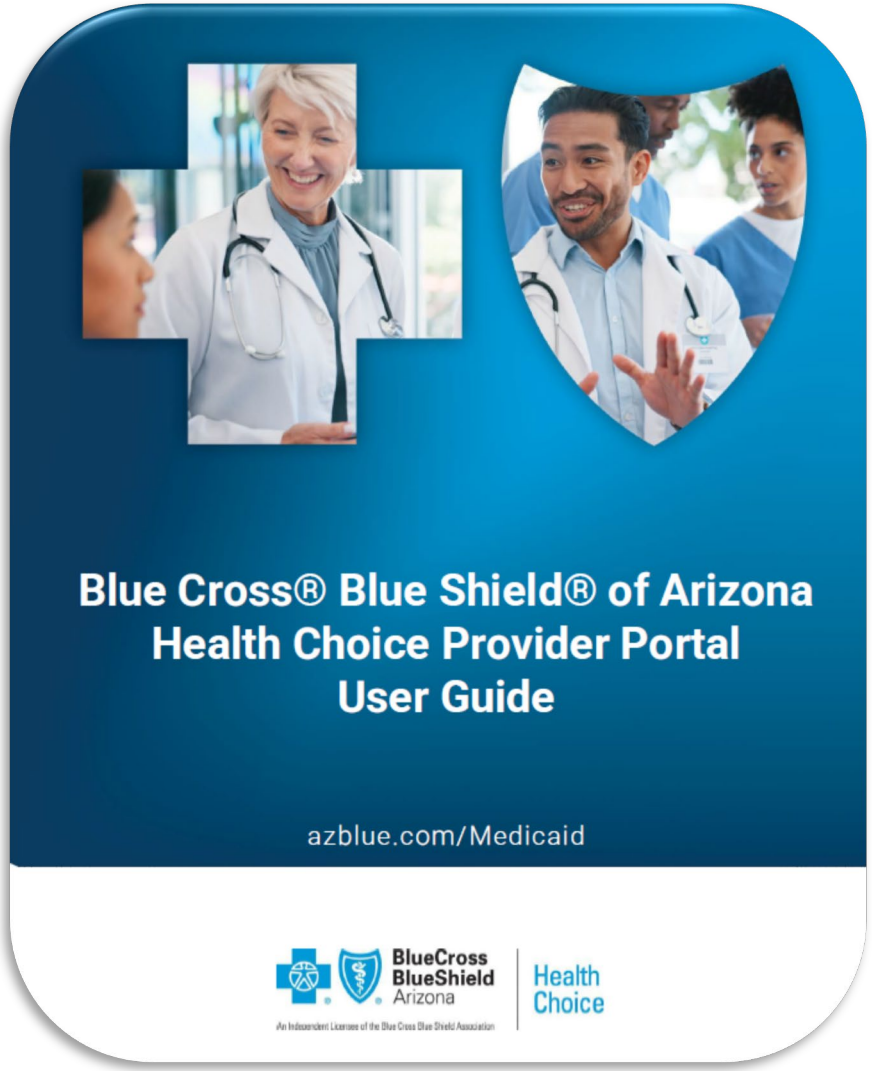
Contact your assigned Provider Representative for other inquiries.

