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	04/2014
	RBHS Provider Enrollment for LEA	04/2017
	Rehabilitative Services - Program Update Form	04/2017
	LEA RBHS Referral Form (four pages)	03/2018
	Parent/Caregiver/Guardian Agreement to Participate in Community Support Services (two pages)	04/2017
	MAPPS Documentation Points	
	MAPPS Screening Form Parent	07/2017
	MAPPS Screening Form Student (two pages)	07/2017
	MAPPS Case Plan	07/2017
	MAPPS Individual or Group Session Form (two pages)	02/2013
	LEA RBHS Exceptions Fax Cover Sheet	07/2018
	Request for Service Limit Exception—Local Education Agencies RBHS (two pages)	07/2018

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)	

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

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'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: or **Mail:**

803-252-0870

Post Office Box 101110
Columbia, SC 29211-9804

DHHS 931 – Updated February 2018

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
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: __________

Local Education Agency Services
Sample Claim Showing TPL Denial
with NPI

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA | CARRIER

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

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

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1999 SEX M [X] F

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

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 29999 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: A12345

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO [X]

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC): 0 00

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: 401

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC): 1

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 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

PATIENT AND INSURED INFORMATION

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI

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

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. 784 5 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								ZZ	1212121212
01 07 14 01 07 14	12		92508		108 00			NPI	1234567890
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: DOE1234

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

28. TOTAL CHARGE $ 108 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use 108 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. NPI b.

33. BILLING PROVIDER INFO & PH # (555) 5555555
ABC School District
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

SAMPLE

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							

STATUS CODES:

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

CERT. PG TOT	MEDICAID PG TOT
$0.00	$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.

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	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	MOD	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	MEDICAID PG TOT
$0.00	$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.		CLAIM ADJUSTMENTS	PAYMENT DATE	PAGE
AB11110000	DEPT OF HEALTH AND HUMAN SERVICES SOUTH CAROLINA MEDICAID PROGRAM		02/28/2014	2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	MOD	ORG CHECK DATE	ORIGINAL CCN
ABB222222	1405200077700000U				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-								

Field	Amount
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
	0.00
TO BE REFUNDED IN THE FUTURE	0.00
CHECK NUMBER	4197304

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.			PAYMENT DATE	PAGE
AB11110000	DEPT OF HEALTH AND HUMAN SERVICES SOUTH CAROLINA MEDICAID PROGRAM	ADJUSTMENTS	02/28/2014	3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME F I 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

Field	Amount
PROVDER INCENTIVE CREDIT AMOUNT	0.00
DEBIT BALANCE PRIOR TO THIS REMITTANCE	0.00
MEDICAID TOTAL	0.00
CERTIFIED AMT	0.00
(unlabeled)	0.00
TO BE REFUNDED IN THE FUTURE	0.00
ADJUSTMENTS	-4338.95
(unlabeled)	0.00
YOUR CURRENT DEBIT BALANCE	0.00
CHECK TOTAL	0.00
CHECK NUMBER	

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

To: Existing and New Local Education Agencies (LEA):

In order to ensure a smooth transition to Rehabilitative Behavioral Health Services (RBHS), please submit the following information to the Division of Behavioral Health as soon as possible:

1. LEA providers must submit a completed Attestation Statement, which confirms that the district will comply with all RBHS policies and procedures. This letter must be on the organization's letterhead and the statements to which the LEA provider is attesting may be found in the sample attestation letter attached. The attestation must be signed by the LEA Director or the Coordinator of the RBHS program.

2. Submit a list detailing the specific RBHS that your LEA intends to provide. The list of RBHS can be found in the LEA and RBHS Policy Manuals in Section 2 located on the SCDHHS website at www.scdhhs.gov.

3. Submit a list of the licensed professional staff employed that may be supervising or rendering the RBHS. The list must include the staff's name, credentials, professional license held (*e.g.,* LPC), and license number.

