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
	Duplicate Remittance Advice Request Form	09/2017
	Claim Reconsideration Form	11/2018
CMS-1500 (02/12)	Sample Claim Showing TPL Denial with NPI	02/2012
	Sample Remittance Advice (four pages)	04/2014
	Psychological Testing/Evaluation Example	05/2010
	Treatment Plan Example	04/2010
	Clinical Service Note Example	05/2010
	SCDHHS LIP Prior Authorization Request Form	12/2013
	SCDHHS Behavioral Health Referral and Feedback Form	12/2013
	LIPS Exceptions Fax Cover Sheet	03/2018
	LIPS Limit Exception Request Form	03/2018
	Corrective Action Plan	05/2021

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:

Q Void Q Void/Replace

Originator:

Q DHHS Q MCCS Q Provider Q MIVS

Reason For Adjustment: (Fill One Only)

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

For Agency Use Only

Analyst ID:

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

Comments:

Signature: _____ Date: _____

Phone: _____

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

DHHS Form 205 (01/08)

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'sName/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 andHuman Services
Dupli cat e 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.**

_____ _____
Authoriz ing Signatu re Date

SCDHHS (Revised09/01/17)

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: _____

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signat ure: _____ Date _____

Sample Claim Showing TPL Denial withNPI

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONALUNIFORMCLAIMCOMMITTEE (NUCC)02/12

PICA

1. MEDICARE [ ] MEDICAID [ ] TRICARE [ ] CHAMPVA [ ] PLAN [ ] OHR [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program n 1lm 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John A.

3. PATIENT'S BIRTH DATE SEX: 0"f 1947 M

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

5. PATIENT'S ADDRESS (No., Street): 123 Windy Lane

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY: Anytown

STATE: SC

ZIP CODE: 29999

TELEPHONE (Include Area Code):

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER: A123450A

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous): [ ] YES [8J NO

b. AUTO ACCIDENT? [ ] YES [8J NO PLACE (State):

c. OTHER ACCIDENT? [ ] YES [ ] NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO

9. OTHER INSURED'S POLICY OR GROUP NUMBER: 0.00

9a. OTHER INSURED'S DATE OF BIRTH MM DD YY: M F

9b. OTHER CLAIM ID (Designated by NUCC):

9c. INSURANCE PLAN NAME OR PROGRAM NAME: 401

9d.

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: Signature on File

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

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

24A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	24B. PLACE OF SERVICE	24C. EMG	24D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	24E. DIAGNOSIS POINTER	24F. $ CHARGES	24G. DAYS OR UNITS	24H. EPSDT Family Plan	24I. ID. QUAL.	24J. RENDERING PROVIDER ID. #
01 07	01 01 14	11		90804			60 :00	2		NPI	1234567890
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 SSN EIN: EIN

26. PATIENT'S ACCOUNT NO.: DOE1234

27. ACCEPT ASSIGNMENT? [8] YES [ ] NO

28. TOTAL CHARGE: $ 60 oo

29. AMOUNT PAID: $ 0i 00

30. Rsvd for NUCC Use: 60 :00

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.

33. BILLING PROVIDER INFO & PH#: (555) 5555555

JaneSmith, MD
11 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

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	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	MEDICAID PG TOT
$0.00	$286.46

CERTIFIED AMT	MEDICAID TOTAL
	0.00

CHECK TOTAL

STATUS CODES:

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

CHECK NUMBER

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. AB00080000 | DEPT OF HEALTH AND HUMAN SERVICES | SOUTH CAROLINA MEDICAID PROGRAM | PROFESSIONAL SERVICES REMITTANCE ADVICE | PAYMENT DATE 02/28/2014 | PAGE 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M 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

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	MEDICAID PG TOT
$0.00	$286.46

CERTIFIED AMT	MEDICAID TOTAL
	0.00

CHECK TOTAL

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

CHECK NUMBER

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	T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	ORG O D	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

0.00

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. AB11110000

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	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	YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER
-4338.95	0.00	0.00	

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Psychological Testing/Evaluation Example