Health Choice Provider Portal

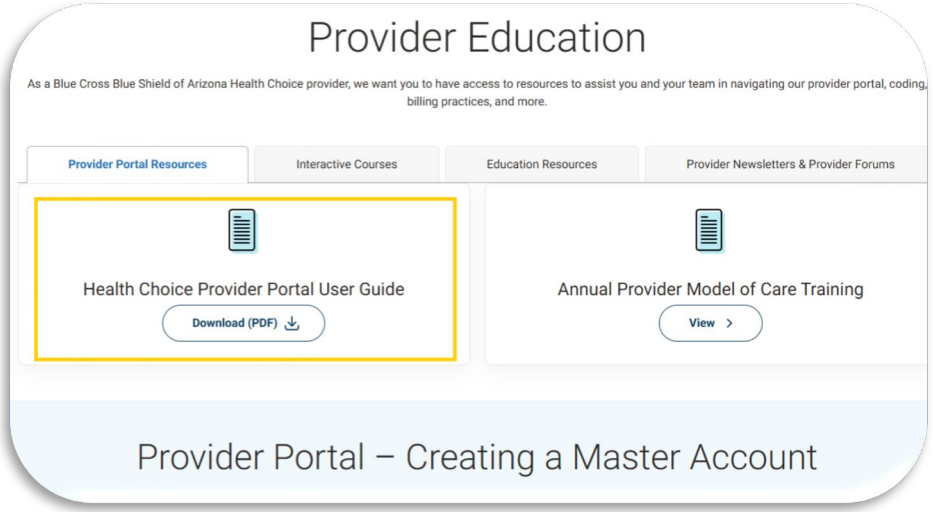
Lazaro Torres – Network Operations

3 Minutes

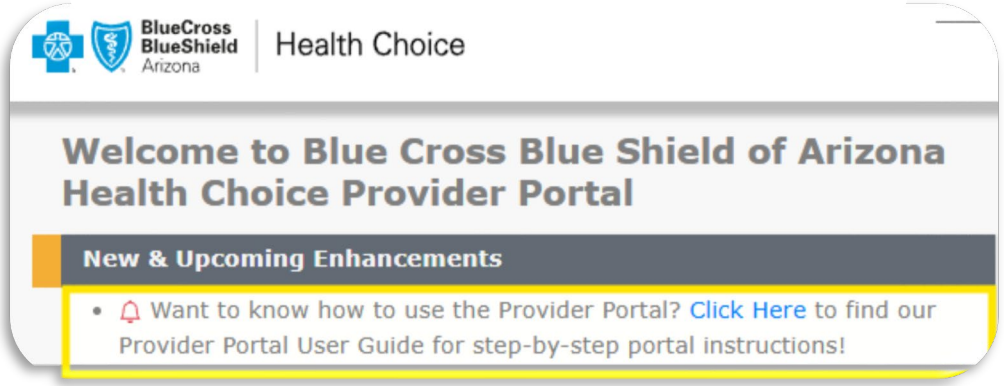
Provider Portal User Guide



For Providers → Provider Education



Provider Portal User Guide

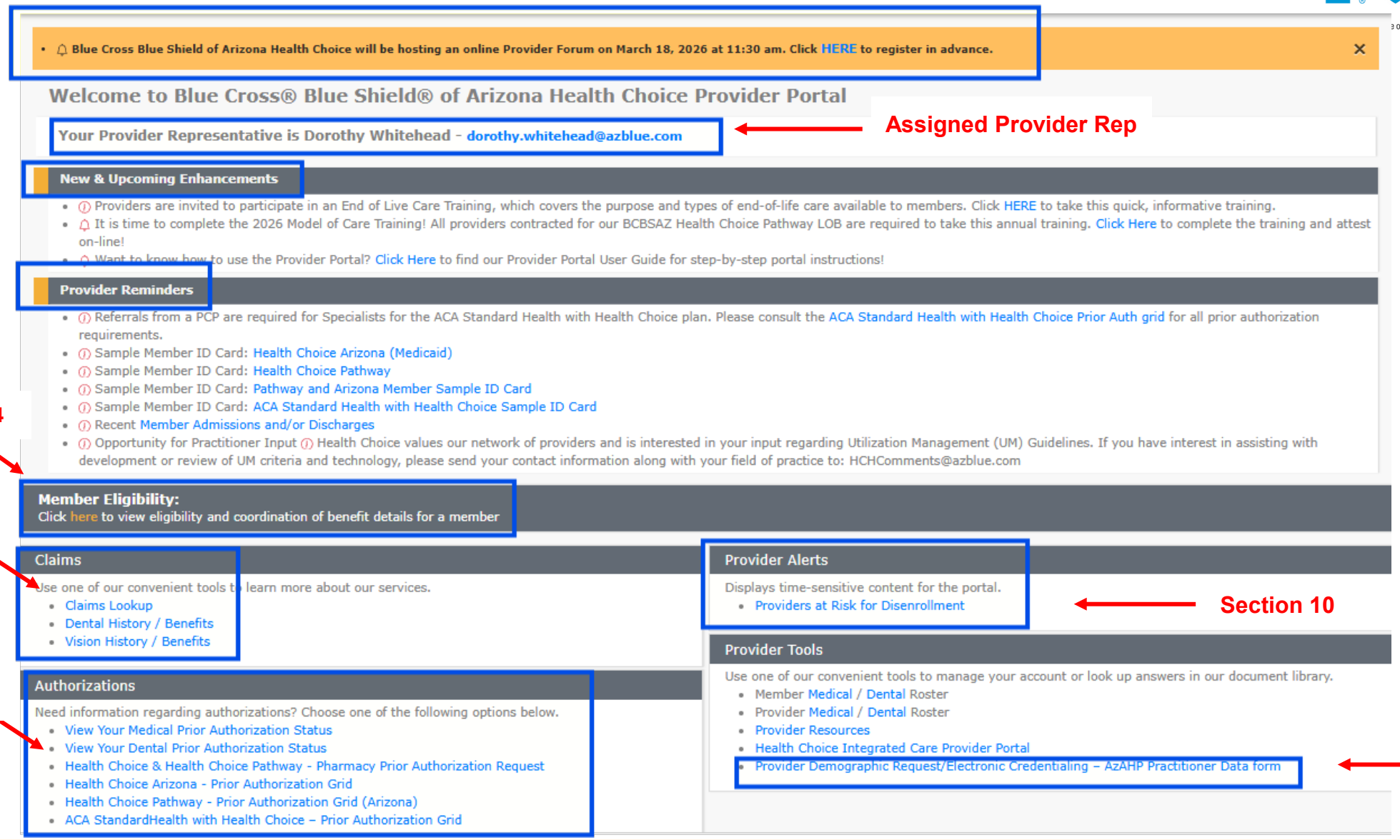


User Guide Sections

Section	Title
1	Introduction
2	Getting Started & Logging In
3	E-Credentialing & Provider Demographic Request
4	Eligibility & Benefits
5	Claims Management
6	Prior Authorizations