Please submit the above-referenced information to the following:

SCDHHS - Division of Behavioral Health
PO Box 8206
Columbia, SC 29202-8206
Fax: (803) 255-8204

Thank you for your participation.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

REHABILITATIVE BEHAVIORAL HEALTH SERVICES (RBHS) – PROGRAM UPDATE FORM

CURRENT PROVIDER INFORMATION	
Organization Name:	Business Director/CEO:
NPI Number:	Medicaid ID Number:

UPDATE ONLY NEW INFORMATION			
Provider Name Change:			
Business Director /CEO:		Clinical Director:	
Primary Practice Location/Street Address:		Suite/Unit #	
City:	State:	County:	ZIP+4:
County:		E-mail Address:	
Business Phone:	Fax Number:	Number (Cell/Other):	

BUSINESS MAILING ADDRESS *(If different from Primary Practice Location address)*				
Street Address:	City	State:	County:	ZIP+4:

LICENSURE AND ACCREDITATION *(Attach a copy of the most recent documentation.)*		
Business License Number:	Place of Municipality:	Expiration Date:
Accreditation Body:		Expiration Date:
Facility License:		Expiration Date:

CLINICAL SPECIALTY *(Check all that apply)*			
Children ☐	Adolescents ☐	Adults ☐	Families ☐

PROVIDER STAFF
(Background verification information must be submitted for all staff.)

Please list all staff, NPI #, job titles, professional license type and number, if applicable. All LPHA staff listed on the SC Medicaid provider enrollment/ordering/referring eligible provider listing must be enrolled in SC Medicaid. Attach additional sheets if necessary. Background Information must be maintained on site for all Staff. Review the current manual for details.

Name of Professional	Job Title	NPI	License Type	License Number

I acknowledge and agree to maintain on file original enrollment information along with required updated information and to make documents available to SCDHHS or its designee. Should the provider cease to operate, files must be retained for five years after final payment for Medicaid claims. If the Provider's Name, CEO or Business Director's name change, the provider must submit a new Disclosure of Ownership and Control Interest Statement Form and an updated W/9 Form with this form. Refer to the SCDHHS web site for the Disclosure form and call for the W/9 form.

I hereby certify that all statements made in this application are true and correct to the best of my knowledge and that Rehabilitative Services shall be provided in accordance with Medicaid policies and procedures.

Name of Business Director: *(Please print)*	**Signature Date:**	SCDHHS Use Only	
		Staff Name:	
Signature of Business Director:		Date:	Approved:

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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

Rehabilitative Behavioral Health Services (RBHS) Referral Form

This form shall be completed only by state agencies and submitted to private RBHS providers in accordance with HIPAA regulations as it contains Protected Health Information (PHI) of Medicaid beneficiaries.

Referring State Agency	☐ Department of Social Services Region: ☐ Department of Mental Health CMHC: ☐ Continuum of Care Region: ☐ Department of Alcohol and Other Drug Abuse Services Commission:	☐ Department of Disabilities and Special Needs Region: ☐ Department of Juvenile Justice Region: ☐ Department of Education District:

Provider (Referred to)				**NPI**	
Address					
City		**State**		**Zip**	
Phone Number		**Fax Number**			

Beneficiary Name					
Legally Responsible Person(s)					
Address					
City		**State**		**Zip**	
Date of Birth		**Gender**	☐ Female	☐ Male	
Social Security Number (last 4 digits)		**Medicaid Number**			

Medical Necessity	
Diagnosis – Code / Description	/
Diagnosis – Code / Description	/
Diagnosis – Code / Description	/
Clinical Rationale for Rehabilitative Behavioral Health Services Recommendations	

I recommend that the above-named Medicaid beneficiary receive Rehabilitative Behavioral Health Services. This beneficiary meets the Medical Necessity criteria for services as evidenced by a mental health and/or substance use disorder from the current edition of the DSM or the ICD.

