



2025 Provider Forum: Blue Cross® Blue Shield® of Arizona Health Choice (Medicaid) & Health Choice Pathway (HMO D-SNP)

Wednesday, October 22, 2025

11:30 AM – 12:30 PM



Health
Choice

Provider Forum Agenda

❖ Welcome & Introductions	5 mins
❖ Government Relations	10 mins
❖ Claims System Migration & Claim Edit Enhancements	5 mins
❖ Availity: Attachment Update	5 mins
❖ Enhancing EHR Data: LOINC & SNOMED	5 mins
❖ DSNP Supplemental Benefits	5 mins
❖ TruHearing – Hearing Aid Benefit	5 mins
❖ Provider Portal Demonstration	5 mins
❖ Cultural Competency	5 mins
❖ Provider Resources and Education	5 mins
❖ Q&A	5 mins



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.





Medicaid Network Provider Forum

Chuck Bassett, Government Relations

INSPIRE HEALTH AND MAKE IT EASY



Rs and Ds see things differently

	Republican Approach	Democratic Approach
Overall Direction	Shrink the program	Grow the program
Work Requirements	<i>"If you're an able-bodied adult with no children, you should be seeking the skills or seeking a better job."</i> - Rep. Don Bacon (NE)	<i>"The reality is the overwhelming majority of people on Medicaid already work or are caretakers for loved ones. This isn't about work, it's about burying people in so much monthly paperwork that they miss a filing deadline and lose their health care and food assistance."</i> - Rep. Frank Pallone (NJ)
Provider Taxes	<i>"The Biden administration issued a rule that permitted states to set payment rates up to average commercial rates through SDPs. This introduces perverse incentives for providers to raise their prices for private payers."</i> - Paragon Institute	<i>"Let's be clear: provider taxes and state directed payments provide the means to offset the crippling underpayment by Medicaid for critical care that meets the medical needs of so many kids, mothers, disabled, and seniors."</i> - American Federation of Hospitals
Cost Sharing	<i>"Modest copayments can help reduce low-value care and fraud, and this [bill's] flexibility allows states to learn from each other."</i> - Paragon Institute	<i>"Cost sharing, such as copays required at point of service, is associated with reduced use of care, worse health outcomes, and increased financial burden. Other research finds that cost sharing often has limited state savings and often means a reduction in reimbursement for providers."</i> - Kaiser Family Foundation
Redetermination	<i>"All I want is one thing. Three words. We don't want any waste, fraud or abuse."</i> - President Donald Trump	<i>"More-frequent redeterminations would increase rates of Medicare churn . . . which reduces enrollees' access to care, adds to enrollees' paperwork hassles, and increases administrative costs for state Medicaid agencies, health plans, and providers."</i> - Urban Institute



OB3 Reflects Republican Priorities

“One Big Beautiful Bill” is law. Included President’s top priorities.

Road to passage was never beautiful or certain. Passed by one vote in Senate. Very close in House.





OB3 Medicaid Provisions – Work requirements

“Community engagement” requirements expected to decrease enrollment and add administrative headaches

Members Affected	Expansion population
Applicable Age	19-64
Hours Required	80 hours of community engagement per month or half-time education
Acceptable Activities	Combination of work, work programs, education programs, community service
Verification	Applicants: Must show 1 month (or up to 3 consecutive months, at state’s option) of engagement before application. Enrollees: Must show 1 month of engagement since last redetermination.
Penalty	Applicants: Denied Enrollees: State issues Notice of Noncompliance and gives member 30 days to prove compliance. If unable, disenrolled.
Exceptions	Pregnant/postpartum women, tribal members, patients with complex conditions, and behavioral health patients
	Parent of child under age 14
	Disabled veterans
	Inmates, within 3 months
	At state’s option, natural disasters and caregiver status
	High-unemployment areas, at state’s option
	Traveling for treatment, at state’s option
Effective Date	12/31/26, but state can start earlier



OB3 Medicaid Provisions – Provider Funding

Provider tax

Reduces the amount the state can tax providers

2028	5.5%
2029	5%
2030	4.5%
2031	4%
2032	3.5%



State Directed Payments

Reduces maximum SDP payments from commercial rates to Medicare rates

2028	Commercial rate - 10%
2029	Commercial rate - 20%
2030	Commercial rate - 30%
* * *	
203?	Medicare Rate



Rural Provider Grants

Designed to offset impact of cuts to rural hospitals. Arizona should get about \$100 million per year.

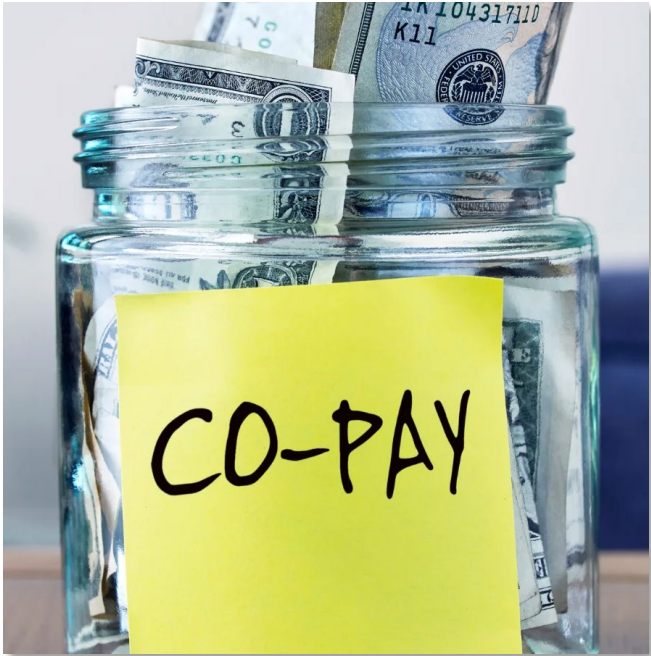
CMS distributes half evenly to states with approved applications	\$25 Billion over 5 years
CMS distributes other half to about a quarter of states based on rural and low income needs.	\$25 Billion over 5 years

Note: Starts in 2026



OB3 Medicaid Provisions - copayments

Application	Expansion population
Amount	Capped at \$35. Cannot exceed 5% of income. Must be nominal for rx and non-emergency care delivered in emergency setting.
Exemptions	Pregnancy-related, emergency, hospice, family planning, primary care, mental health, substance abuse services and vaccines, as well as care delivered in a federally qualified health center, behavioral health center, or rural health clinic.
Effective	10/1/2028
Provider Discretion	Allows a healthcare provider to demand payment up front or to waive or reduce the amount due.





OB3 Medicaid Provisions – redetermination & verification

Requires semi-annual, rather than annual, redetermination for expansion population. *Expect 27,000 people to fall through the cracks.*

State must pursue legitimate addresses and make sure members are not enrolled in multiple states. Share data with CMS.

State must crosscheck member and provider information against Social Security death records.





