FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	02/2018
	Reasonable Effort Documentation	04/2014
	Electronic Funds Transfer (EFT) Authorization Agreement	08/2017
	Duplicate Remittance Advice Request Form	09/2017
	Claim Reconsideration Form	11/2018
CMS-1500 (02/12)	Sample Health Insurance Claim Form	02/2012
	Sample Remittance Advice (four pages)	04/2014
DHHS 175	Community Long Term Care Service Provision Form	07/1992
ID/RD A-3	SCDDSN ID/RD Waiver – Authorization for Services to Be Billed to Medicaid Personal Care	04/2017
ID/RD A-9	SCDDSN ID/RD Waiver – Authorization for Services to Be Billed to Medicaid Psychological Services	04/2017
ID/RD A-12	SCDDSN ID/RD Waiver – Authorization for Services to Be Billed to Medicaid Nursing Services	04/2017
ID/RD A-13	SCDDSN ID/RD Waiver – Authorization for Services to Be Billed to Medicaid Private Vehicle Modification	04/2017
ID/RD A-23	SCDDSN ID/RD Waiver – Authorization for Services to Be Billed to Medicaid Adult Day Health Care Services	04/2017
ID/RD A-25	SCDDSN ID/RD Waiver – Authorization for Services to Be Billed to DSN Board Respite Services	04/2017
ID/RD A-27	SCDDSN ID/RD Waiver – Authorization for Services to Be Billed to Medicaid Behavior Support Services	04/2017

FORMS

Number	Name	Revision Date
ID/RD A-28	SCDDSN ID/RD Waiver – Authorization for Services to Be Billed to DSN Board Residential Habilitation	04/2017
ID/RD A-31	SCDDSN ID/RD Waiver – Authorization for Services to Be Billed to Medicaid Audiology Services	04/2017
ID/RD A-32	SCDDSN ID/RD Waiver – Authorization for ICF/IID (Institutional) Respite Services to Be Billed to DSN Board	04/2017
ID/RD 16	SCDDSN ID/RD Waiver Notice of Termination of Service	04/2017
ID/RD 16 (reverse)	SCDDSN ID/RD Waiver Process for Appealing Decisions	04/2017
HASCI 12-D	SCDDSN HASCI Waiver – Authorization for Medicaid Waiver Nursing Services	02/2004
HASCI 12-E	SCDDSN HASCI Waiver – Authorization for Psychological Services	02/2004
HASCI 12-F	SCDDSN HASCI Waiver – Authorization for PERS Services	02/2004
HASCI 12-H	SCDDSN HASCI Waiver – Authorization for Respite Services	02/2004

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:	
NPI or MEDICAID PROVIDER ID: (if applicable)	MEDICAID RECIPIENT ID NUMBER: (if applicable)
ADDRESS OF SUSPECT:	LOCATION OF INCIDENT:
	DATE OF INCIDENT:
COMPLAINT:	

NAME OF PERSON REPORTING: (Please print)	SIGNATURE OF PERSON REPORTING:	DATE OF REPORT

ADDRESS OF PERSON REPORTING:	TELEPHONE NUMBER OF PERSON REPORTING:
	SIGNATURE: (SCDHHS Representative Receiving Report)

SCDHHS Form 126 (revised 06/07)

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Provider ID:

NPI:

Recipient ID:

Adjustment Type:

◯ Void ◯ Void/Replace

Originator:

◯ DHHS ◯ MCCS ◯ Provider ◯ MIVS

Reason For Adjustment: (Fill One Only)

- ◯ Insurance payment different than original claim
- ◯ Keying errors
- ◯ Incorrect recipient billed
- ◯ Voluntary provider refund due to health insurance
- ◯ Voluntary provider refund due to casualty
- ◯ Voluntary provider refund due to Medicare
- ◯ Medicaid paid twice - void only
- ◯ Incorrect provider paid
- ◯ Incorrect dates of service paid
- ◯ Provider filing error
- ◯ Medicare adjusted the claim
- ◯ Other

For Agency Use Only

Analyst ID:

- ◯ Hospital/Office Visit included in Surgical Package
- ◯ Independent lab should be paid for service
- ◯ Assistant surgeon paid as primary surgeon
- ◯ Multiple surgery claims submitted for the same DOS
- ◯ MMIS claims processing error
- ◯ Rate change
- ◯ Web Tool error
- ◯ Reference File error
- ◯ MCCS processing error
- ◯ Claim review by Appeals