Name of LPHA: ______________________________ Credentials: ___________________

Signature of LPHA: ______________________________ Date: ______________

Recommendations for Rehabilitative Behavioral Health Services							
	Service Description	Procedure Code	Unit	Total Units Authorized	Start Date	End Date	Specific Frequency (# of units per day, # of days per week)
SCREENING AND ASSESSMENT SERVICES							
☐	Behavioral Health Screening	H0002	15 minutes				
☐	Psychiatric Diagnostic Assessment without Medical Services - Initial	90791	Encounter				
☐	Psychiatric Diagnostic Assessment with Medical Services – Initial	90792	Encounter				
☐	Mental Health Comprehensive Diagnostic Assessment – Follow–up	H0031	Encounter				
☐	Psychological Testing / Evaluation	96101	60 minutes				
☐	Comprehensive Evaluation – Initial	H2000	Encounter (average of 3 hours)				
☐	Comprehensive Evaluation – Follow up	H0031	Encounter				
SERVICE PLAN DEVELOPMENT							
☐	Mental Health Service Plan Development (Non-physician)	H0032	15 minutes				
☐	Service Plan Development (Team Conference w/ Client/Family)	99366	Encounter (minimum 30 minutes)				
☐	Service Plan Development (Team Conference w/o Client/Family)	99367	Encounter (minimum 30 minutes)				
CORE TREATMENT – PSYCHOTHERAPY AND COUNSELING SERVICES							
☐	Individual Psychotherapy	90832	30 minutes				
☐	Individual Psychotherapy	90834	45 minutes				

Recommendations for Rehabilitative Behavioral Health Services							
	Service Description	Procedure Code	Unit	Total Units Authorized	Start Date	End Date	Specific Frequency (# of units per day, # of days per week)
☐	Individual Psychotherapy	90837	60+ minutes				
☐	Group Psychotherapy	90853	60+ minutes				
☐	Family Psychotherapy w/o Client	90846	60+ minutes				
☐	Family Psychotherapy w/ Client	90847	60+ minutes				
☐	Multiple Family Group Psychotherapy	90849	60+ minutes				
☐	Crisis Management	H2011	15 minutes				
☐	Medication Management	H0034	15 minutes				
COMMUNITY SUPPORT SERVICES							
☐	Psychosocial Rehabilitation Service (PRS)	H2017	15 minutes				
☐	Behavior Modification (B-Mod)	H2014	15 minutes				
☐	Family Support (FS)	S9482	15 minutes				
☐	Therapeutic Child Care	H2037	15 minutes				
☐	Community Integration Services	H2030	15 minutes				

Note: Prior authorized periods of time for Community Support Services are as follows:

- Beneficiaries ages 0 to 21: Up to 90 days
- Beneficiaries age 22 and older: Up to 180 days

State Agency Representative Authorization (optional, per internal state agency processes)

Name: ___________________________________

Phone: ______________________

Title: ____________________________________

Signature: _______________________________ Date: ______________

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Rehabilitative Behavioral Health Services (RBHS)
Parent/Caregiver/Guardian Agreement to Participate in Community Support Services

Name of Beneficiary: Date of Birth:
Medicaid Number:

What are Rehabilitative Behavioral Health Services (RBHS) Community Support Services? RBHS Community Support Services help the child and you develop skills to live successfully in the home and community. Services include Psychosocial Rehabilitation Services (PRS), Behavior Modification (B-Mod), Family Support (FS), and Therapeutic Child Care (TCC). These services are for youth with mental health and/or substance use disorders. Services are not for summer camps, after-school programs, recreation or mentoring services.

The child has been diagnosed with the following mental health and/or substance use disorder(s).
Please list both code and description (*your provider is required to explain the diagnoses to you*):

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

The provider has recommended the following services (check all that apply):

☐ Psychosocial Rehabilitation Services (PRS): PRS helps the child build skills to successfully live in the home and community, succeed in school and/or work and build healthy relationships with family, friends and others.

☐ Behavior Modification (B-Mod): B-Mod helps the child to reduce undesirable behaviors. You and the child will receive training in managing these behaviors. This training will help the child replace undesired behaviors with suitable ones, during and after treatment.

☐ Family Support (FS): FS helps you to serve as an active member of the child's treatment team and improve your ability to care for the child's behavioral health needs. FS can connect you to groups that support youth with mental health needs. FS may also encourage you to participate in other types of groups which may be helpful to you.