OB3 Medicaid provisions – summary impact

Provision	Start Date	Enrollment	Admin Costs	Hospital Financial Impact
Work requirements	1/1/27*	↓	↑	↓
More frequent eligibility checks	1/1/27	↓	↑	↓
More verification of enrollee information	1/1/27	↓	↑	↓
New provider tax cap; steps down from 6% to 3.5%	1/1/28	-	-	↓
Cuts to state-directed payments	1/1/28	-	-	↓
Cost-sharing for some enrollees	10/1/28	↓	↑	↓



Medicaid at the state level

Medicaid at the state level has the same tensions as the federal level. Major concerns:

- *Fraud*
- *Cost* – Not getting easier. State estimates \$1.1 billion needed to conform to OB3.
- *Bids*



Senate Health & Human Services Committee Announces Special Hearing on Medicaid Fraud in Arizona

FOR IMMEDIATE RELEASE
Thursday, July 10, 2025



Senate Health & Human Services Committee Announces Special Hearing on Medicaid Fraud in Arizona

PHOENIX, ARIZONA— Senate Health & Human Services Committee Chairwoman Carine Werner is announcing a special hearing on August 18, 2025, at 2 pm at the Arizona State Senate to address the alarming rise in Medicaid fraud, abuse, and waste across the state.

Several AHCCCS-related bills from the 2025 legislative session:

SB 1741/Chap. 239
Delays ACC bids for one year or more.

SB 1132/Chap. 180
Allows a provider to prescribe a continuous glucose monitor under either the AHCCCS pharmacy or DME benefit

SB 1711/Chap. 218 Study whether to increase AHCCCS coverage for obesity treatments

Thank You



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Claims System Migration, Edit Enhancements & Availability

Matthew Kingry – Reimbursement Services

10 Minutes



Claims System Migration



Phased Approach

- HCA utilizes two claiming systems
- Full transition to a single claims system in 2025

Improve Provider Satisfaction

- Increase efficiency and our auto-adjudication rate
- Timely claims management
- Faster claims re-processing



Next Steps

- No changes in claims submissions and reimbursement
- Future communication regarding any updates will be provided.

Current Status

As of
Dates of
Service
10/1/2025 ->

What's Outstanding

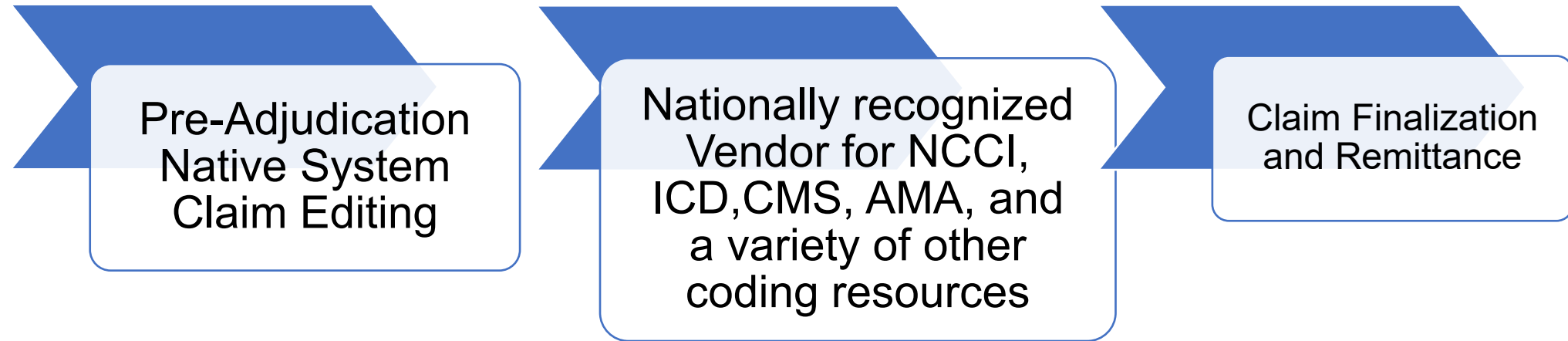
- **Dental**
- **Medicare -> Medicaid**
Claims when the Member has
Health Choice Pathway and
Health Choice Arizona

Migration is
95% Complete



Claim Edit Enhancements

Life Cycle of Claim Editing



Accurate and precise editing up-front prevents unnecessary reconciliation and offsets on the back-end

Supported Transactions*

BCBSAZ Health Choice Arizona

(Payer ID 62179)

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

BCBSAZ Health Choice Pathway

(Payer ID 62180)

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

BCBSAZ ACA Standard Health w/ Health Choice

(Payer ID RP105)

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

***Coming Soon (Q4 of 2025)**

275 (Claim Attachments) and 278 (Authorization Requests)

Resources



[Availity EDI Connection
Guide](#)



[Availity EDI Companion
Guide](#)



For questions or
assistance, contact
HCEDIGroup@azblue.com



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azblue.com/hca

Enhancing EHR Data: LOINC and SNOMED Codes

Chih Lee – Quality Informatics

5 Minutes



LOINC & SNOMED: Clinical Coding



Logical Observation Identifiers Names and Codes (LOINC) Represent “Questions”

LOINC codes ensure consistent capture of clinical data by standardizing lab tests and clinical observations.

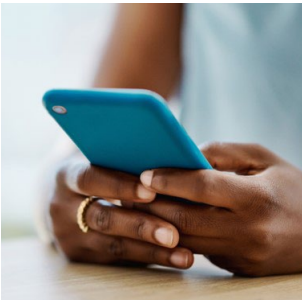
- Provides the granularity for apples-to-apples comparison of data from diverse sources
- LOINC has expanded beyond lab tests and now includes standardized survey and patient-reported outcomes measures, clinical documents, nursing management data and nursing assessments



Systematized Nomenclature of Medicine (SNOMED) Encodes Clinical “Answers”

SNOMED codes encode clinical findings, diagnoses and procedures for precise and structured clinical answers.

- In the U.S., EHR systems are required to use SNOMED as the clinical terminology standard for documenting patient health problems, diagnoses, procedures and some clinical findings (e.g. smoking status)
- Stage 2 Meaningful Use requirement as a common language for different healthcare IT and EMR systems



How Do LOINC and SNOMED work together?

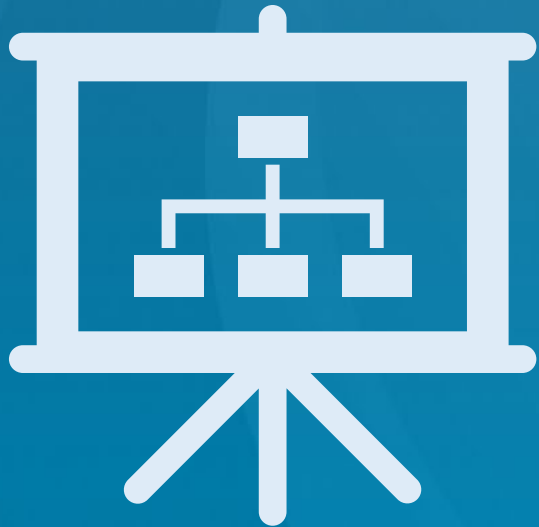
LOINC and SNOMED are often used together in EHRs to create a complete picture of a patient's health information

- The **"Question"**: LOINC codes can be used for identifying specific questions asked during a social needs screening
- The **"Answer"**: SNOMED codes can describe a patient's social context and related clinical findings