Comments:

Signature:_____ Date:_____

Phone:_____

DHHS Form 130 Revision date: 03-13-2007

South Carolina Department of Health and Human Services
Form for Medicaid Refunds

Purpose: This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. **Attach appropriate document(s) as listed in item 8.**

1. Provider Name: _____

2. Medicaid Legacy Provider # ☐☐☐☐☐☐
(Six Characters)

OR

3. NPI# ☐☐☐☐☐☐☐☐☐☐ **& Taxonomy** ☐☐☐☐☐☐☐☐☐☐

4. Person to Contact: _____ **5. Telephone Number:** _____

6. Reason for Refund: [check appropriate box]

☐ Other Insurance Paid (please complete **a – f** below and attach insurance EOMB)
- **a** Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
- **b** Insurance Company Name _____
- **c** Policy #:_____
- **d** Policyholder: _____
- **e** Group Name/Group: _____
- **f** Amount Insurance Paid:_____

☐ Medicare
- ( ) Full payment made by Medicare
- ( ) Deductible not due
- ( ) Adjustment made by Medicare

☐ Requested by DHHS (please attach a copy of the request)

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

7. Patient/Service Identification:

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

8. Attachment(s): [Check appropriate box]

☐ Medicaid Remittance Advice (required)

☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)

☐ Explanation of Benefits (EOMB) from Medicare (if applicable)

☐ Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

_____ a. beneficiary has never been covered by the policy – close insurance.

_____ b. beneficiary coverage ended - terminate coverage (date) _____

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax: 803-252-0870 **or** **Mail:** Post Office Box 101110 Columbia, SC 29211-9804

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER _____ DOS _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

_____

(SIGNATURE AND DATE)

ATTACH A COPY OF THE FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014

South Carolina Department of Health and Human Services
Electronic Funds Transfer (EFT) Authorization Agreement

PROVIDER INFORMATION

Provider Name _____

Doing Business As Name (DBA) _____

Provider Address

Street _____

City _____ State/Province _____

Zip Code/Postal Code _____ Medicaid Provider Number _____

Provider Federal Identification Number (TIN) or
Employer Identification Number (EIN) _____

National Provider Identifier (NPI) _____

Provider EFT Contact Information

Provider Contact Name _____

Telephone Number _____ Telephone Number Extension _____

Email Address _____

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name _____

Financial Institution Address _____

Street _____

City _____ State/Province _____

Zip Code/Postal Code _____

Financial Institution Routing Number _____

Type of Account at Financial Institution (select one) ☐ Checking ☐ Savings

Provider's Account Number with Financial Institution _____

Account Number Linkage to Provider Identifier (select one)

☐ Provider Tax Identification Number (TIN)

☐ National Provider Identifier (NPI)

REASON FOR SUBMISSION: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

By signing this form, I authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to the checking or savings account indicated above at the financial institution identified above. Credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the Department of Health and Human Services to make an adjusting debit entry to the account up to the amount of the excess payment. Credit entries to the above account are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws. I certify that the information shown is correct and agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.

Written Signature of Person Submitting Enrollment _____

Printed Name of Person Submitting Enrollment _____

Submission Date _____

TO PROCESS YOUR EFT ENROLLMENT OR CHANGE EXISTING INFORMATION, PLEASE RETURN THIS COMPLETED FORM ALONG WITH VERIFICATION OF YOUR ELECTRONIC DEPOSIT INFORMATION ON YOUR FINANCIAL INSTITUTION'S LETTERHEAD TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 870-9022

SPECIAL INSTRUCTIONS: For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider web page for instructions on how to complete updates to your EFT information.

Effective January 01, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDHHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching trace number and your ERA can be directed to the Provider Service Center at 1-888-289-0709.

South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form

Purpose: This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

Please contact the SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for instructions on submission of your request.