☐ Therapeutic Child Care (TCC): TCC helps children with severe emotional and/or behavioral problems. You and your child will work on your relationship in order to reduce the impact of traumatic experiences. TCC helps children to gain social and emotional skills needed to interact well with parents, adults, and playmates.

What will be asked of you?
You will be asked to:

- Participate in treatment planning meetings
- Participate in training sessions where you will be taught skills to help the child like modeling, redirecting, coaching, and reinforcing
- Monitor the child's behaviors and report to the treatment team
- Based on the child's needs, you may be asked to participate in other activities the treatment team recommends

What can you expect of ________________________ staff?
(Provider Name)

- Explain all treatments in language you will understand
- Explain all known benefits and risks of the treatment in a way you will understand

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
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MEDICAID

Name of Beneficiary: Date of Birth:
Medicaid Number:

- Treat you and all your family members with respect
- Treat you as an essential member of the treatment team
- Work with you to schedule visits, and notify you in advance if the provider must cancel or reschedule
- Discuss the child's progress with you during every visit
- Answer any questions you have regarding the child's treatment
- Respond to your concerns in a timely and respectful manner
- Provide information about community resources

Because your participation is a key to success, you will be asked to confirm your willingness to participate in these services every ninety (90) days.

By signing this form:

- I, ______________________________, agree to participate in the following recommended RBHS
  (Name of Parent/Caregiver/Guardian)
  Community Support Services:

  ☐ Psychosocial Rehabilitation Services (PRS)
  ☐ Behavior Modification (B-Mod)
  ☐ Family Support (FS)
  ☐ Therapeutic Child Care (TCC)

- I give permission for ______________________________, to participate in the following
  (Name of Beneficiary)
  recommended RBHS Community Support Services:

  ☐ Psychosocial Rehabilitation Services (PRS)
  ☐ Behavior Modification (B-Mod)
  ☐ Family Support (FS)
  ☐ Therapeutic Child Care (TCC)

- I agree the provider has explained the mental health and/or substance use disorder diagnoses to me.

I understand that at any time I can let staff know, either verbally in or writing, that I (a) no longer wish to participate in these services and/or (b) no longer wish for the child to receive these services. I also understand that I can end these services at any time, unless participation is court-ordered.

______________________________ ______________________________
Printed Name of Parent/Caregiver/Guardian Relationship to Beneficiary

______________________________ ______________________________
Signature of Parent/Caregiver/Guardian Date

____
Printed Name of Staff

____
Name of Provider

______________________________ ______________________________
Signature and Credentials of Staff Date

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES

DOCUMENTATION POINTS

S9445-FP —Patient Education, not otherwise classified, non-physician provider, Individual, per session. Address a minimum of three (3) documentation points from the list below plus the client's response.

S9446-FP —Patient Education, not otherwise classified, non-physician provider, Group, per session. Address a minimum of five (5) documentation points from the list below plus the client's response.

1) **Discussion of adolescent development as it relates to human growth, development, sexuality, and pregnancy prevention**
2) **Information on the importance of family planning, responsible sexual behavior, and its effect on overall reproductive health**
3) **Discussion of the benefits of abstinence as it relates to normal growth and development for teens and pregnancy prevention**
4) **Discussion of the benefits of delaying sexual activity as it relates to healthier birth outcomes and pregnancy prevention**
5) **Discussion of the benefits of delaying pregnancy**
6) **Discussion of the long- and short-term health risks related to early sexual activity**
7) **Discussion of birth control methods, including abstinence, and the options available**
8) **Instruction on the proper and appropriate use of birth control methods**
9) **Importance of compliance with prescribed family planning methods and follow-up medical visits**
10) **Information on the benefits and risks of long-term birth control methods**
11) **Identification of family planning problems**
12) **Discussion of the availability of other health care resources related to family planning**
13) **Information on STDs and prevention of STDs as it relates to reproductive health and family planning**