LOINC & SNOMED: Summary

	LOINC	SNOMED
Focus	Lab tests, clinical observations, and measurements.	Clinical findings, procedures, diseases, and microorganisms.
The “Question”	Defines the "what" that is being measured or observed.	Can also represent "observables" but its primary role is for the "answer".
The “Answer”	Not typically used for the answer, especially for non-numeric results.	Used for the "answer," particularly for complex, non-numeric findings.
Examples	88124-3: Hunger Vital Sign™ (HVS) Food Insecurity Screening LA19952-3 is Positive Finding LOINC Code	464031000124101: Referral to food pantry program 710925007: Provision of food

HEDIS Electronic Clinical Data Systems (ECDS) Reporting



- Many ECDS measures require EHR codes
- Many provider groups do not have the screening numerator codes (i.e., LOINCs) or the intervention codes (i.e., SNOMEDs) entered in their EHRs

ECDS Depression, Alcohol, and Social Need Screening and Follow-Up Measures

MY 2025 ECDS Measure	EHR Numerator Code Sets	Traditional Measure?	Can You Report an Accurate ECDS Measure Rate Without the EHR Numerator Code Sets?	Medicare	Commercial	Medicaid	Exchange
Prenatal Depression Screening and Follow-Up (PND-E)	LOINC, SNOMED	No	No		✓	✓	
Postpartum Depression Screening and Follow-Up (PDS-E)	LOINC, SNOMED	No	No		✓	✓	
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	LOINC, SNOMED	No	No	✓	✓	✓	✓
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)	LOINC	No	No	✓	✓	✓	
Depression Remission or Response for Adolescents and Adults (DRR-E)	LOINC	No	No	✓	✓	✓	
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)	LOINC	No	No	✓	✓	✓	
Social Need Screening and Intervention (SNS-E)	LOINC, SNOMED	No	No	✓	✓	✓	✓

Transitioning EHR Data Feed for ECDS Reporting

Expanded HEDIS Value Set Codes

LOINC and SNOMED codes are included in the HEDIS value sets to support ECDS reporting.

Transition Data Feeds to Capture All EHR Data

Start transitioning from using HEDIS-oriented EHR data feeds that only capture a limited number of target HEDIS measures to data feeds that **capture all medical group EHR data**

Benefit to Traditional HEDIS measures

LOINC and SNOMED codes can also assist with gap closures in over 30 traditional HEDIS measures. (e.g., CT colonographies, systolic and diastolic blood pressures, and mammograms)



Key Considerations

How is your EMR/EHR vendor handling Meaningful Use Stage 2 requirements?

- Many vendors utilize “maps” between ICD-10-CM and SNOMED codes to meet MU Stage 2 requirements without affecting the provider’s time

How can my IT Department access LOINC and SNOMED data?

- Work with your internal IT resources to determine if LOINC and SNOMED codes are readily available for extract and inclusion in EHR data feeds.
- May need to coordinate with EHR vendor to identify how to access the codes

Is system maturity and integration an issue?

- Older or less advanced EHR systems may have poorly documented or less structured data, making extraction and mapping more difficult.
- The maturity of the EHR and extraction platform directly impacts the complexity



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Health Choice Pathway (HMO - DSNP)



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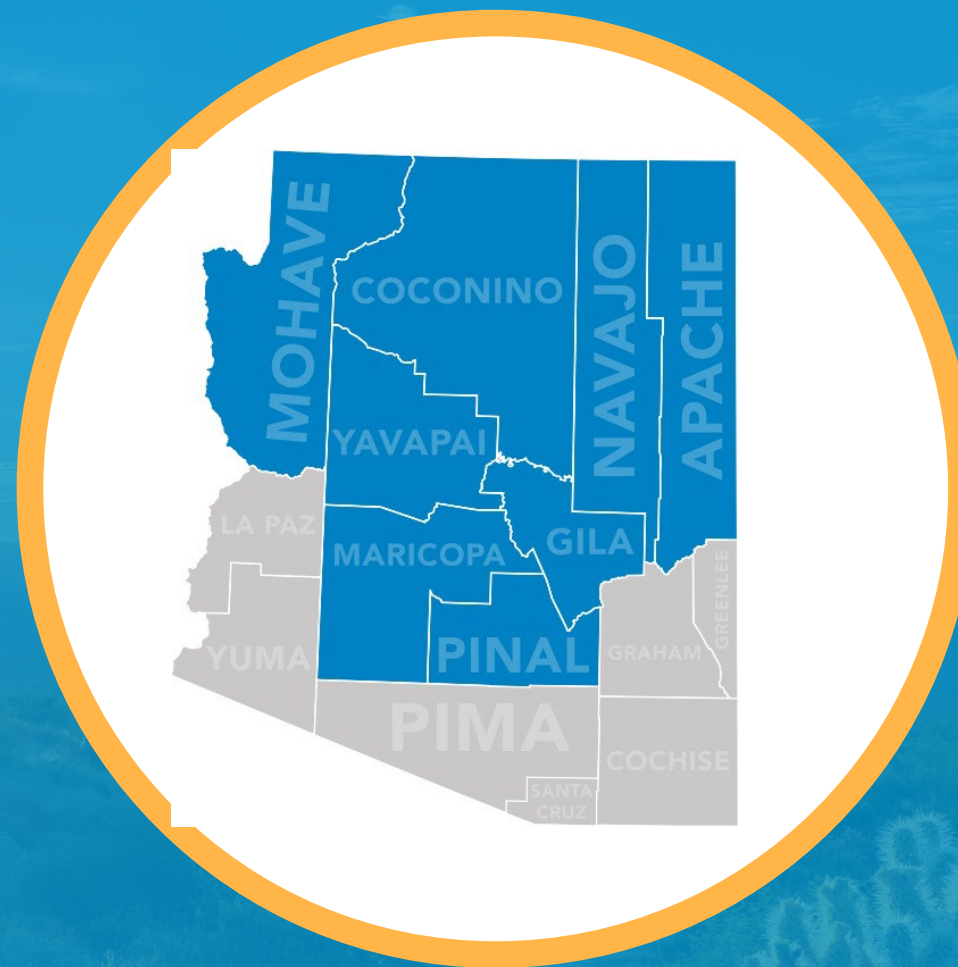
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Service Area

Our covered service area includes the following counties:

- Apache
- Coconino
- Gila
- Maricopa
- Mohave
- Navajo
- Pinal
- Yavapai



There are no new expansion counties in 2026.

Our Extra Benefits

- Dental
- Vision
- Hearing
- Over-the-Counter (OTC) Items
- Transportation
- Healthy Food and Produce flex card

And more!

Dental

\$3,500 allowance towards comprehensive dental services like dentures (every 5 years), crowns, fillings, extractions, endodontics, and bridges. Covers 2 oral exams, 2 cleanings, 2 x-rays, 1 fluoride treatment.

Vision

\$350 allowance towards contacts and/or eyeglasses. One routine eye exam (eye refraction) every year.

Hearing

2 hearing aids, one per ear, every 3 years. 1 free routine hearing exam per year. Unlimited evaluation/fitting.

Over-the-Counter (OTC) Card

\$50 allowance every quarter. No rollover.

Meal Benefit /Post Acute Meals

28 meals per admit, once per calendar year, immediately following an acute inpatient hospital stay.

Chronic Meals

28 meals once per calendar year. The member must be actively engaged with Health Choice Pathway care management and have one or more of the following qualifying chronic conditions:

- Congestive Heart Failure (CHF)
- Diabetes
- Chronic obstructive pulmonary disease (COPD)

Transportation

AHCCCS provides transportation at no cost to covered medical appointments, pharmacies, and labs.

24 one-way trips to plan approved health related locations not covered by AHCCCS such as Dental, Vision, and Hearing providers.

Fitness

The SilverSneakers® Program provides members with the following services:

- Fitness Center Program
- Digital Workouts members can view on-demand videos via the workout library.

Personal Emergency Response System (PERS)

Medical alert system to provide continuous in-home and mobile monitoring to aging and at-risk populations.

Prescription Benefits

- \$1.60 (Level 2) or \$5.10 (Level 1) or \$0 (Level 3) copay for Generic prescription drugs
 - \$4.90 (Level 2) or \$12.65 (Level 1) or \$0 copay (Level 3) for Brand-name prescription drugs
 - 31 day or 100 day supply through retail or mail-order.
- Copays may vary due to member's Extra Help/LIS Level.

Telehealth

Telehealth services provided by BlueCare Anywhere lets members talk to a primary care doctor, specialist, or urgent care from the comfort of their own home. 24 hours a day.

Nurse Advice Line

Speak to a licensed nurse 24/7 to answer health related questions.

Healthy Rewards

\$25 reward for completing specific preventative care exams such as:

- Medicare annual wellness visit
- Diabetic eye exam
- Colon cancer screening
- Annual Health Risk Assessment (HRA)

\$50 reward for completing the following preventative care exams such as:

- Breast cancer screenings
- Osteoporosis management

Special Supplemental Benefits for Chronically Ill Members

Healthy Food and Produce Card

\$225 allowance every 3 months towards healthy food and produce. No rollover. To be eligible for the food card benefit, members must be diagnosed with a chronic condition, such as:
Chronic alcohol use disorder and other substance abuse disorders (SUDs)
Cardiovascular disorders
Chronic Heart Failure
Diabetes mellitus
Overweight, obesity, and metabolic syndrome
Chronic gastrointestinal disease
Chronic lung disorders
Chronic and disabling mental health conditions
Chronic conditions that impair vision, hearing, (deafness), taste, touch, and smell
Conditions that require continued therapy services in order for individuals to maintain or retain functioning, or another qualifying condition.

What makes us different?

Our Member Services Team

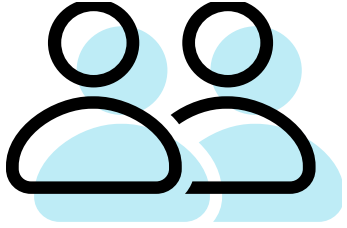


- Located in the heart of Phoenix, Arizona.
- Our goal is to answer every phone call in less than 30 seconds.
- Your clients will speak to a live person without pressing any prompts.
- We can help your clients in any language.
- We are here to support them and address their concerns.

**Our Member Services team is available
8 a.m. to 8 p.m., 7 days a week!**

What makes us different?

Our Health Care Buddy



Every member is assigned a personal Health Care Buddy, who can help them with:

- Answering questions about benefits
- Finding contracted providers
- Setting up healthcare appointments
- Getting prescription drugs
- Getting prior authorization for medical services
- And more

What makes us different?

Care Transitions Made Easy

Transition of Care staff provide timely support members after they're discharged from a hospital stay.

- Scheduling follow up appointments with their primary care provider (PCP) or specialists
- Arranging transportation to appointments
- Ensuring medications are picked up from the pharmacy
- Referring to Care Management if needed
- Supporting members with acute or chronic diseases with our Care Management programs

Members are to be encouraged to contact us if they need additional assistance.

Health Choice Pathway (HMO D-SNP) & TruHearing® - Hearing Aid Supplemental Benefit

Aimee Perez – Network Services



New Partnership Announcement

Health Choice Pathway (HMO-DNP) & TruHearing®

- TruHearing® is the exclusive administrator of the supplemental hearing benefit for Health Choice Pathway (HMO D-SNP) members.
- Members receive \$0 out-of-pocket for Advanced technology hearing aids.
- All appointments must be scheduled through TruHearing® to access the benefit

TruHearing® Hearing Aid Benefit Effective January 1, 2026

- Providers interested in joining the TruHearing® network must contact TruHearing®'s Provider Contracting team at 801-938-1294 or ProviderContracting@TruHearing.com
- Only contracted and credentialed providers can offer and be reimbursed for supplemental hearing services.
- Providers not contracted with TruHearing® cannot collect payment from members for these services.

Provider Portal Overview and Demonstration

Holly Balderrama – Network Services

7 Minutes (11:45 – 11:50 AM)



Provider Portal Features



Prior Authorization (PA)

- PAs can be submitted via the provider portal. Rendering and referring providers can view PA submissions
- Documentation can be uploaded



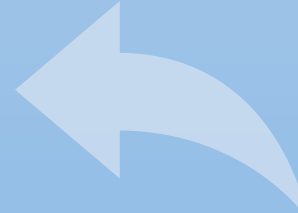
Provider Roster

- Listing of all credentialed providers, including their credentialing date and the date they were linked to a Tax ID



Member Roster

- Listing of all members assigned to medical or dental provider(s) as of the first day of the month



Claims & Documents

- View claims status, reconsideration submissions
- Submit appeal after one reconsideration submission
- Paper EOB's and 835 data can be found



Eligibility

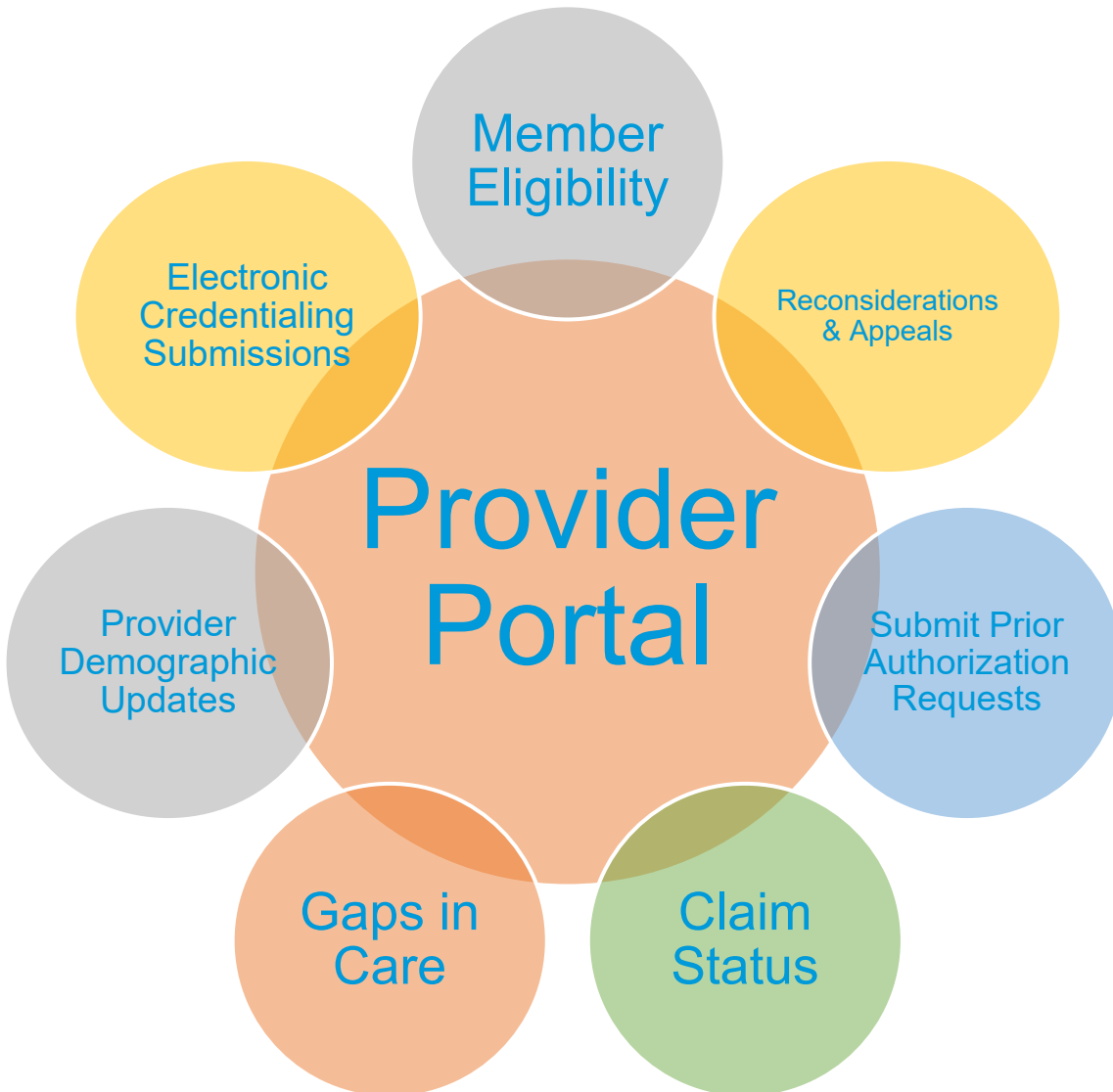
- Verify eligibility for all lines of business
- Grace periods and Out of Pocket balances can be seen for our Marketplace members.



Revalidation

- Ability to view list of providers at risk for termination due to revalidation

Provider Portal & Resources



Provider Resources

Please note that user Account passwords should NOT be shared between employees. Sharing passwords is prohibited. BCBSAZ 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 or (800) 322-8670.

Visit us online under our "For Providers" tab for content specific to education-related material.

[BCBSAZ Health Choice \(Medicaid\)](#)

[BCBSAZ Health Choice Pathway \(Dual SNP HMO Medicare Advantage\)](#)

Provider Manuals

- [BCBSAZ Health Choice](#)
- [BCBSAZ Health Choice Pathway](#)
- [ACA StandardHealth with Health Choice](#)

Provider Notices

- [BCBSAZ Health Choice](#)
- [BCBSAZ Health Choice Pathway](#)
- [ACA StandardHealth with Health Choice](#)

Prior Authorization Guidelines

- [BCBSAZ Health Choice](#)
- [BCBSAZ Health Choice Pathway](#)
- [ACA StandardHealth with Health Choice](#)

Provider Forms

- [BCBSAZ Health Choice](#)
- [BCBSAZ Health Choice Pathway](#)
- [ACA StandardHealth with Health Choice](#)

Provider Education (POLT List, Portal Training Videos, Newsletters, Quality Coding)

- [BCBSAZ Health Choice](#)
- [BCBSAZ Health Choice Pathway](#)
- [ACA StandardHealth with Health Choice](#)

Dental Matrix and Clinical Review Criteria

- [BCBSAZ Health Choice Dental Benefits Matrices](#)
- [BCBSAZ Health Choice Pathway Supplemental Benefits](#)
- [ACA StandardHealth with Health Choice](#)

Home Screen

Welcome to Blue Cross Blue Shield of Arizona Health Choice Provider Portal

Your Provider Representative is Holly Balderrama - holly.balderrama@azblue.com

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

- 🔔 **SAVE THE DATE:** You are invited to attend our BCBSAZ Health Choice Provider Forum to be held virtually on Wednesday, October 22, 2025 from 11:30 am - 12:30 pm. Click [here](#) to register.
- 🔔 **Attention Pediatric Providers:** Partner with the Outreach Team to help you close member care gaps. Contact our Outreach Manager, Lupe Campos, for more details: Guadalupe.campos@azblue.com or 480-270-2615.
- 🔔 **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

Claims

Use one of our convenient tools to learn more about our services.

- [Claims Lookup](#)
- [Dental History / Benefits](#)
- [Vision History / Benefits](#)

Authorizations

Need information regarding authorizations? Choose one of the following options below.

- [View Your Medical Prior Authorization Status](#)
- [View Your Dental Prior Authorization Status](#)
- [Health Choice & Health Choice Pathway - Pharmacy Prior Authorization Request](#)
- [Health Choice Arizona - Prior Authorization Grid](#)
- [Health Choice Pathway - Prior Authorization Grid \(Arizona\)](#)
- [ACA StandardHealth with Health Choice - Prior Authorization Grid](#)

Provider Alerts

Displays time-sensitive content for the portal.

- [Providers at Risk for Disenrollment](#)

Provider Tools

Use one of our convenient tools to manage your account or look up answers in our document library.

- Member [Medical](#) / [Dental](#) Roster
- Provider [Medical](#) / [Dental](#) Roster
- [Provider Resources](#)
- [Health Choice Integrated Care Provider Portal](#)
- [Provider Demographic Request/Electronic Credentialing - AzAHP Practitioner Data form](#)

PROVIDER PORTAL DEMONSTRATION

Electronic Credentialing

Holly Balderrama

Resources: [Credentialing Portal How-To & Portal FAQ](#)

Give us your Feedback – Survey Live

We Value Your Opinion



Please take a few moments to share your suggestions with us. Your feedback is important in helping us enhance your Provider Portal experience. Thank you for your participation.

Take Survey



What do you like about the BCBSAZ Health Choice Provider Portal?



What improvements or features would you like to see?



Give us your thoughts on the BCBSAZ Health Choice Provider Portal

Provider Authorization (PA) Grids & PA Submissions

Holly Balderrama – Network Services

3 Minutes (11:45 – 11:50 AM)



Important Reminders

- PA Grids updated as of 10/1/2025
- Multiple codes no longer require PA
- Refer to the updated PA grids to ensure compliance with new requirements.

- ❖ [PA Guidelines | Health Choice AZ](#)
- ❖ [Prior Authorization Guidelines | Health Choice Pathway](#)

Prior Auth (PA) Grids



- 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

Provider Portal Utilization



- 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

Technical Support



Cultural Competency & Language

Jeanette Mallery- Cultural Competency Administrator

Jeanette.Mallery@azblue.com

5 Minutes





Goals



Respect for Diverse Values

Cultural competency requires respecting values and beliefs across race, ethnicity, gender, disability, and language differences.



Understanding Cultural Influence

Understanding cultural factors helps explain health behaviors and outcomes crucial for effective patient care.



