Blue Cross® Blue Shield® of Arizona Health Choice Provider Portal User Guide

azblue.com/Medicaid

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Health Choice

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1.INTRODUCTION

The Health Choice Provider Portal is a secure, innovative digital platform designed to support providers in delivering high-quality, efficient, and coordinated care. Developed with our network's operational needs in mind, the portal serves as a centralized hub for managing critical administrative and clinical functions. Providers and their staff can seamlessly verify member eligibility, review benefits, submit and monitor claims, track prior authorizations, and maintain accurate provider demographic information—all within a single, intuitive interface.

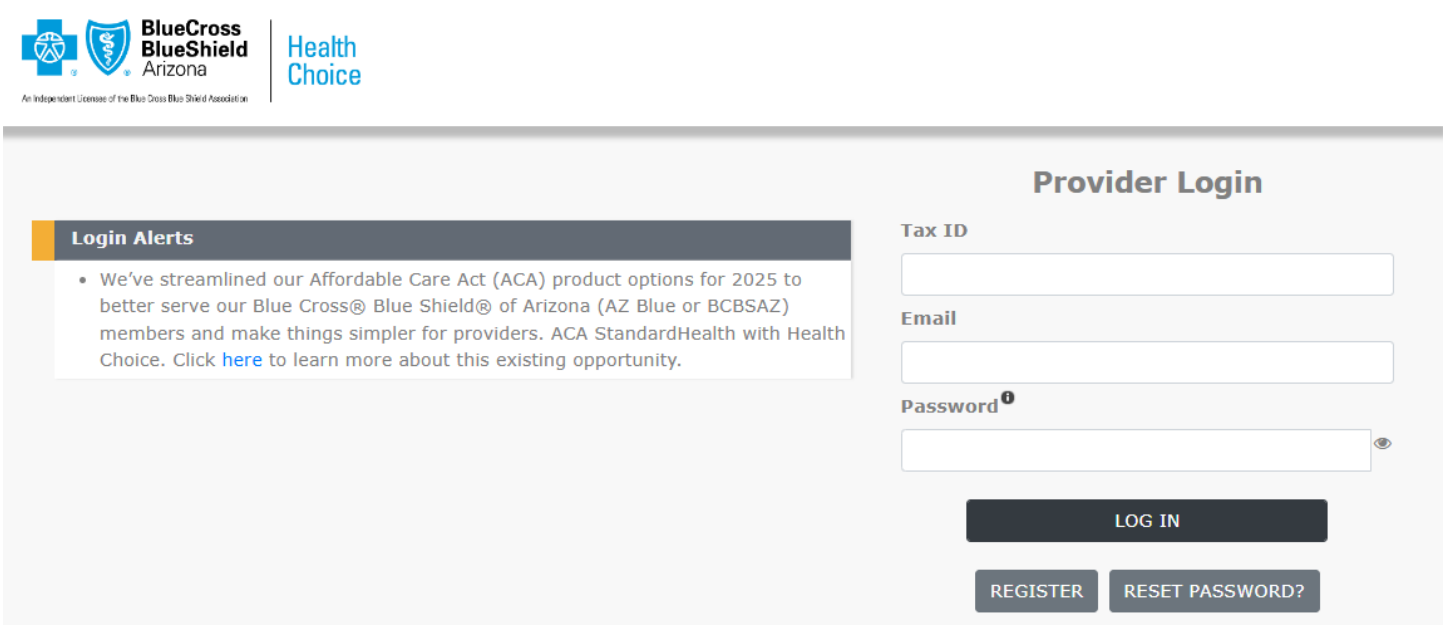
By streamlining routine workflows and reducing administrative burden, the Health Choice Provider Portal enhances the provider experience and helps ensure that members receive timely, uninterrupted access to care. Our commitment to service excellence, transparency, and collaboration is reflected in every aspect of the portal, empowering providers with the tools they need to work more effectively and stay connected with Health Choice.

Homepage

Providers can access the Health Choice Provider Portal by visiting **azblue.com/Medicaid**, where you'll find a streamlined entry point designed to connect you quickly and securely to the tools you need.

Direct Link

You may also access the portal directly through Log in - Health Choice Provider Portal offering a convenient, direct path to your secure login and online provider resources.



1.1 Technical Support

Please note that user Account passwords should NOT be shared between employees. Sharing passwords is prohibited. Health Choice encourages the Prime Administrator Account holders to set up individual user accounts in order for individual employees to use.

If you have any questions, please contact the **Provider Portal Coordinator at:**

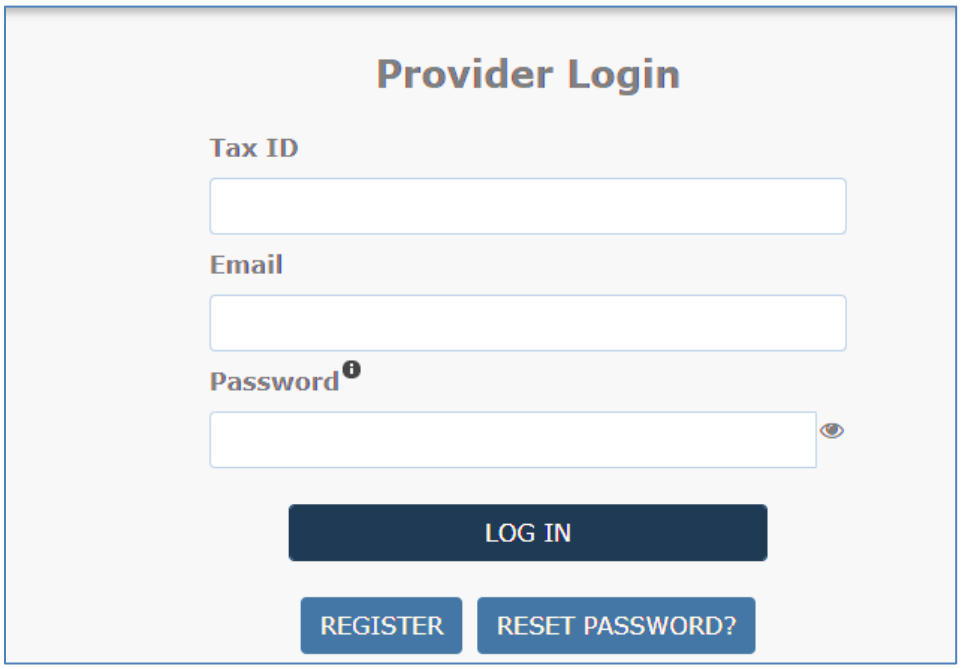
- 480-760-4651
- 800-322-8670
- HCHproviderportal@azblue.com

2. GETTING STARTED & LOGGING IN

The Health Choice Provider Portal requires each organization to create a secure account before accessing eligibility, claims, authorizations, or provider tools. Registration is completed online and includes verification steps to ensure accuracy and protection of member information.

2.1 Access the Provider

- Visit: https://providerportal.healthchoiceaz.com
- On the login screen, click Register to begin creating a new account.



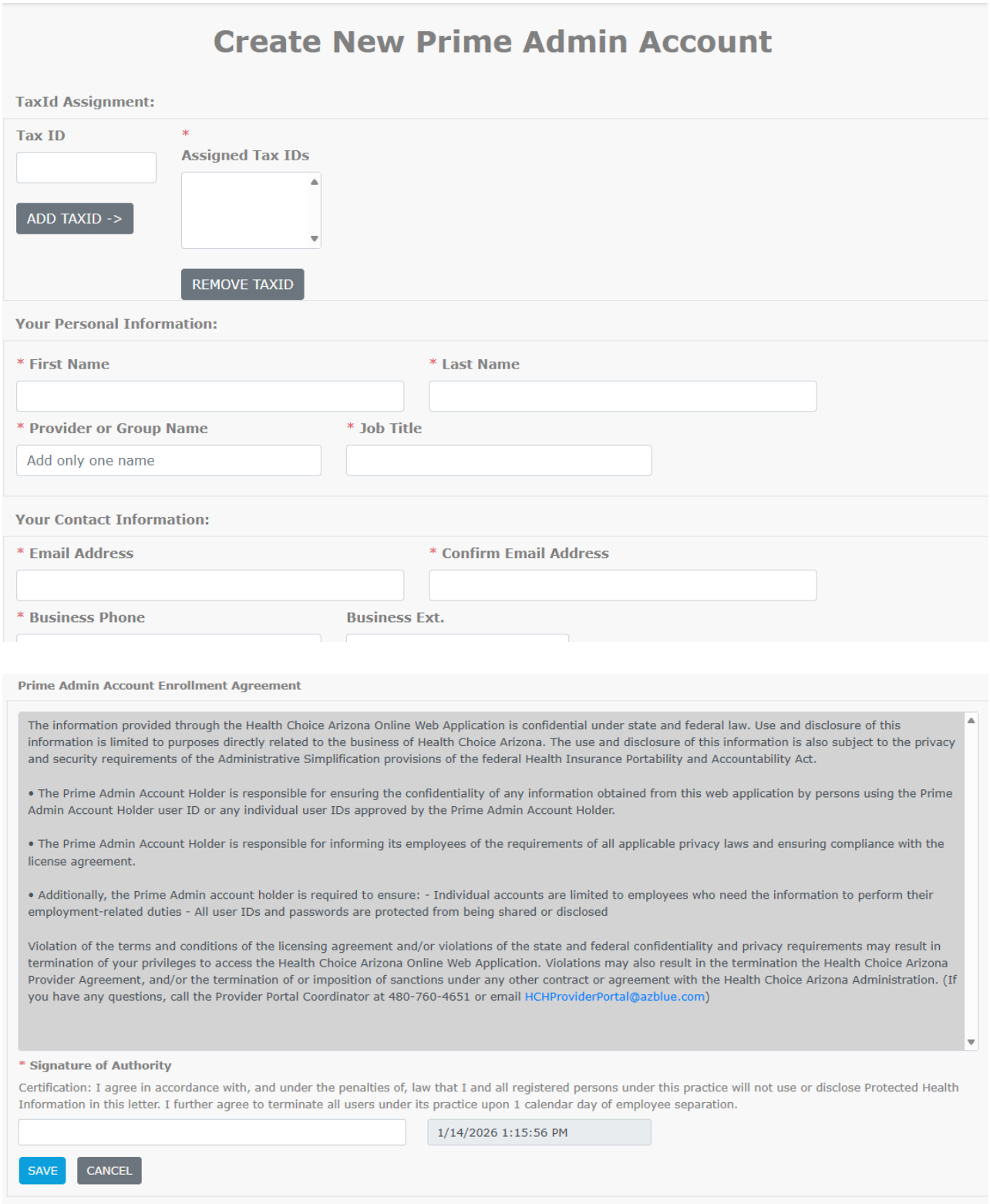
2.2 Complete the Registration Verification

You will be prompted to enter the required fields (marked with an asterisk). This includes:

- Tax ID (TIN)
- Email address
- First and Last Name
- Job Title
- Contact information
- Assigned Tax IDs
- Security question

Once submitted:

- A Registration Verification Form is sent to the Provider Portal Registration Team.
- Your account will be reviewed and activated by a Portal Coordinator.



2.3 Check Your Email for the Activation Link

When your registration is approved, you'll receive an email from Health Choice with a secure link to validate your email address.

Click the link in the email to continue.

Notes:

- If you cannot click the link, copy/paste it into your browser.
- Check junk/spam folders if you do not see the email sent from:
  - healthchoice-noreply@azblue.com.
- The activation link is valid for 24 hours. If the link expires, please call us at 480-760-4651 to request a new link.

2.4 Create Your Password

After clicking the email link, you will be directed to the **Create New Password** page.

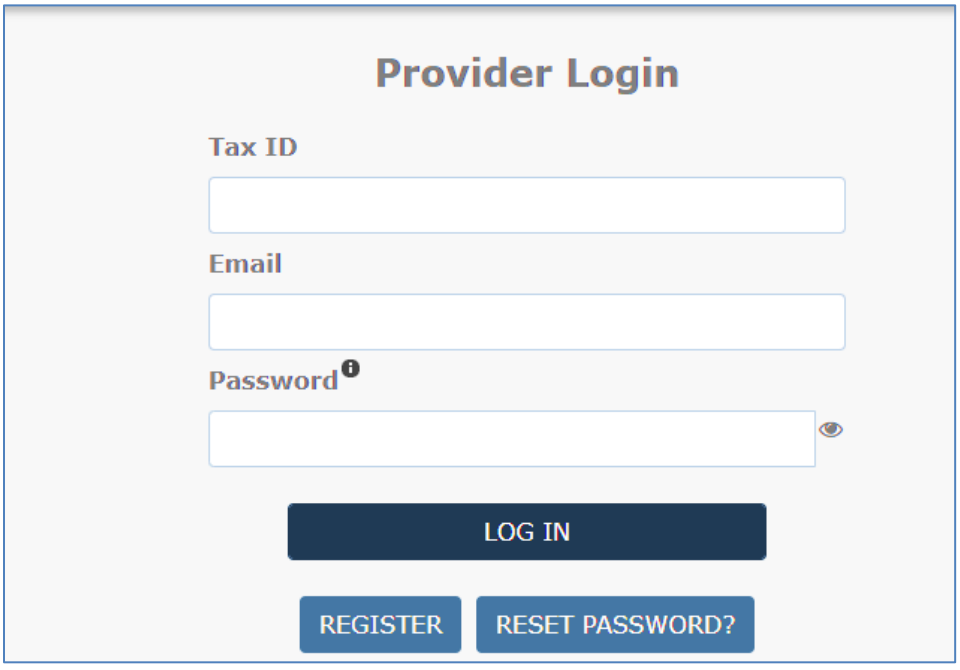
- Enter and confirm your new password to complete the registration process.
- A confirmation message will appear once your password is successfully created.

2.5 Log In to the Provider Portal

Return to the login page and enter:

- Tax ID
- Email
- Password

Click **Log In** to access the Provider Portal.



2.6 Prime Administrator Setup

Each organization must designate one **Prime Administrator (Prime Admin)** during registration.

The Prime Admin is responsible for:

- Adding and removing portal users
- Updating user roles
- Managing Tax IDs linked to the account
- Approving new users requesting access

The portal allows **unlimited Admins and Users**, but only Prime Admins and Admins may manage account access.

Prime Administrator Changes
If the designated Prime Administrator is no longer employed with your organization, please contact Health Choice immediately. Our team will provide a Prime Administrator Change Request form for your organization to complete. Once the form is submitted and approved, we will update the administrator's information and restore the appropriate access to your account.

Contact information:
- 480-760-4651
- 800-322-8670
- HCHproviderportal@azblue.com

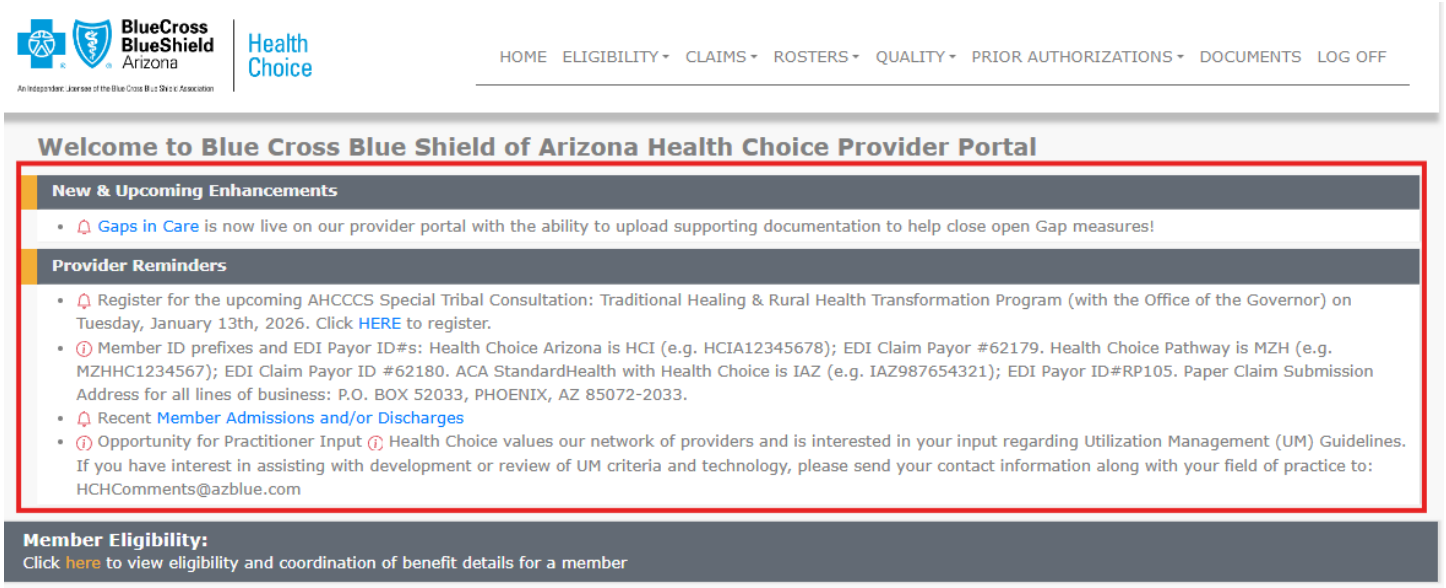
2.7 Need to Add More Users?
After the Prime Admin is activated, they can log in and navigate to:
Provider Tools → Manage My Users

From there, the Prime Admin or Admin can:
- Add new users
- Assign roles (User or Admin)
- Edit or deactivate existing users

2.8 Complete the Registration
Through these multifaceted efforts, Blue Cross Blue Shield of Arizona Health Choice is building a resilient, equitable, and member-centered network that empowers individuals and communities to thrive. Our commitment to innovation, collaboration, and continuous improvement ensures that we remain a trusted partner in advancing health equity and delivering high-quality care across Arizona.

2.9 Homepage Alerts & Notices
When logged into the Health Choice Provider Portal, providers will see important **Alerts & Notices** displayed prominently on the portal homepage. This section includes new enhancements, operational reminders, regulatory updates, assigned provider relations representative, training opportunities, and time-sensitive notices that may directly impact your practice.

Providers are strongly encouraged to review this section regularly, as the information posted here supports day-to-day operations and helps ensure continued compliance with AHCCCS and Health Choice requirements. Staying up to date with these alerts can help prevent disruptions to billing, authorizations, credentialing, and other administrative workflows.