7	EOB / ERA Search
8	Gaps in Care
9	Provider and Member Rosters
10	Revalidation
11	Education & Resources
12	Frequently Asked Questions (FAQ)

Direct Link:
Provider Education | Medicaid | AZ Blue

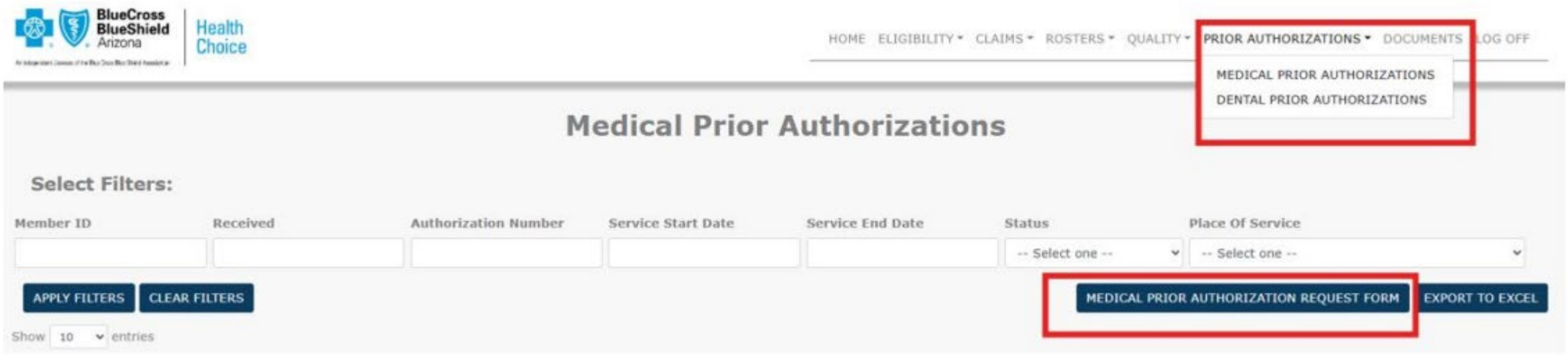
Health Choice Provider Portal

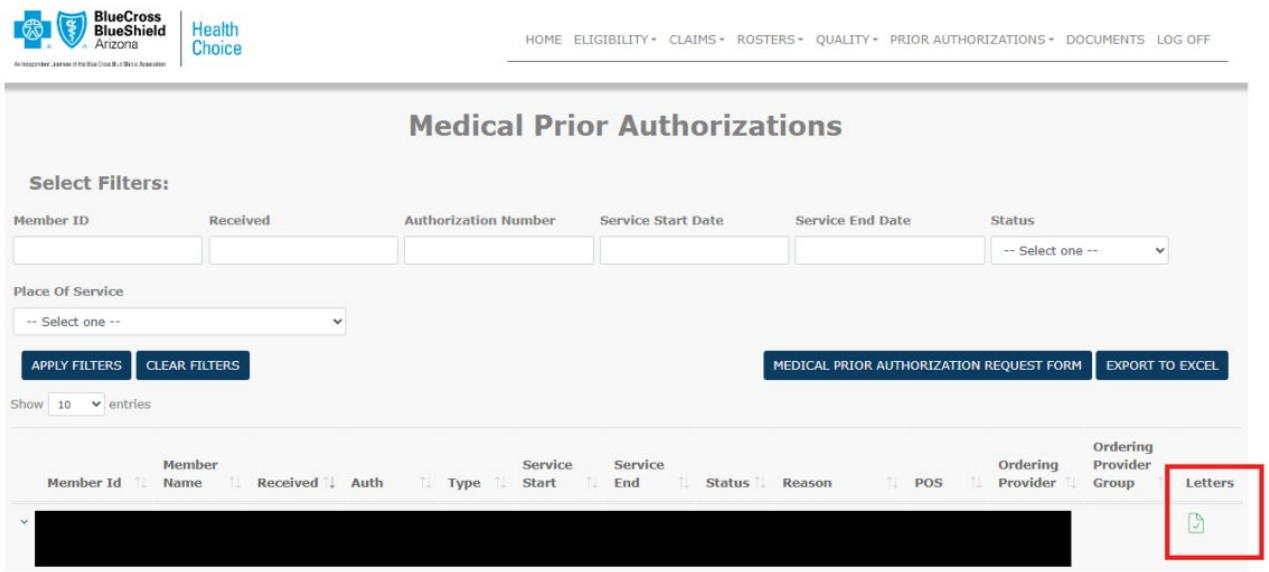


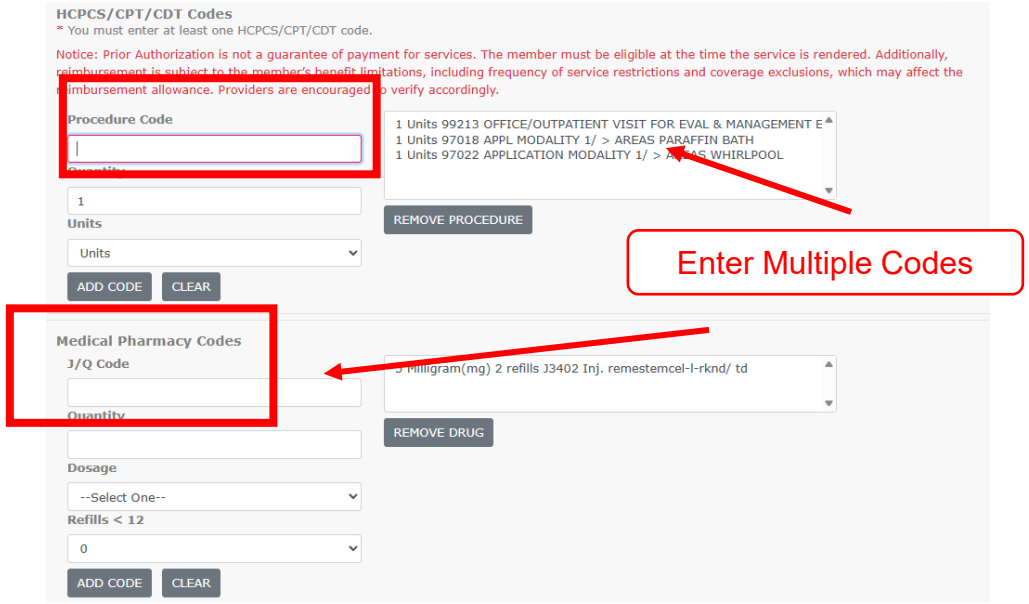
Need access? Contact your Admin User or Provider Portal Support 480-760-4651 or 800-322-8670 or email HCHproviderportal@azblue.com

