

Instructions for submitting a corrected claim, informal reconsideration request or a formal claim appeal/provider grievance for an Ambetter from Arizona Complete Health Marketplace claim via our secure provider portal:

The pages below outline how to submit a corrected claim, an informal reconsideration request or a formal Marketplace claim appeal/provider grievance via our secure portal. We encourage you to use the corrected claim process and/or reconsideration process PRIOR to submitting a formal claim appeal/provider grievance whenever possible. When needed, the formal claim appeal/provider grievance process may be used to challenge a claim payment or denial.

1. Once you've logged on to the secure portal <https://www.azcompletehealth.com/providers/login.html>, use the Claims option to look up the claim and access its details
2. Click **Dispute**

Claim:
Status: Denied

Submitted Denied

Member

Member Name	XXXXXXXXXX
Date of Birth	MM/DD/YYYY
Member ID	XXXXXXXXXX
Medicaid ID	XXXXXXXXXX
Plan Type	Medicaid

Type and Dates

Type	CMS-1500
Service Dates	07/25/2023 - 07/25/2023
Received Date	07/27/2023

Payment

Billed	\$2,736.00	Check #/ EFT	XXXXXXXXXX
Paid	\$0	Check Date	08/01/2023
Payment Date	08/02/2023	Total Check Amount	\$136,281.20

+ COPY + VOID/RECOUP **DISPUTE**

3. Select the applicable option

Dispute Claim:

Select Option 1: Correct the Claim

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

Select Option 2: Submit Reconsideration Request

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

Select Option 3: Formal Claim Appeal/Provider Grievance

- An appeal/provider grievance is a formal review of your claim
- A response will be issued within **30 calendar days** of submission
- Please refer to the [Appeals and Grievance Guide](#) for more details

Corrected Claim

1. Select **Option 1**
2. Complete the fields and resubmit

Dispute Claim: ✕

Select

Option 1: Correct the Claim

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

Select

Option 2: Submit Reconsideration Request

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

Select

Option 3: Formal Claim Appeal/Provider Grievance

- An appeal/provider grievance is a formal review of your claim
- A response will be issued within **30 calendar days** of submission
- Please refer to the [Appeals and Grievance Guide](#) for more details

Reconsideration

1. Select **Option 2**

Dispute Claim: ✕

Select

Option 1: Correct the Claim

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

Select

Option 2: Submit Reconsideration Request

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

Select


Option 3: Formal Claim Appeal/Provider Grievance

- An appeal/provider grievance is a formal review of your claim
- A response will be issued within **30 calendar days** of submission
- Please refer to the [Appeals and Grievance Guide](#) for more details

2. Select Reconsideration Type from the drop-down box

Reconsider Claim ✕

Claim No.
Member Name
DOB

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

Select Reconsideration Type

Denied for a Global/Unbundled Procedure

Denied for Untimely Filing

Denial Related to an Authorization

Claim Paid at the Incorrect Amount

Coordination of Benefits (COB)

Co-insurance/Co-pay/Deductible Applied Incorrectly

Emergency Department Services

CANCEL

SUBMIT RECONSIDERATION

Associated Documents
Attachment1

3. Enter the reason for your reconsideration request including pertinent facts and data that support it. There is a 500-character limit, so this should be a summary
4. Scroll down to Upload Documents. Drag and drop files or select files from your computer to upload your medical records, and/or other supporting documentation
5. Check the box at the bottom of the screen to receive email status updates and then click SUBMIT RECONSIDERATION

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

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

6. Reconsiderations may be submitted within 1 year from the date of the original explanation of payment or denial. Reconsiderations are reviewed within 60 days of receipt. If the claim is overturned, you'll receive an updated remittance advice. If the original processing is upheld, and the reconsideration was submitted by mail, you'll receive a determination letter outlining the decision. If the reconsideration is submitted via the secure portal, the portal will reflect the upheld decision in the claim details

Formal Claim Appeal/Provider Grievance

1. Select **Option3**

Dispute Claim: ✕

Select

Option 1: Correct the Claim

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

Select

Option 2: Submit Reconsideration Request

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

Select

Option 3: Formal Claim Appeal/Provider Grievance

- An appeal/provider grievance is a formal review of your claim
- A response will be issued within **30 calendar days** of submission
- Please refer to the [Appeals and Grievance Guide](#) for more details

2. Select **Appeal Type** from the drop-down box (you'll be able to add details or specific comments in Step 3, for this step, simply select the appeal type that best fits your current dispute reason)

Appeal Claim ✕

Claim No.

Member Name

DOB

⚠ **For Appeals Only!**

Not for reconsiderations. Please refer to your Provider Manual.

Select Appeal Type

Denied for a Global/Unbundled Procedure

Denied for Untimely Filing

Denial Related to an Authorization

Claim Paid at the Incorrect Amount

Coordination of Benefits (COB)

CANCEL

SUBMIT APPEAL

Check Date 08/01/2023

Total Check Amount \$136,281.20

25/2023

3. Enter the reason for your claim appeal/provider grievance including pertinent facts and data that support your request for payment/additional payment. There is a 500-character limit, so this should be a summary. **You must also complete the Provider Claim Dispute Resolution Form** (available on the Provider Resources page located on the Ambetter from Arizona Complete Health website) **and upload it along with pertinent medical records and/or other supporting documents in Step 4**
4. Scroll down to Upload Documents. Drag and drop files or select files from your computer to upload your Claim Dispute Form, medical records, and/or other supporting documentation and click SUBMIT APPEAL

Appeal Claim

Denial Related to Itemized Billing

Notes

Brief Explanation

500 Character Limit

Upload Documents

Medical record attachment **Required**

Drag and Drop Files

Or [Select Files](#) from your computer

File size limit: 25 MB each. | Accepted file types: .PDF, .TIFF, .TIF, .JPEG, .JPG.

CANCEL SUBMIT APPEAL

5. A “Success” notification appears once you’ve submitted the claim appeal/provider grievance

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

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

Claim:
Status: Denied

Submitted Denied

6. Claims appeal/provider grievance decisions are issued within 30 calendar days. Refer to the Appeals and Grievance Guide on the Ambetter from Arizona Complete Health website on the Provider Resources page for more details.
7. If you need status of a successfully submitted claim appeal/provider grievance *and it has been over 30 calendar days* since your submission, you may submit an email inquiry to the Arizona Complete Health Grievance and Appeals Department AzCHMarketplace2@azcompletehealth.com.

If you require assistance with our secure provider portal, please contact your Provider Engagement Account Manager for assistance. If you need your assigned Provider Engagement Account Manager’s contact information, please email AzCHProviderEngagement@azcompletehealth.com