



Non-Emergency Medical Transportation Daily Trip Report

The purpose of this training is to detail how to complete the AHCCCS Daily Trip Report.

*Materials are designed for FFS programs, including AIHP, TRBHAs and Tribal ALTCS

November 2021








AHCCCS Daily Trip Report

The Daily Trip Report is available as a PDF and Excel File to allow providers to expand the additional information section if needed.

- Only the AHCCCS approved Daily Trip Report should be used. Providers may NOT make changes to the DTR as this is considered an alteration.
- Providers are not permitted to create their own versions of the AHCCCS Daily Trip Report for submission. Only the AHCCCS approved Daily Trip Report can be used.
- The attachment in the Fee-For-Service Provider Billing Manual, Chapter 14 Exhibit 14-1 is the only version that may be submitted.

[NON-EMERGENCY MEDICAL TRANSPORTATION DAILY TRIP REPORT INSTRUCTIONS EXHIBIT 14-2](#)

AHCCCS Fee-For-Service Provider Billing Manual

- Chapter 14: Transportation Services 
 - Exhibit 14-1, Daily Trip Report (PDF) 
 - Exhibit 14-1, Daily Trip Report (Excel File) 
 - Exhibit 14-2, Non-emergency Medical Transport Daily Trip Report Instructions 
 - Exhibit 14-3, Tribal Contact Information 

Link to document:

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html>

AHCCCS IHS/638 Provider Billing Manual

The attachment in the IHS/Tribal Provider Billing Manual, Chapter 11 Exhibit 11-1 is the only version that may be submitted.

- Chapter 11: Transportation Services 
 - Exhibit 11-1, Daily Trip Report (PDF) 
 - Exhibit 11-1, Daily Trip Report (Excel File) 
 - Exhibit 11-2, Non-emergency Medical Transport Daily Trip Report Instructions 
 - Exhibit 11-3, Tribal Contact Information 

Link to document:

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.html>

NON-EMERGENCY MEDICAL TRANSPORTATION DAILY TRIP REPORT INSTRUCTIONS EXHIBIT 11-1



NEMT AHCCCS Provider ID, Name, Address, and Phone Number
 007835, NEMT Test
 123 Main St, USA
 123-456-7890

AHCCCS DAILY TRIP REPORT
 Driver's Name: NEMT Driver
 Date: 09/23/2019
 Vehicle License/Fleet ID: CDL00000
 Vehicle Make & Color: Honda, White
 Vehicle Type: Wheelchair Van Taxi Bus
 Stretcher Car Other (List type) Mini Bus

* One Daily Trip Report Per Member, Per Day
 AHCCCS #: A09340007 Date of Birth: 03/21/1959
 Member Name: Cookie, Sugar Mailing Address: 124 Main St, USA

1st Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
124 Maint St, USA	10:00 a.m./p.m.	5000	
1st Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
Home Care Clinc 600 Main St, USA	10:30 a.m./p.m.	5100	100

Type of Trip: One Way Multiple Stops _____
 Reason for Visit: Doctor Visit
 Name of Escort: none Relationship: _____

* For Round Trip Transportations please fill out the 1st Pick-Up and Drop-Off Location and the 2nd Pick-Up and Drop-Off Location fields.

2nd Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
Home Care Clinc 600 Maint St, USA	11:15 a.m./p.m.	5200	
2nd Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
124 Main St, USA	11:45 a.m./p.m.	5300	100

Type of Trip: Round Trip One Way _____ Multiple Stops _____
 Reason for Visit: Return to home
 Name of Escort: none Relationship: _____

3rd Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
	a.m./p.m.		
3rd Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
	a.m./p.m.		

Type of Trip: Round Trip _____ One Way _____ Multiple Stops _____
 Reason for Visit: _____
 Name of Escort: _____ Relationship: _____

page ___ of ___

AHCCCS #: _____ Date of Birth: _____
 Member Name: _____

4th Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
	a.m./p.m.		
4th Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
	a.m./p.m.		

Type of Trip: Round Trip _____ One Way _____ Multiple Stops _____
 Reason for Visit: _____
 Name of Escort: _____ Relationship: _____

5th Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
	a.m./p.m.		
5th Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
	a.m./p.m.		

Type of Trip: Round Trip _____ One Way _____ Multiple Stops _____
 Reason for Visit: _____
 Name of Escort: _____ Relationship: _____

6th Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
	a.m./p.m.		
6th Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
	a.m./p.m.		