Refer to User Guide: Section 2.7

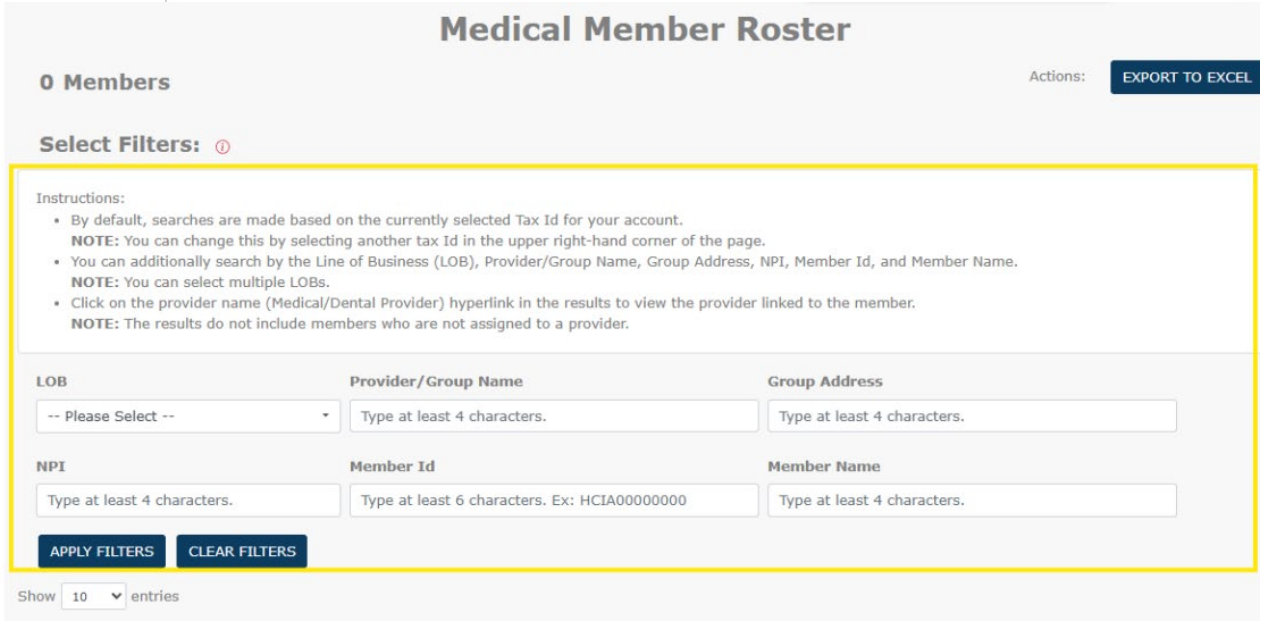
Prior Authorization – Section 6

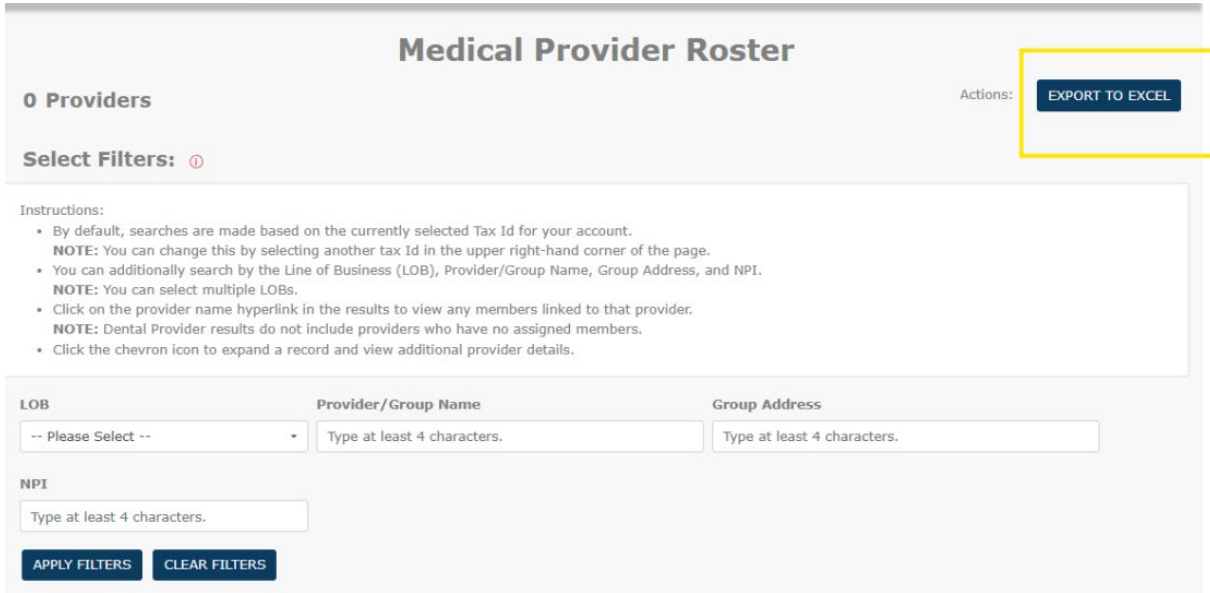




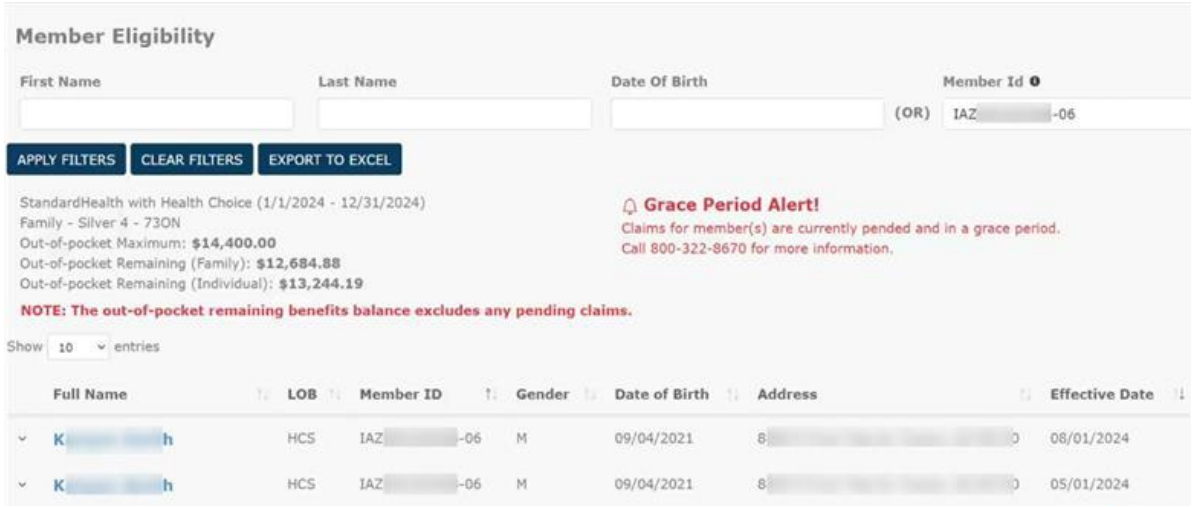


Provider & Member Rosters – Section 9



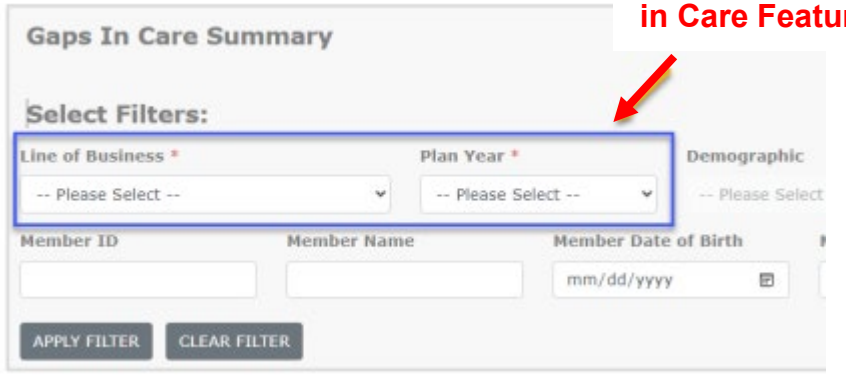


Eligibility & Gaps in Care

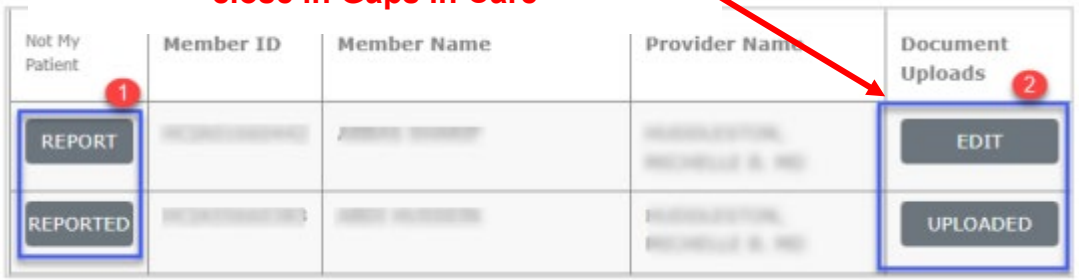


Section 4: Eligibility Screen: Effective Date, Grace Period, Out-of-Pocket Remaining,

Section 8: Gaps in Care Feature



Section 8 – Upload documentation to close in Gaps in Care



Cultural Competency and Language Access Services

Jeanette Mallery
Cultural Competency Administrator

Jeanette.Mallery@azblue.com

Arizona Population Languages

Language	Number of Speakers Age 5+	% of Population Age 5+
English only	4,980,000	78.6
Spanish	1,290,000	20.4
Navajo	82,700	1.3
Chinese (Mandarin, Cantonese)	30,200	0.5
Other Native American	26,500	0.4
Tagalog (incl. Filipino)	23,800	0.4
Vietnamese	23,300	0.4
Arabic	23,100	0.4
German	21,500	0.3
French (incl. Cajun)	16,800	0.3
Hindi	10,500	0.2
Other Indo-European	10,300	0.2
Korean	9,942	0.2
Afro-Asiatic (e.g., Somali)	8,797	0.1
Russian	7,786	0.1
Serbo-Croatian	7,590	0.1
Austronesian (e.g., Ilocano)	7,413	0.1
Japanese	6,737	0.1
Italian	6,676	0.1
Persian (Farsi, Dari)	6,624	0.1

Data Source: American Communities Survey Data

At least every three years, we evaluate census level data to identify threshold and spoken languages for the Arizona population. The chart on the left reflects 2025 American Communities Survey Data

English and Spanish were identified as threshold languages for translation purposes of vital materials. (i.e., languages spoken by 5% of the population or 1,000 individuals, whichever is less)

English, Spanish, and Navajo were identified as threshold languages spoken (i.e., languages spoken by 1% of the population or 200 individuals, whichever is less) for purposes of notification of language services

We provide a written notice in English, Spanish, Navajo and Vietnamese about the availability of free language assistance and how to access it

AZ Blue Health Choice Member Primary Languages (Calendar Year 2025) – Medicaid and D-SNP Members

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Health Choice

Primary Language	All Members	
	Member Count	Portion of Membership
Albanian	1	0.0004%
American Sign Language	14	0.0058%
Arabic	266	0.1100%
Armenian	5	0.0021%
Chinese	140	0.0579%
English	218,903	90.4857%
French	41	0.0169%
German	1	0.0004%
Greek	5	0.0021%
Hindi	28	0.0116%
Hmong	1	0.0004%
Hungarian	1	0.0004%
Japanese	11	0.0045%
Khmer	1	0.0004%
Korean	48	0.0198%
Lao	8	0.0033%
Navajo; Navaho	48	0.0198%
North American Indian (Other)	3	0.0012%
Persian	50	0.0207%
Polish	10	0.0041%
Portuguese	3	0.0012%
Russian	42	0.0174%
Somali	63	0.0260%
Spanish	21,374	8.8352%
Tagalog	37	0.0153%
Unknown	559	0.2311%
Vietnamese	257	0.1062%

Data Source: Enrollment data

Language Access Services

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Types of Language Services

Language access includes oral interpretation, sign language, and written translation services and auxiliary aids for those with disabilities.

- We provide these services to our members at no cost when they are communicating with health plan staff.
- Providers are required to provide these services to patients at no cost during their engagements with patients and during healthcare encounters.
- Family members, friends, and minor children are not permitted to interpret and/or translate, except in cases of emergency where no qualified interpreter or translator is available.

Informing Patients

Providers must notify patients about available language assistance in their preferred language at all points of contact to ensure equitable access.

Legal Compliance

Compliance with Title VI and Executive Order 13166 is mandatory, including documentation of language services provided.

Resources for Providers

BlueCross BlueShield Arizona
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Conversation Starters: Culture and Needs Tool

- This tool includes questions to begin a respectful conversation about a member's cultural needs. It can be used to prepare for and conduct the intake process, as well as for engaging with members during a visit, but is not an assessment.

Language Services Provider Job Aid

- This tool details the expectations and resources as it relates to language services, including but not limited to interpretation, translation, ASL, alternate formats, use of auxiliary aids and more.

Cultural and Language Requirements for Delivering Care Training

- This on-demand training cover topics including federal regulations, CLAS Standards, language services, use of auxiliary aids, and physical accommodations.