CLIENT'S NAME: _____
MEDICAID NUMBER: _____
DIAGNOSIS CODE: _____

DATE	TIME	TEST	BILL TIME	UNITS
_____	_____	DIAGNOSTIC INTERVIEW	X MINS	X
_____	_____	WISC-III	Y MINS	Y
_____	_____	WPPSI-R	Z MINS	Z
_____	_____	WAIS-R	A MINS	A
_____	_____	KBIT	B MINS	B
_____	_____	PPVT-R	C MINS	C
_____	_____	BEERY DTVMI	*	*
_____	_____	BENDER-GESTALT	*	*
_____	_____	WIAT	*	*
_____	_____	WRAT-3	*	*
_____	_____	BURKS BEH RATING SCALE	*	*
_____	_____	ADDES-HOME VERSION	*	*
_____	_____	MMPI-A	*	*
_____	_____	MMPI-2	*	*
_____	_____	BECK DEPRESSION INV	*	*
_____	_____	BECK ANXIETY INV	*	*
_____	_____	BECK HOPELESSNESS SCALE	*	*
_____	_____	REYNOLDS CHILD DEP SCALE	*	*
_____	_____	REYNOLDS ADOL DEP SCALE	*	*
_____	_____	CHILDREN'S DEPRES. INV	*	*
_____	_____	REYNOLDS SUICIDE IDEA	*	*
_____	_____	RCMAS	*	*
_____	_____	ROBERTS APPERCEPTION	*	*
_____	_____	RORSCHACH INKBLOT	*	*
_____	_____	SENTENCE COMPLETION	*	*
_____	_____	KINETIC FAMILY DRAWING	*	*
_____	_____	FACES	*	*
_____	_____	ISEL	*	*
_____	_____	FAMILY EVAL SCALE	*	*
_____	_____	OTHER	*	*

PSYCHOLOGIST'S SIGNATURE: _____
DATE: _____

NOTE: THIS SAMPLE IS INTENDED AS A GUIDE TO ASSIST PROVIDERS IN IDENTIFYING MEDICAID DOCUMENTATION REQUIREMENTS. EACH PROVIDER SHOULD TAILOR HIS/HER DOCUMENTATION TO APPROPRIATELY REFLECT THE SERVICES RENDERED.

Revised 05/2010

INDIVIDUAL PLAN OF CARE	Beneficiary: Birth Date: / / **Medicaid ID#:** **Diagnosis:**

Reasons for Referral / Presenting Problems:

Goals/ Objectives	Specific Intervention	Criteria for Achievement	Frequency	Target Date	Completion Date
1				/ /	/ /
2.				/ /	/ /
3.				/ /	/ /
4.				/ /	/ /

Individual Plan of Care
(04/2010 Version)

Primary Caregiver Signature _____ Date _____ Authorized Clinical Staff Signature /Title _____ Signature Date _____

Other Caregiver Signature _____ Date _____ Beneficiary's Signature _____ Date _____

Clinical Service Note Example

CLIENT NAME: _____

DATE: _____

START TIME: _____

END TIME: _____

SERVICE RENDERED: _____

PLACE OF SERVICE: _____

1. Observations (Description of client affect):

2. Focus of session (as related to treatment goals):

3. Interventions:

4. Response –- client/family's response, input, reactions to interventions:

5. Plan –- plans for follow-up:

SIGNATURE (TITLE): _____

SIGNATURE DATE: _____

NOTE: THIS SAMPLE IS INTENDED AS A GUIDE TO ASSIST PROVIDERS IN IDENTIFYING MEDICAID DOCUMENTATION REQUIREMENTS. EACH PROVIDER SHOULD TAILOR HIS/HER DOCUMENTATION TO APPROPRIATELY AND ACCURATELY REFLECT THE SERVICES RENDERED.

SCDHHS LIP Prior Authorization Request Form

"KePRO/ SCDHHS now require any Medicaid Provider submitting Service Authorizations using their National Provider Identifier (NPI) or Atypical Provider Identifier (API) to provide their 9 digit zip code. If you do not know your 9 digit zip code then please visit: *http://zip4.usps.com/zip4/welcome.jsp"*

Submit fax request for Prior Authorization to: 1-855-300-0082 or call KePRO Customer Service at 1-855-326-5219. Web submissions can be made at: http://scdhhs.kepro.com. Requests may be submitted up to 30 days prior to scheduled procedures/ services, provided the Member is eligible.

1. D Initial Review D Continued Treatment Review D Retrospective Review D Change Request D Cancel					
2. Date of request: / /	3. Medicaid ID#:	**4.** Last Name:	5. First Name:	6. Date of Birth: / /	7. Gender: D Male D Female
8. NPI/ Requesting Service Provider Name, Address and fax number: 9 **digit zip code (mandatory):**				**10. DSM** IV: **Axis** I: **Axis** II: **Axis** III: **Axis IV:**	
9. NPI/Rendering Service Provider Name, Address and fax number: **9 digit zip code (mandatory):**					

11. Clinical Information:

For **Initial Review,** please submit Comprehensive Assessment along with this form.