1. Provider Name: _____

2. Medicaid Legacy Provider # _____ (Six Characters)

   NPI# _____ Taxonomy _____

3. Person to Contact: _____ Telephone Number: _____

4. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:
   _____
   _____
   _____
   _____
   _____

   Note: Remittance advices are available electronically through the Web Tool. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

5. Street Address for delivery of request:

   Street: _____

   City: _____

   State: _____

   Zip Code: _____

6. Charges for duplicate remittance advice(s) are as follows:

   Request Processing Fee - $20.00

   Page(s) copied - .20 per page

I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.

_____ _____

Authorizing Signature **Date**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Submit your Claim Reconsideration request to:

Fax: 1-855-563-7086

or

Mail: South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

CLAIM RECONSIDERATION FORM

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. A separate SCDHHS CR form is required for each claim control number (CCN). Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709. **Note:** Timely filing guidelines apply.

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____ Medicaid Beneficiary ID: _____

Section 2: Provider Information

Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other (DME, Lab, Home Health Agency, etc.): _____

NPI: _____ Medicaid Provider ID: _____ Facility/Group/Provider Name: _____

Return Mailing Address: _____
Street or Post Office Box *State* *ZIP*

Contact: _____ Email: _____ Telephone #: _____ Fax #: _____

Section 3: Claim Information ***(Only one CCN allowed per request.)***

Communication ID: _____ CCN: _____ Date(s) of Service: _____

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below)

- ☐ Ambulance Services
- ☐ Autism Spectrum Disorder (ASD) Services
- ☐ Clinic Services
- ☐ Community Long Term Care (CLTC)
- ☐ Community Mental Health Services
- ☐ Department of Disabilities and Special Needs (DDSN) Waivers
- ☐ Durable Medical Equipment (DME)
- ☐ Early Intervention Services
- ☐ Enhanced Services
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Home Health Services
- ☐ Hospice Services
- ☐ Hospital Services
- ☐ Licensed Independent Practitioner's Rehabilitative Services (LIPS)
- ☐ Local Education Agencies (LEA)
- ☐ Medically Complex Children's (MCC) Waivers
- ☐ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- ☐ Optional State Supplementation (OSS)
- ☐ Pharmacy Services
- ☐ Physicians Laboratories, and Other Medical Professionals Specify: _____
- ☐ Private Rehabilitative Therapy and Audiological Services
- ☐ Psychiatric Hospital Services
- ☐ Rehabilitative Behavioral Health Services (RBHS)
- ☐ Rural Health Clinic (RHC)
- ☐ Targeted Case Management (TCM)
- ☐ Other: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature:_____ Date: _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Remittance Advice (page 1)

This page of the sample Remittance Advice shows a paid claim, suspended claim and rejected claim.

PROVIDER ID. | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE

AB00080000

DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

REMITTANCE ADVICE

02/14/2014

1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB1AA	1403004803012700A				27.00	6.72	P	1112233333	M CLARK				
	01		101713	71010	27.00	6.72	P			026		0.00	0.00
ABB2AA	1403004804012700A				259.00	0.00	S	1112233333	M CLARK				
	01		101713	74176	259.00	0.00	S			026		0.00	0.00
ABB3AA	1403004805012700A				24.00	0.00	R	1112233333	M CLARK			0.00	
	01		071913	A5120	12.00	0.00	R			000			0.00
	02		071913	A4927	12.00	0.00	R			000			0.00
									Edits: L00 946 L02 852 08/30/13				
	TOTALS		3		310.00							0.00	0.00

$6.72

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT: $0.00

MEDICAID PG TOT: $286.46

CERTIFIED AMT

MEDICAID TOTAL: 0.00

CHECK TOTAL

CHECK NUMBER

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 2)

This page of the sample Remittance Advice shows a paid claim, as well as a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle.

PROVIDER ID. | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE

AB00080000 | DEPT OF HEALTH AND HUMAN SERVICES | 02/28/2014 | 1

SOUTH CAROLINA MEDICAID PROGRAM

REMITTANCE ADVICE

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER		PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT	MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	1405200415812200A					1192.00	243.71		P	1112233333	M CLARK			0.00	
		01		021814	S0315	800.00	117.71		P			000			0.00
		02		021814	S9445	392.00	126.00		P			000			0.00
	VOID OF ORIGINAL CCN 13283002244813300A PAID 20131018														
ABB222222	1405200077700000U					1412.00-	273.71-		P	1112233333	M CLARK				
		01		100213	S0315	1112.00-	143.71-		P			000			
		02		100213	S9445	300.00-	130.00-		P			000			
	REPLACEMENT OF ORIGINAL CCN 1304711253670430A PAID 20131018														
ABB222222	1405200414812200A					1001.50	42.75		P	1112233333	M CLARK			0.00	
		01		100213	S0315	142.50	42.75		P			000			0.00
		02		100313	S9445	859.00	0.00		R			000			0.00
														0.00	0.00
								$286.46							