Member Language Services Flyer

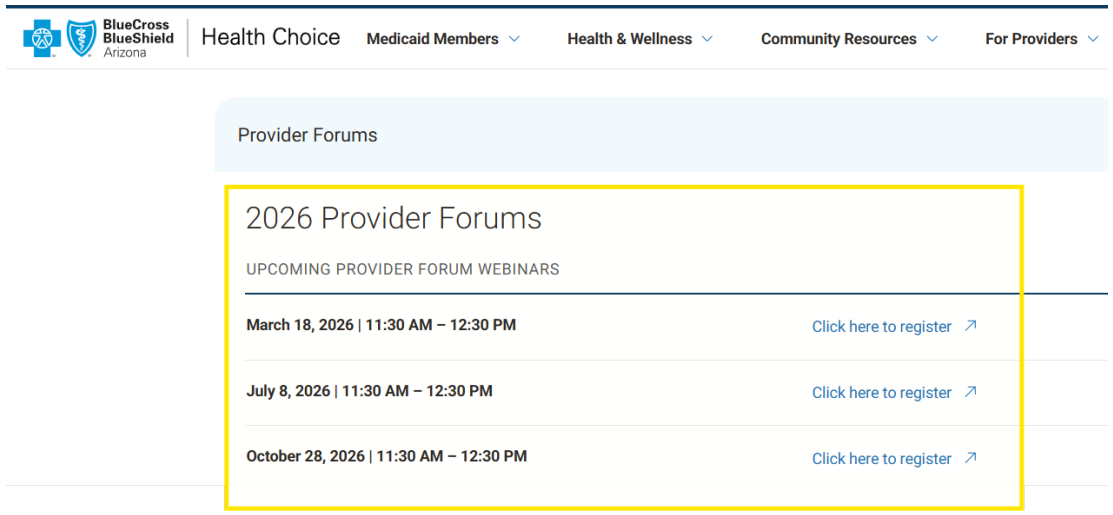
- This tool provides information on what to expect during appointments, as well as resources. It is downloadable on the website in English, Spanish, Navajo, and Vietnamese, and may be used by providers and members.

Upcoming Health Choice Provider Forums

Lazaro Torres

Upcoming Provider Forums

2026 Upcoming Provider Forum Webinars	
March 18, 2026 | 11:30 AM – 12:30 PM	**Published**
July 8, 2026 | 11:30 AM – 12:30 PM	**Slide Deck Coming Soon**
October 28, 2026 | 11:30 AM – 12:30 PM	Click here to register



Azblue.com/Medicaid → For Providers → Provider Education → Provider Forums & Newsletters

BlueCross BlueShield Arizona
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Questions?

ProviderConnect@azblue.com

Provider Resources & Education

Holly Balderrama – Network Services

EPSDT Forms & Missed Appointment Logs

BlueCross BlueShield Arizona
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Health Choice

EPSDT Form Submission – Key Reminders

- ✓ Submit promptly after each well-child visit (do not hold for bulk submission)
- ✓ At minimum, submit monthly to meet AHCCCS expectations
- ✓ Complete the age-appropriate AHCCCS EPSDT form (or approved EHR equivalent)
- ✓ Submit to BCBSAZ Health Choice (not AHCCCS)
- ✓ 2026 Providers Medicaid EPSDT Alert

Missed Appointment Logs – Key Reminders

- ✓ Submit missed medical and dental appointment logs weekly (preferred)
- ✓ Timely submission allows Health Choice to:
  - ✓ Conduct outreach to members and families quickly
  - ✓ Support care coordination efforts
  - ✓ Assist with rescheduling and reduce gaps in care
- ✓ Delays in reporting missed visits limit timely follow-up and member engagement

Model of Care (MOC) Training & Attestation

Health Choice Pathway 2026 Annual MOC training is available online!

CMS requires all D-SNPs to maintain a Model of Care (MOC), and all Health Choice staff, vendors, and providers must complete basic MOC training.

Visit our page to complete the required MOC Training and Attestation

[Provider Education - BCBSAZ Health Choice Pathway]

Key Reminders

Keep Provider Information Current

Submit timely updates to demographics (address, phone, panel status) to ensure directory accuracy.

Respond Timely to Requests

Promptly address outreach (records requests, audits, follow-ups) to stay compliant.

Utilize the Provider Portal

Use the portal for eligibility checks, claims status, prior authorizations, e-credentialing, and more.

Align with AHCCCS Requirements

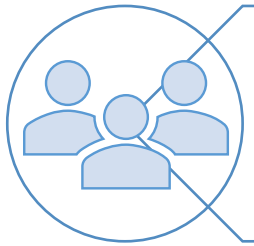
Maintain compliance with documentation, access standards, and site visit readiness.

Submit Complete Prior Authorizations

Ensure requests are accurate and submitted timely to prevent delays in care and processing.

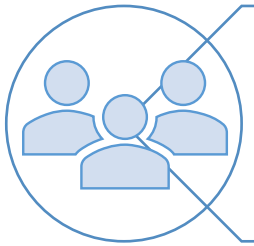
Leverage Your PPR

Partner with your Provider Relations Representative for support, issue resolution, and training.



Ensure Claims Accuracy

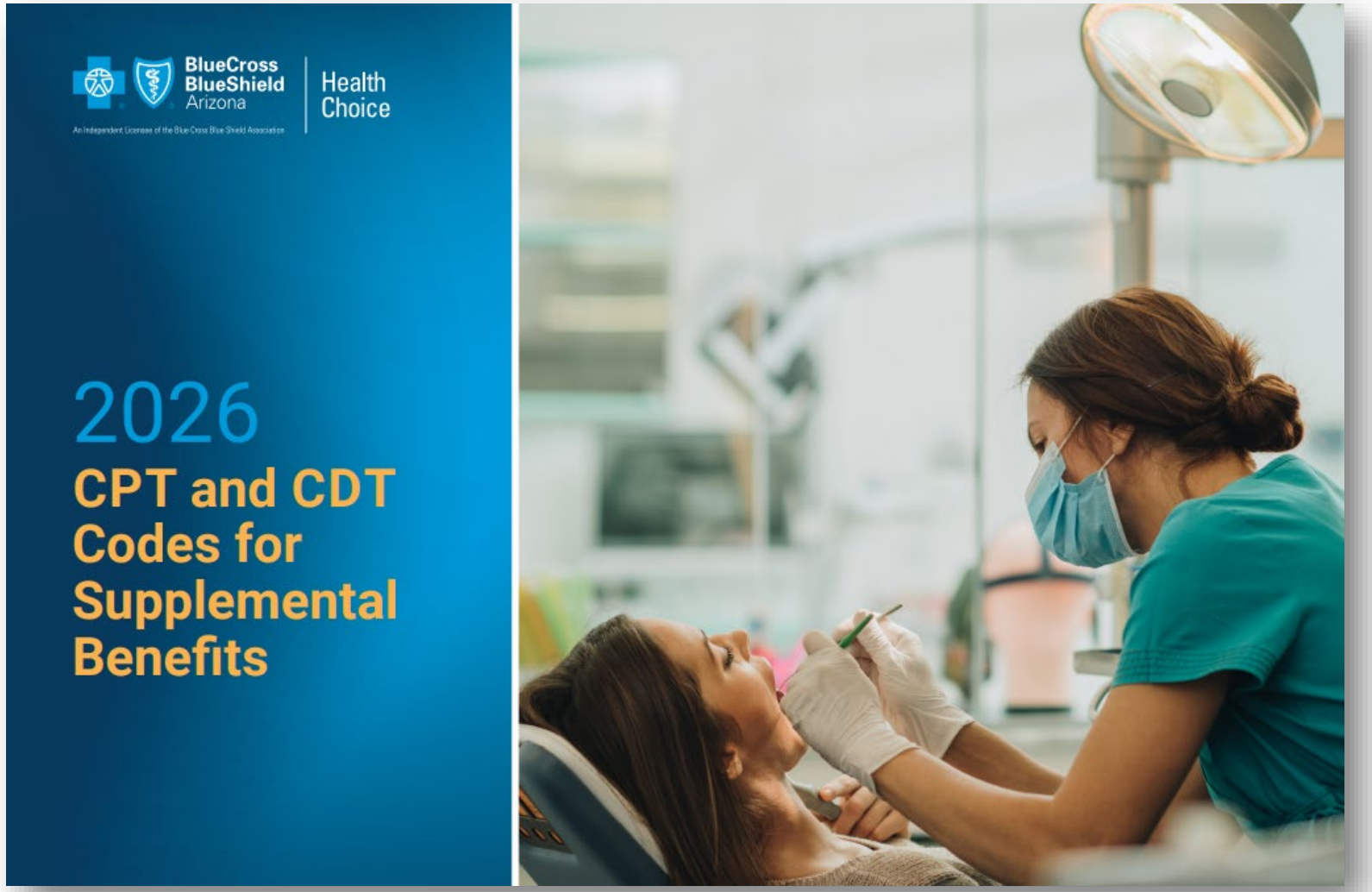
Submit clean claims with correct coding and documentation to reduce denials and rework.