For **Continued Treatment Review,** please submit most recent treatment plan and progress summary along with this form.

For **Psychological Testing** & **Evaluation,** please provide:

Reason for testing:

Referral source:

SCDHHS LIP Prior Authorization Request Form

Number	12. HCPCS/ CPT Code	13. Code Description	14. Units Requested	15. Frequency	16. Dates of Service (up to 6 months)	
					From (mm/dd /yyyy)	Thı (mm /dd /yyyy)
I.					/ /	/ /
2.					/ /	/ /
3.					/ /	/ /
4.					/ /	/ /
5.					/ /	/ /
6.					/ /	/ /
7.					/ /	/ /
8.					/ /	/ /
9.					/ /	/ /
10.					/ /	/ /
II.					/ /	/ /
12.					/ /	/ /
13.					/ /	/ /
14.					/ /	/ /
15.					/ /	/ /
16.					/ /	/ /
17.					/ /	/ /
18.					/ /	/ /

Created 12/2013

SCDHHS LIP Prior Authorization Request Form

This Prior Authorization Request fonn is required when requesting outpatient Initial Review, Continued Treatment Review, Retrospective Reviews, and Change or Cancel requests When submitting, please be certain that the cover sheet has a confidentiality notice included.

Please be certain that all infonnation blocks contain the requested infonnation. Incomplete fonns may result in the case being denied or returned via FAX for additional information. Only infonnation provided on KePRO fonns can be entered.

If KePRO detennines that your request meets appropriate coverage criteria guidelines, final approval is contingent upon passing remaining Member and Provider eligibility/emollment edits. The Prior Authorization (PA AUTH) number provided by KePRO will be provided to you via Fax and will be available to providers registered on the web-based program Atrezzo Connect (http://scdhhs.kepro.com). **This excludes weekends and holidays.**

1. **Request type:** Place a or **X** in the appropriate box.
   - **Initial Review:** Use for all new requests. Resubmitting a request after receiving a reject would be an initial request also.
   - **Continued Treatment Review:** A request for continued services (items) beyond the expiration of the previous Prior Authorization would be a Continued Treatment request.
   - **Change:** A change to a previously approved request; the provider may change the quantity of units, dollar amount approved (DME) or dates of service due to changes in delivery or rescheduling and appointment. If additional units are requested for the same dates of service, enter the total number of units needed and not only the increased amount. Any change request for increased services must include appropriate Justification. The provider may not submit a "change" request for any item that has been denied or is pended.
   - **Cancel:** Use to cancel all or some of the items under one Prior Authorization number. An example of canceling all lines is when an authorization is requested under the wrong Member number.
2. **Date of Request:** The date you are submitting the Prior Authorization request.
3. **Member Medicaid ID Number:** It is the provider's responsibility to ensure the Member's Medicaid number is valid. This should contain 10 digits
4. **Member Last Name:** Enter the Member's last name exactly as it appears on the Medicaid card.
5. **Member First Name:** Enter the Member's first name exactly as it appears on the Medicaid card.
6. **Date of Birth**: D ate of birth is critically important and should be in the fonnat of mm/dd/yyy y (for example, 02/25/2004).
7. **Gender:** Please place a or **X** to indicate the sex of the member.
8. **a. NPI/Requesting Service Provider Name and ID Number:** Enter the requesting/service provider name and National Provider Identifier (NPI).

   b. **9 digit Zip Code (Mandatory):** Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI number being submitted.
9. **a. NPI/Rendering Service Provider Name and ID Number:** Enter the referring provider name and National Provider Identifier (NPI) for the provider requesting the service.

   b. 9 digit Zip Code (Mandatory): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI number being submitted,
10. **DSM IV Code /Description:** Provide the primary diagnosis code and/or description indicating the reason for service(s).

    NOTE: First one listed will be marked as primary, unless otherwise indicated

Created 12/2013

SCDHHS LIP Prior Authorization Request Form

11. Clinical Information:

- For Initial Review, please submit comprehensive assessment along with this form
- For Continued Treatment Review, please submit most recent treatment plan and progress summary along with this form
- For Psychological Testing & Evaluation, please provide reason for testing and referral source.

12. **HCPCS/CPT:** Provider the HCPCS/CPT procedure code

13. **Code Description:** Provide the HCPCS/CPT procedure code description

14. **Units Requested:** Provider the number of services/visits requested. Knowledge of Interqual/SCDHHS criteria will be extremely helpful. Place numbers only in the Units requested block.

15. **Frequency:** Enter Frequency usage of Service requested.