Inclusive and Responsive Care

Culturally competent care ensures inclusiveness, improving communication and patient satisfaction for diverse populations.



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 (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)

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

Calendar Year 2024*: Member Primary Languages – Medicaid and D-SNP Members

Primary Language	Member Count	Proportion of Membership
English	234,059	90.33%
Spanish	23,443	9.05%
Unknown	557	0.22%
Vietnamese	276	0.11%
Arabic	217	0.08%
Chinese	159	0.06%
Somali	57	0.02%
Russian	51	0.02%
Korean	50	0.02%
Navajo; Navaho	45	0.02%
Persian	44	0.02%
French	37	0.01%
Tagalog	34	0.01%
Hindi	32	0.01%
American Sign Language	16	0.01%
Lao	10	0.00%
Japanese	8	0.00%
Polish	8	0.00%
Portuguese	6	0.00%
Armenian	2	0.00%
Greek	2	0.00%
North American Indian (Other)	2	0.00%
Albanian	1	0.00%
German	1	0.00%
Hmong	1	0.00%
Hungarian	1	0.00%
Italian	1	0.00%
Khmer	1	0.00%

Data Source: Enrollment Data



Provider Responsibilities

Culturally Competent Care

Providers must deliver care that respects diverse cultural backgrounds and ensures sensitivity in treatment options.

Effective Communication

Ensuring clear communication with individuals including those with disabilities is essential in healthcare delivery. Providers must notify patients about available language assistance in their preferred language to ensure equitable access.

Compliance with Standards

Providers must follow professional, legal, and accreditation standards to maintain high-quality care. Compliance with Title VI and Executive Order 13166 is mandatory, including documentation of language services provided.

Provider Resource

Spoken interpretation, Sign language, Written translation and aids for hearing and visually impaired. These services help ensure clear and respectful communication with members.

Provider responsibilities:

- Must **coordinate and pay** for language services.
- Must **contract with language vendors** as needed.

Guidelines:

- Language services must be **at no charge for members**.
- Use **qualified staff or approved vendors**.
- **Avoid using family members or minors** as interpreters—except in emergencies—to protect privacy and ensure accuracy

Languages Services Aid

Required by law: Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, Americans with Disabilities Act (ADA), Affordable Care Act (ACA) Section 1557



Delivering Language Services to BCBSAZ Health Choice Members

AHCCCS health plan members qualify for language services. Language services may include interpretation services, translation services, American Sign Language, services for the blind, deaf, hard of hearing, or speech-impaired, auxiliary aids, and alternative formats. These services must be provided at no cost to the member and be accurate, timely, and protect their privacy and independence.

Reminders for Providers

- 1 Hire qualified staff who speak the language needs of your members or contract with an agency to provide these services.
- 2 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.
- 3 Ensure interpretation services are available at no cost to the member during all hours of operations.
- 4 Notify patients of their rights to language services at all points of contact and use tools to show what languages are needed. Visit: ["I Speak" Poster | Homeland Security \(dhs.gov\)](#)
- 5 Working with an Interpreter: talk directly to the member. The interpreter will relay the information between you and the member. Visit: [Appropriate Use of Medical Interpreters | AAFP](#)
- 6 Provide assisted technology, auxiliary aids, or licensed sign-language interpreters that meet the needs of the member upon request.
 - Auxiliary aids include but are not limited to computer-aided transcriptions, written materials, assistive listening devices, or systems, closed and open captioning, and other effective methods of making aurally delivered materials available to persons with hearing loss.
- 7 Have access to assistive technology products used by people who are blind or visually impaired.

Vendor List

Vendors for you to contract with for Video Relay, Translation, Interpretation, and Face to Face services:

- **Cyracom:**
1-800-713-4950 ext. 1
(call to set up an account),
1-866-745-5010
(call if you already have an account)
- **Transperfect:**
1-855-886-2909
(call to set up an account),
1-855-866-2901
(call if you already have an account and your client ID/PIN)

Vendors for you to contract with for Deaf and Hard of Hearing services:

- **AZ Relay Services:**
1-800-842-4681, TTY: 711
The Arizona Commission for the Deaf and the Hard of Hearing provides a listing of licensed interpreters, information on auxiliary aids, and the complete rules and regulations of the profession of interpreters in the State of Arizona.

Provider Responsibilities

Providers are responsible for coordinating and paying for the language needs of their members and to contract with language vendors to meet these needs as required under Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, and the Affordable Care Act Section 1557. If you do not have qualified staff to meet your needs, please contract with a vendor to meet these needs.

8220 N. 23rd Avenue, Phoenix, AZ 85021
T: 480-968-6866 F: 480-784-2933
[HealthChoiceAZ.com](#)

Provider Resource

Purpose: To initiate respectful conversations about a member's cultural needs during intake and visits.

Note: This tool is not an assessment.

Questions are grouped into 10 categories, including:

Communication

What is your preferred language?

What language do you speak at home?

How do you speak with others in your family?

Family, Friends, and Community

Are you connected with any family members or friends?

Are you involved with your community?

Conversation Starters



Member Resources



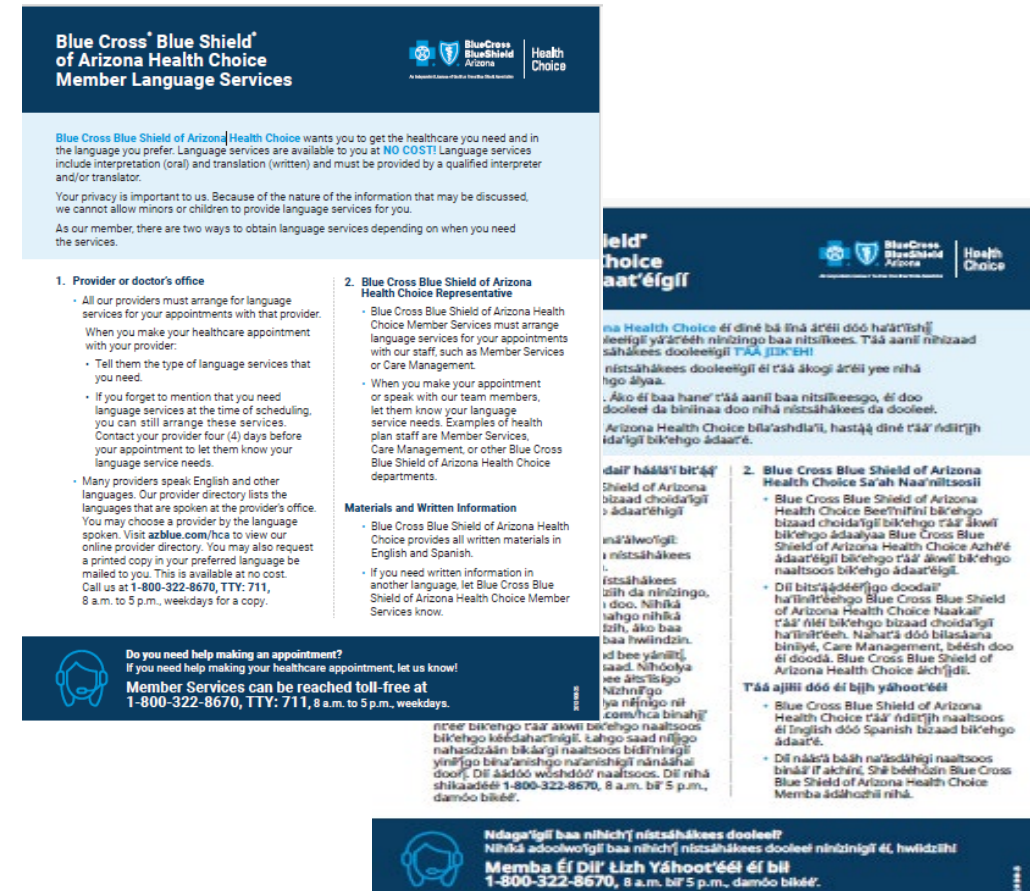
Health Choice

Member Webpage – Understanding Your Care

Language Information Flyer - emphasizing the importance of member engagement and communication.

- Members are encouraged to utilize available resources and tools for managing their health care effectively, including online access to information.
- Providers and members can download the flyer in English, Spanish, Navajo, and Vietnamese

Language Information



On-Demand Provider Training

Culture and Language Requirements for Delivering Care, Launched in October 2024

- Intended to support providers in delivering culturally and linguistically appropriate care
 - Supports requirements as described in Provider Manual – Chapter 4
 - Includes information from the CLAS standards
- The training is accessible through the Provider Education page of the website

[Training: Cultural and Language Requirements for Delivering Care](#)





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Health
Choice

azblue.com/hca

Understanding Doulas: Roles, Benefits, and AHCCCS Requirements

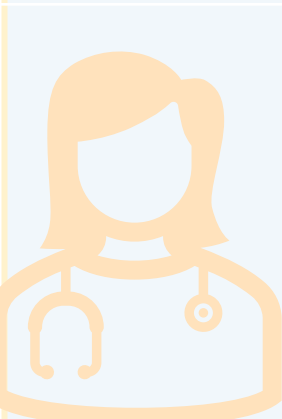
Network Services

5 Minutes



Doula Providers – Provider Type “DU”

Doula Services Requirements

- 
- Doula services are covered AHCCCS members during pregnancy, labor, and up to 1 year postpartum when the following requirements are met:
 - ADHS* Certification & registration with AHCCCS
 - Services within scope of practice (AAC R9-16-901-909)
 - Services are provided in complement to, and do not replace, prenatal, labor and delivery, and postpartum care provided by a physician, Certified Nurse Midwife, Licensed Midwife, or other licensed provider for which maternity care is within their scope of practice
 - Provider referral is required for Doula services.

Provider Type DU effective Oct 1, 2024

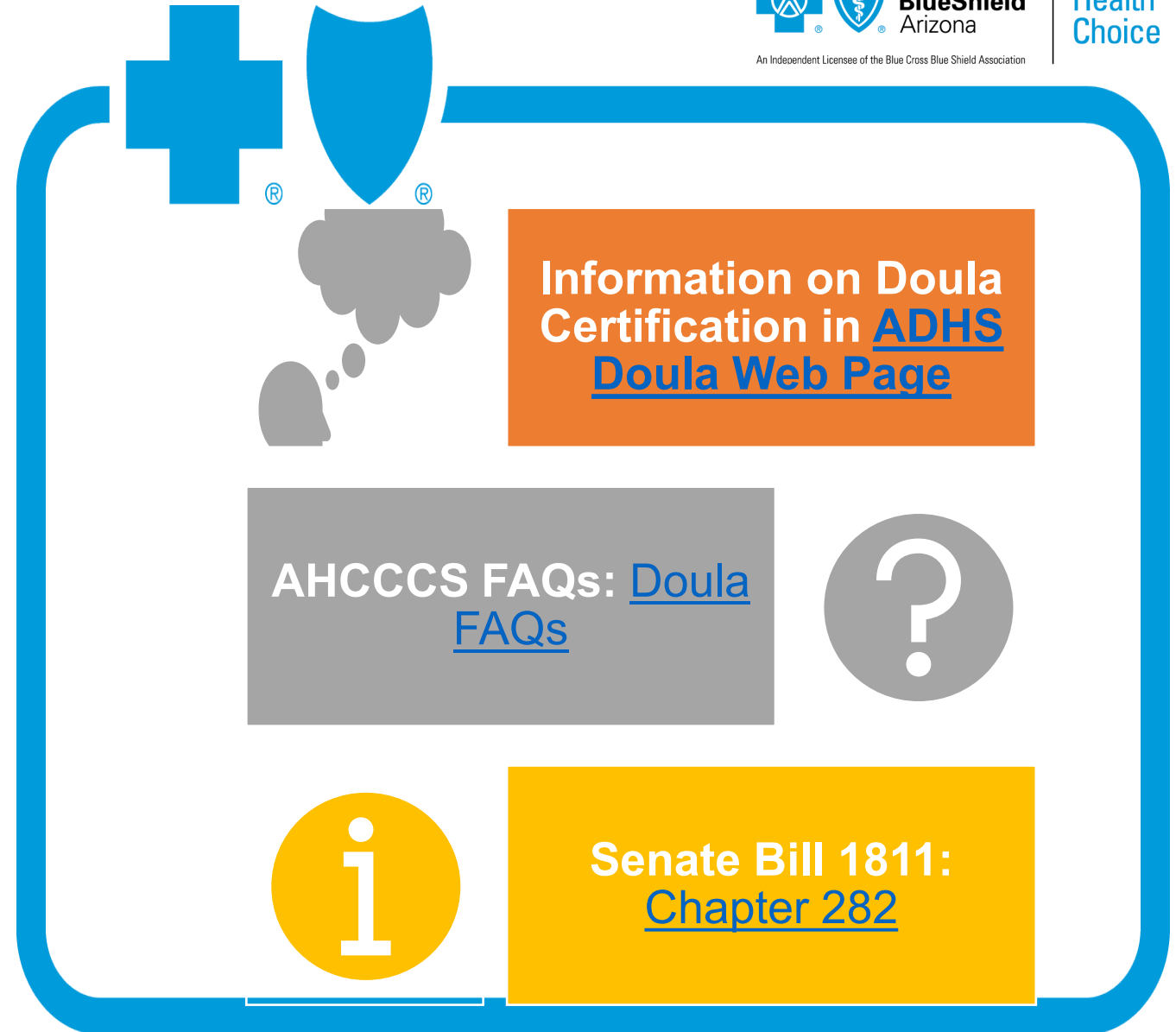
Role of a Doula

- 
- Promote holistic healthy mother and infant outcomes supporting the dynamics of birthing families
 - Information on pregnancy, labor, and postpartum experience

Doulas Help to Reduce Maternal Health Inequities

Black, Indigenous, and People of Color (BIPOC) Doulas Recognizing that (BIPOC) experience poor mental, physical, and spiritual health and birth outcomes

Indigenous Doula – Provide Native birthing people with the emotional, spiritual, and physical care which is rooted in traditional and cultural norms.



Provider Resources & Education

Network Services

5 Minutes



Stay Informed!



Provider Forum

Fax Blasts

Newsletters

Communication

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](#)
- [Behavioral Health Services Matrix, Guide, and Same Day Disallow Table](#)
- [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.