Engage and Provide Feedback

Ask questions and share input—your feedback helps improve processes and provider experience.

2026 Supplemental Benefits
Health Choice Pathway



Dental X-Ray Coverage Update

- Members are limited to **two dental X-rays per year**, which may include
  - **Two bitewings** (D0272 or D0274), **or**
  - **One bitewing** (D0272 or D0274) **and One Complete Set (FMX/Panoramic)** (D0210 or D0330)
- Complete set/panoramic X-rays are limited to once every 36 months
- D0220 and D0270 are covered as needed and count toward the $3,500 annual dental benefit limit

Click here for information: CDT-and-CPT-Codes-for-Supplemental-Benefits.pdf

Electronic Visit Verification (EVV)

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Topics

- Auto-Verified Visits vs. Manual Visits
- EVV Compliance Definitions and Expectations
- What Makes a Visit “Manual”
- What Qualifies as an Auto-Verified Visit
- EVV Auto-Verification as a Compliance Indicator
- Aggregator Reports (Visit Verification Summary)
- Monitoring EVV Performance Metrics
- Differential Adjusted Payment (DAP) Overview
- Auto-Verification Threshold Requirements
- Live-In Caregiver EVV Data Requirements
- Live-In Caregiver Compliance Expectations

EVV Compliance - AHCCCS Slide Deck

EVV Webinar

AHCCCS Provider Training Videos

Visit the AHCCCS Website: Electronic Visit Verification (EVV) Website

FWA & Incident-To Billing – Compliance Awareness

Reporting Fraud, Waste & Abuse (FWA)

- Providers are required to report suspected or potential FWA.

Reporting options:

- Provider Services Representative
- SIU Hotline: 1-800-232-2345 ext. 4875 | 602-864-4875 | TTY 711 (24/7)
- Email: HCHFWA@azblue.com
- Reports should include all available supporting information
- Additional guidance available via Code Blue

Resources

- About OIG from the Arizona Office of Inspection General AHCCCS
- HHS-OIG Compliance Training
- A Roadmap for New Physicians: Guide for physicians on how to avoid Fraud & Abuse.

Fraud, Waste & Abuse (FWA)

- Incident-to billing is not permitted for AHCCCS Medicaid members
- Services must be billed under the actual rendering provider's NPI
- Applies to physicians and non-physician practitioners
- Limited exception: properly registered Locum Tenens arrangements
- Rendering and ROPA providers must be registered with AHCCCS

References

- Chapter_07_General_Billing_Rules_HCA.pdf
- AHCCCS FFS Manual Chapter 3: Provider Records and Registration
- Provider Participation Agreement
- FFSChapter3ProviderRecordsandRegistration.pdf
- ROPA

Incident-To Billing (AHCCCS Medicaid)

Provider Resources / Trainings

BlueCross BlueShield Arizona
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Health Choice

- Provider Language Services Job Aid
- AHCCCS Contractors' Interpreter Services - Quick Reference Guide
- Required Training: Cultural and Language Requirements for Delivering Care
- Conversation Starters: Culture and Needs

Cultural Competency

• We developed an interactive training course for providers and their staff, called “End of Life Care” with content on Advance Directives, Advance Care Planning, Hospice, and Palliative Care. Click here to access our Provider Education resources.

• HealthCurrent, Arizona’s Health Information Exchange, maintains a free registry called the “Arizona Healthcare Directives Registry” where individuals can send advance directives for secure storage and accessibility to healthcare providers and loved ones.

Advance Directives

- **Member Rights & Responsibilities & Privacy Notices** are included in the Member Handbook and can be located on the Health Choice website at:
- azblue.com/medicaid/members/member-services (Member Rights and Responsibilities tab)
- azblue.com/health-choice-pathway/members/member-information (Member Rights and Responsibilities tab)
- azblue.com/medicaid/privacy-and-legal

Member Rights

*Refer to the PA Grid in our website for complete and accurate information

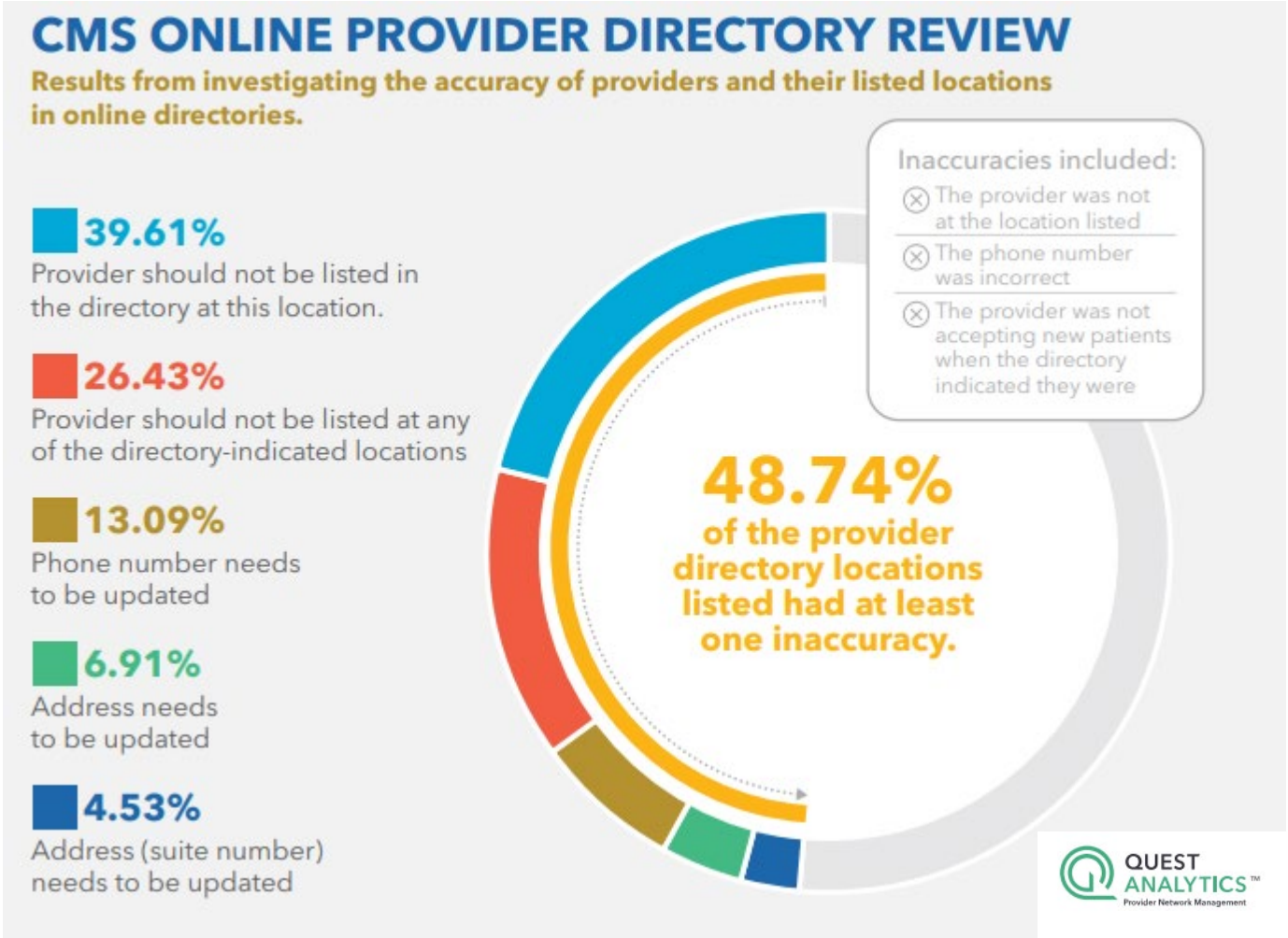
REMINDER: Provider Updates Matter

Best Practices

- Notify your Rep in writing at least 90 days prior to the effective date of change or as soon as possible

Inaccuracies Include

- Provider not at the location listed
- Incorrect phone number
- Provider was not accepting new patients when the directory indicated they were



Provider Manual Section 3.9 – Changes to Provider Information on File, ACOM 406, 42 CFR 438.10(h), NET 5

Provider Resources (cont.)