16. **Dates of Service:** Indicate the planned service dates using the mm/dd/yyyy format. The From and Thru date must be completed even if they are the same. Prior authorizations will only be indicated for a 6 month period.

17. **Contact Name:** Enter the name of the person to contact if there are any questions regarding this fax form

18. **Contact Telephone Number:** Enter the phone number with the area code of the contact name

19. **Contact Fax number:** Enter the fax number with the area code to respond if there is an approval, denial, pend.

- **Note: Incomplete data may result in the request being denied; therefore, it is very important that this field be completed as thoroughly as possible with the pertinent medical/clinical information. The purpose of Prior Authorization is to validate that the service being requested is medically necessary and meets SCDHHS criteria for reimbursement. Prior Authorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the Member's continued Medicaid eligibility and the ongoing medical necessity for the service being provided.**

Created 12/2013

SCDHHS Behavioral Health Referral & Feedback Form

Physician Referral for Licensed Independent Practitioner Services

Date: ( ) **Initial** () **Follow-up**

Referring Physician Name: _____

Address: _____

(Street/PO Box) **City** **State** **Zip**

Fax: L__) **Phone:** (_____J _____

Patient's Name: _____ **DOB:** _____

Parent's Name (if minor): **Address:** _____ **Phone:**

Date(s) Patient Seen: _____

Reason(s) for Referral: _____

Any Specific Questions or Requests: _____

_____

Referring Physician's Printed Name/Signature

Thank you for evaluating this patient. To facilitate communication and treatment, please make copies of the following form to retain in the patient's record; complete a form after initial assessment; complete additional forms periodically during treatment (as indicated) and when treatment is terminated; and mail or fax completed form(s) to the physician listed above. This is not a request for copies of psychotherapy notes, which require a signed consent to release. Thank you for your collaboration.

Licensed Independent Practitioner's Report

Date(s) Patient Seen: _____

☐ Patient did not make appointment.
☐ Patient made an appointment but did not keep appointment.
☐ Patient not seen within 60 days.

Initial Diagnoses:

1. _____
2. _____
3. _____

Recommendations: _____

Medications Prescribed: _____

Follow-up Arranged or Provided by Consultant:

☐ Further diagnostic testing _____
☐ Individual psychotherapy
☐ Family psychotherapy
☐ Medication management
☐ Group psychotherapy
☐ Lab tests
☐ Return visit _____

Other Care Needed:

☐ Medication management by PCP
☐ Referrals recommended
☐ Follow-up recommended
☐ Other: _____

Name (type or print) Signature

FAX. to

\# ***Contact Person***

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

Henry McMaster GOVERNOR
Joshua O. Baker DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

FAX COVER SHEET

CONFIDENTIAL INFORMATION ENCLOSED

DATE:_____

TO: SCOHHS - Division of Behavioral Health

Attn: LIPs Exceptions

Fax# 803-255-8204

FROM:_____

Telephone#:_____

Contact Person:_____

Total Number of PagesTransmitted:____ (Including Cover Sheet)

COMMENTS:

Confidentiality Note

This message is intended for the use of the person or entity to which it is addressed and may contain information, including health information, that is privileged, confidential, and the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this in error, please notify us immediately and destroy the related message. Thank you.

Behavioral Health Services
P.O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2565 Fax (803) 255-8204

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Healthy Connections
MEDICAID,

Henry McMaster GOVERNOR
Joshua O. Baker DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Request for Service Limit Exception-Licensed Independent Providers

Beneficiary Information	
Name:	
Address:	
Medicaid ID#:	
Date of Birth:	

Provider Information	
Provider Name:	
Provider NPI:	
Address:	
City/ State/ Zip Code	
Phone Number	
Fax Number	

Diagnosis - Code/ Description:	/
Diagnosis - Code/ Description:	/
Diagnosis - Code/ Description:	/

Clinical Rationale for Request

Services Requested			
Procedure Code	**Service Name**	**# of Units Currently Authorized**	**# of Additional UnitsRequested**

LPHA Name: _____

Credentials: _____

Signature: _____

Date: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Robert M. Kerr DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

The Division of Behavioral Health Corrective Action Plan

Provider Name			
Contact Person		**Phone Number**	
Contact Email		**Fax Number**	
Date Submitted to SCDHHS			

Item # on Summary	Opportunity for Improvement	Corrective Action Steps to be Implemented	Person(s) Responsible for Implementation	Target Date to Implement Corrective Action	Completion Date for Implementation
1					
2					
3					
4					
5					

Additional questions to be addressed: