

# Documentation Type Requirement for Alaska Medicaid

Last modified on 03/19/2026 10:06 am EDT

If you are billing claims to Alaska Medicaid on the HCFA-1500 form and including documentation, the type of documentation attached must be listed in Box 9B on the HCFA form. You can add this information easily from the Live Claims Feed. If you need to be set up for this feature, please reach out to your Account Manager or [support](#) and ask that it be turned on for your account.

1. Navigate to **Billing > Live Claims Feed**
2. Select the patient by name, payer ID, DrChrono Claim ID, or date of service.

The screenshot shows the 'Live Claims Feed' interface. At the top, there are several filter buttons: 'Select All Offices', 'Select None', 'C new office All', 'Primary Office All', and 'Test office All'. Below these are more filters: 'Claim Type All', 'Claim St All', 'Billing St: All', 'Appt Profiles: All', a 'Calculate Counts' button, a 'What's this?' link, and a 'TFL Warning' checkbox. A search bar contains fields for 'Patient', 'Payer Name', 'Payer ID', 'drc claim #', 'From', 'To', and 'Clinical Note'. There are also checkboxes for 'Open window in new tab' and 'Exclude future follow-up dates', along with 'Check All', 'Clear', and 'Update Filter' buttons. Below the search bar are buttons for 'Batch Status Change', 'Export to File', 'Custom Export', 'Display', '+ Schedule', and 'Internal'. A 'PAGE 1' indicator is on the right. The main table has columns: 'Info', 'Claim ID', 'Patient', 'Date of Service', 'Office', 'Provider', 'Supervising Provider', 'Billing Provider', 'Billed', 'Allowed', 'Adjmt', 'Ins 1 Paid', 'Ins 2 Paid', 'Pt Paid', 'Ins Bal', and 'Pt Line Item Bal'. A row of totals is shown: 'Totals: \$1,570,934.23 \$1,460,616.75 \$110,317.48 \$148,033.51 \$0.00 \$15.00 \$4,761.13 \$1,307,807.11'. A single claim row is visible with ID '330869573', patient 'Jenny (Jen) Harris', date '11/19/2024 12:00AM', and office 'Primary Office'.

3. On the right-hand side of the screen, you will find an option titled **Attachment Type**.

The screenshot shows a configuration form for 'Attachment Type'. It includes several fields with dropdown menus: 'Claim Type' (Default), 'Emergency Service' (No), 'Delay Reason' (- Not Used -), 'Onset Date' (- Onset Date), 'Other Date' (- Other Date), 'Employment' (No), 'Auto Accident' (No), and 'Other Accident' (No). There are also checkboxes for 'Acute Manifestation Date', 'EDI Billing Note' (with a note '(HCFA/CMS-1500 Line 19)'), and 'Providers'. A red arrow points to the 'Attachment Type' dropdown menu, which currently shows 'Select Code'. The 'Onset Date' and 'Other Date' fields have a note '(HCFA box 14)' and '(HCFA box 15 & 19)' respectively.

4. From the drop-down, you will have the following options:
  - a. The options listed match the requirements of Alaska Medicaid.

<b>Attachment Type</b>	<input checked="" type="checkbox"/> Select Code CK - Sterilization Consent Form EB - Explanation of Benefits OZ - Support Data for Claim / Medical Justification
------------------------	---

9b.	Reserved for NUCC Use	C	Required for ambulance providers Complete if there are attachments to the claim. Enter the code that corresponds to the type of documentation attached:								
			<table border="1" style="width: 100%;"> <thead> <tr> <th style="background-color: #4F81BD; color: white;">Code</th> <th style="background-color: #4F81BD; color: white;">Type of Documentation</th> </tr> </thead> <tbody> <tr> <td>CK</td> <td>Sterilization Consent Form</td> </tr> <tr> <td>EB</td> <td>Explanation of Benefits</td> </tr> <tr> <td>OZ</td> <td>Support Data for Claim / Medical Justification</td> </tr> </tbody> </table>	Code	Type of Documentation	CK	Sterilization Consent Form	EB	Explanation of Benefits	OZ	Support Data for Claim / Medical Justification
Code	Type of Documentation										
CK	Sterilization Consent Form										
EB	Explanation of Benefits										
OZ	Support Data for Claim / Medical Justification										

5. Once an attachment type is selected and Verify and Save is selected, the associated code will appear in box 9A on the HCFA 1500 form.

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  a. OTHER INSURED'S POLICY OR GROUP NUMBER  b. RESERVED FOR NUCC USE <b>EB</b> ←	10. IS PATIENT'S CONDITION RELATED TO:  a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  b. AUTO ACCIDENT?    PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	11. INSURED'S POLICY GROUP OR FECA NUMBER  a. INSURED'S DATE OF BIRTH    SEX MM   DD   YY    M    F 04   01   2022    M <input checked="" type="checkbox"/> F  b. OTHER CLAIM ID (Designated by NUCC)  c. INSURANCE PLAN NAME OR PROGRAM NAME Medicaid AK  d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a and 9d.</i>
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	