BlueCross BlueShield Arizona
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- AHCCCS Medical Policy Manual – Exhibit 300-2B
- AHCCCS Covered Behavioral Health Services Guide (CBHSG)
- AHCCCS CBHSG FAQ
- B2 Matrix
- Same Day Disallow Table
- ASAM CONTINUUM Implementation

Behavioral Health Resources

Key Highlights

- New ICD-10 and CPT codes active as of October 1, 2025, and January 1, 2026.
- 97154 with TJ – Correct Usage
- Guidance on code 97154 with TJ modifier for ABA services.
- Updates to Telehealth Code Set and policy.
- Updated AHCCCS EPSDT Service Code Set
- Transitional Care Management Codes
- Click here for more information

AHCCCS Medical Coding Newsletters

- Complete the age-appropriate AHCCCS EPSDT form (or approved EHR equivalent)
- Missed medical and dental appointment logs should be submitted—weekly, if possible.
- EPSDT Forms & Resources
- Forms | Medicaid | AZ Blue
- AHCCCS Medical Policy Manual (AMPM)

EPSDT Clinical Sample Templates

UM Criteria and Medical Decision-Making (MDM)

BlueCross BlueShield Arizona
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Health Choice

Utilization Management (UM) Criteria and Medical Decision Making (MDM)

Blue Cross Blue Shield of Arizona Health Choice applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of healthcare services.

Evidence-based criteria includes InterQual, LCD, NCD, and health plan-developed guidance.

Given your clinical expertise, we welcome your involvement in developing and reviewing criteria. We value our network of providers and are interested in your input regarding Utilization Management (UM) Guidelines. If you have an interest in assisting with the development or review of UM criteria and technology, please send your contact information along with your field of practice to: **HCHComments@azblue.com.**

Access Clinical Practice Guidelines

Our plan encourages providers to stay informed by reviewing our current clinical practice guidelines located here. Our webpage includes information including, but not limited, to the topics below.

- Bronchiolitis in Early Childhood
- Children and Adolescents with Obesity
- Chronic Kidney Disease
- Chronic Pain
- Concussion in Children
- Depression
- Diabetes
- Migraine in Children and Adolescents
- Oral Health for Infants, Children, and Adolescents
- Pregnant and Parenting Women with Substance Use Disorder
- Substance Use Disorders

You may also find information from nationally recognized resources such as InterQual Guidelines, CMS Coverage Determinations, Hayes Knowledge Center, and UpToDate.

Visit our website for more information: Clinical Guidelines | Medicaid | AZ Blue

2026 Faster Prior Authorization Decisions for Providers – Effective 1/1/2026

BlueCross BlueShield Arizona
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Health Choice

What's changing

- Standard Prior Authorization (PA) turnaround time reduced from 14 calendar days to 7 calendar days
- No change to expedited/urgent PA timeframes

Benefits to Providers

- Faster determinations support quicker care decisions and scheduling
- Reduced administrative follow-up on pending PA requests

What providers should know

- Applies to standard (non-urgent) PA requests
- Submitting complete clinical documentation with the initial request helps avoid delays

Updated Provider Manuals

- Health Choice (Medicaid) – Chapters 6 and 20
- Health Choice Pathway – Chapter 6
- ACA StandardHealth with Health Choice – Chapter 6

Health Choice Provider Portal Feature

PA Reminders

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Health Choice

Prior Auth (PA) Grids

- PA Guidelines | Health Choice AZ
- Prior Authorization Guidelines | Health Choice Pathway
- PA Guidelines | ACA StandardHealth Health Choice

Provider Portal Utilization

- Utilize the Health Choice Provider Portal for expedited responses & processing
- For out-of-network (OON) authorizations, the PA team will ask you to refer to an in-network provider

Technical Support

- Work with your Provider Portal admin to add you as a user

Technical Support

- HCHProviderPortal@azblue.com
- (480) 760-4651

Need a personalized walkthrough?

- Contact your assigned Provider Representative

*Refer to the PA Grid in our website for complete and accurate information

Stay Up To Date With AHCCCS Notifications

- AHCCCS Medical Policy Manual (AMPM)
- AHCCCS Contractors Operations Manual (ACOM)
- Medical Coding Resources & AHCCCS Encounters Resource
- Public Notices and Opportunities for Public Comment
- AHCCCS News & Press Releases
- Visit the CMS website and subscribe to email updates for the latest information on Medicare and Marketplace enrollment, policies, benefits, etc.

Provider Revalidation

A provider must revalidate enrollment of their provider id periodically to maintain Medicaid billing privileges. In general, providers are required to revalidate every four years. AHCCCS also reserves the right to request off-cycle revalidations.

As part of the revalidation process the provider is subject to the same screening and disclosures captured during the initial enrollment. Additionally, based on provider type the process could include an enrollment fee, site visit, and fingerprint criminal background check required as a part of the screening requirements.

Beginning November 2022, AHCCCS-Division of Member and Provider Services (DMPS) will begin notifying providers through the United States Postal Service mail who are required to revalidate their Medicaid id. The revalidation process will ascend over a 10-month period beginning in November 2022 through August 2023.

Provider Revalidation Dates Spreadsheet

Note: If you don't see your name on the provider spreadsheet no further action is required.

What AHCCCS Providers Need to Know:

- Any provider who has not completed the revalidation process in the AHCCCS Provider Enrollment Portal (APEP) will be listed on the Provider Revalidation Spreadsheet, receive written notification, and have 90 days (about 3 months) to apply.
- The notification will include a temporary 14-digit application id number required to access the provider file for the first time.
- Providers who fail to respond to the request could experience delays such as termination and/or loss of billing privileges, access to AHCCCS Online Portal which is required to view and submit claims and prior authorizations.
- Providers with questions, those who are no longer participating as a Medicaid provider, and those no longer employed with an organization, are asked to contact APEPTrainingQuestions@azahcccs.gov

How Providers Can Complete the Revalidation Process

To begin your revalidation application today, login to your Existing Providers: To access APEP Direct

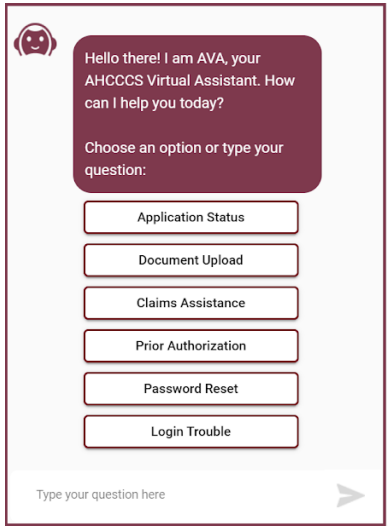
Below are step-by-step instructions designed to teach providers how to complete a revalidation using a 14-digit Application ID APEP.

For additional questions regarding how to troubleshoot through APEP to complete the revalidation application, contact APEPTrainingQuestions@azahcccs.gov or Provider Assistance (602)417-7670 option 5, include the provider name, NPI, and a brief description of the issue.

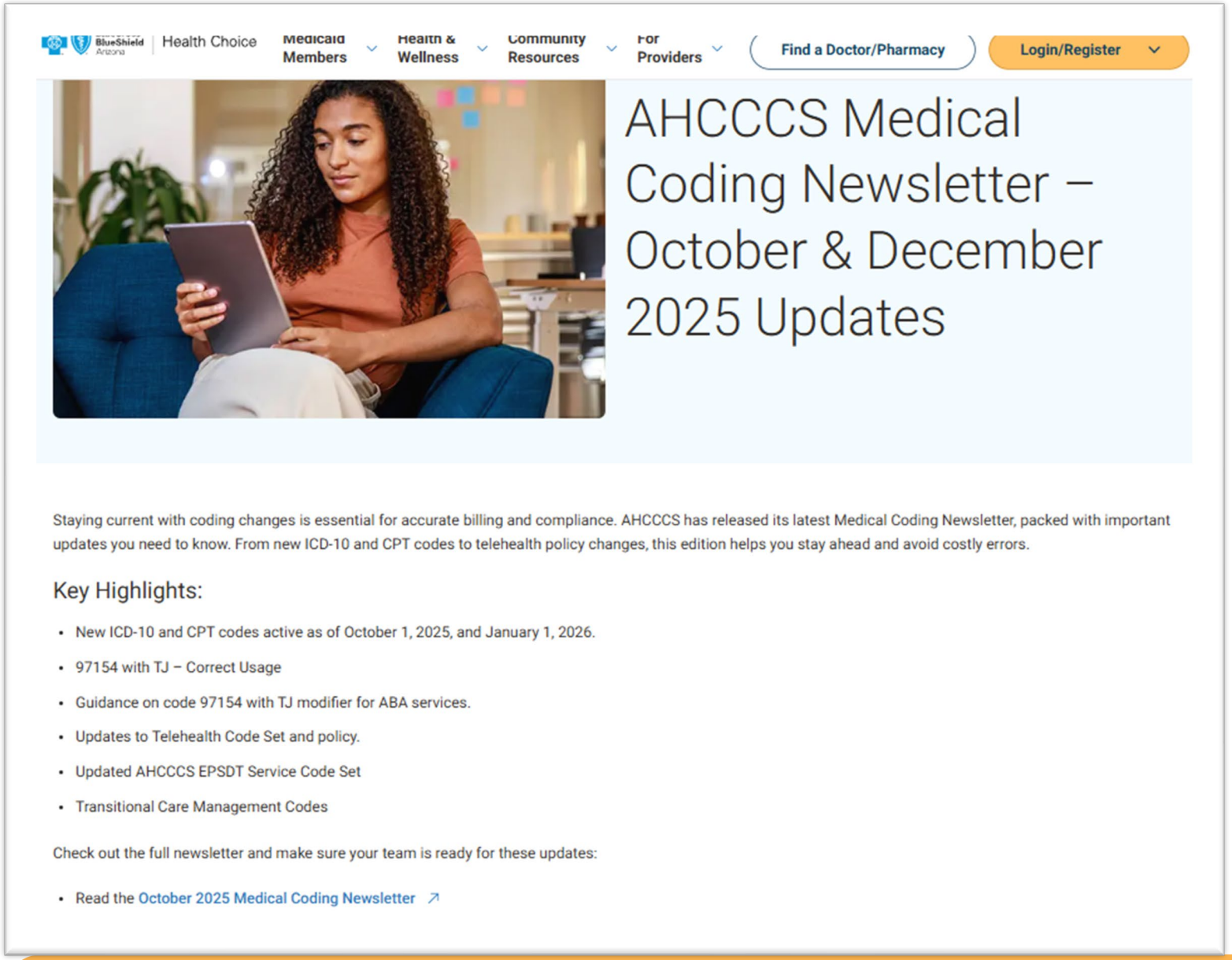
AHCCCS Resources:

If the provider has questions about the process, they are encouraged to review resources on the AHCCCS website, www.azahcccs.gov/apep, which include:

- Domain access in APEP
- Provider FAQ
- Provider Chat Bot, AVA, located at the bottom right-hand corner https://chat.azahcccs.gov/



Medical Coding Resources



Resources:

- Health Choice Provider Newsletter
- AHCCCS Medical Coding Resources
- AHCCCS Fee-For-Service Fee Schedules

The AHCCCS Medical Coding Unit has published FAQs with answers, policy links, and related resources. View FAQ.

Blue Cross® Blue Shield ® of Arizona
Health Choice Websites & Provider Manual

Health Choice Arizona Medicaid

Website:
https://www.azblue.com/medicaid

Provider Manual:
https://www.azblue.com/medicaid/providers/provider-manual

Health Choice Pathway – HMO D-SNP

Website: https://www.azblue.com/health-choice-pathway

Provider Manual:
https://www.azblue.com/health-choice-pathway/providers/provider-manual

ACA StandardHealth with Health Choice

Website: https://www.azblue.com/aca-standardhealth-health-choice

Provider Manual:
https://www.azblue.com/aca-standardhealth-health-choice/providers/provider-manual

Our Providers Manual also include samples of our Member ID Cards for each Line of Business (LOB)

Provider Reimbursement

Claim Submission Process

Providers must submit any professional, institutional and dental claims (837 P/I/D) to BCBSAZ Health Choice through Availity EDI Clearinghouse using specified payer IDs.

For 837 Submissions the Subscriber ID must be as follows:

- BCBSAZ Health Choice Arizona (#**62179)** = 9 characters and begins with ‘A’ or 12 characters and begins with ‘HCIA’.
- BCBSAZ Health Choice Pathway (#**62180)** = 9 characters and begins with ‘HC’ or 12 characters and begins with ‘MZH’.
- BCBCAZ ACA Standard Health with Health Choice (**#RP105**) = 9-11 characters all numeric or 12-14 characters and begins with ‘IAZ’ then all numeric.

ERAs Availability

BCBSAZ Health Choice 835 ERAs are available through Availity

Registration

- Register with Availity EDI Clearinghouse or another clearinghouse of your choice that has an established connection with Availity
- If you work with a software vendor that provides EDI services, let them know which clearinghouse you have chosen

Claim Submissions

BlueCross BlueShield Arizona
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Health Choice

All providers are recommended to submit claims electronically. Electronic billing ensures efficiency, accuracy, timeliness of payments, ease of administrative burden, eliminates cost of sending paper claims, and reduces clerical data entry errors.

BCBSAZ Health Choice (AHCCCS)

Health Choice Arizona Payer ID# 62179

P.O. BOX 52033, Phoenix, AZ 85072-2033

BCBSAZ Health Choice Pathway (Medicare Advantage D-SNP)

Health Choice Pathway Payer ID# 62180

P.O. BOX 52033, Phoenix, AZ 85072-2033

ACA StandardHealth with Health Choice

ACA StandardHealth with Health Choice Payer ID# RP105

P.O. BOX 52033, Phoenix, AZ 85072-2033

Keep your records updated to prevent claim rejections, delays in payment, and/or returned payments.

Claim Submission Reminders

BlueCross BlueShield Arizona
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Health Choice

- Do not staple documents or claims
- Attachments should indicate the claim numbers on each page

No Staples Required on Paper Claims

- Submit claims with the full and complete Prior Authorization number, including leading zeros

Prior Authorization Number

- Indicate which department your mail should be routed to

Attention: SPECIFIC DEPARTMENT
8220 N. 23rd Ave
Phoenix, AZ 85021

Sending Correspondence?

Reminder
Contracted providers located in contiguous counties to Arizona must submit claims directly to Health Choice

Reminder
Visit our website for updated Prior Authorization (PA) Grids

Bordering Counties*

CA: San Bernardino

NV: Clark, Lincoln

UT: Kane, Washington

CO: Montezuma

NM: San Juan, McKinley, Cibola, Catron, Grant, Hidalgo

*Subject to change.

BlueCross BlueShield Arizona

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azblue.com/hca