BlueCross BlueShield Arizona
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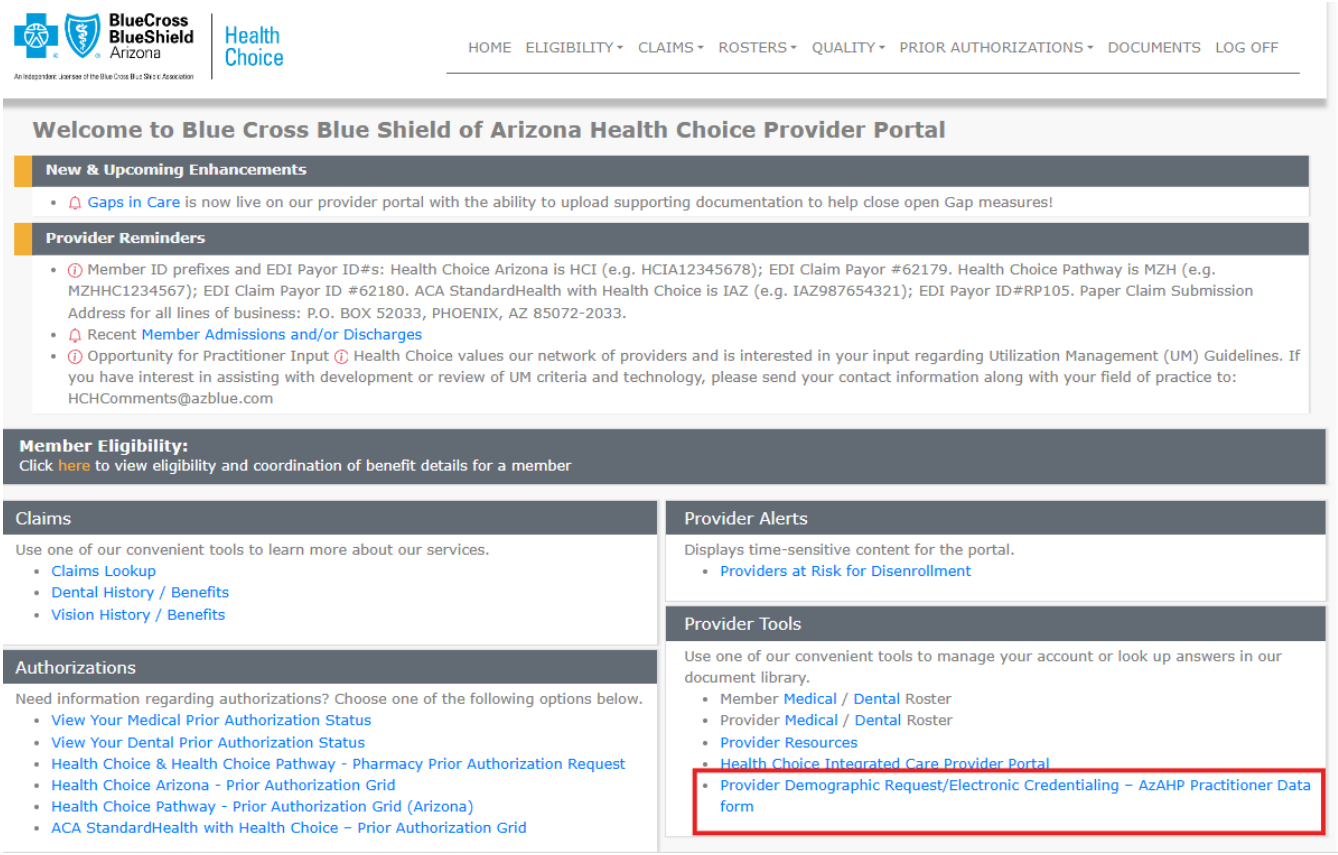
Health Choice
HOME ELIGIBILITY CLAIMS ROSTERS QUALITY PRIOR AUTHORIZATIONS DOCUMENTS LOG OFF
Welcome to Blue Cross Blue Shield of Arizona Health Choice Provider Portal
New & Upcoming Enhancements
Gaps in Care is now live on our provider portal with the ability to upload supporting documentation to help close open Gap measures!
Provider Reminders
Register for the upcoming AHCCCS Special Tribal Consultation: Traditional Healing & Rural Health Transformation Program (with the Office of the Governor) on Tuesday, January 13th, 2026. Click HERE to register.
Member ID prefixes and EDI Payor ID#s: Health Choice Arizona is HCI (e.g. HCIA12345678); EDI Claim Payor #62179. Health Choice Pathway is MZH (e.g. MZHHC1234567); EDI Claim Payor ID #62180. ACA StandardHealth with Health Choice is IAZ (e.g. IAZ987654321); EDI Payor ID#RP105. Paper Claim Submission Address for all lines of business: P.O. BOX 52033, PHOENIX, AZ 85072-2033.
Recent Member Admissions and/or Discharges
Opportunity for Practitioner Input Health Choice values our network of providers and is interested in your input regarding Utilization Management (UM) Guidelines. If you have interest in assisting with development or review of UM criteria and technology, please send your contact information along with your field of practice to: HCHComments@azblue.com
Member Eligibility:
Click here to view eligibility and coordination of benefit details for a member

3.E-CREDENTIALING & PROVIDER DEMOGRAPHIC REQUEST

The Health Choice Electronic Credentialing Portal (AzAHP Practitioner Data Portal) allows providers to securely submit credentialing applications, complete required assessments, and track the progress of their submissions. This online process streamlines credentialing, reduces paperwork, and ensures accurate submission of provider data.

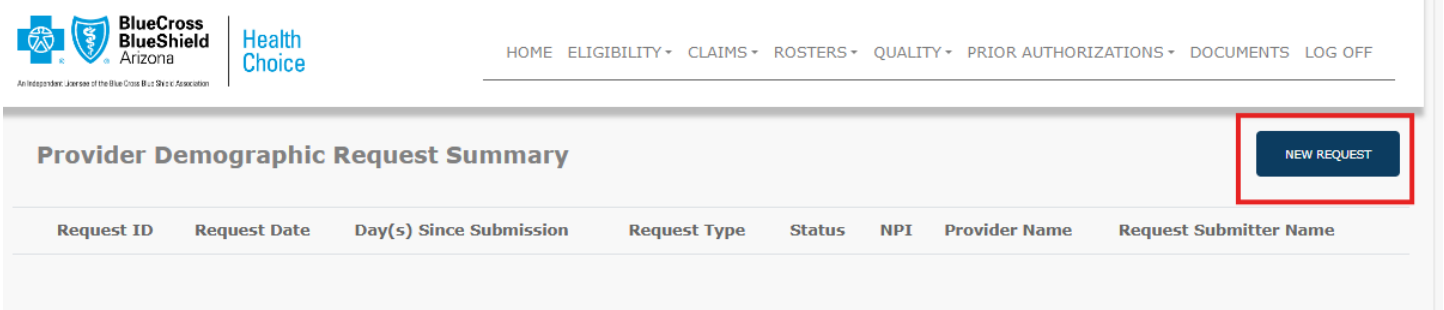
3.1 Access the E-Credentialing Tool

Select **Provider Demographic Request/Electronic Credentialing – AzAHP Practitioner Data Form**



3.2 New Request

Select **New Request**

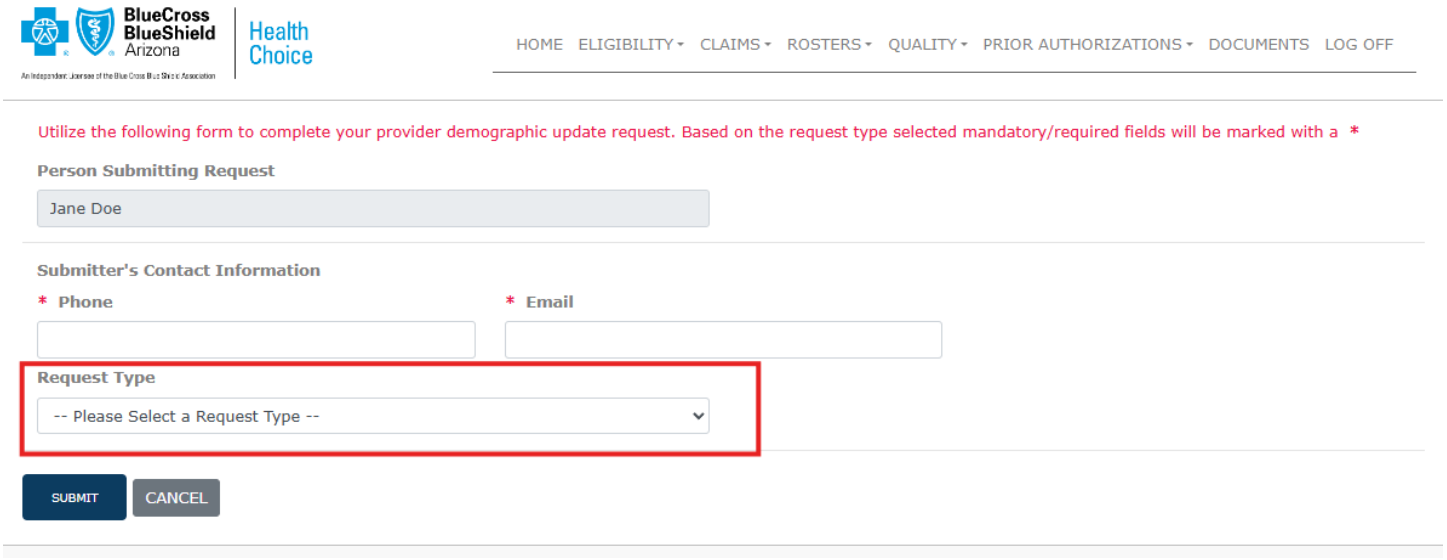


3.3 Person Submitting Request

Utilize the following form to complete your provider demographic update request. Based on the request type selected mandatory/required fields will be marked with a *.

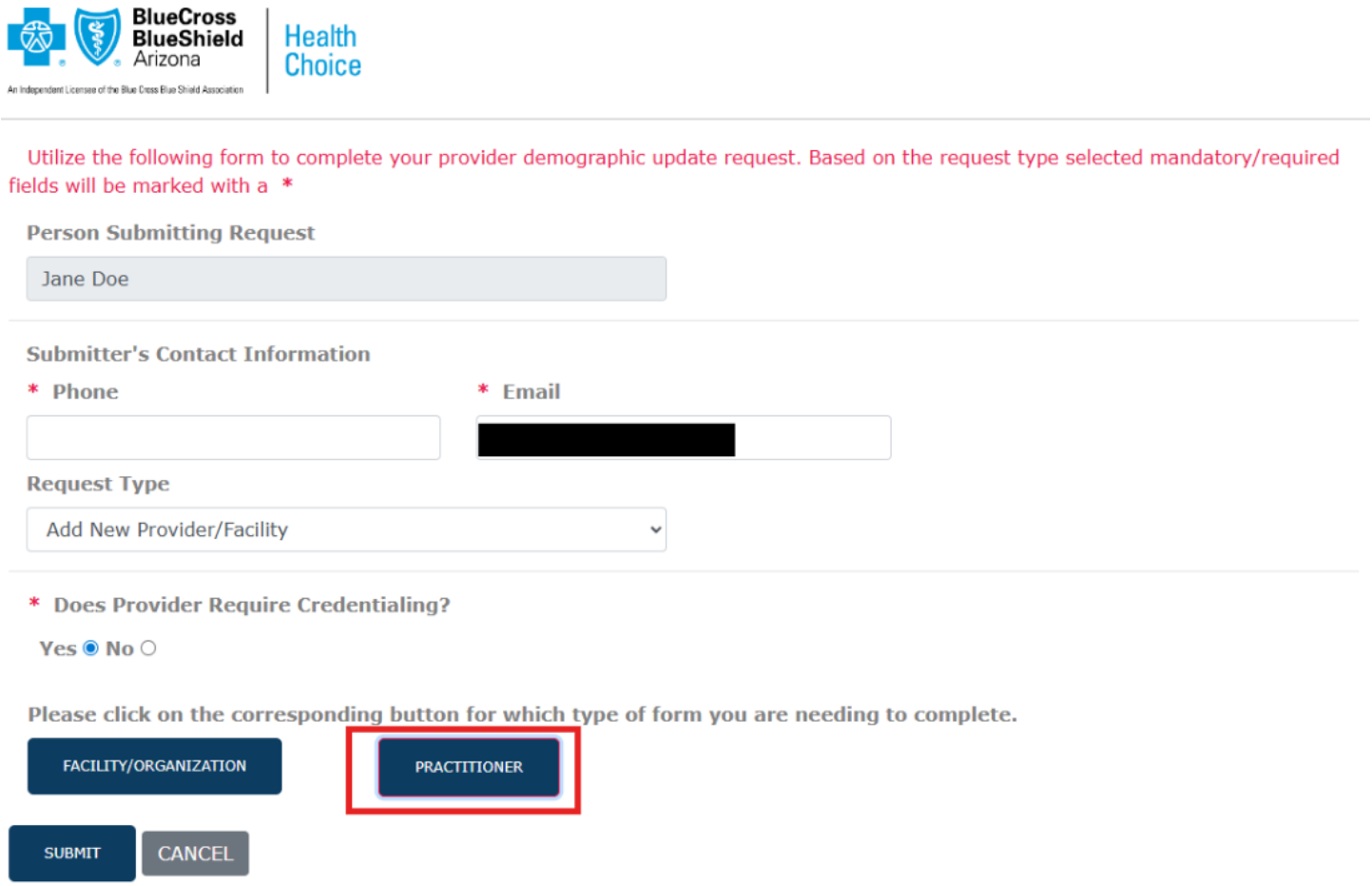
Select the **Request Type:**

- **Add New Provider/Facility**
- **Add New Location**
- **Termination**



3.4 Does the Provider Require Credentialing?

Select **Yes** if the practitioner has not been previously credentialed for your group. Then select **PRACTITIONER.** Note: electronic credentialing feature for **FACILITY/ORGANIZATION** is forthcoming in 2026. **hbalderrama**

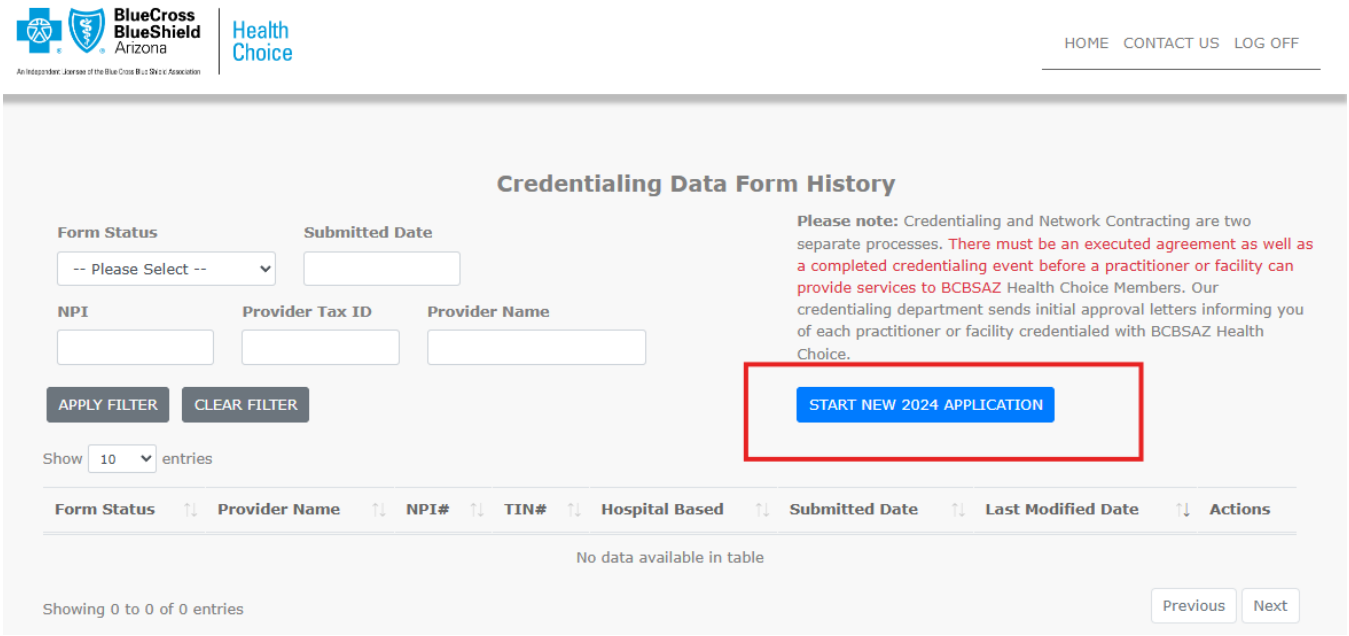


3.5 Start New Application

Select **Start New Application**

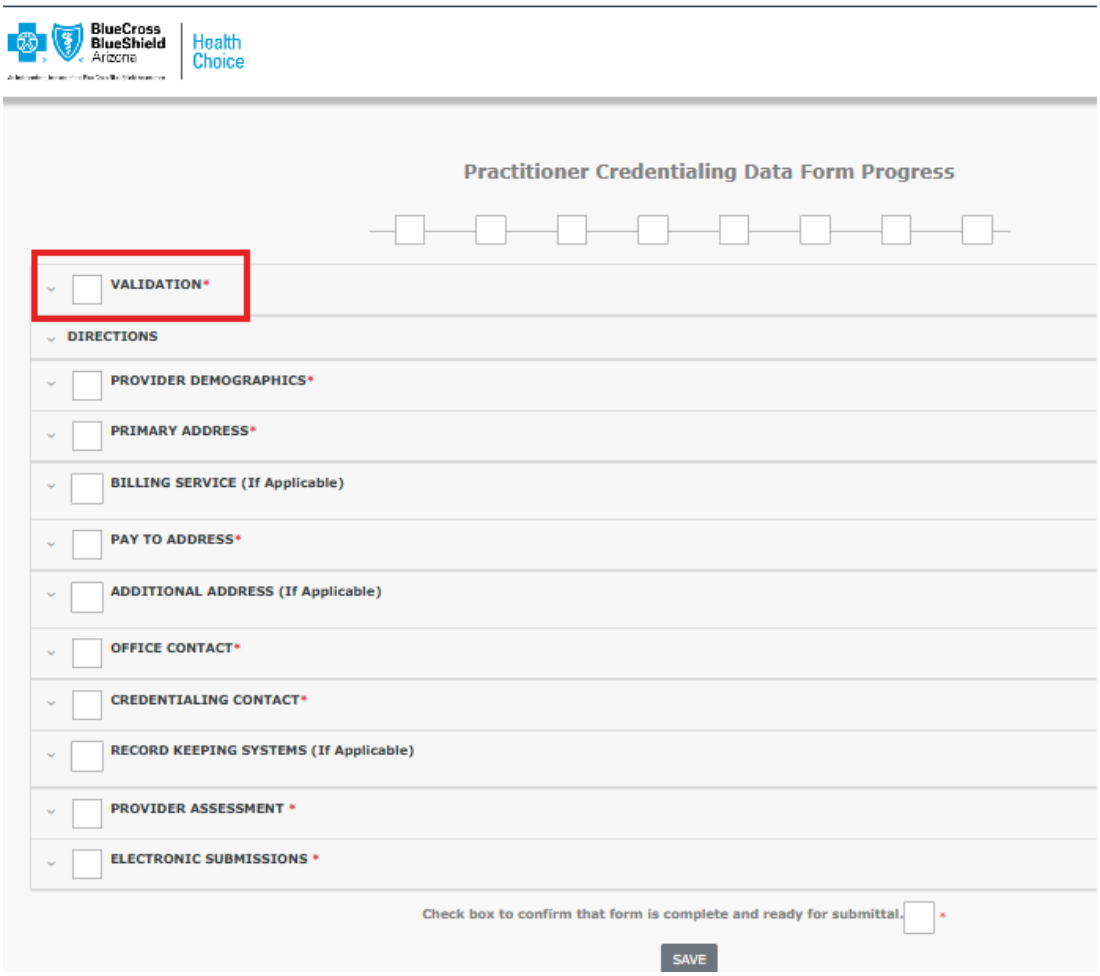
Please note: Credentialing and Network Contracting are two separate processes. **There must be an executed agreement as well as a completed credentialing event before a practitioner or facility can provide services to Health Choice Members**. Our credentialing department sends initial approval letters informing you of each practitioner or facility credentialed with Health Choice.

Note: if you do not see this option, you can click here:
https://providerportal.healthchoiceaz.com/Azahp



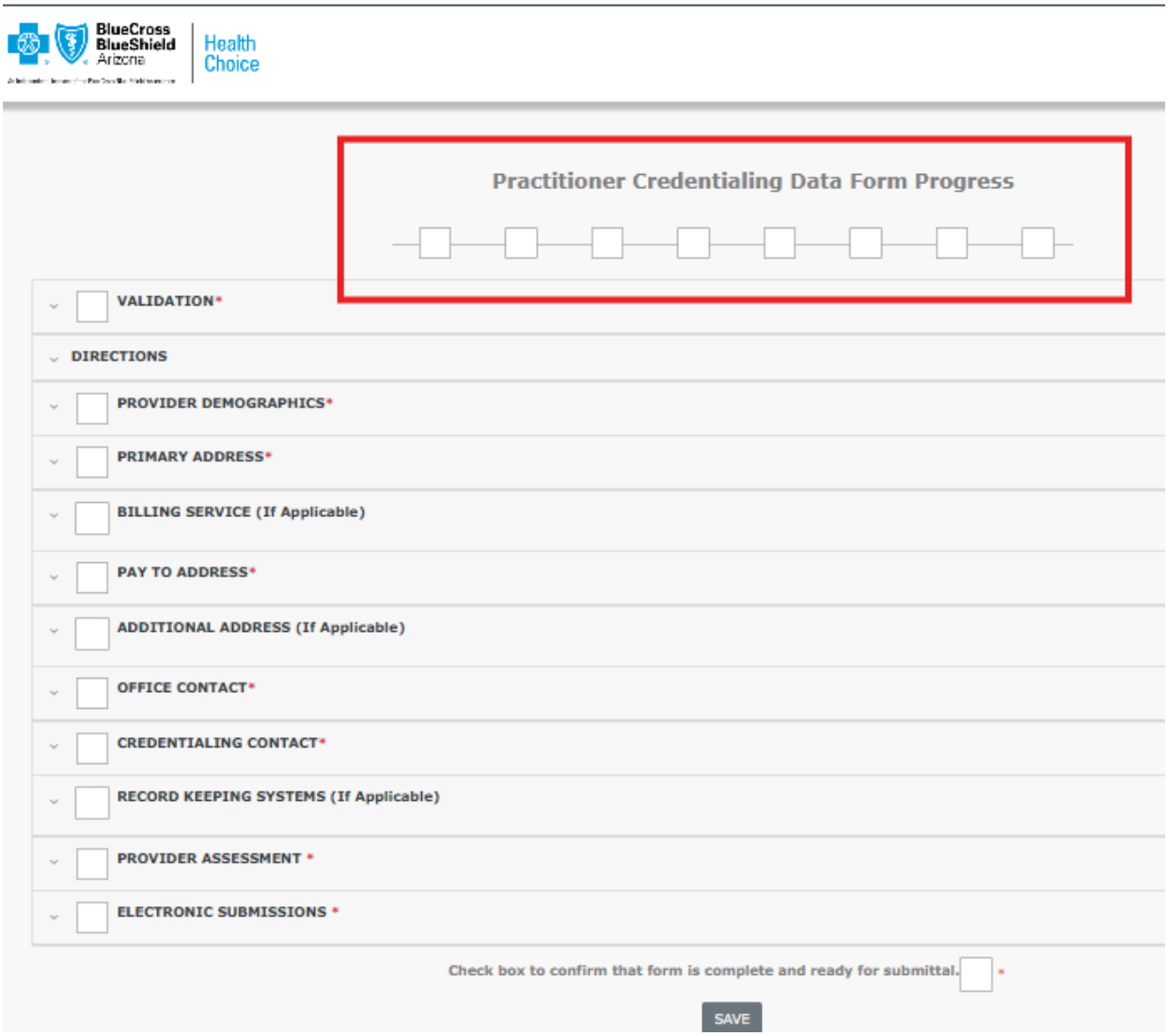
3.6 Practitioner Credentialing Data Form

a. In the "Practitioner Credentialing Data Form Progress" screen, users must complete the **Validation** section. Note: expand section using the arrow if data fields are not visible.