CERT. PG TOT $0.00 | MEDICAID PG TOT $286.46

CERTIFIED AMT | MEDICAID TOTAL 0.00

CHECK TOTAL | CHECK NUMBER

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 3)

This page of the sample Remittance Advice shows a claim-level Void without a corresponding Replacement claim.

PROVIDER ID.: AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE: 02/28/2014

PAGE: 2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	O D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	14052000777000000U				513.00-	197.71-	P	1112233333	CLARK	M			131018	1328300224813300A
	01		100213	S0315	453.00	160.71-	P					000		
	02		100213	S9445	60.00	33.00-	P					000		
	TOTALS	1			513.00-	193.71-								

PROVDER INCENTIVE CREDIT AMOUNT: 0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 0.00

MEDICAID TOTAL: $243.71

ADJUSTMENTS: $193.71-

CHECK TOTAL: $50.00

CERTIFIED AMT: 0.00

CHECK NUMBER: 4197304

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 4)

This page of the sample Remittance Advice shows four gross-level adjustments.
Gross-level adjustments always appear on the final page of the Remittance Advice.

PROVIDER ID. ABC1110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE 02/28/2014

PAGE 3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME F M I I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	1404900004000100U	-						DEBIT	-2389.05	
TPL 4	1405500076000400U	-						DEBIT	-1949.90	
TPL 5	1404900004000100U	-						DEBIT	-477.25	
TPL 6	1405500076000400U	-						CREDIT	477.25	
							PAGE TOTAL:		4338.95	0.00

PROVDER INCENTIVE CREDIT AMOUNT	DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT		TO BE REFUNDED IN THE FUTURE
0.00	0.00	0.00	0.00	0.00	0.00

ADJUSTMENTS		PROVIDER NAME AND ADDRESS
-4338.95	0.00	ABC HEALTH PROVIDER
YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PO BOX 000000
0.00	0.00		FLORENCE SC 00000

Community Long Term Care
Service Provision Form

PROVIDER: VERIFY
MEDICAID ELIGIBILITY MONTHLY

TYPE OF AUTHORIZATION:
New

From:

AUTHORIZATION IS HEREBY GIVEN TO PROVIDE THE FOLLOWING SERVICE(S) UNDER YOUR CONTRACT WITH THE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR THE PROVISION THEREOF.

Service(s) Authorized: _____ CLTC PROCEDURE CODE: _____

Authorized Start Date: _____ Authorized End Date: (if applicable) _____

Comments:

Total Units Authorized: Sun Mon Tue Wed Thur Fri Sat Unit Cost: $

CLIENT INFORMATION				
NAME		BIRTHDATE	SEX	
ADDRESS				
CLTC CLIENT NO.	SOCIAL SEC NO.	MEDICAID NO.	ELIGIBILITY TYPE	
PRIMARY PHONE	SECONDARY PHONE	THIRD PHONE		
RESPONSIBLE PARTY				
NAME	ADDRESS			
RELATIONSHIP		HOME TELEPHONE	WORK TELEPHONE	

Physician: _____
Directions to client's home:

_____

_____

_____

_____

Case Manager's Signature: _____ Date: _____

Sent: _____ Date: _____ Initials: _____ ☐ PROVIDER ☐ BILLING CLERK ☐ FILE

SCDHHS FORM 175 JUL 92

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES TO BE *BILLED TO MEDICAID*

TO: _____

_____

RE: _____
Recipient's Name / Date of Birth

_____
Address

Medicaid # / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / /

Personal Care Services (T1020) – Attach ID/RD Form 10

☐ Personal Care I (PC I) S5130

☐ Personal Care II (PC II) T1019

Number of Units Per Week to be Provided: _____ (one unit = 15 minutes)
Start Date: _____

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

ID/RD Form A-3 (04/17)

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES TO BE *BILLED TO MEDICAID*