AHCCCS Policy Update Notifications

Subscribe to receive AHCCCS policy notifications on Public Comment and ACOM/AMPM publication updates.

* Email Address

* First Name

* Last Name

Company

97154 + TJ modifier - Correct Usage

97154: *Group adaptive behavior treatment by protocol, administered by a technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes.*

TJ Modifier: *Program group, child, and/or adolescent.*

Important Note:

The combination **97154 + TJ** should **not** be reported when a single technician is working with multiple patients. It is only appropriate when **multiple technicians** are working with **multiple patients** in group ABA settings. All services must be clearly documented to support the use of this code-modifier combination. This is related to the ABA providers utilizing the community school model.

TELEHEALTH CODE SET UPDATES

AHCCCS has updated the **Telehealth Code Set** to include new codes effective **October 1, 2025**.

Please note:

AHCCCS **does not utilize** Place of Service (POS) codes **02** or **10**.

AHCCCS **does not accept** modifiers **93** or **95**.

Refer to **Tabs 1 and 2** of the Telehealth Code Set for guidance and policy details.

AHCCCS publishes its own telehealth billing guidelines. If AHCCCS is the **primary payor**, providers must follow AHCCCS-specific policies.

New Codes Effective October 1, 2025

The following codes are newly opened and effective as of **October 1, 2025**:

H0051 – Traditional Healing (*See IHS/Tribal Provider Billing Manual*)

H2018 – Psychosocial rehabilitation services, per diem

H2016 – Comprehensive community support services, per diem

H2038 – Skills training and development, per diem

T1017 – Targeted case management, each 15 minutes

G2214 – Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional

(*Note: G2214 must not be reported in the same month by the same provider with CPT codes 99492–99494. See CPT coding book for full guidance.*)

Effective **October 1, 2025**, age restrictions have been updated for the following services:

Cochlear Implants

Adult Speech Therapy

These services are now available to **adult members**. No new codes were added; only age restrictions were removed unless otherwise specified in the code description. Policy updates will be published once finalized.

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](#)

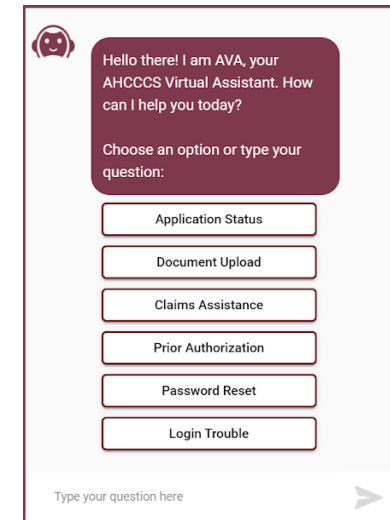
[APEP](#) 

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/a pep, which include:

- [Domain access in APEP](#)
- [Provider FAQ](#)
- Provider Chat Bot, AVA, located at the bottom right-hand corner <https://chat.azahcccs.gov/>



Hello there! I am AVA, your AHCCCS Virtual Assistant. How can I help you today?

Choose an option or type your question:

- Application Status
- Document Upload
- Claims Assistance
- Prior Authorization
- Password Reset
- Login Trouble

Type your question here

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 DSNP

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)

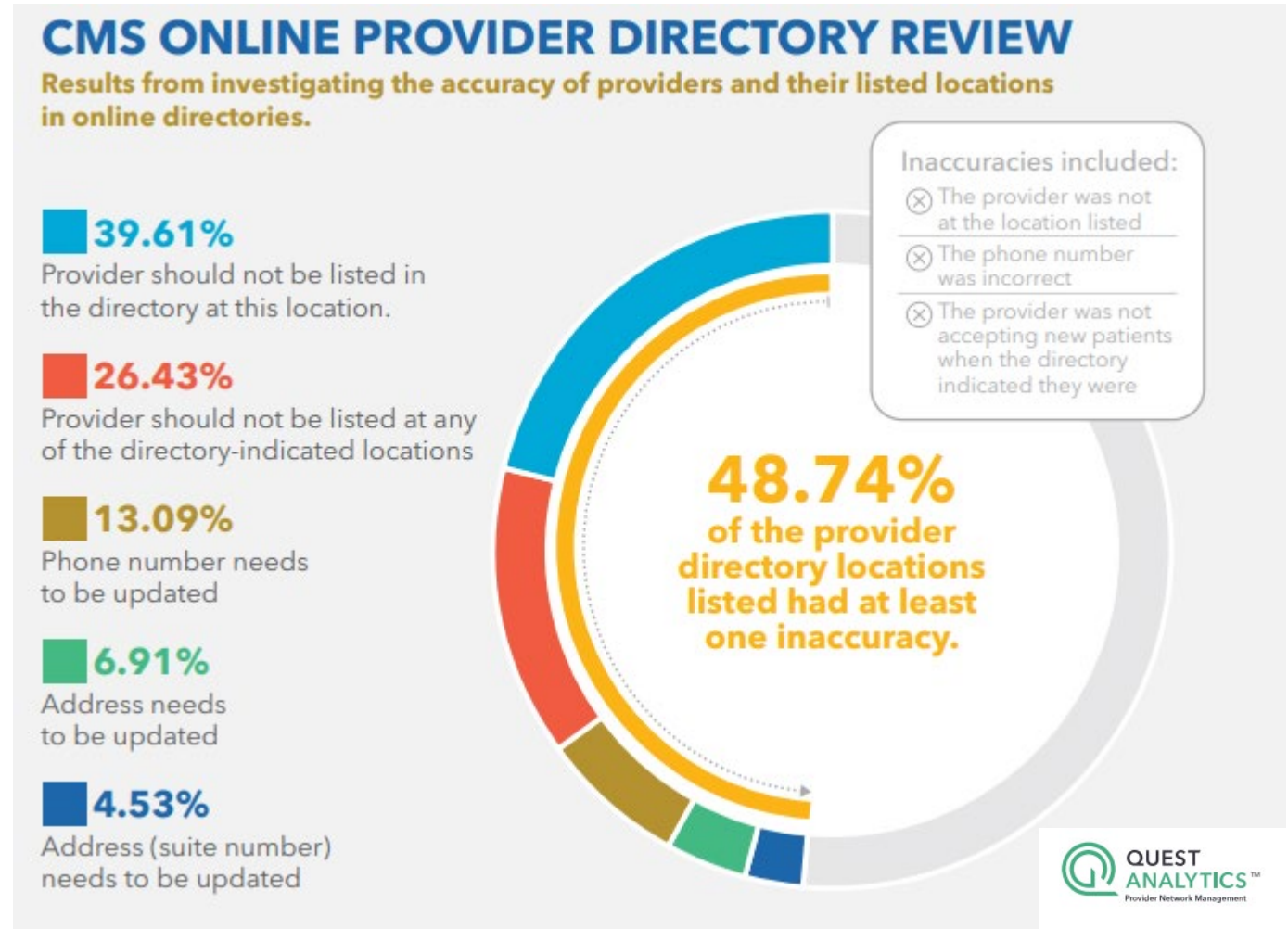
REMINDER: Provider Updates Matter

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

REMINDER: Model of Care (MOC) Training & Attestation



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



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

- 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



Questions?

ProviderConnect@azblue.com



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Health
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azblue.com/hca