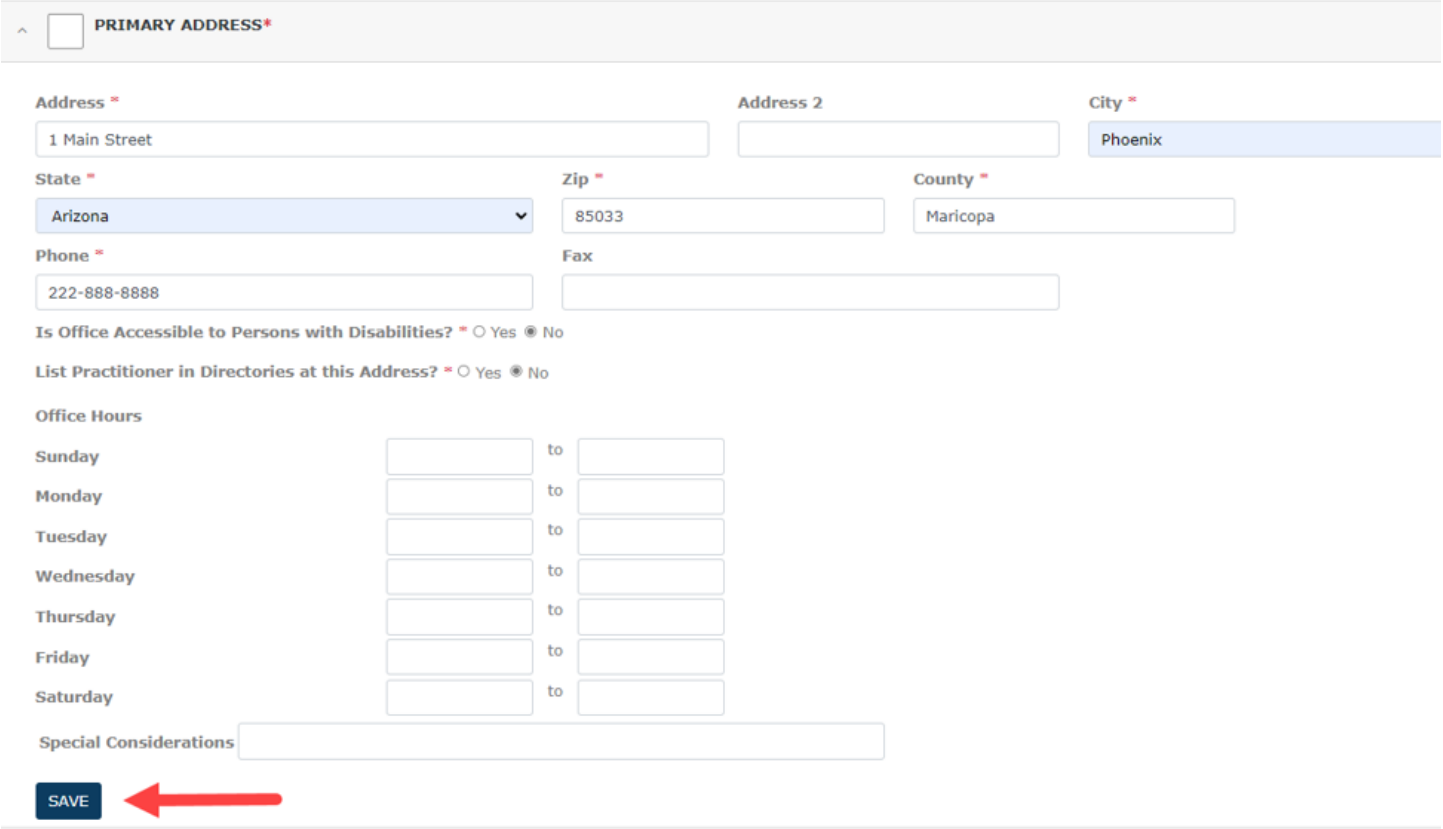
b. Complete all other required sections before submitting the form. When each section is completed the **Application Progress** box is checked off. If you're missing information or can't finish the application right now, save your progress and come back to it later.

Note: all sections marked with an asterisk symbol ("*") must be completed.



c. **Save Forms**

A **Save** button is provided at the bottom of each section. Please ensure that you click the Save button after working in each section. Saving your progress, even if section is incomplete, will preserve any entered information and allow you to finalize section(s) later.



Action buttons on the Summary page:

- **Copy** – Generates a new credentialing form by transferring most responses from an existing form.
- **Print** – Produces a completed PDF version of the entered data. This document can be printed and submitted to other health plans for credentialing purposes.
- **Resume** – Enables users to continue completing a form that is currently marked as 'incomplete' and has been previously saved.

Textboxes vs. dropdown lists:

While some textboxes are for free-form entries, some have auto populated lists. For these, a list will populate after a few characters are entered. i.e. Hospitals and ASC - type in 'BAN' and a list of facilities that start with BAN will generate.

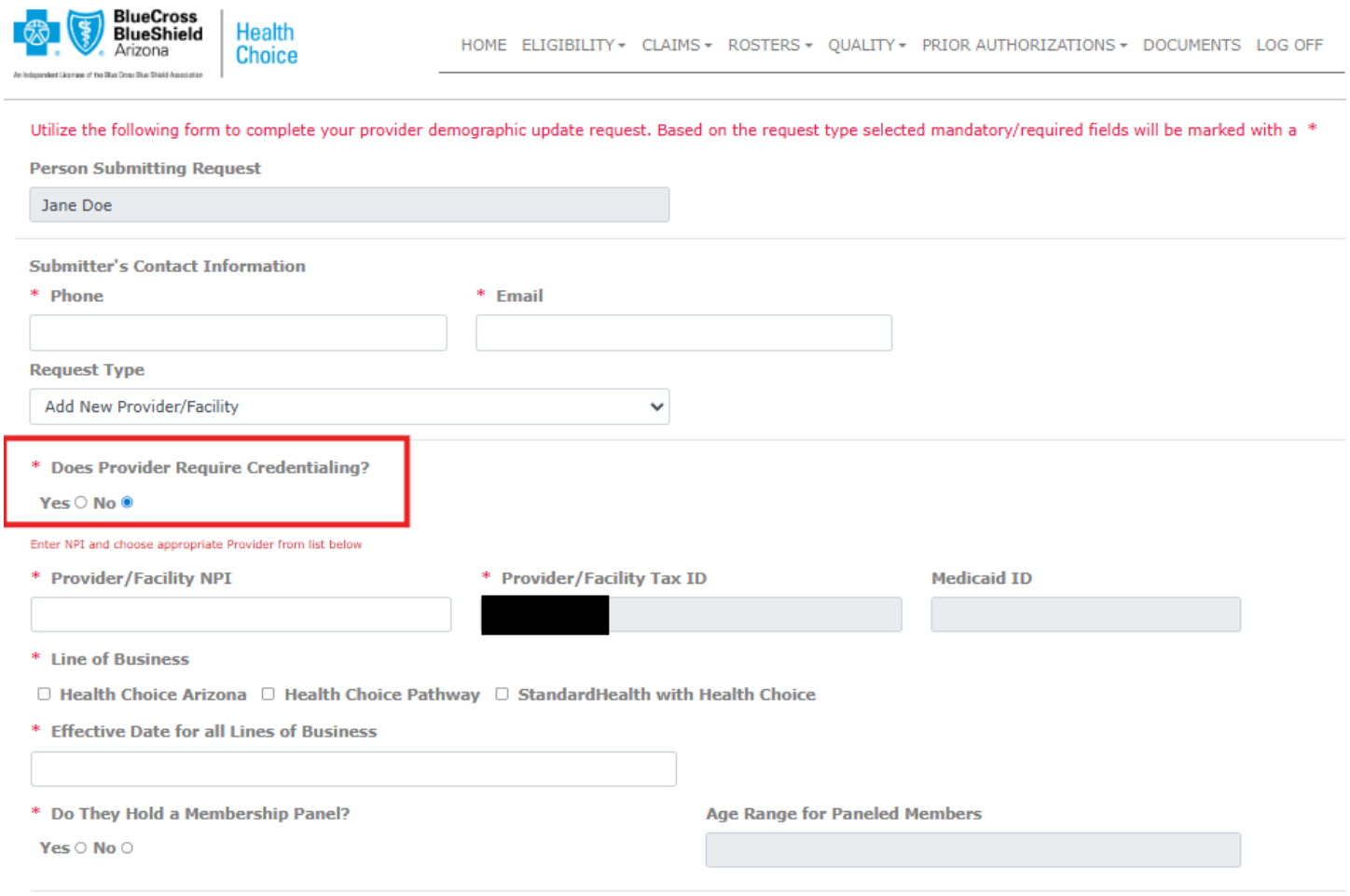
Provider Assessment section:

- An assessment must be completed for both the primary address and each additional address.
- Assessments are not required for other address types, such as billing service or pay-to addresses.
- Assessments cannot be saved until all mandatory assessments have been completed **and** at least one question has been answered "Yes."
- To select another address, click the 'Save' button; the application will then direct you to the addresses drop-down list.
- Select the next address from the dropdown, complete its assessment, and click 'Save.'

- Repeat this process until an assessment has been submitted for every applicable address.

3.7 Submit Provider Demographic Change

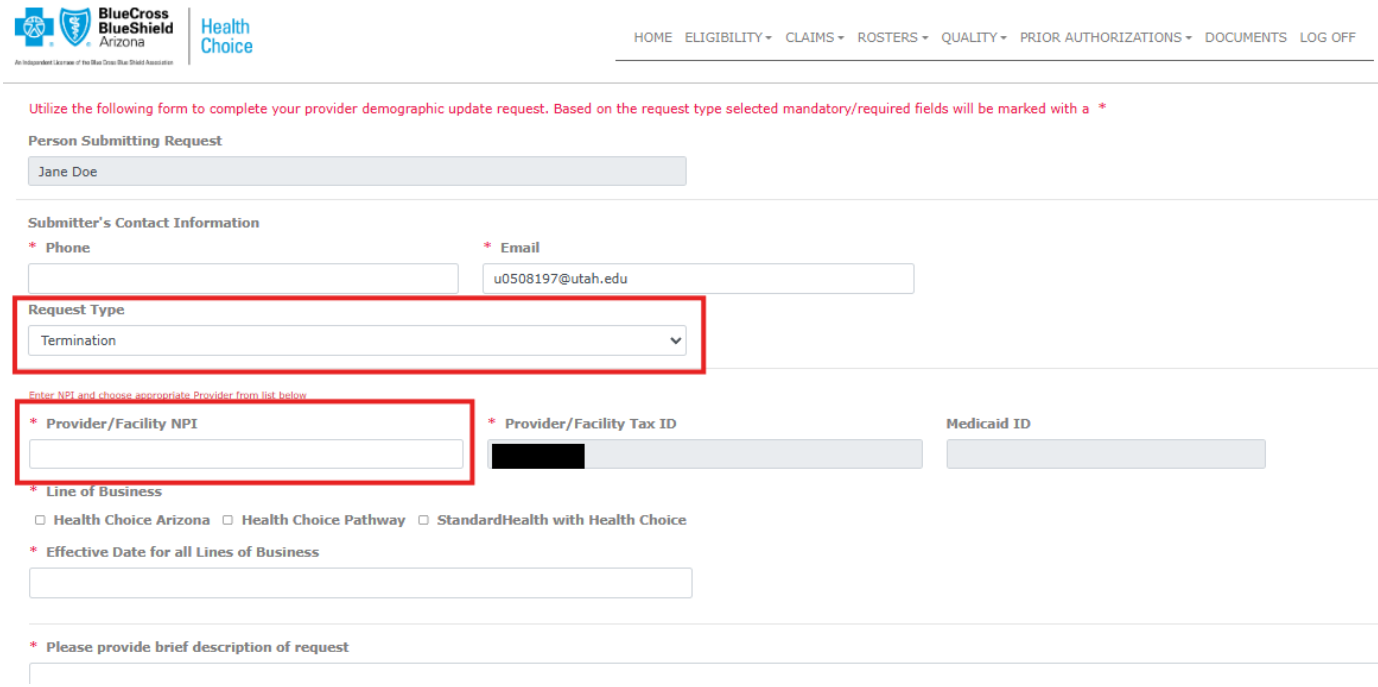
Select **No** and complete each required field.



3.8 Termination Request

Select the **Termination** in the **Request Type** field

- Enter the required information
- Enter NPI and choose appropriate Provider from list below
- Complete all required fields
- Select **Submit**

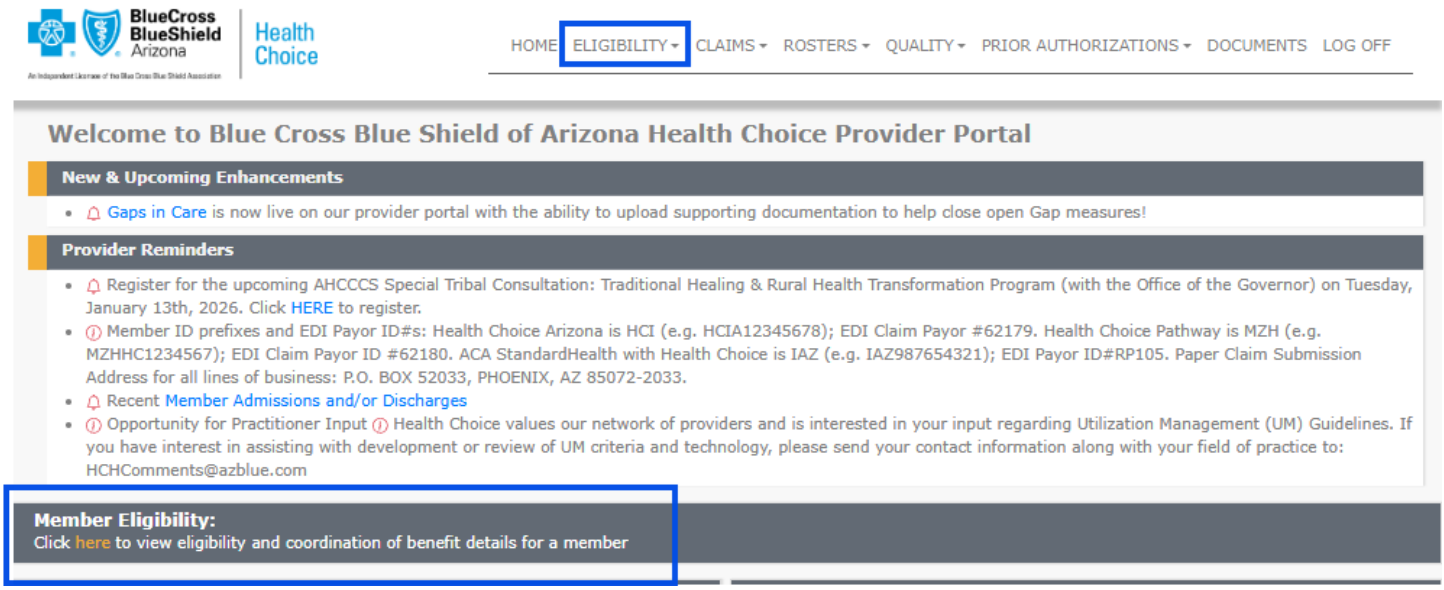

BlueCross BlueShield Arizona
Health Choice
HOME ELIGIBILITY CLAIMS ROSTERS QUALITY PRIOR AUTHORIZATIONS DOCUMENTS LOG OFF
Utilize the following form to complete your provider demographic update request. Based on the request type selected mandatory/required fields will be marked with a *
Person Submitting Request
Jane Doe
Submitter's Contact Information
* Phone
* Email
u0508197@utah.edu
Request Type
Termination
Enter NPI and choose appropriate Provider from list below
* Provider/Facility NPI
* Provider/Facility Tax ID
Medicaid ID
* Line of Business
Health Choice Arizona
Health Choice Pathway
StandardHealth with Health Choice
* Effective Date for all Lines of Business
* Please provide brief description of request

4. ELIGIBILITY & BENEFITS

The Eligibility feature within the Health Choice Provider Portal allows providers to quickly verify a member's active coverage, plan details, and benefit information. This tool supports efficient intake processes, reduces administrative follow-up, and ensures that services are delivered to members with confirmed eligibility.

4.1 Accessing Eligibility

From the Provider Portal home page, select the **Eligibility** tab or the **Member Eligibility** shortcut to begin a search.



4.2 How to Search for Eligibility

You can search for a member using:

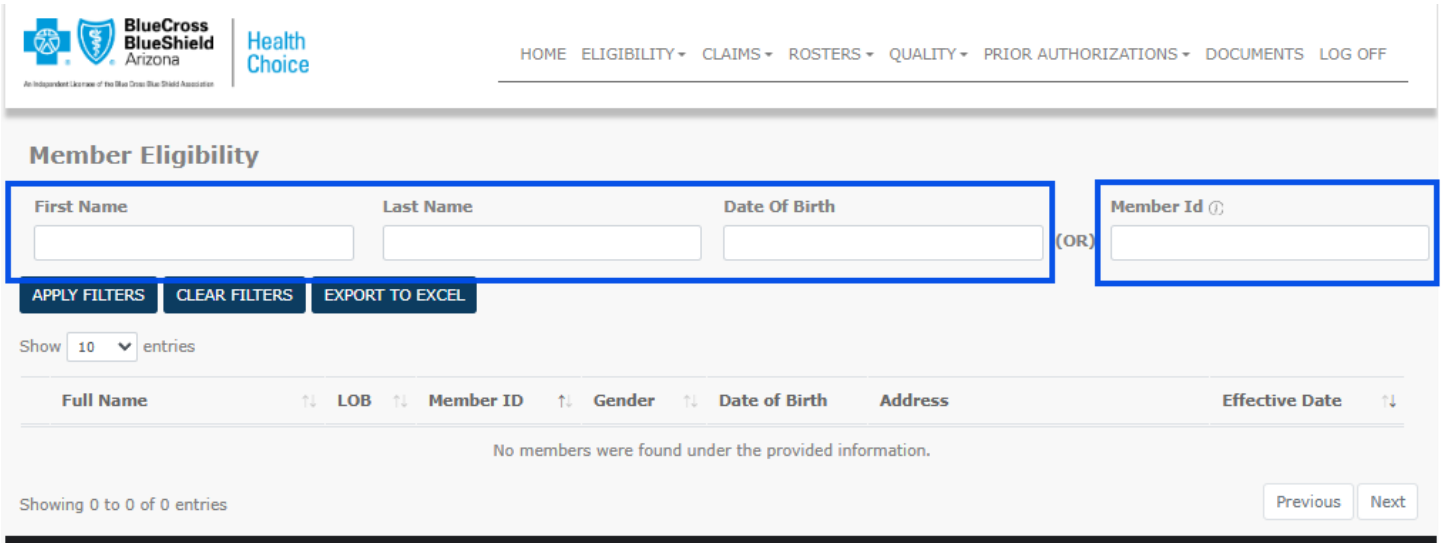
- **Member ID** (most accurate)
- **Member name** (first and last)
- **Date of birth**

Steps to Search

- Click the **Eligibility** tab.
- Enter the **Member ID** including any required prefix. Note: only BCBS members with the following prefixes will display in the Health Choice Provider Portal: **HCIA**, **MZHHC,** or **IAZ**
- If the Member ID is not available, enter the **full name** and **date of birth**.
- Click **Search**.

Helpful Notes When Searching

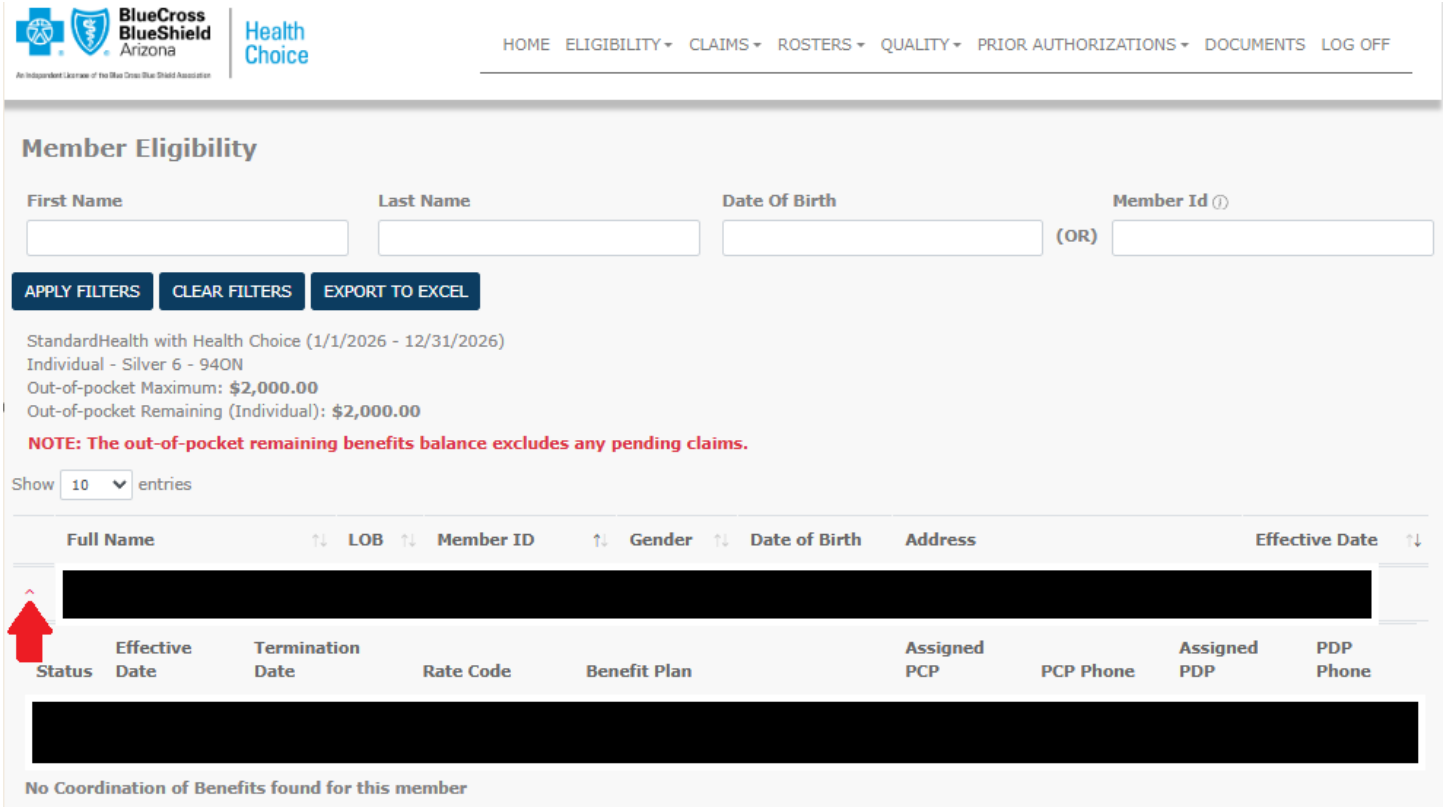
- Using the **complete Member ID—including the prefix—is strongly recommended**, as it provides the highest accuracy and reduces mismatched results.
- If no results appear, try clicking **Clear Filters** and searching again.
- Ensure the member is part of a Health Choice plan; incorrect plan selection commonly causes search errors.



4.3 Understanding Search Results

When results appear, the portal displays key information to help verify coverage by expanding the view identified by the red arrow in the image below :

- **Member name and DOB**
- **Line of Business (LOB)**
  - HCA: Health Choice Arizona (Medicaid)
  - HCP: Health Choice Pathway (Medicare DSNP)
  - HCS: ACA StandardHealth with Health Choice (Marketplace)
- **Eligibility start and end dates**
- **Active/terminated/pending status**
- **Primary Care Provider (if applicable)**
- **Out-of-pocket remaining** (Marketplace members)
- **Grace period status** (Marketplace members)
- **Deductible information** (*coming soon*)
- **Additional plan-specific details**



4.4 Important Notes About Eligibility Results

- Eligibility should be checked **on the date of service**, especially for **Medicaid** members whose eligibility can change frequently (even daily).
- Marketplace member may display a **grace period alert** if premium payments are overdue; providers should inform members that they may be financially responsible if the grace period is not resolved.

4.5 If No Eligibility Information Appears

If a search returns no member data:

- Confirm spelling of the member's name.
- Verify the correct Member ID prefix was used.
- Use **Clear Filters** and try again.
- Confirm that the member is assigned to a Health Choice plan.

5. CLAIMS MANAGEMENT

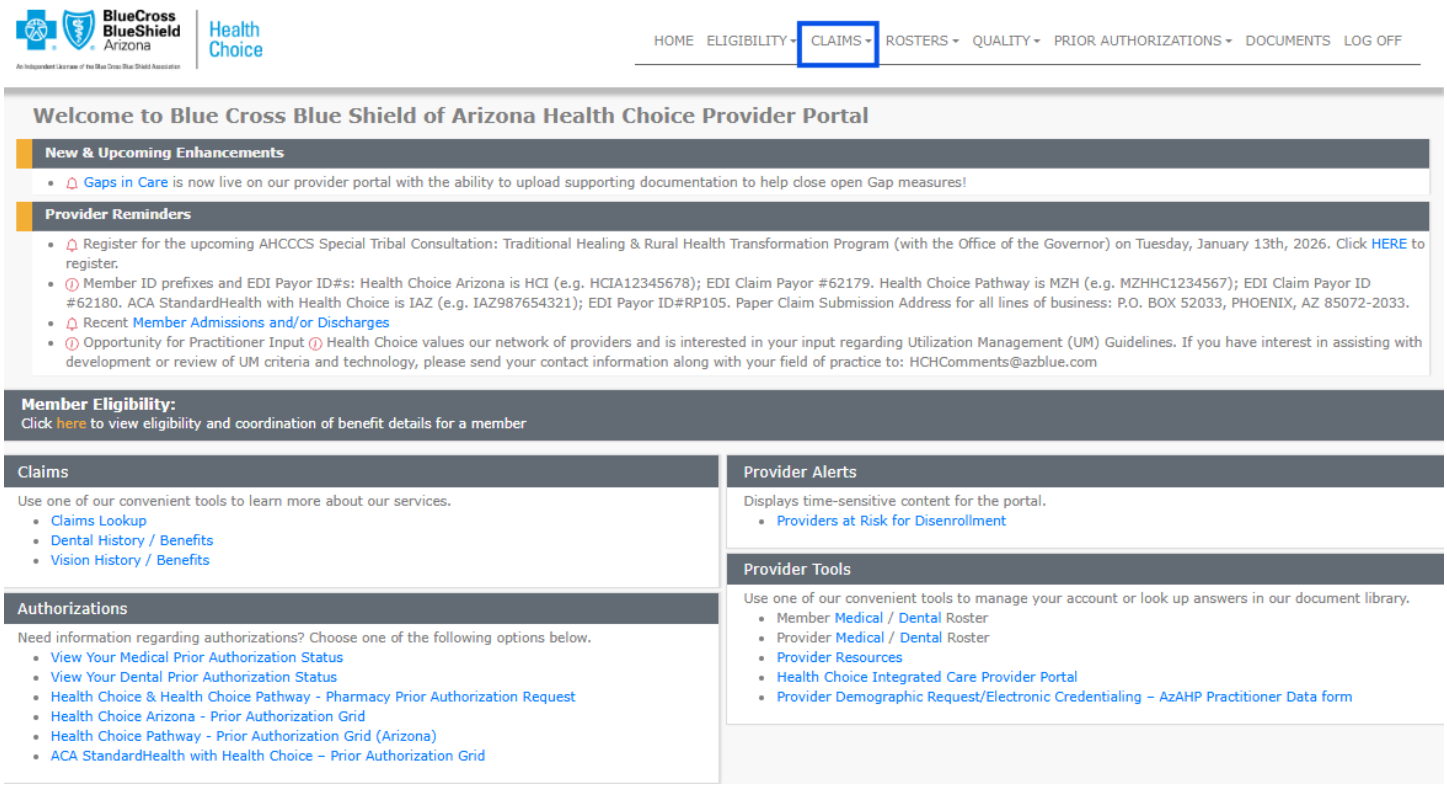
The Claims section of the Health Choice Provider Portal allows providers to search for claims, review claim details, request reconsiderations, and submit formal disputes. This tool helps ensure timely review of claims, supports correction of errors, and provides insight into payment status and adjudication decisions.

5.1 Searching for a Claim

The Claims feature allows providers to look up claim information quickly and easily—whether to review payment status, view processed details, retrieve remittances, or begin a follow-up action such as a reconsideration.

How to Search for a Claim

a. Select **CLAIMS** from the top navigation bar.
b. Click **VIEW ALL CLAIMS**.
c. Use any combination of filters, such as:
   - **Member ID** (include prefix like HCIA, MZHHC, IAZ)
   - **Date of Service**
   - Claim number
   - Provider NPI or TIN
d. Click **APPLY FILTERS** to display matching claims.



Helpful Tips When Searching

- If you don't see the expected claim, click **Clear Filters** and search again.
- Broadening your search criteria can help if too many filters narrow results.
- Claim search is useful for:
  - Reviewing processed claim details

- Confirming payment status
- Verifying denial reasons
- Accessing remittance information
- Beginning a reconsideration when needed

5.2 Submitting a Claim Reconsideration

A claim reconsideration is a request for Health Choice to re-adjudicate a claim. The portal allows up to **two reconsiderations** per claim.

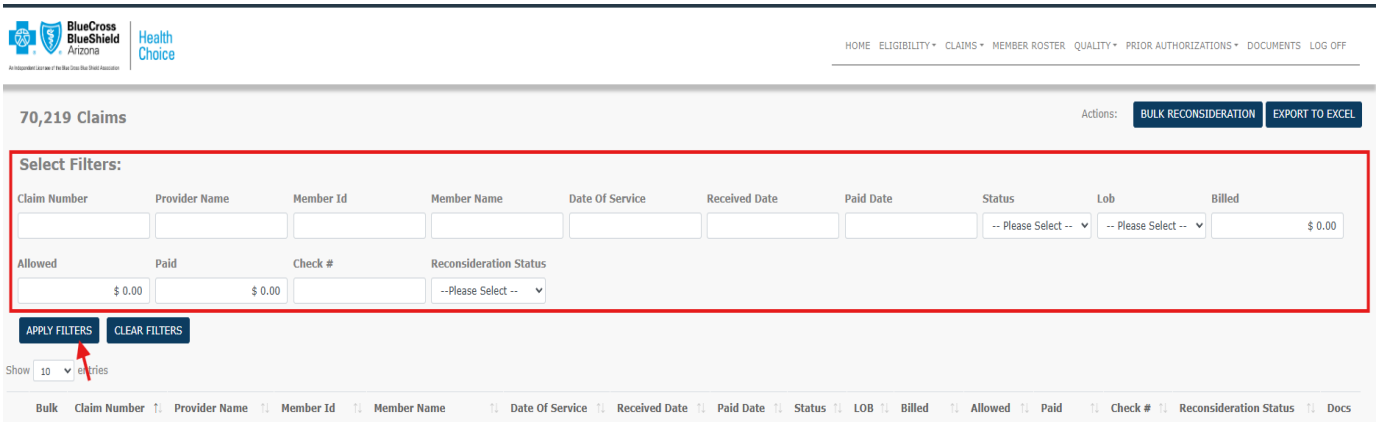
Before You Start (Important Requirements)

- Reconsideration eligibility depends on the **original date of service**.
- Timeframes:
  - **Health Choice Arizona**: within **12 months** of DOS
  - **Health Choice Pathway**: within **18 months** of DOS
- Only claims in **Paid** or **Denied** status may be reconsidered.
- If a claim falls outside the allowed timeframe, you will see a warning message.

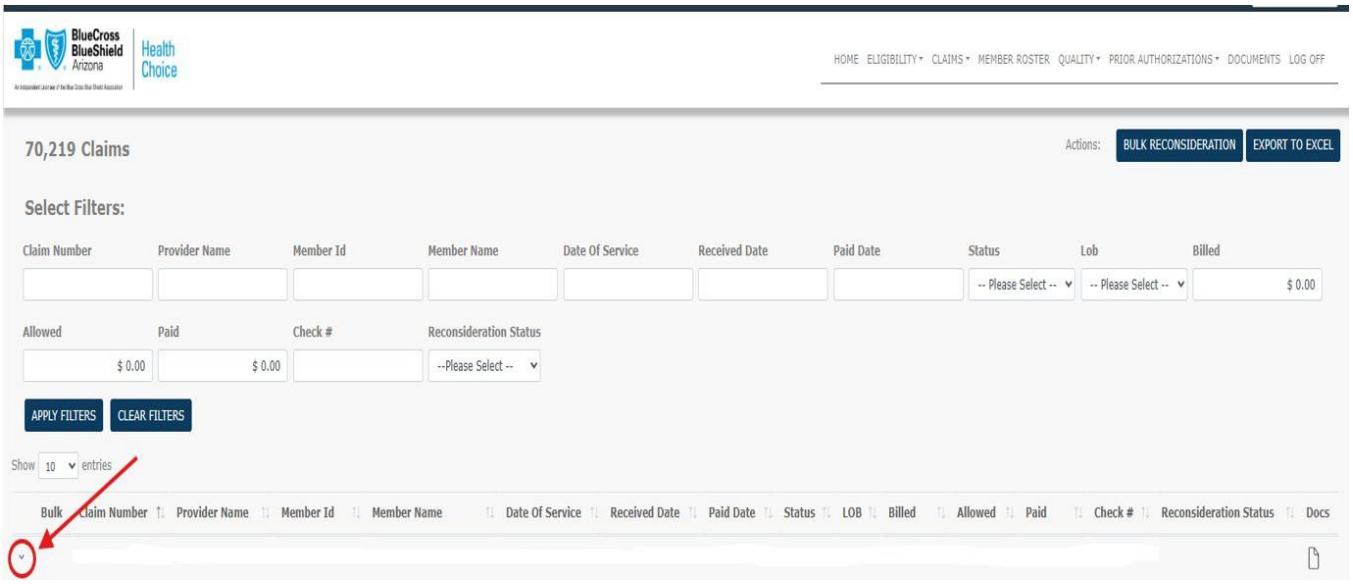
How to Submit a Reconsideration

a. Go to **CLAIMS → VIEW ALL CLAIMS**.

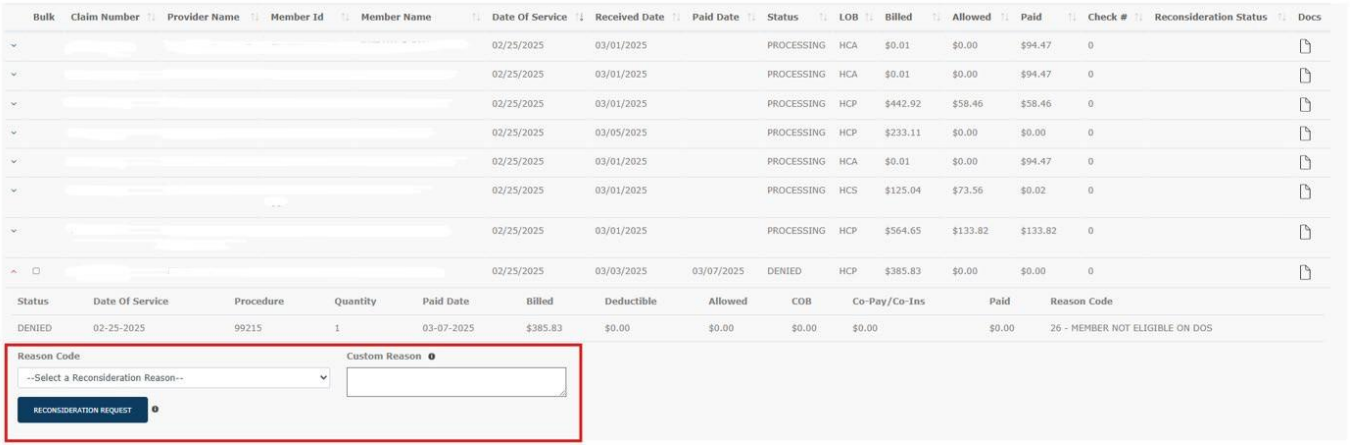
b. Locate the claim using the search filters, then **APPLY FILTERS**.



c. Click the **down arrow** to expand the claim and view details.

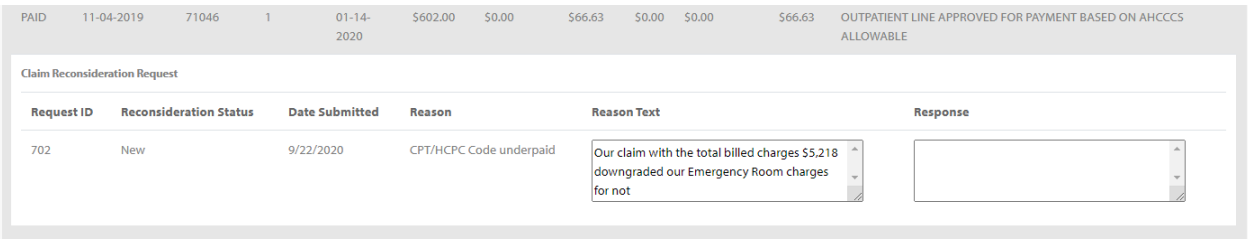


d. Under the **Reconsideration** section:
   - Select a **Reason Code**.
   - Enter a brief explanation in the **Custom Reason** box.



e. Click **RECONSIDERATION REQUEST** to submit.

The reconsideration attaches directly to the claim record.

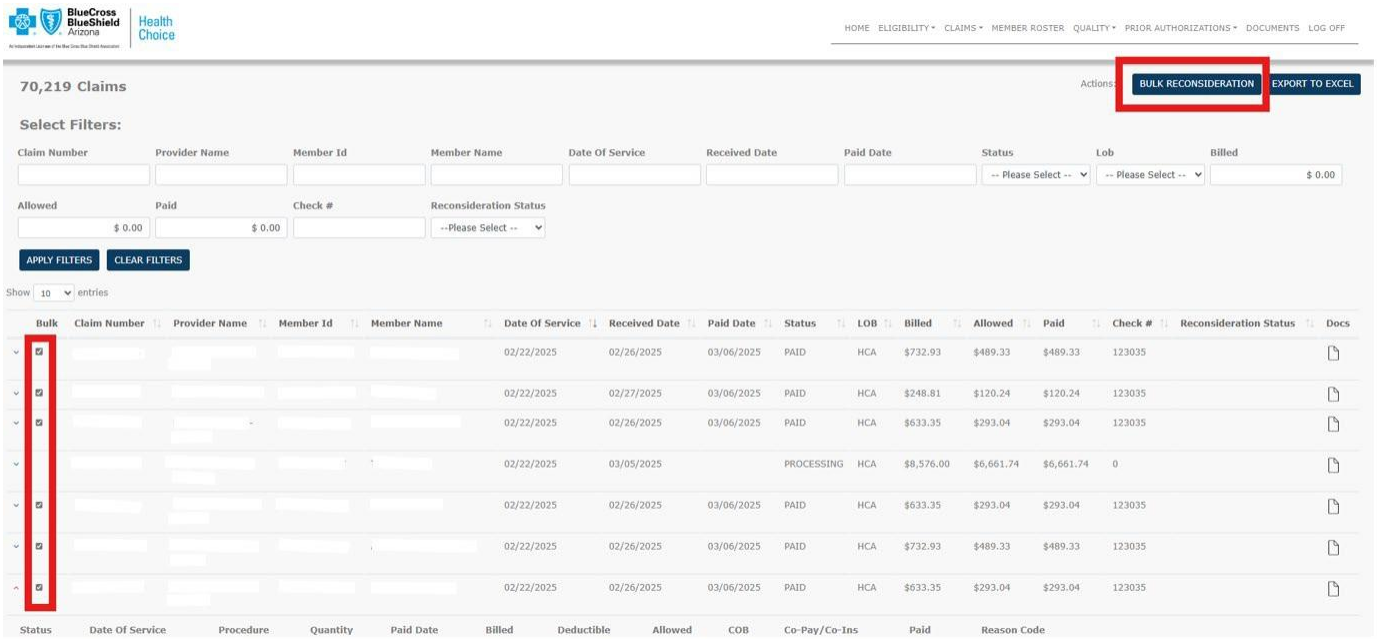


5.3 Bulk Reconsiderations

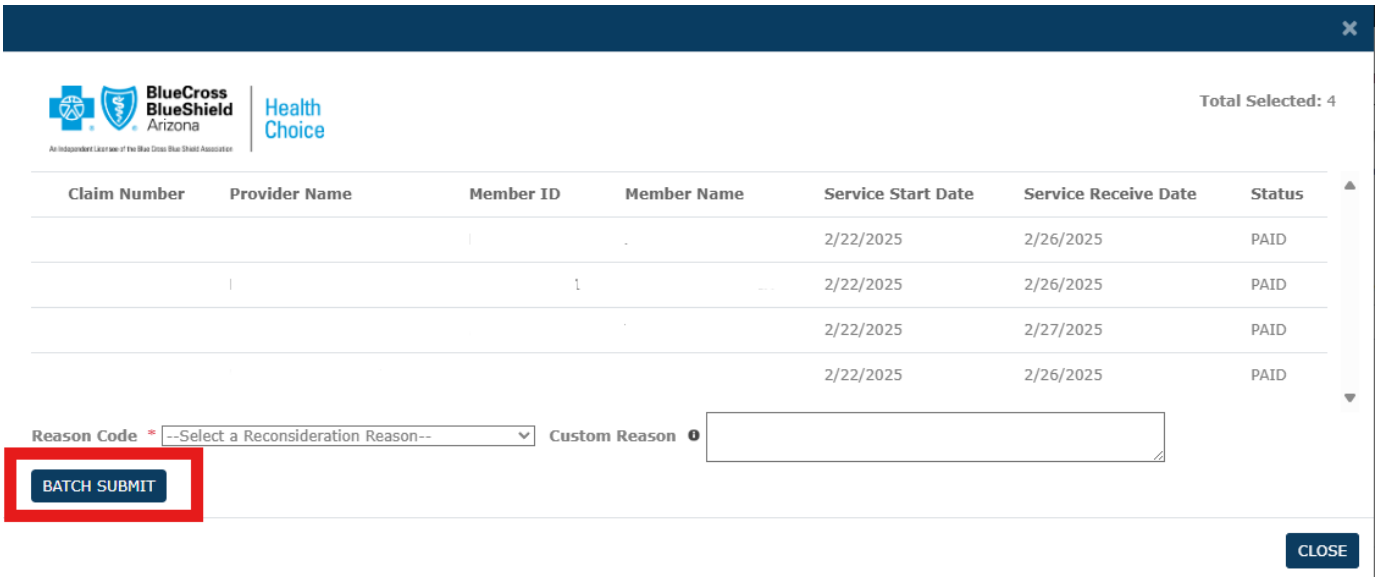
If several claims need reconsideration for the **same reason**, you can submit them together. If there are **more than 20 claims** with the same reason to reconsider, please reach out to your Provider Performance Representative for assistance.

How to Submit a Bulk Reconsideration

a. Search for the set of claims you want to submit.
b. Check the **Bulk** box next to each eligible claim.
    - If a claim is **not eligible**, the Bulk checkbox will not appear.
c. Click **BULK RECONSIDERATION**.



d. A popup will appear listing the selected claims.
e. Select **one Reason Code** and enter **one Custom Reason** for all claims.
f. Click **BATCH SUBMIT**.

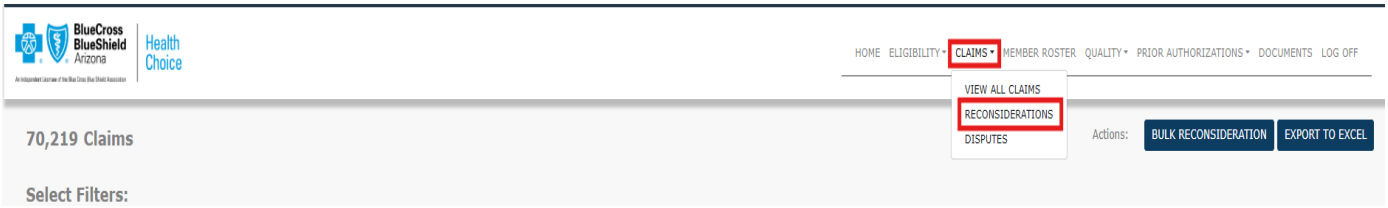


5.4 Checking Reconsideration Status

Reconsiderations can take up to **30 calendar days** to process.

How to Check Status

a. Go to **CLAIMS → RECONSIDERATIONS**.



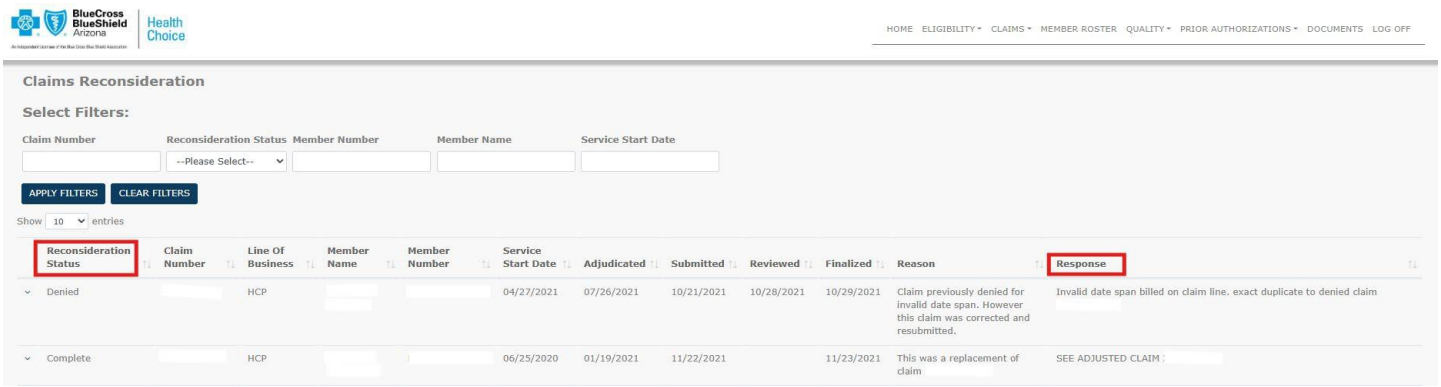
b. Scroll or use filters to locate the claim.

c. Review the date-stamped fields:

- **Submitted**
- **Reviewed**
- **Finalized**

d. View the **Response** section for processor notes.

- If reprocessed, a **new claim number** will appear.
- If denied, Health Choice agreed with the original decision.



You may submit a **second reconsideration** following the same steps if allowed.

5.5 Submitting a Formal Dispute

A formal dispute is the next step if reconsiderations are exhausted or a formal appeal is needed. The portal allows **one dispute per claim**.

Eligibility for Dispute Submission

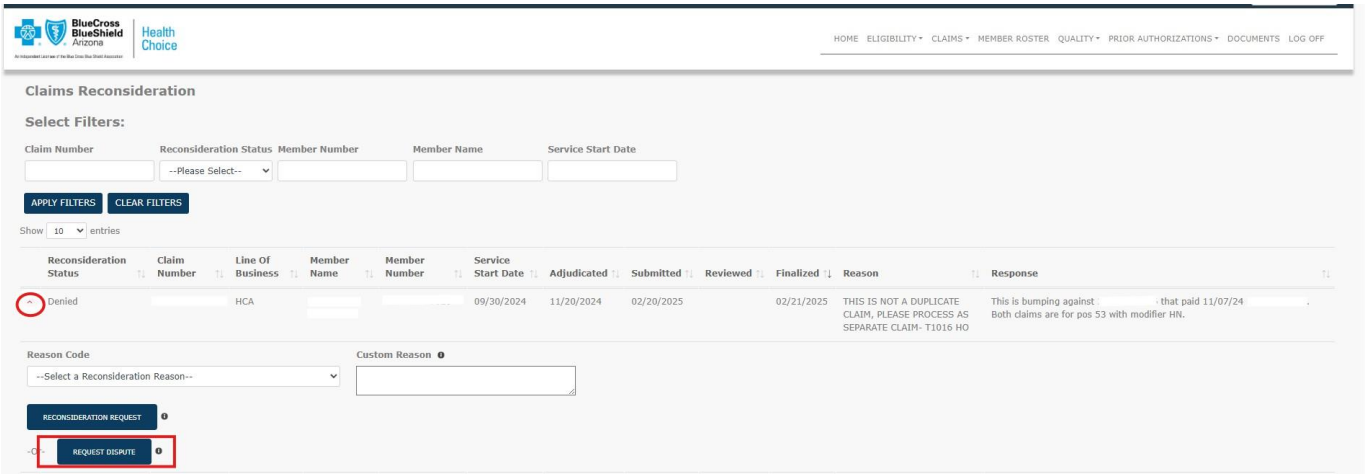
A claim must have a **finalized reconsideration status**:

- **Denied**
- **Complete**

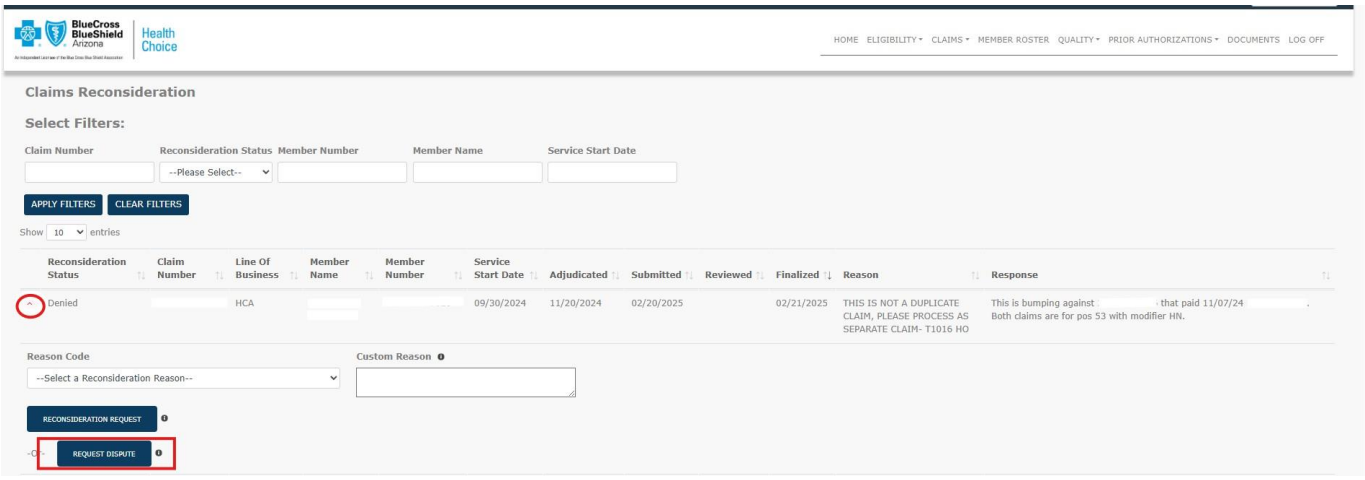
How to Submit a Dispute

a. Go to **CLAIMS → RECONSIDERATIONS**.

b. Find and expand the claim.
c. Select **REQUEST DISPUTE**.



d. Complete the **Dispute a Claim** form (all fields required).
e. Attach supporting documents by clicking **Choose Files**.
    - For Health Choice Pathway:
        - If you answer **"No"** to the Contract question, a link to the **Waiver of Liability (WOL)** will appear.
        - Complete and attach the WOL form before submitting.
f. Click **SUBMIT**.



5.6 Checking the Status of a Claim Dispute

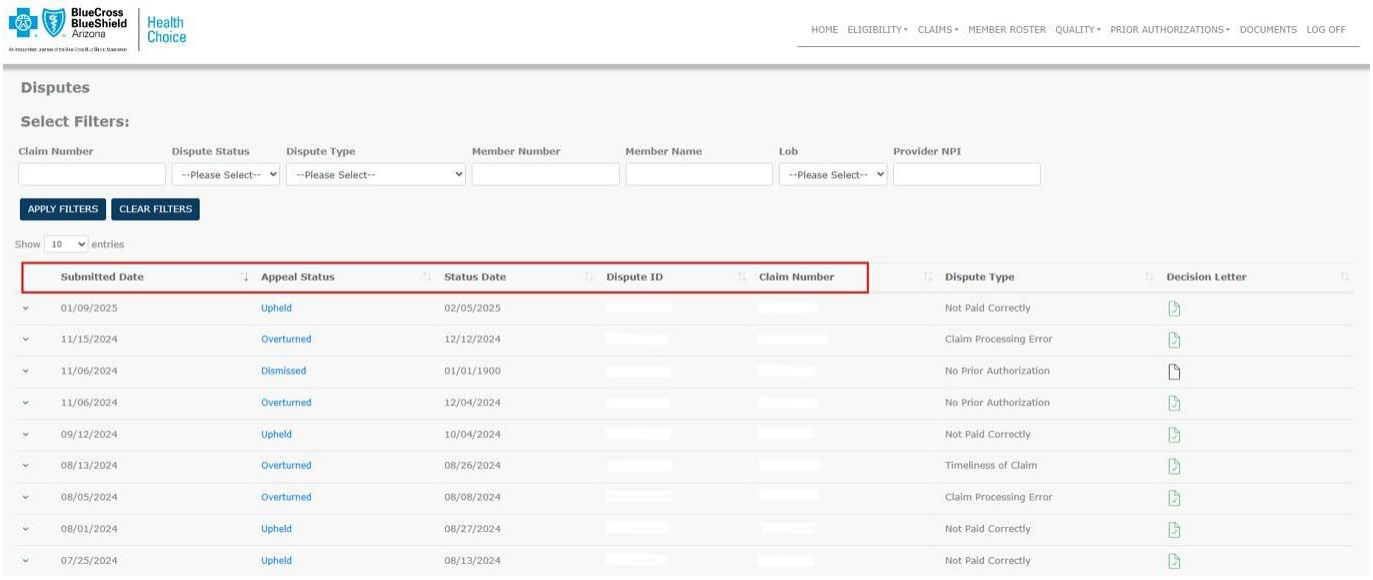
Dispute processing timeframes:

- **Health Choice Arizona**: up to **30 calendar days**
- **Health Choice Pathway**: up to **60 calendar days**

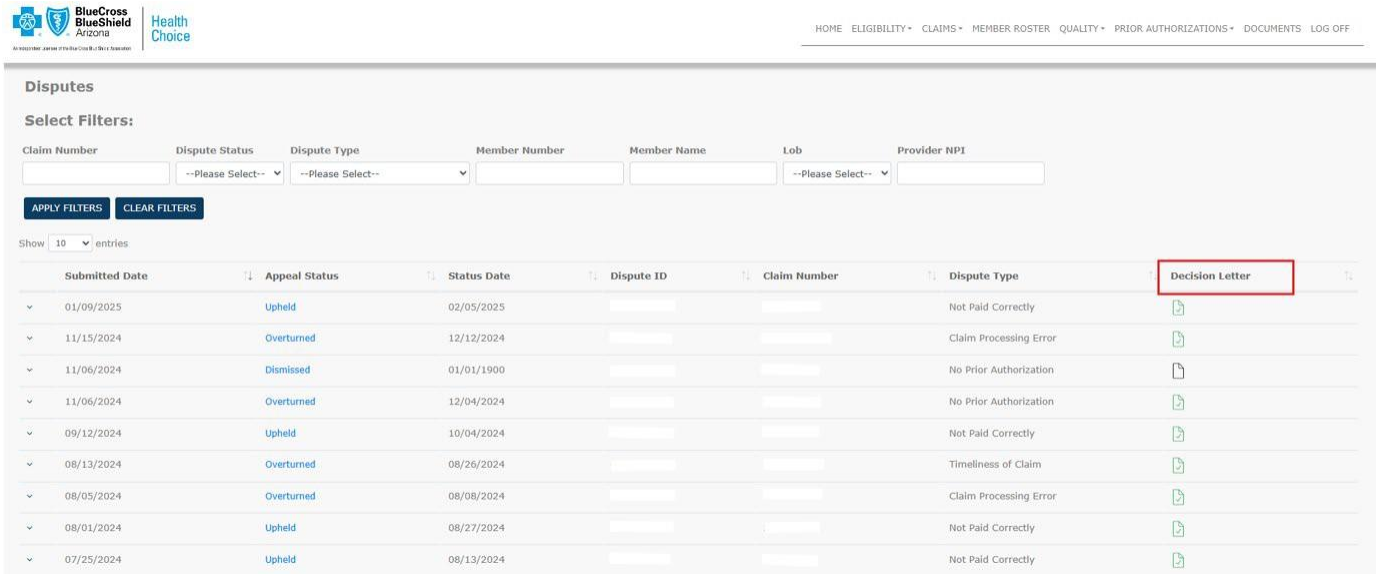
How to Check Status

a. Go to **CLAIMS → DISPUTES**.

b. Locate the claim using scroll or filters.
c. Review the date-stamped fields:
    - **Submitted Date**
    - **Processing Date**
    - **Mailed Date**



d. Look for final determinations:
    - **Upheld** = Original decision stands
    - **Overturned** = Decision changed; may include a new claim number
e. A **Decision Letter** will be attached once complete.



If a Second Level Appeal is needed after the First Level Appeal, the provider must follow the instructions in the Provider Manual (Chapter 15 for HCA & HCS or Chapter 9* for HCP).
**For Health Choice Pathway—a dispute is referred to as an appeal*

6. PRIOR AUTHORIZATIONS

The Prior Authorization (PA) feature within the Health Choice Provider Portal allows providers to submit medical and dental PA requests and referrals, upload supporting documentation, and track the status of submitted authorizations—all in one centralized location. This online submission process ensures faster review, improved accuracy, and compliance with Health Choice and AHCCCS requirements.

Note: BCBSAZ Health Choice, BCBSAZ Health Choice Pathway, and ACA StandardHealth with Health Choice is partnered with eviCore for radiology benefits management of select MRI, CT, PET, ultrasound and cardiac imaging studies. To submit a new request for imaging services and select cardiac testing/procedures, contact eviCore by: Phone: 888-693-3211, Fax: 888-693-3210, or the eviCore website.

6.1 When to Use the Portal for Prior Authorizations

Use the portal whenever you need to:

- Submit new medical or dental PA requests
- Track real-time PA status updates
- Access PA guidelines and grids

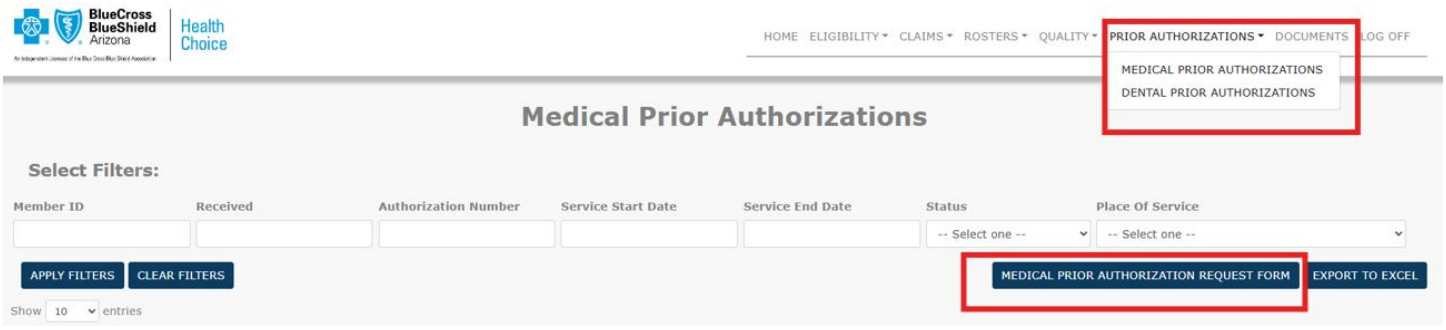
This expedites processing and reduces administrative burden for both providers and Health Choice.

6.2 How to Submit a Prior Authorization Request

Follow the steps below to submit a PA request through the portal:

Step 1: Start a New Request

- Navigate to **Prior Authorizations**
- Select **Medical** or **Dental** authorization.
- Select **Prior Authorization Request Form**



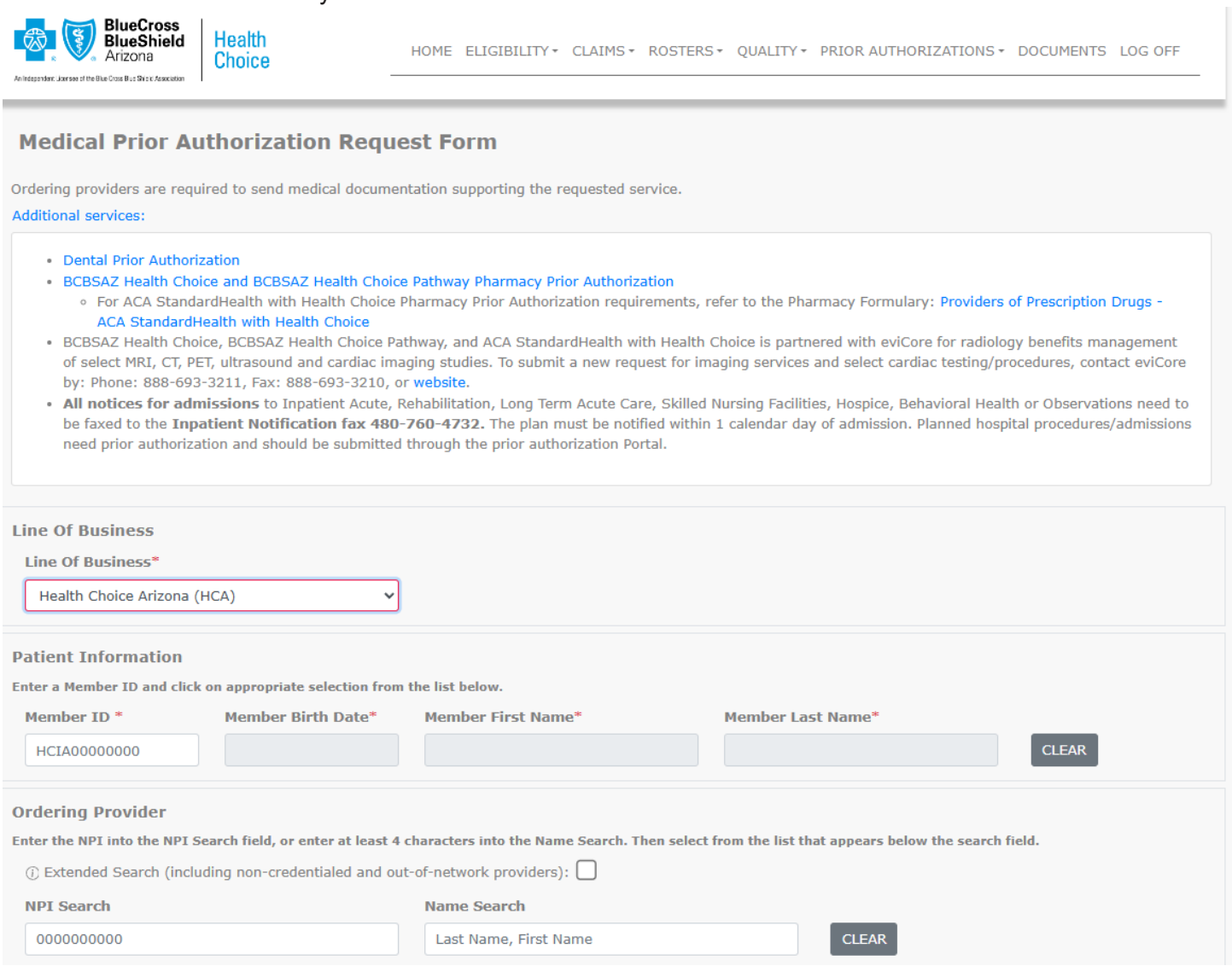
Step 2: Enter Member Information

- Select LOB
- Enter the **Member ID**
- Confirm member details (name, DOB, plan type).

Step 3: Enter Details

Complete the following sections and required fields identified by an asterisk (*):

- Requesting (Ordering) Provider
- Servicing Provider
- Requested Medical Service/Procedure/Course of Treatment
- HCPCS/CPT/CDT Codes
- Medical Pharmacy Codes



Step 4: Upload Required Documentation

Attach supporting documents such as:

- Clinical records
- Lab/imaging results
- Treatment plans
- Progress notes
- Dental X-rays (for dental PA)
- Any other documentation needed to support medical necessity

You may upload multiple files before submitting.

Step 5: Select Request Type

- **Standard:** 7 calendar days
- **Expedited:** 72 hours

Step 6: Review, Attest & Submit

- Review the completed form for accuracy.
- Click **Submit** to send your request for processing.

The request will appear in your portal **PA Status** list immediately with a reference number. Providers made export PA list in Excel.

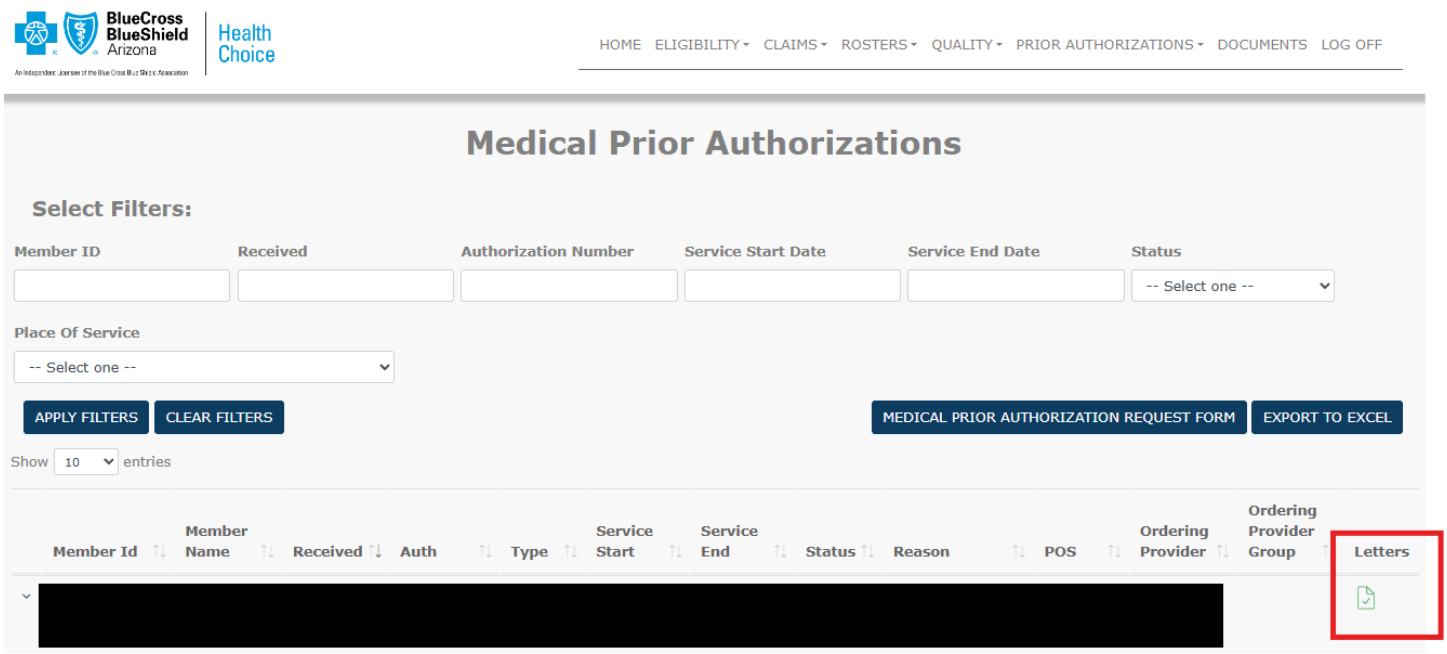
Note: Refer to the Provider Manual Chapter 6 for details and restrictions on Medical Authorization and Notifications and refer to PA Grids mentioned in the Education & Resources section of this user guide.

6.3 Checking the Status of a PA Request

To review the status of a previously submitted PA:

a) Navigate to **Prior Authorizations** → **Select Medical or Dental**
b) You may narrow down your search by:
   - Member ID
   - Auth number
   - Date range
c) View:
   - Received date
   - Status
   - Reason, etc.

Providers may print PA determination letters directly from the portal.



7.EOB/ERA SEARCH

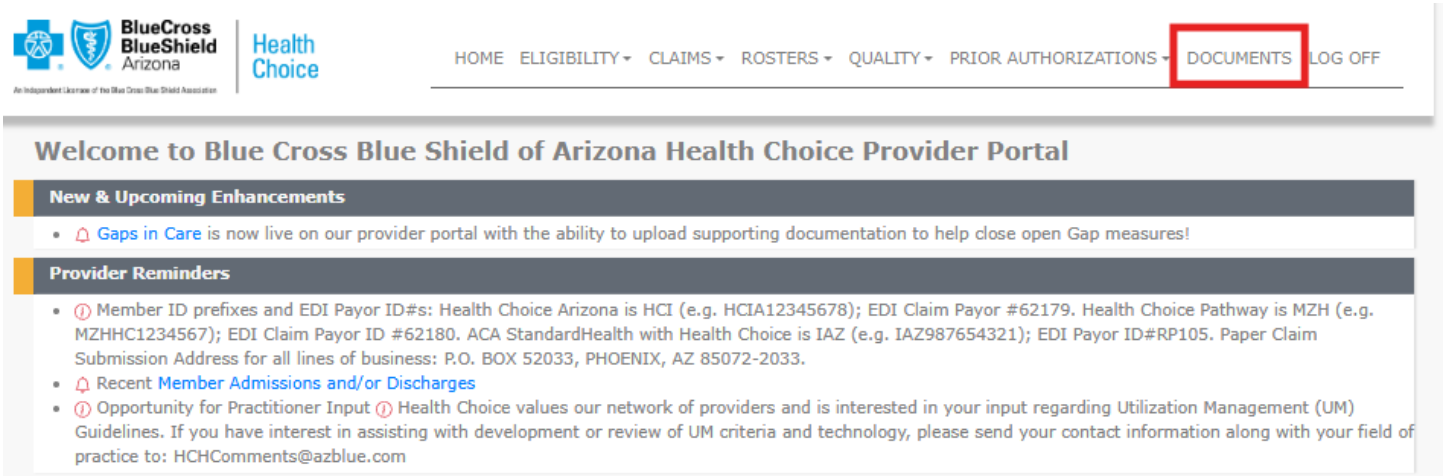
The Documents tab allows providers to access claim remittances (EOB/ERA files).

7.1 Downloading EOB/ERA Files

The portal allows providers to download electronic and paper remittance information (EOB/ERA) for processed claims associated with your Tax ID.

How to Locate and Download EOB/ERA Files

a) Navigate to the **Claims** tab and locate the relevant claim.
b) Note the **Check Number and Paid Date** associated with that claim.
c) Go to the **Documents** tab.



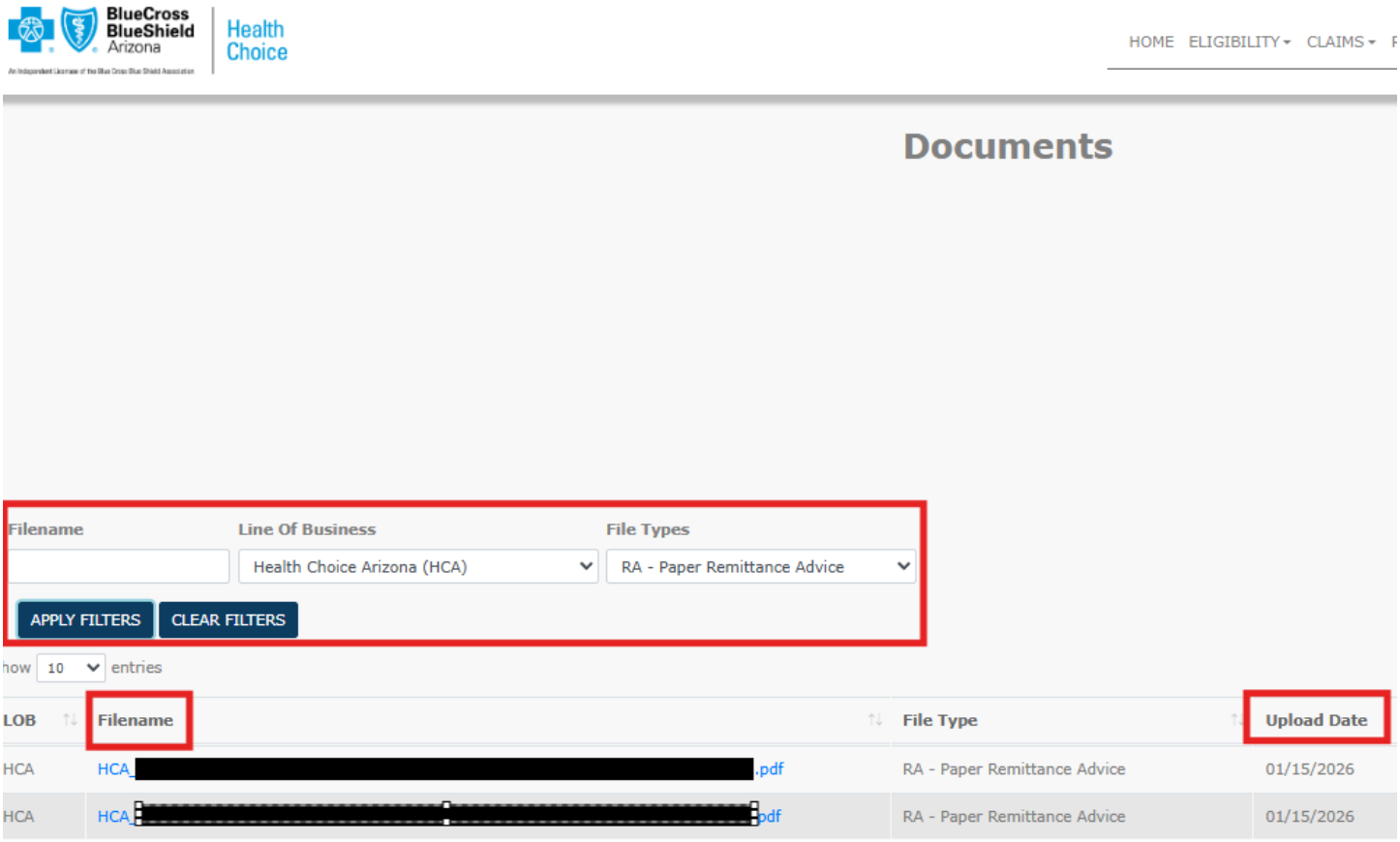
d) Narrow search by applying the following filters or you may skip to step e) below.
   - **Filename** – if applicable, enter the check number for "**RA Paper Remittance Advice**" file types
   - **Line of Business** – if needed, select the Line of Business (LOB)
   - **File Types** – select "**RA Paper Remittance Advice"** or **"835 – Electronic Remittance Advise"**
   - **Apply Filters**

e) Locate the EOB/ERA hyperlink located in the **Filename** column
   - Naming convention description: **LOB_TIN_Group_RemitType_XX_YYYYMMDD_Check Number_FileType**
     - "LOB" = Line of Business
     - "TIN" = Tax ID
     - "Group" = Pay-To Name
     - "RemitType" = 835 or RA
     - "YYYYMMDD" = paid date associated with claim(s)
     - "CheckNumber" = check number (applicable to "RA Paper Remittance Advice" file types)
     - "FileType" = 'PDF' for paper EOB or 'txt' for 835 data

   NOTE: The date in the EOB/ERA file is typically **one to two days after** the date found in the **Upload Date** column**.**

f) Click the file link in blue to open or download a PDF or txt file. Each file includes:

- All claims paid on the corresponding remittance advice
- Payment amounts and denial codes
- Associated member and claim details



8. GAPS IN CARE

The Provider Portal is used by external (providers) and internal (staff) to access provider related features and services, such as Gaps in Care.

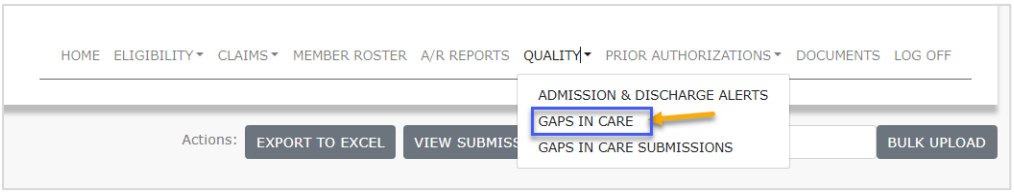
8.1 Gaps in Care Features

- View a member's open gap measures
- Export to Excel open gap results
- Select applicable measures and submit supporting documentation
- Bulk upload supporting documentation
- Identify when a member is not my patient
- View all submissions

8.2 General Instructions

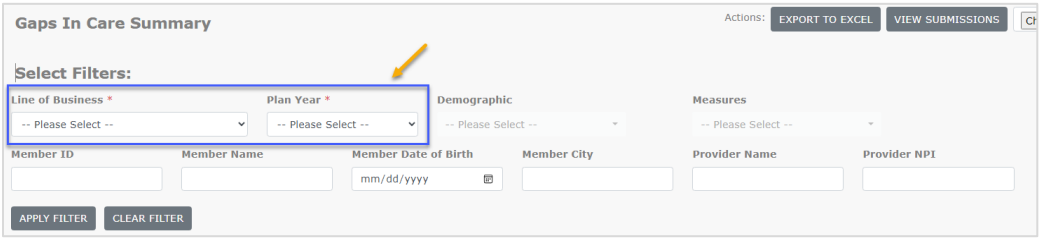
a. Provider Portal – https://providerportal.healthchoiceaz.com/ and log in.

b. Click on the top-level "Quality" menu and select "Gaps in Care".



c. Choose a Line of business and Plan year and click "Apply Filter".

- Additional filter options (i.e., Demographic, Measures, Member ID, Member Name, Provider name, etc.) are available to narrow to desired search.
- Demographic defaults to "Recommended Measures".



d. From the results grid, click Edit or Uploaded button in the Document Uploads column to go to the Edit Gaps in Care page. This page is used to submit supporting documentation for an open gap measure. NOTE 1: The button changes from Edit to Uploaded when a document has been uploaded. NOTE 2: Documentation can only be uploaded for the current year. Uploading documentation for the previous year will be disabled.

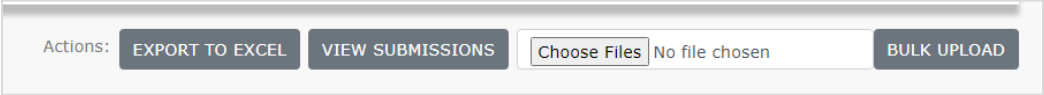
e. On the Edit Gaps in Care page - Choose open measure(s) and upload its supporting documentation. Selected measures are removed from the open gap measures list and added in

the supporting documentation grid below. After uploading all documents, click submit. NOTE: A file can be removed before it is submitted by clicking the “X” in the “Remove” column.

f. Once done, you are returned to your search results on the previous page. Or, you can select “Return to Summary” to stay on the Edit page.

8.3 Additional features

a. Click “Report” button to indicate when a member is not a provider’s patient. NOTE: The button changes from Report to Reported once its clicked. *See #1 in image A above.*
b. Export to Excel – exports the search results on Excel spreadsheet
c. View submissions page allows you to see all Gaps in Care updates (uploaded documents, not my patient updates and batch uploads).
d. Bulk upload is used to submit batch files for multiple members.



8.4 Gaps in Care Submission Page

a. View Open Gaps button takes you to the Gaps in Care Summary page to view member open gaps.
b. Export to Excel – exports the search results on Excel spreadsheet
c. Submission Type filter options:
   - Member uploads – view supporting documentation uploads for a single member via the Gaps in care edit page.
   - Bulk uploads – view batch file uploads for multiple members via the Gaps in Care summary page.
   - Not my patient – view members reported as not my patient for the provider.
d. File statuses filter options:
   - Submitted – view files successfully submitted
   - Rejected – view files that was rejected internally. A reason for the rejection is provided. If the file was rejected, an email will be sent to the submitter, and the file should be resubmitted.
e. Click on the member ID hyperlink to go to the Gaps in care edit page for that member.
f. Click on the filename hyperlink to see download and view the file.

9. PROVIDER AND MEMBER ROSTERS – MEDICAL AND DENTAL

The Provider & Member Rosters section of the Health Choice Provider Portal gives practices a clear, real-time view of the providers linked to their Tax ID and the members assigned to them. These roster tools support accurate panel management, help ensure providers are credentialed and active, and offer quick insight into member assignments across medical and dental lines of business.

9.1 Provider Rosters

The Provider Roster displays all credentialed providers associated with your group's Tax Identification Number (TIN). This includes information needed for staffing, contracting, and access-to-care compliance.

Information Included in the Provider Roster

Depending on your line of business and portal release phase, the roster may include:

- Provider name
- Credentialing status
- Credentialing effective date
- Network effective date
- "Practice As" name (if applicable)
- Whether the provider is accepting new patients
- Linked TIN(s)

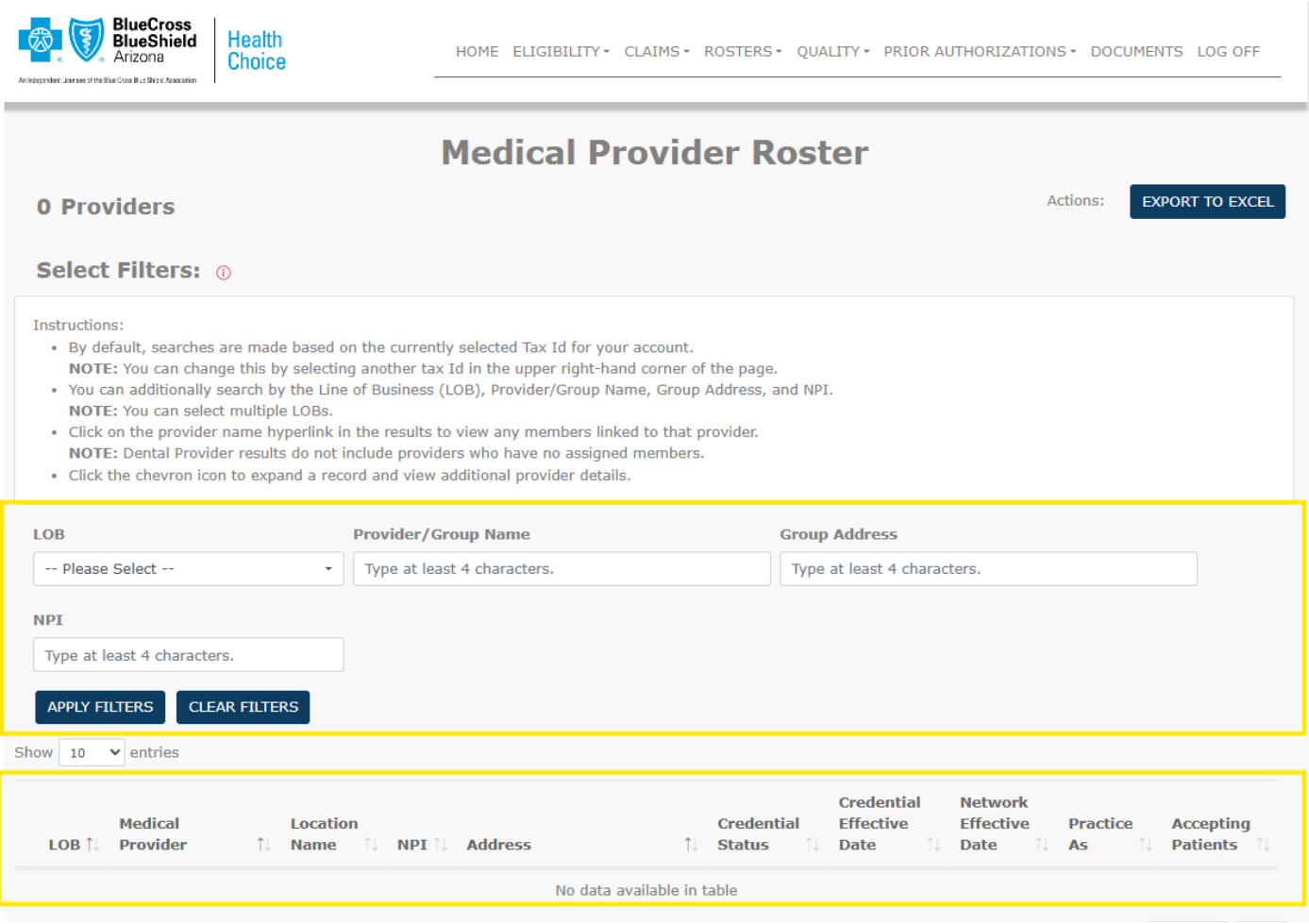
How to Access the Provider Roster – Medical or Dental

a. Log in to the Provider Portal.

b. Navigate to the **Rosters** or **Provider Roster** section from the homepage or main navigation.

c. **Select Filters:**

- By default, searches are made based on the currently selected Tax Id for your account.
- NOTE: You can change this by selecting another tax Id in the upper right-hand corner of the page.
- You can additionally search by the Line of Business (LOB), Provider/Group Name, Group Address, and NPI.
- NOTE: You can select multiple LOBs.
- Click on the provider name hyperlink in the results to view any members linked to that provider.
- NOTE: Dental Provider results do not include providers who have no assigned members.
- Click the chevron icon to expand a record and view additional provider details.



When to Use the Provider Roster

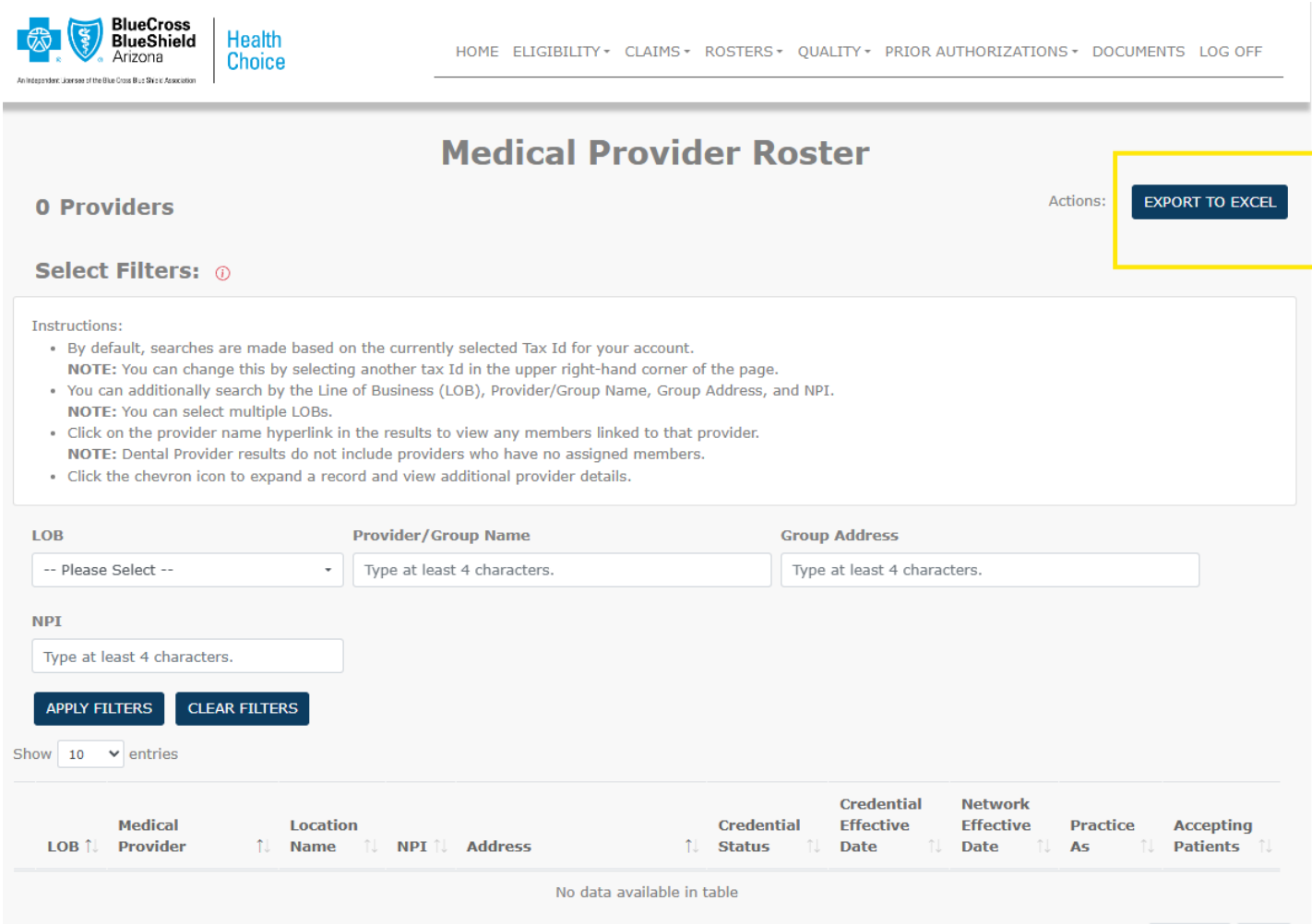
- Confirming providers are active and credentialed
- Validating network participation
- Supporting contracting or credentialing updates

Important Notes About Provider Rosters

- Only providers with linked TINs appear in the roster.
- Credentialing and contracting are **separate processes**—a provider must be both contracted and credentialed to appear as fully active on the roster.

Exporting Rosters

Provider rosters can be exported in Excel format for easier filtering, sorting, and internal reporting and/or validation.



9.2 Member Rosters

Member Rosters show all members assigned to your medical or dental providers as of the first day of each month.

Information Included in Member Rosters

Depending on your line of business and portal release phase, the roster may include:

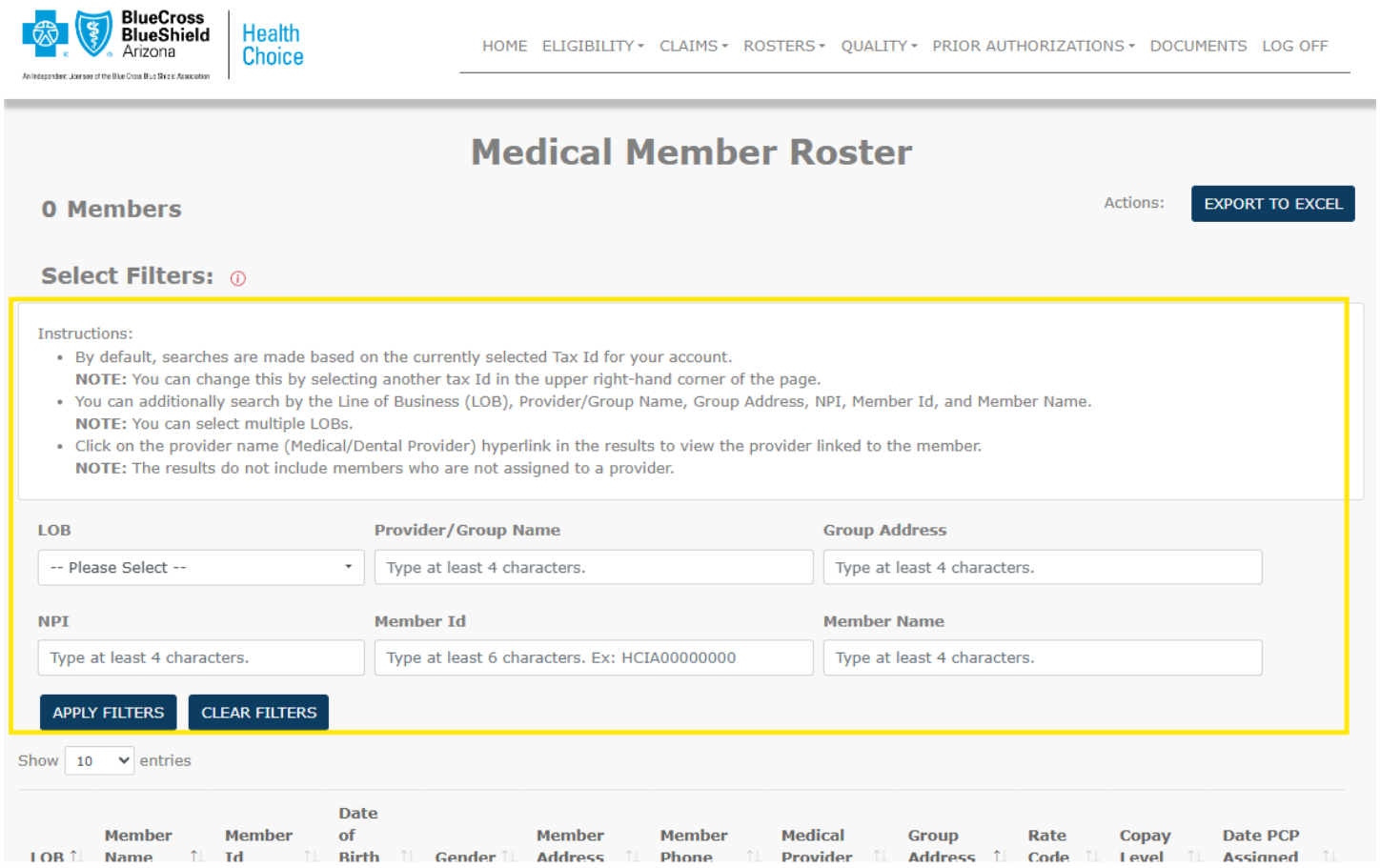
- Member name
- Member ID
- Assigned provider
- Effective date of assignment
- Line of business
- Age or demographic details (depending on roster type)
- Dental services history (exam, fluoride, sealants)
- Credentialing status

How to Access the Member Roster – Medical or Dental

a. Log in to the Provider Portal.
b. Navigate to Rosters → Member Roster.

c. Select Filters:

- By default, searches are made based on the currently selected Tax Id for your account.
- NOTE: You can change this by selecting another Tax ID in the upper right-hand corner of the page.
- You can additionally search by the Line of Business (LOB), Provider/Group Name, Group Address, NPI, Member Id, and Member Name.
- NOTE: You can select multiple LOBs.
- Click on the provider name (Medical/Dental Provider) hyperlink in the results to view the provider linked to the member.
- NOTE: The results do not include members who are not assigned to a provider.



When to Use Member Rosters

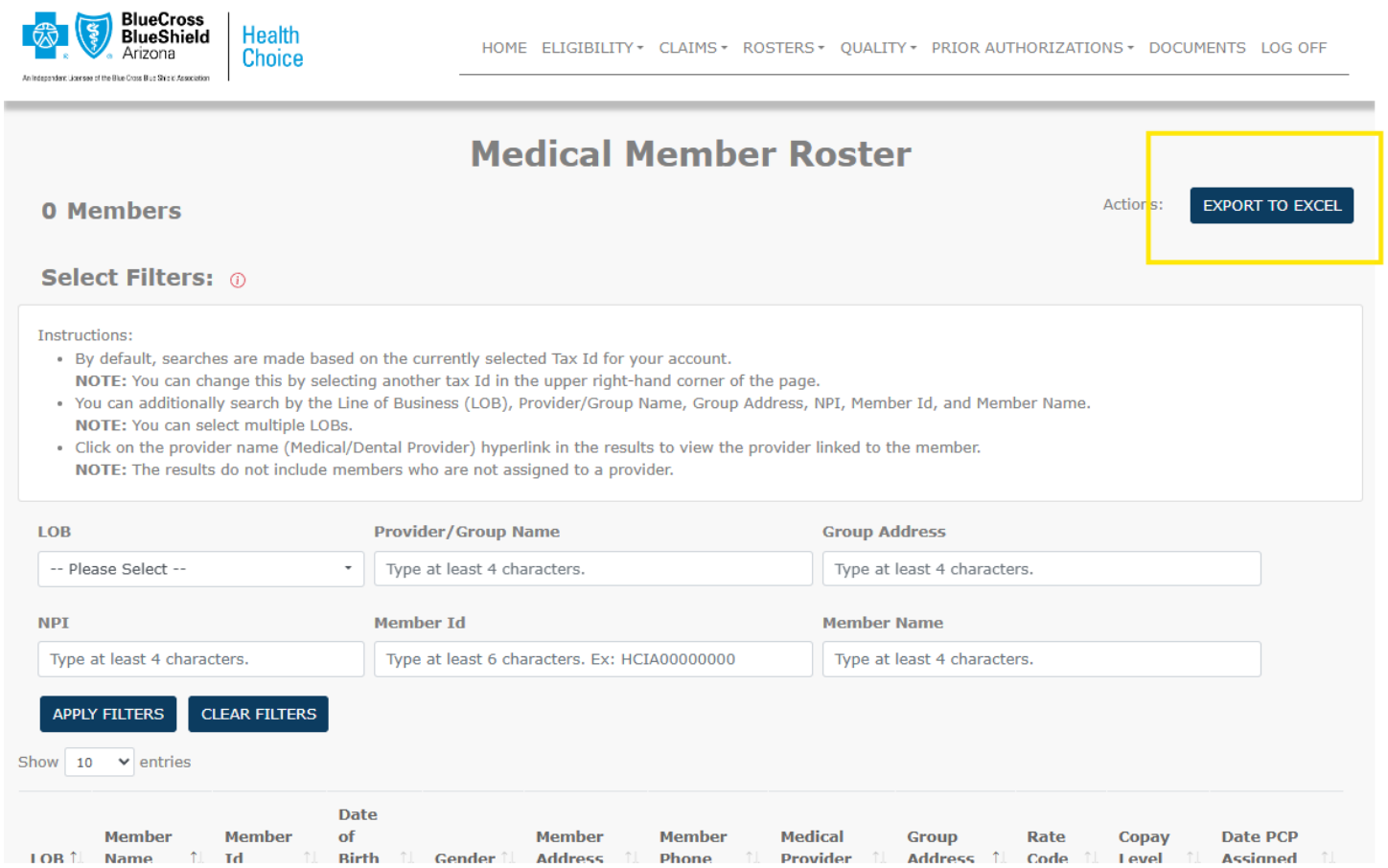
- Monthly panel management
- Validating active member assignments

Important Notes About Member Rosters

- Member assignments refresh at the start of every month.
- Only providers with assigned members will appear in Member Rosters.

Exporting Rosters

Members rosters can be exported in Excel format for easier filtering, sorting, and internal reporting and/or validation.



10. REVALIDATION

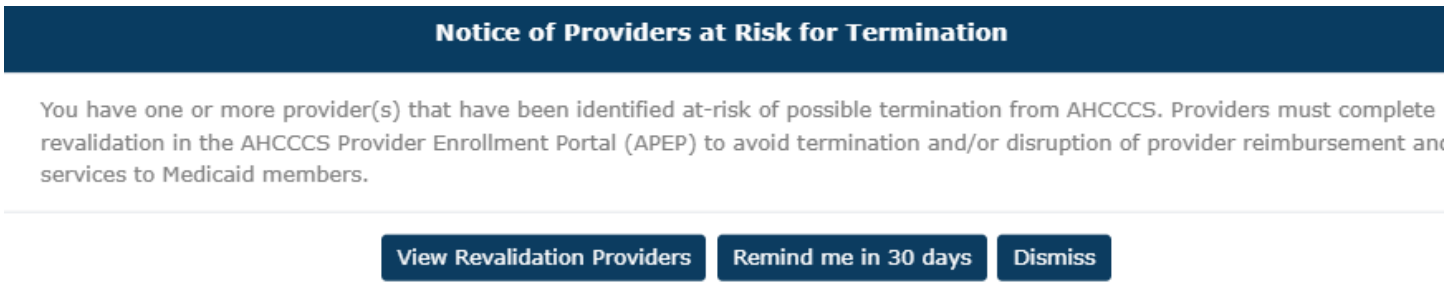
To maintain active Medicaid billing privileges, all AHCCCS-registered providers must complete revalidation of their enrollment every four years (or sooner, if requested by AHCCCS). Revalidation must be completed through the AHCCCS Provider Enrollment Portal (APEP) to avoid termination and disruption in reimbursement.

Health Choice supports providers by offering **portal-based revalidation alerts**, ensuring practices are aware of upcoming deadlines and required actions before any interruption occurs.

10.1 Portal Revalidation Alerts

When a provider associated with your Tax ID is due—or overdue—for revalidation, the Health Choice Provider Portal will display a pop-up alert immediately upon login, labeled:

"Notice of Providers at Risk for Termination"



This notification appears when AHCCCS has identified one or more providers under your TIN as **at-risk for possible termination** due to an incomplete or overdue revalidation.

The message explains that providers must complete revalidation in APEP to avoid termination and potential disruption of Medicaid billing and services.

10.2 Options Available on the Revalidation Alert

a. View Revalidation Providers

Selecting this option takes you directly to a list of providers within your organization who are at-risk due to revalidation requirements.

From this list, you can:

- View all affected NPIs
- Determine which providers require immediate action
- Plan follow-up steps with your credentialing or administrative team

This helps ensure timely submission and prevents billing disruption.

b. Remind Me in 30 Days

Choosing this option will temporarily dismiss the alert and prompt the portal to **remind you again in 30 days**.

This is best used when:

- You are aware of the revalidation requirement
- Action is already underway
- You need time to coordinate with providers or administrative staff
- You want a future reminder without dismissing the alert entirely

c. Dismiss

- This option closes the alert **for the current login session only**.
- Selecting *Dismiss* does **not** remove the provider from revalidation status and does **not** reset the reminder cycle.
- The alert will reappear later if the provider remains at risk.
- Use this option when you simply need to continue working in the portal without interruption.

10.3 What Happens if Revalidation Is Not Completed

If revalidation is not completed in the required timeframe:

- AHCCCS will **terminate the provider's enrollment**
- Health Choice must follow and terminate the provider from the network
- Claims will deny until revalidation is completed
- The provider will not appear in the provider directory or rosters

Why This Feature Matters

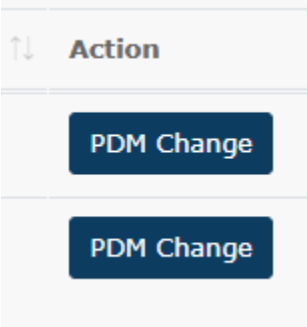
The revalidation alert feature serve as an early warning system to prevent:

- Billing interruptions
- Network termination
- Member access issues
- Unexpected claim denials

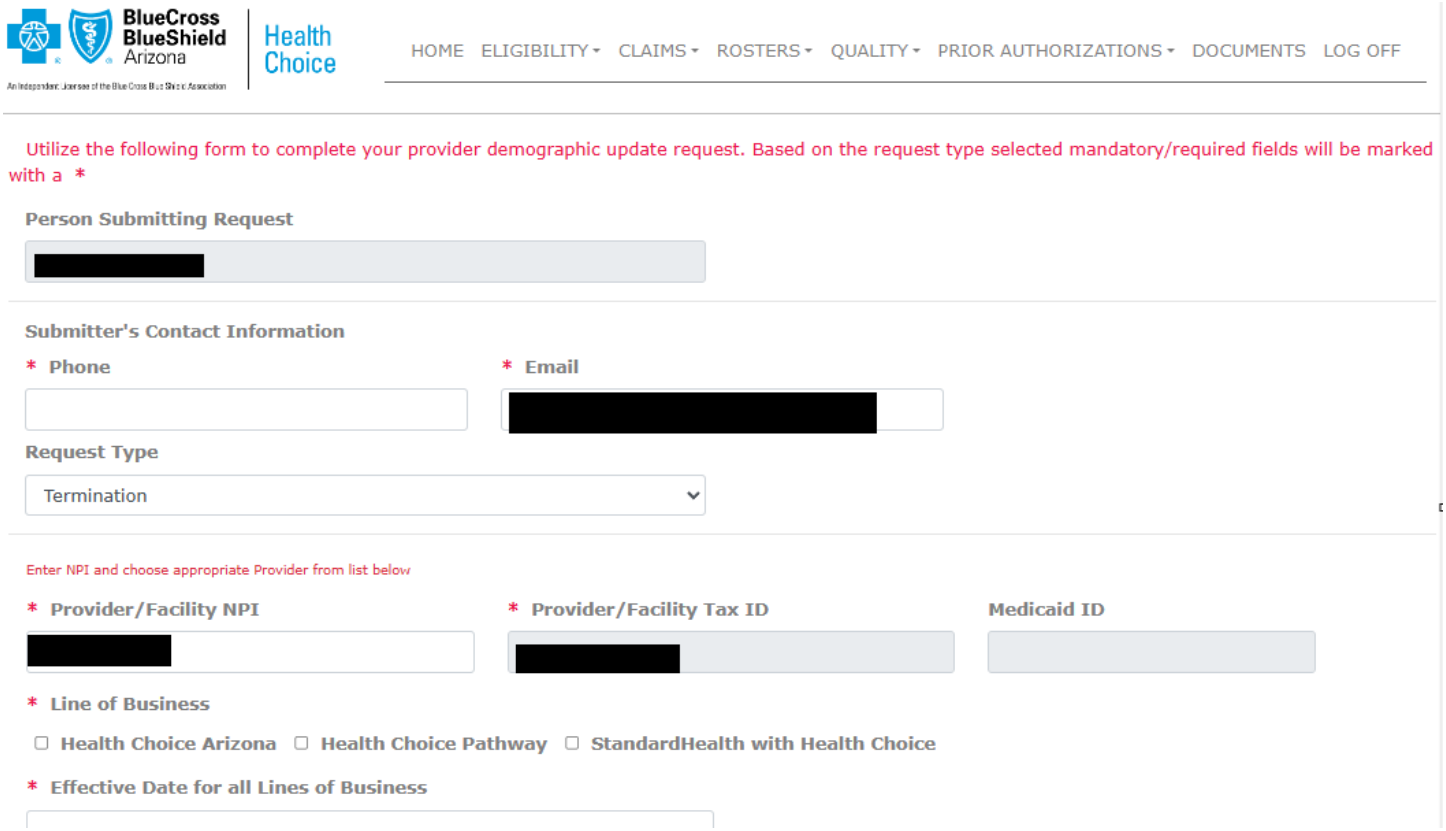
It also helps practices proactively manage provider compliance across all NPIs linked to their TIN.

10.4 Provider Demographic Change

If the provider(s) listed are no longer practicing with your group, please click the "PDM Change" action button to request to terminate the corresponding practitioner(s) from your group.



Follow the prompts:


BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice
HOME ELIGIBILITY CLAIMS ROSTERS QUALITY PRIOR AUTHORIZATIONS DOCUMENTS LOG OFF
Utilize the following form to complete your provider demographic update request. Based on the request type selected mandatory/required fields will be marked with a *
Person Submitting Request
[redacted]
Submitter's Contact Information
* Phone
* Email
[redacted]
Request Type
Termination
Enter NPI and choose appropriate Provider from list below
* Provider/Facility NPI
[redacted]
* Provider/Facility Tax ID
[redacted]
Medicaid ID
* Line of Business
Health Choice Arizona
Health Choice Pathway
StandardHealth with Health Choice
* Effective Date for all Lines of Business

11. EDUCATION & RESOURCES

The Health Choice Provider Portal offers a centralized location for training materials, operational guidance, policy references, and support tools to help providers successfully navigate Health Choice processes. These resources ensure providers remain informed, compliant, and equipped to deliver high-quality care.

11.1 Technical Support

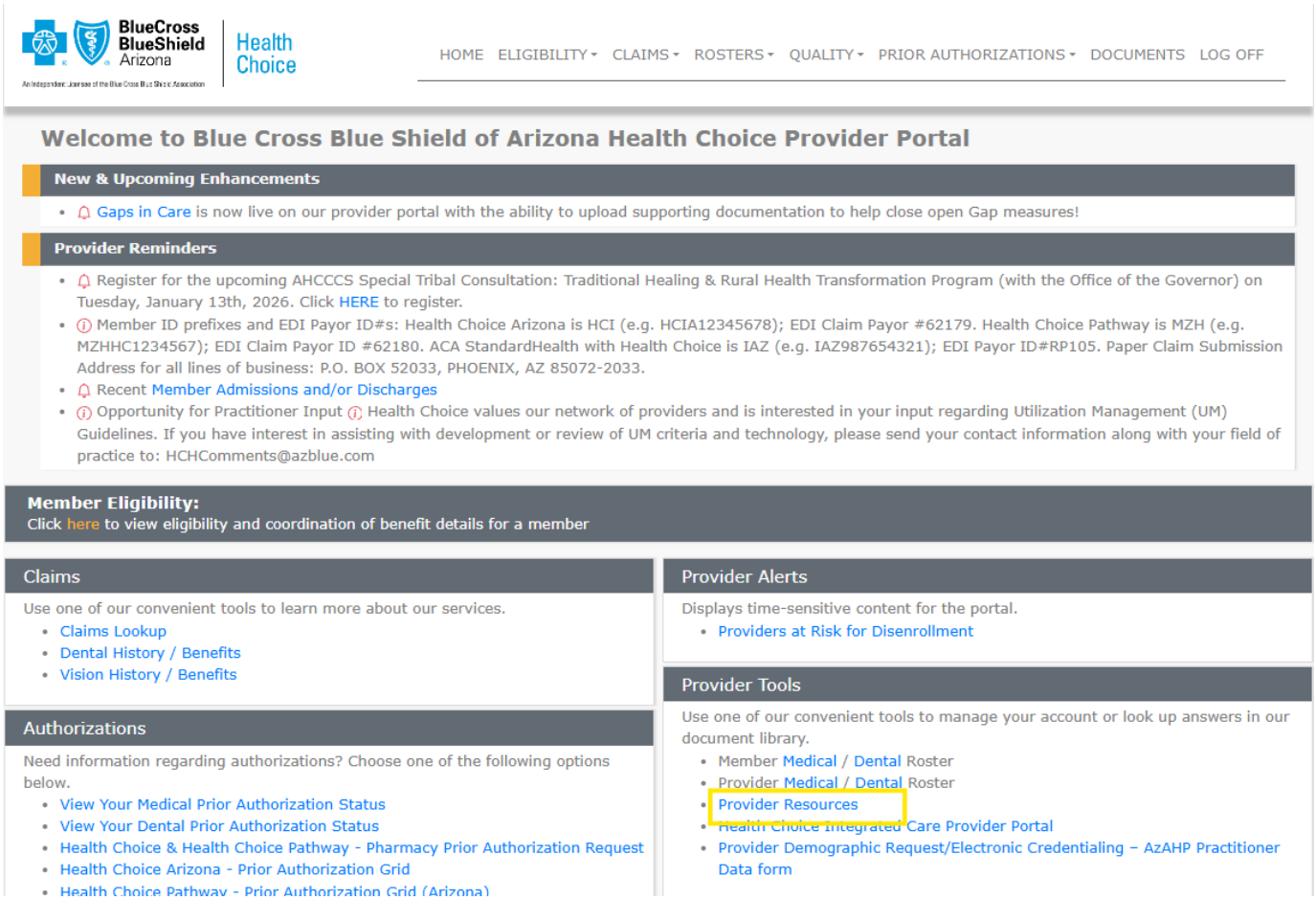
Please note that user Account passwords should NOT be shared between employees. Sharing passwords is prohibited. Health Choice encourages the Prime Administrator Account holders to set up individual user accounts in order for individual employees to use.

If you have any questions, please contact the **Provider Portal Coordinator at:**

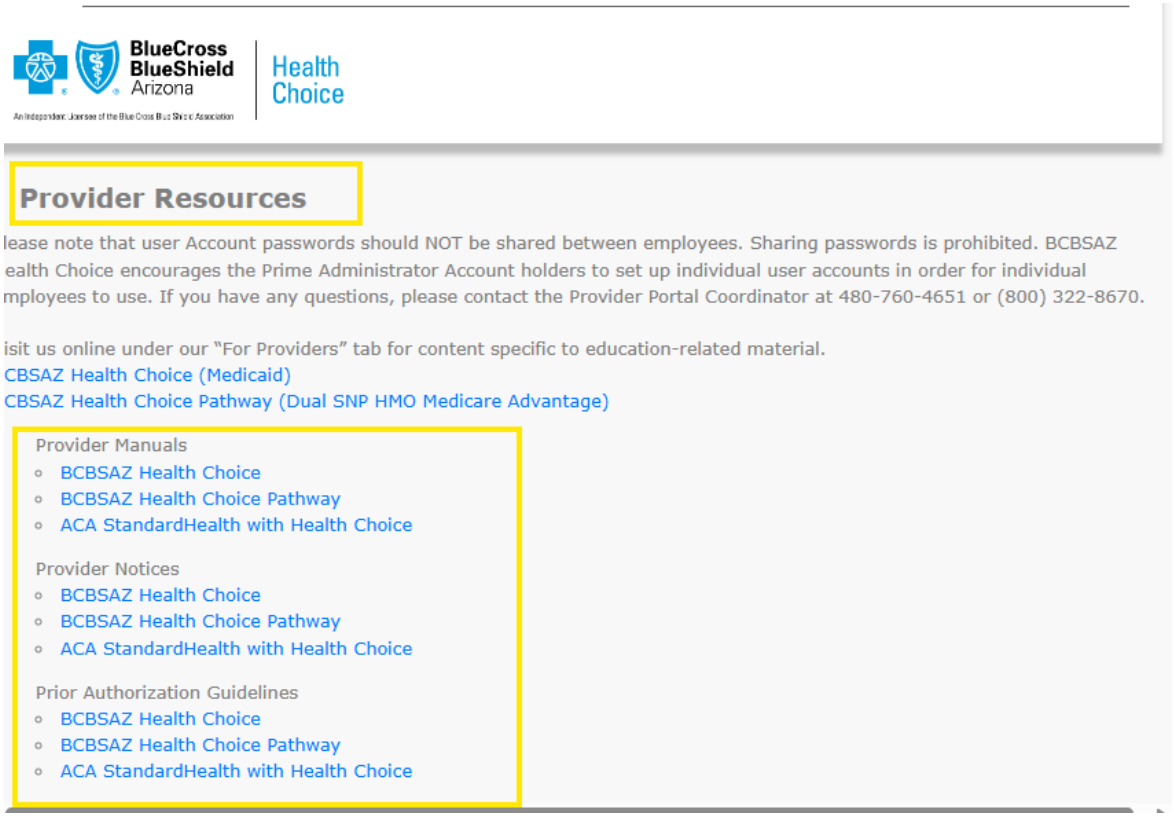
- 480-760-4651
- 800-322-8670
- HCHproviderportal@azblue.com

11.2 How to Access Provider Resources from Provider Portal

From the Home Page, click on **Provider Resources.**



11.3 Provider Resources Webpage



11.4 Provider Manuals

For all lines of business (LOBs)

11.5 Provider Notices

Notices and communications for all LOBs

11.6 Prior Authorization Guidelines

Detailed PA requirements

11.7 Provider Forms

Forms used for clinical, administrative, and operational processes

11.8 Provider Education Resources

- POLT List
- Portal training videos
- Newsletters
- Quality coding guidance

11.9 Dental Matrix & Clinical Review Criteria

- Dental benefit matrices
- Supplemental benefits (Pathway)

11.10 Model of Care (Pathway)
Annual required training for DSNP providers

11.11 Prescription Drug Formularies
Drug lists and coverage guidelines

11.12 Cultural Competency Resources
Required training and supporting materials

11.13 Clinical Guidelines
Evidence-based practice guidelines

11.14 Quality & Performance Measures
Quality reporting and performance expectations

11.15 Medical Management
Policies, procedures, and UM guidance

11.16 Behavioral Health Resources
BH clinical tools, forms, and guidelines

11.17 Fraud, Waste & Abuse
Reporting instructions and compliance guidance

12. FREQUENTLY ASKED QUESTIONS (FAQ)

Brief Description of section and its purpose. Brief Description of section and its purpose. Brief Description of section and its purpose. Brief Description of section and its purpose. Brief Description of section and its purpose. Brief Description of section and its purpose.

12.1 FAQ – Questions & Responses

Registration & Account Management

1. How do I register for the Provider Portal? Click Register on the Provider Portal login page and complete the Registration Verification form with your TIN, name, and required contact information. Once reviewed, you'll receive an activation email to complete your account setup.

2. What if I never received the activation email? Check your junk/spam folder. If the email is still missing, ensure your email was entered correctly or contact the Provider Portal Coordinator for assistance. Activation links expire after 24 hours, so a new link may need to be issued.

3. Who can add or remove users from our portal account? Only the Prime Administrator or assigned Admins can add, update, or deactivate users via Provider Tools → Manage My Users.

4. How do I update/change the Prime Administrator user role? If the designated Prime Administrator is no longer employed with your organization, please contact Health Choice immediately. Our team will provide a Prime Administrator Change Request form for your organization to complete. Once the form is submitted and approved, we will update the administrator's information and restore the appropriate access to your account. Contact information: 480-760-4651, 800-322-8670, HCHproviderportal@azblue.com

5. Can users share login credentials? No. Password sharing is prohibited. Each staff member must have their own account.

Eligibility & Benefits

6. Why can't I find a member's eligibility? Try clearing filters, verify the correct Member ID prefix is HCIA, MZHHC, IAZ, and ensure the member is enrolled with a Health Choice plan.

7. What does it mean if a member shows a "Grace Period" alert? For Marketplace (HCS) members, this indicates overdue premium payments. Members may be financially responsible for services depending on the grace period status.

Claims Management

8. Which claims are eligible for reconsideration? Claims must have a status of Paid or Denied and fall within the allowable timeframe:
   - 12 months for Health Choice Arizona
   - 18 months for Health Choice Pathway

9. How many reconsiderations can I submit? Up to two reconsiderations per claim, followed by one formal dispute if needed.

Disputes

10. When can I submit a formal dispute? Only after the reconsideration has a finalized status (Denied or Complete).

11. How long does it take to receive a dispute decision?
    - 30 calendar days for Health Choice Arizona
    - 60 calendar days for Health Choice Pathway

Prior Authorizations

12. How do I submit a prior authorization? Go to Prior Authorizations in the top navigation, enter the required member and service information, and upload supporting documentation.

13. Can I upload documentation with my PA request? Yes. The portal supports uploading all necessary clinical records as part of the request.

E Credentialing & Provider Demographic Updates

14. Where do I submit credentialing requests or demographic updates? Use the Provider Demographic Request / Electronic Credentialing – AzAHP Practitioner Data Form in the portal.

15. Can I save a credentialing application and finish later? Yes. Use the Save button at the bottom of each section to return later without losing progress.

16. What if a provider no longer works for our group? Use the Termination option within the Provider Demographic Request tool. Or, if seen in the Revalidation alert, click PDM Change.

17. How do I become a provider of Health Choice? Visit our website, www.HealthChoiceAZ.com, click on the “Providers” tab from the main menu and then click on Provider Overview & Joining Our Network “Electronic Credentialing – AzAHP Practitioner Data Form” or “Forms” to download the Request for Participation – AzAHP Practitioner Data Form.

18. What is credentialing? Credentialing is an industry-standard systematic approach to the collection and verification of a practitioner applicant’s professional qualifications. These qualifications include, but are not limited to: review of relevant training, licensure, certification, and/or registration to practice in a health care field, and academic background. Health Choice utilizes the Council for Affordable Quality Healthcare (CAQH) for gathering credentialing data for physicians and other health care professionals. Please note: The Health Choice credentialing process is completed before a practitioner is accepted into the Health Choice network. Credentialing and Network Contracting are two separate processes.

19. What are the steps in the full credentialing process for a new physician? Our credentialing process includes a review for network need, primary source verification and our credentialing committee review. After receiving a completed application, we perform primary source verification. This portion of the process takes approximately 30 business days to complete. Next, we present your request for participation to our Credentialing Committee. Once approved, we will send notification of the Committee’s final credentialing decision within 10 business days. Health Choice will then reach out to the physician to complete the next phase of the network contracting process.

20. Must the entire CAQH ProView form be completed? Yes, you are expected to complete all

questions on the CAQH application. The electronic application will present the questions to you in an interview style approach, with logic that presents the questions that are relevant to your particular specialty or provider type. The entire application must be completed prior to your verification of its accuracy, and before the participating health plans that you have authorized can access it.

21. How can we contact CAQH for assistance? CAQH Provider Help Desk is available online at proview.caqh.org, by email at providerhelp@proview.caqh.org and by calling: 888-599-1771 (Monday through Thursday, 7 AM to 9 PM EST; and Friday 7 AM to 7 PM EST).

22. What are some common reasons that we may not be credentialed or recredentialed so that we can avoid them? The physician and other health care professional is encouraged to ensure that:

    - CAQH applications are complete (listed Cov-erring Physician/Partners, 5-year work history with explanations for gaps over 3+ months).
    - Do not have an expired attestation status.
    - All applications having current supporting documentation (DEA cert., liability coverage face sheet) and that nothing is expired.
    - You are requesting credentialing only for those specialties in which you are trained (e.g., do not send in a request for pain management with a residency in anesthesia only).
    - You have adequate liability coverage as required.

23. How do we complete recredentialing with Health Choice? Recredentialing is conducted every three years after initial credentialing to ensure professional qualifications remain valid and current. If you have attested to all of the data in CAQH on the regular interval required, you do not need to do anything. Health Choice simply pulls your information from CAQH to review for updates and changes. Please remember to review, re-attest and authorize data access once every four months. If you keep this information up-to-date, Health Choice will only send you a notification letter at the end of the recredentialing process.

24. How much professional liability (malpractice) insurance does Health Choice require? Health Choice requires a minimum of $1,000,000 per occurrence / $3,000,000 in aggregate to participate.

25. What are my rights in credentialing? Physicians and other health care professionals applying for the Health Choice network have the following rights regarding the credentialing process:
    - To review the information submitted to sup-port your credentialing application
    - To correct erroneous information
    - To be informed of the status of your credentialing or recredentialing application; upon request.

26. How long is the credentialing process? Health Choice strives to process complete credentialing applications in 60 days or less. It may take longer if you submit an incomplete application or if requested attachments are not submitted with the application.

27. What if the Credentialing Committee denies my initial application for participation or my recredentialing application? Health Choice reserves the right to deny an appeals process for initial applicants. However, depending on the reasoning of the Credentialing Committee's decision for denied/termed recredentialing, you will be offered the opportunity to submit an

appeal. The recredentialing denial or termination letter will explain your rights, the appeals process and contact information.

Gaps in Care

28. Why can't I upload documentation for last year's gaps? The portal only accepts supporting documentation for the current year.

29. What if a member is no longer my patient? Use the Report button to mark the member as "Not My Patient."

Provider & Member Rosters

30. Why don't some providers appear on my roster? Only providers linked to your TIN and fully credentialed/contracted will appear.

31. Why do some dental providers show no members? Dental results only display providers with active member assignments.

Revalidation

32. Why am I receiving a "Providers at Risk for Termination" alert? AHCCCS has identified one or more providers tied to your TIN as overdue or approaching revalidation deadlines.

33. What happens if revalidation is not completed? The provider will be terminated by AHCCCS and Health Choice, resulting in claim denials and loss of network status.

Education & Resources

34. Where can I access manuals, forms, PA grids, or training videos?

From the portal homepage under Provider Resources, or by visiting the "For Providers" section at azblue.com/medicaid.

azblue.com/Medicaid

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