TO: _____

_____

RE: _____
Recipient's Name / Date of Birth

_____
Address

Medicaid # / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / /

PSYCHOLOGICAL SERVICES (H0046):

Assessment: Number of Units _____ (one unit = 30 minutes)

Counseling/Therapy: Start Date: _____
Number of Units (one unit = 30 minutes) _____
Frequency: _____

**** NO MORE THAN 8 HOURS/16 UNITS PER DAY MAY BE AUTHORIZED ****

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES TO BE *BILLED TO MEDICAID*

TO: _____

_____

RE: _____
Recipient's Name / Date of Birth

_____
Address

Medicaid # /__/__/__/__/__/__/__/__/__/__/

NOTE: The provider is responsible for pursuing all other resources prior to accessing Medicaid. State Plan Medicaid resources must be exhausted before accessing ID/RD Waiver. Our information indicates this person has:

☐ Medicaid Only ☐ 3rd Party liability ☐ Medicare

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # /___/___/___/___/___/___/___/___/

Nursing Services:

Total Number of Units Per Week to be Provided: _____ (one unit = 60 minutes)

☐ LPN Hours/Week (S9124) _____

☐ RN Hours/Week (S9123) _____

Start Date: _____

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

ID/RD Form A-12 (04/17)

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES TO BE *BILLED TO MEDICAID*

TO: _____

_____

RE: _____
Recipient's Name / Date of Birth

_____
Address

Medicaid # / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / /

Private Vehicle Modification (X9322):

General Description: _____

_____

_____

Cost: _____
(Attach a copy of the bid)

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

ID/RD Form A-13 (04/17)

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES TO BE *BILLED TO MEDICAID*

TO: _____

_____

RE: _____
Recipient's Name / Date of Birth

_____
Address

Medicaid # /__/__/__/__/__/__/__/__/__/__/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # /__/__/__/__/__/__/__/__/

Adult Day Health Care Services (X6987)

Number of Units Per Week: _____ one unit = 1 (5 hour) day

Start Date: _____

OR

The above named recipient cannot tolerate 5 hour day. Therefore you are authorized to provide:
Number of Units Per Week:_____ (one unit = _____ hours per day)

Start Date: _____

Service coordinator: Name / Address / Phone # (Please Print):

_____

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE ***BILLED TO DSN BOARD***

TO: _____

_____

RE: _____
Recipient's Name / Date of Birth

_____
Address

Medicaid # _/__/__/__/__/__/__/__/__/__/__/_

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Respite Services

Hourly Respite
Number of Units Per Week: _____ (one unit = 1 hour of service)

Daily Respite:
Number of Units Per _____ : _____
(one unit = 1 respite period of more than 8 consecutive hours)

REMIT BILL TO (Please print):

_____

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES TO BE *BILLED TO MEDICAID*

TO: _____

_____

RE: _____
Recipient's Name / Date of Birth

_____
Address

Medicaid # / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / /

BEHAVIOR SUPPORT SERVICES (H0045)

Assessment: Number of Units _____ (one unit = 30 minutes)

Number of Units (one unit = 30 minutes) _____
Frequency: _____
Start Date: _____

**** NO MORE THAN 8 HOURS/16 UNITS PER DAY MAY BE AUTHORIZED****

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE ***BILLED TO DSN BOARD***

TO: _____

_____

RE: _____
Recipient's Name / Date of Birth

_____
Address

Medicaid # _/__/__/__/__/__/__/__/__/__/__/_

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Residential Habilitation

Hourly:
Number of Units Per Week: _____
(one unit = 1 hour of service provided to someone in an SLP I setting)

Daily:
Number of Units Per Year: _____
(one unit = 1 night (present at midnight) in a CTH I, CTH II, CRCF or SLP II)

REMIT BILL TO (Please print):

_____

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO MEDICAID

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / /

Audiology Services:

____ Hearing Aid Evaluation: $49.00
____ Hearing Aid Orientation: $24.00
____ Hearing Aid Analysis: $10.50
____ Hearing Aid Re-Check: $16.00
____ Conduction Test: $8.50
____ Impedance Test: $10.25
____ Hearing Consultation: $13.00

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR ICF/IID (INSTITUTIONAL) RESPITE SERVICES TO BE *BILLED TO DSN BOARD*