Type of Trip: Round Trip _____ One Way _____ Multiple Stops _____
 Reason for Visit: _____
 Name of Escort: _____ Relationship: _____

Did multiple members get transported in the same vehicle on this trip? Yes No
 If the above answer is yes, were the pick-up and drop-off locations different for the members? Yes No
 Additional Information: _____

Member Signature: _____ Member Signature HERE _____
 Member is unable to sign. Identify the person signing for the member or include member's fingerprint.

(Attendant / Escort / Guardian / Parent / Provider) _____



This is to certify that the information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Driver Signature: _____ NEMT Driver Signature HERE _____ Date: 09/23/2019
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AHCCCS DAILY TRIP REPORT



Upper Left Hand Corner

Provider Information:

- Provider Name
- 6 digit AHCCCS Provider ID
- Provider Address
- Provider Phone Number

Note: Using a stamp is acceptable.

NEMT AHCCCS Provider ID, Name, Address, and Phone Number

* One Daily Trip Report Per Member, Per Day

AHCCCS DAILY TRIP REPORT

Driver's Name: _____

Date: _____

Vehicle License/Fleet ID: _____

Vehicle Make & Color: _____

Vehicle Type: Wheelchair Van Taxi Bus

Stretcher Car Other (List type) _____

AHCCCS #: _____ Date of Birth: _____

Member Name: _____ Mailing Address: _____

1st Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
	a.m./p.m.		
1st Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
	a.m./p.m.		

Type of Trip: One Way _____ Multiple Stops _____

* For Round Trip Transportations please fill out the 1st Pick-Up and Drop-Off Location and the 2nd Pick-Up and Drop-Off Location fields.

Reason for Visit: _____

Name of Escort: _____ Relationship: _____

AHCCCS DAILY TRIP REPORT



NEMT AHCCCS Provider ID, Name, Address, and Phone Number

AHCCCS DAILY TRIP REPORT

Driver's Name: _____

Date: _____

Vehicle License/Fleet ID: _____

Vehicle Make & Color: _____

Vehicle Type: Wheelchair Van Taxi Bus
 Stretcher Car Other (List type) _____

* One Daily Trip Report Per Member, Per Day

AHCCCS #: _____ Date of Birth: _____
Member Name: _____ Mailing Address: _____

1st Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)

1st Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)

Type of Trip: One Way _____ Multiple Stops _____

Reason for Visit: _____
Name of Escort: _____ Relations: _____

Upper Right Hand Corner

- Driver's name: Print **FIRST** and **LAST** name
- Date: date of service (**mm/dd/yyyy**)
- Vehicle License/Fleet ID:
 - State the vehicle is licensed in
 - License Plate Number/Fleet Number
- Vehicle Make & Color: Make and Color
- Vehicle Type: Check the box next to the type of vehicle used (car, van, wheelchair van, stretcher van, etc.)

AHCCCS DAILY TRIP REPORT



NEMT AHCCCS Provider ID, Name, Address, and Phone Number

007835, NEMT Test
123 Main St, USA
123-456-7890

AHCCCS DAILY TRIP REPORT

Driver's Name: NEMT Driver

Date: 09/23/2019

Vehicle License/Fleet ID: CDL00000

Vehicle Make & Color: Honda, White

Vehicle Type: Wheelchair Van Taxi Bus
 Stretcher Car Other (List type) Mini Bus

* One Daily Trip Report Per Member, Per Day

AHCCCS #: A09340007 Date of Birth: 03/21/1959

Member Name: Cookie, Sugar Mailing Address: 124 Main St, USA

Member Information

AHCCCS ID #: The recipients AHCCCS ID # (A99999999)

Member Name: Enter the members **First Name**, and **Last Name**

Date of Birth: Recipients Date of Birth (MM/DD/YYYY)

Mailing Address: Recipients **Full Mailing Address**

AHCCCS DAILY TRIP REPORT

1st Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
124 Maint St, USA	10:00 <input type="radio"/> a.m. <input checked="" type="radio"/> p.m.	5000	
1st Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
Home Care Clinc 600 Main St, USA	10:30 <input type="radio"/> a.m. <input checked="" type="radio"/> p.m.	5100	100
Type of Trip: One Way <input checked="" type="checkbox"/> Multiple Stops <input type="checkbox"/>		* For Round Trip Transportations please fill out the 1st Pick-Up and Drop-Off Location and the 2nd Pick-Up and Drop-Off Location fields.	
Reason for Visit: <u>Doctor Visit</u>			
Name of Escort: <u>none</u> Relationship: _____			

Pick-Up Address: Complete address (including street address, city, state and zip code) of pick-up destination.

Pick-Up time: Clock time including the a.m./p.m. indicator (example: 7:12 AM). Please circle the appropriate time of day (a.m./p.m.) provided.

Pick-Up Odometer: Document the actual odometer reading at the pick-up location

AHCCCS DAILY TRIP REPORT

1st Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
124 Maint St, USA	10:00 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	5000	
1st Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
Home Care Clinc 600 Main St, USA	10:30 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	5100	100

Type of Trip: One Way Multiple Stops _____

* For Round Trip Transportations please fill out the 1st Pick-Up and Drop-Off Location and the 2nd Pick-Up and Drop-Off Location fields.

Reason for Visit: Doctor Visit

Name of Escort: none Relationship: _____

Drop-Off Address: Complete address (including street address, city, state and zip code) of drop-off address.

Drop-Off Time: Clock time including the a.m./p.m. indicator (example: 7:12 PM). Please circle the appropriate time of day (a.m./p.m.) provided.

Drop-Off Odometer: Document the actual odometer reading at the drop-off location.

AHCCCS Daily Trip Report - Trip Miles

Trip miles: Subtract the Pick-Up odometer reading from the Drop-Off odometer reading, and that will equal the total number of trip miles.

- Example:
 - Drop-Off Odometer Reading is 250 miles
 - Pick-Up Odometer Reading is 310 miles
 - $310 \text{ miles} - 250 \text{ miles} = \text{Total Trip Miles of } 60 \text{ miles}$

AHCCCS DAILY TRIP REPORT

1st Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
124 Maint St, USA	10:00 a.m. p.m.	5000	
1st Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
Home Care Clinc 600 Main St, USA	10:30 a.m. p.m.	5100	100
<p>Type of Trip: One Way <input checked="" type="checkbox"/> Multiple Stops <input type="checkbox"/></p> <p>* For Round Trip Transportations please fill out the 1st Pick-Up and Drop-Off Location and the 2nd Pick-Up and Drop-Off Location fields.</p>			
Reason for Visit: <u>Doctor Visit</u>			
Name of Escort: <u>none</u> Relationship: _____			

Type of Trip Information

One Way (e.g. To Doctor)

Multiple Stops (e.g. Home → Doctor → Pharmacy → Home)

Round Trip (For round trip transportation the 1st pick up and drop-off location and the 2nd pick-up and drop-off location must be filled out)

AHCCCS DAILY TRIP REPORT

1st Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
Home Care Clinc 600 Main St, USA	10:30 a.m. p.m.	5100	100
Type of Trip: One Way <input checked="" type="checkbox"/> Multiple Stops <input type="checkbox"/>		* For Round Trip Transportations please fill out the 1st Pick-Up and Drop-Off Location and the 2nd Pick-Up and Drop-Off Location fields.	
Reason for Visit: <u>Doctor Visit</u>			
Name of Escort: <u>none</u> Relationship: _____			

Reason for Visit

Only include as much information as the member is willing to share.

Note: When transportation services are initially arranged, the transportation provider must obtain sufficient information to determine whether the transportation is occurring to an AHCCCS covered service.

AHCCCS DAILY TRIP REPORT

1st Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
Home Care Clinic 600 Main St, USA	10:30 a.m. p.m.	5100	100
Type of Trip: One Way <input checked="" type="checkbox"/> Multiple Stops <input type="checkbox"/>		* For Round Trip Transportations please fill out the 1st Pick-Up and Drop-Off Location and the 2nd Pick-Up and Drop-Off Location fields.	
Reason for visit: <u>Doctor Visit</u>			
Name of Escort: <u>none</u>		Relationship: _____	

Escort

Name of Escort: If member is traveling with an escort, include their first and last name.

Relationship: Indicate the escort's relationship to the member

Note: This is not a required field, only applies if applicable.

Multiple Members

Did multiple members get transported in the same vehicle on this trip? Yes No

If the above answer is yes, were the pick-up and drop-off locations different for the members? Yes No

Additional Information: _____

Did multiple members get transported in the same vehicle on this trip?

Mark yes if multiple AHCCCS members are being transported in the same vehicle.
If you mark yes, you must also answer the second question.

Were the pick-up and drop-off locations different for the members?

- Any additional information that the provider thinks is needed for the processing of the claim can be entered here.

Did multiple members get transported in the same vehicle on this trip? Yes No

If the above answer is yes, were the pick-up and drop-off locations different for the members? Yes No

Additional Information: _____

If the answer to the first question is “No”, the second question will not be applicable.

Member Information

Member Signature: _____ Member Signature HERE _____

Member is unable to sign. Identify the person signing for the member ***or*** include member's fingerprint.

(Attendant / Escort / Guardian / Parent / Provider)



Member Fingerprint

Member Signature

Member **must sign**, if able. If member is unable to sign, please check the appropriate box and identify the person* signing for the member or include the member's fingerprint.

Typing the member's name in cannot serve as a substitute for an actual signature or fingerprint.

Fingerprint

A fingerprint may also be used if the member is unable to sign.

Member Signature & Date

Clarification of member's "signature" requirement

- If a member is physically unable to sign (or fingerprint) the non-emergency medical transport Daily Trip Report then a parent or guardian, caretaker, escort, or family member can sign for the member and indicate their relationship to the member.
- If the member is transporting alone, then the trip report may be signed by the provider at the medical service appointment.
- When someone else signs the trip report for the member, the trip report should show the member's name and a notation such as "by J Smith, daughter" to identify the person signing for the member.
- **Under no circumstances is the transport driver to sign for a member.**
 - Even if the transport driver is a physical or behavioral health care provider for the member, they still cannot sign for the member. If the member cannot sign for themselves then a parent, guardian, caretaker, escort, or other family member would have to sign for them. The driver cannot sign, even if the driver overlaps one of the categories that normally could.

Driver Signature & Date

This is to certify that the information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Driver Signature: _____ NEMT Driver Signature HERE _____ Date: 09/23/2019

page of

Driver's Signature

The driver must sign each page.

If a tablet or other electronic device is being used, a method for the driver to sign their signature must be available (typically by an electronic pen or using their fingertip to sign their name).

Typing the driver's name in cannot serve as a substitute for an actual signature or fingerprint.

Date

The driver must date each page.

Multiple Pages

This is to certify that the information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Driver Signature: _____ NEMT Driver Signature HERE

Date: 09/23/2019

page 2 of 2

Page (s)

Indicate each page number and the total number of pages used to document all transports for the member, for the same date of service.

You may print out the trip report, double sided.



Reminders

Things to Remember Operations on Tribal Land

Effective 4/1/2014 all non-emergency transportation providers that transport AHCCCS recipients (pick up and/or drop off) on reservation will be required to obtain a Tribal business license from the Tribe.

- A copy of the Tribal business license must be submitted to AHCCCS Provider Registration for documentation.
- When auditing claims AHCCCS will ensure that this documentation is on file. Failure to obtain and submit your Tribal business license will result in claims recoupment.

Things to Remember

Use of More than One Vehicle

If the driver uses more than one vehicle for the same date of service, for the same member, then they must use a new Daily Trip Report for each separate vehicle *and* they must indicate (at the bottom right) the page number.

All pages become the complete Daily Trip Report for the transport services, for that recipient, on that service date.

Things to Remember

Methods of Filling out the Trip Report

The AHCCCS Daily Trip Report must be completed in pen. It may be filled out in either blue or black pen.

- Erasures and white-out are not acceptable. If an error is made, draw a single line through the error and enter the correct information.

The AHCCCS Daily Trip Report may be filled out on a tablet or another electronic device, as long as all federal and state requirements are taken to protect member information.

Things to Remember

Format of AHCCCS Daily Trip Report

- AHCCCS **will not** accept HTML files of the AHCCCS Daily Trip Report.
- AHCCCS **will not** accept Excel files of the AHCCCS Daily Trip Report. If a provider uses the Excel file, they must convert to a PDF before submission. The Excel file version available on the website was made available due to *provider request*. These providers convert this to a PDF file prior to submitting.
- AHCCCS **will** accept PDF files of the AHCCCS Daily Trip Report.
 - Note: If the AHCCCS Daily Trip Report is submitted as a PDF file through the 275 Provider Portal, it is necessary that the PDF file *allow AHCCCS to **extract** the document*, otherwise AHCCCS will not be able to view the submitted PDF file. If you are uncertain of how to make a file 'extractable' please consult with your team's IT division.

Things to Remember

Multiple Members and Wait Times

Wait time shall only be billed for the amount of time the driver actually waited at the member's medical service destination if the distance traveled was such that it was not feasible for the driver to return to the provider's base of operations or the origination site.

- Wait time is billed with code T2007 where each unit is 30 minutes.
- If transporting multiple members at one time, the wait time shall be reimbursed for no more than one member.

Things to Remember

Multiple Members and Wait Times

In addition, billing for wait time is not appropriate:

If the odometer reading changes from the drop-off at the medical service to the pick-up at the medical service;

- For a one way trip;
- When two different vehicles and/or drivers are used for the round trip;
- If wait time is less than 30 minutes; or
- If the distance to the medical service location is 10 miles or less.

Things to Remember

Multiple Stops

Only one trip report should be filled out per member, per day.

If there are more than three stops for one member, in one day, please use multiple pages.

If more than one vehicle is used and/or if more than one driver transports the member on the same day, please use multiple pages (one for each vehicle) and document that more than one vehicle and/or driver was used in the additional information section.

If multiple pages are used, the page number must be indicated at the bottom right of the Daily Trip Report. All pages become the complete Daily Trip Report for the transport services for that member, on that service date.

Bus Passes

Public Transportation Coverage

Effective 10/1/2021, providers with a Category of Service (COS) 31 may offer Public Transportation options to FFS members (such as a bus pass) when they travel to and from an AHCCCS approved service, in accordance with AMPM 310-BB.

The following shall be considered when offering public transportation to a member:

1. Location of the member to a transportation stop.
2. Location of the provider of services to a transportation stop.
3. The public transportation schedule in coordination with the member's appointment.
4. The ability of the member to travel alone on public transportation.
5. Member preference

Provider types that are eligible to claim reimbursement for public transportation passes include 02, 05, 13, 14, 25, 27, 29, 41, 77, 81, 85, 86, 87, A3, A4, A6, B7, BC, C2, and C5.

Public Transportation Requirements

- Transportation passes may be up to 1 month in duration
- Replacement or duplicate transportation passes are not eligible for Medicaid reimbursement
- There shall be a continuous need for transportation to Medicaid reimbursable services consistent with the length of the purchased transportation pass
- Providers shall determine the appropriate type/duration of public transportation pass to issue to members in accordance with the member's treatment plan and existing future appointment dates.

Claim Submission

- Bill using code A0110 for the net cost of the [transportation pass](#), not to exceed the cost of a 30-day pass.
- Submitted Claims must include the following documentation.
 - Copy of public transportation pass,
 - Itemized receipt specifying cost of public transportation pass,
 - Pricing that corresponds with the price of the pass in the geographic areas of issuance, and
 - Completed [Public Transportation Pass form](#) to include the following:
 - o Provider's name and ID#,
 - o Public Transportation pass type (daily, weekly, or monthly),
 - o Price of the Public Transportation pass,
 - o Date of issuance,
 - o Name, title, signature, and signature date of person issuing Public Transportation pass to the member,
 - o Member name, AHCCCS ID#, signature and signature date.
- Public Transportation Pass Form:
 - https://www.azahcccs.gov/PlansProviders/Downloads/FFSPProviderManual/FFSChap_14TransportationExhibit4.pdf



DFSM Provider Training Unit

DFSM Provider Training

The DFSM Provider Education and Training Unit can assist providers with the following:

- How to submit and status claims or prior authorization requests through the AHCCCS Online Provider Portal (FFS programs, including AIHP, TRBHAs and Tribal ALTCS).
- Submission of documentation using the Transaction Insight Portal (i.e. the AHCCCS Daily Trip report, requested medical records, etc.).

Additionally, the DFSM Provider Training unit offers trainings with informational updates to program changes, system updates, and changes to the AHCCCS policy, AHCCCS guides and manuals.

Education and Training Questions?

The DFSM Provider Education and Training Unit does not instruct providers on how to code or bill for a particular service.

For additional information on rates and coding please follow the below guidelines:

- Rates - Questions on AHCCCS FFS rates should be directed to the rates team at FFSRates@azahcccs.gov
- Coding - Questions on AHCCCS Coding should be directed to the coding team at CodingPolicyQuestions@azahcccs.gov
 - NOTE: The Coding team cannot instruct providers on how to code or bill for a particular service. Those questions should be directed to the provider's professional coder/biller.
- ACC Plan Claims - Questions regarding the submission of claims to an AHCCCS Complete Care (ACC) Health Plan should be directed to the appropriate ACC Health Plan.

The DFSM Provider Training Team can be reached at ProviderTrainingFFS@azahcccs.gov

Thank You.