☐ Center-Based Respite

☐ Coastal Center

☐ Midlands Center

☐ Pee Dee Center

☐ Saleeby Center

☐ Whitten Center

☐ Community ICF/MR

_____
Name of facility

TO: _____
For Center Based: Claims and Collections (See Attached)
For Community ICF/IID : Board/Provider Finance Director

_____
Address

RE: _____
Recipient's Name / Date of Birth

Medicaid # / / / / / / / / / / /

Social Security # / / / / / / / / / / /

You are hereby authorized to provide institutional respite to the consumer named above. The consumer cannot be admitted to the ICF/IID (DHHS 181 completed) without first notifying the Service Coordinator (noted below) and verifying that the consumer has been disenrolled from the ID/RD Waiver. Please note: This nullifies any previous authorization to this provider for this service.

Institutional Respite

☐ Number of Units _____ (one unit = number of nights spent in the ICF/IID)
Start Date: _____

Service Coordinator: _____

Board/Provider: _____

Address: _____

Phone Number (with extension when appropriate): _____

_____ _____
Signature of Person Authorizing Services Date

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER-NOTICE OF TERMINATION OF SERVICE

DATE FORM IS COMPLETED: _____

PROVIDER: _____

_____

RE: _____ _____/_____/_____
Recipient's Name Date of Birth

Medicaid # _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
1 2 3 4 5 6 7 8 9 10

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF _____/_____/_____ MAY BE BILLED.

For SC/EI: the effective date is 10 calendar days from the date the form is completed with the exception of death, loss of Medicaid, or admission to an ICF/IID or NF. This allows the consumer 10 days notice prior to termination of service.

- ☐ Respite Care
- ☐ Adult Day Health Care
- ☐ Assistive Technology:_____
- ☐ Personal Care Services
- ☐ Medicaid Waiver Nursing Services
- ☐ Habilitation (specify)
  - ☐ Residential habilitation
  - ☐ Day Habilititation
  - ☐ Prevocational services
  - ☐ Supportive Employment services
- ☐ Prescribed Drugs
- ☐ Adult Dental Services
- ☐ Envionmental Modifications
- ☐ CheckBox14
- ☐ CheckBox15
- ☐ CheckBox22
- ☐ Physical Therapy Services
- ☐ CheckBox17
- ☐ CheckBox18
- ☐ CheckBox19
- ☐ CheckBox20
- ☐ Private Vechicle Modifications

Reason:

- ☐ Change in need no longer justifies original request
- ☐ Change in ICF/IID Level of Care
- ☐ Change in provider availability
- ☐ CheckBox28
- ☐ CheckBox30
- ☐ Death (do not send a copy to the family
- ☐ Medical Condition has improvided
- ☐ No longer meets ICF/IID Level of Care
- ☐ Medicaid ineligible
- ☐ Consumer moved out of state
- ☐ Hospital/Nursing home stay exceeded more than 30 consecutive calendar days

Comments (required for all reasons:_____

_____

Service Coordinator/Early Interventionist: _____

DSN Board/Provider: _____ Phone: _____

Address: _____

Signature: _____ Date: _____/_____/_____

Original: Provider Copy: Consumer/Legal Guardian and File

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Intellectual Disabled/Related Disabilities (ID/RD) Waiver and the Head and Spinal Cord Injury (HASCI) Waiver. A request for reconsideration of an adverse decision **must be** sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the consumer, representative, or person assisting the consumer in filing the request. If necessary, staff will assist the consumer in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the consumer/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the consumer/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the consumer/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the consumer/representative fully completes the above reconsideration process and is dissatisfied with the results, the consumer/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The consumer/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision:

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The consumer/representative must attach a copy of the written reconsideration decision received from the SCDDSN regarding the specific matter on appeal. In the appeal request the consumer/representative must clearly state with specificity, which issue(s) the consumer/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The consumer/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for Medicaid Waiver Nursing Services

Medicaid #: _____
1 2 3 4 5 6 7 8 9 10

Referred To: _____

_____

_____

Individuals Name	**Address**
Date of Birth	**City/State/Zip**

Prior Authorization Number: _____ Billing should be submitted to: ☐ DHHS ☐ DSN Board
1 2 3 4 5 6 7

You are hereby authorized to provide:

Medicaid Waiver Nursing Services: ☐ **LPN (S9124)** ☐ **RN (S9123)**

Start Date: _____

Authorized Total: _____ **Units per** _____

Only the number of units rendered may be billed.
Please note: This nullifies any previous authorization to this provider for Medicaid Waiver Nursing Services.

The service is authorized for the individual named above. Only medical services may be billed to the Waiver under Medicaid Waiver Nursing Services and documentation must be provided for any services rendered. The services must be specifically for the Waiver participant and must be medically necessary, as indicated by the individual's physician.

The following services are requested:

_____

_____

_____

_____

Comments: _____

_____

_____

_____

PLEASE PRINT

DSN Board Name: _____ Svc. Coord.: _____

Address: _____

Phone: ( ) - ext. _____

Signature: _____ Date: _____

South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for Psychological Services

Medicaid #: _____
1 2 3 4 5 6 7 8 9 10

Referred To: _____

_____

_____

Individuals Name	**Address**
Date of Birth	**City/State/Zip**

Prior Authorization Number: _____
1 2 3 4 5 6 7

Billing should be submitted to: ☐ DHHS ☐ DSN Board

You are hereby authorized to provide:

Psychological Services

☐ Psychological Assessment (HØØ23)
☐ Cognitive Rehabilitation Therapy (HØØ23)
☐ Drug and Alcohol Abuse Counseling (T1ØØ7)
☐ Family/Individual Therapy - Psychologist (HØØ23)
☐ Family/Individual Therapy - LISW (HØØ23)
☐ Family/Individual Therapy - BA/MH Practitioner (HØØ23)
☐ Psychiatric Services (HØØ23)
☐ Neuropsychological Assessment (GØ114)

Start Date: _____

Authorized Total: _____ **Units per** _____

Only the number of units rendered may be billed.
Please note: This nullifies any previous authorization to this provider for psychological services..

Comments: _____

_____

_____

_____

PLEASE PRINT

DSN Board Name: _____ Svc. Coord.: _____

Address: _____

Phone: ( ) - ext. _____

Signature: _____ Date: _____

South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for PERS Services

Medicaid #: _____
1 2 3 4 5 6 7 8 9 10

Referred To: _____

_____

_____

Individuals Name	**Address**
Date of Birth	**City/State/Zip**

Prior Authorization Number: _____
1 2 3 4 5 6 7

Billing should be submitted to: ☐ DHHS ☐ DSN Board

You are hereby authorized to provide:

☐ **PERS Services**

☐ **PERS Installation (S516Ø)** **Start Date:** _____

☐ **PERS Monitoring (S5161)** **Start Date:** _____

Only the number of units rendered may be billed.
Please note: This nullifies any previous authorization to this provider for PERS Services.

PLEASE PRINT

DSN Board Name: _____ **Svc. Coord.:** _____

Address: _____

Phone: ( ) - ext. _____

Signature: _____ Date: _____

South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for Respite Services

Medicaid #: _____
1 2 3 4 5 6 7 8 9 10

Referred To: _____

_____

_____

Individuals Name	**Address**
Date of Birth	**City/State/Zip**

Prior Authorization Number: _____ Billing should be submitted to: ☐ DHHS ☐ DSN Board
1 2 3 4 5 6 7

You are hereby authorized to provide:

Respite Services:

Services will be provided in the following location:

☐ **Individual's Home** ☐ **Hourly (X7Ø28)** ☐ **Daily (X7Ø27)**
☐ **Caregiver's Home** (must be licensed by DDSN) ☐ **Hourly (X7Ø28)** ☐ **Daily (X7Ø27)**
☐ **Licensed Respite Care Facility (X7Ø027)**
☐ **ICF/MR (HØØ45)**
☐ **Nursing Facility (HØØ45)**
☐ **Hospital (HØØ45)**
☐ **CRCF (T1Ø2Ø)**

Start Date: _____

Authorized Total: _____ **Units per** _____

Only the number of units rendered may be billed.
Please note: This nullifies any previous authorization to this provider for respite services..

Comments: _____

_____

_____

_____

PLEASE PRINT

DSN Board Name: _____ Svc. Coord.: _____

Address: _____

Phone: ( ) - ext.

Signature: _____ Date: _____