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

.SCREENING FORM PARENT

1. Name of Participant: (First, Middle Initial, Last)____
2. Age of Participant: _______________ Date of Birth: ___________________ Gender: ☐Male ☐ Female
3. Social Security #: ___________________Medicaid # _____________________ Patient Account: _______
4. Eligibility: ☐ Medicaid ☐ Foster Care ☐ Child Protective Services
5. Date of Assessment: (Month, Date, Year) _____________________________________
6. Racial or Ethnic Background of Participant: (Check one)

   ☐ White or Anglo, Not of Hispanic Origin ☐ Black, Not of Hispanic Origin ☐ Hispanic

   ☐ American Indian ☐ Asian or Pacific Islander ☐ Other: ___________________________
7. Special needs of the participant: (Check All That Apply)

   ☐ None ☐ Attention Deficit Disorder (ADD) ☐ Learning Disability ☐ Emotionally Handicapped

   ☐ Other: (Specify) ____
8. Does the participant have a primary medical care provider? If so, name and address:

   ____

   Managed Care Plan __________________________
9. Parent/Guardian: ____ SSN: ______________________
10. Employment Status of the Mother/Guardian: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Other: _____
11. Employment Status of the Father/Guardian: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Other: _____
12. Marital Status of Parent (s): ☐ Married ☐ Single ☐ Separated ☐ Widowed ☐ Other:_______

Environmental

13. Address of Participant:

Street Address:		
Mailing Address: (If Different from Street Address)		
City/Town:	State:	Zip Code:
Telephone: (Home):	Other:	☐ No Telephone

14. Household Members:

Name	Relationship to Participant	Age	Grade	School or Place of Employment of Household Members

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

.SCREENING FORM STUDENT

1. Name of Participant: (First, Middle Initial, Last) ______________________________
2. Age of Participant: __________ Date of Birth: ____________ Gender: □ Male □ Female
3. Social Security #: ______________ Medicaid #: ____________________ Patient Account: _________
4. Date of Assessment: (Month, Date, Year) ______________________________
5. Access to Transportation: (Check One): □ Yes □ No Comment ______________________

Referral/ Health Risk Factors

6. What was the referral source for MAPPS? (Check One)
   □ DSS □ Teacher □ Counselor □ Relative □ Friend □ Other: (Specify) ____________________
7. Referral Risk Factor(s): (Explain in Narrative)
   □ Participant is a Teen Parent □ Participant is Sexually Active □ Participant has a history of Sexual Abuse
   □ Peer Pressure to engage in sexual activity is identified as a problem by the adolescent (give details)
8. Is the participant currently sexually active? □ Yes □ No
   If no, has the participant ever been sexually active? □ Yes □ No
9. Has the participant ever been an expecting parent (abortion/fetal death)? □ Yes □ No
10. Has the participant ever used a birth control method? □ Yes □ No
    Method Used: (Check All That Apply)
    □ Birth Control Pills □ Condom □ Depo-Provera Shot □ Diaphragm □ IUD □ Rhythm
    □ Other: ____
11. Does the participant understand or know the health risks associated with having sex? □ Yes □ No
12. Has the participant ever had a STD? □ Yes □ No If yes, specify: ______________________
13. Has the participant ever experimented with alcohol, tobacco, and/or other drugs? □ Yes □ No
    If yes, what kind? ____

Activities

14. Does the participant engage in extracurricular activities? □ Yes □ No
    If yes, list activities: ____
15. How does the participant spend his/her free time?
    After School: ____
    Weekends: ____
16. Do household rules cause any conflict between the parent/guardian and the participant? □ Yes □ No
    If yes, explain: ____
    ____
    What are the parent/guardian's and the participant's feelings about the household rules? ____________
    ____
17. Does participant have friend? □ Yes □ No
    If yes, gender and age? ____

When they spend time together, what do they do? ____

How does the participant get along with friends? ____

18. How does the participant get along with adults? (Including teachers) ______________________________

____

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES

CASE PLAN

Treatment Protocol (T1023-FP)

Participant's Name ______________________________**Medicaid Number** ________________________

Needs Statement: ____
____
____
____
____
____

Plan of Care: ____
____
____
____
____

Goals and Objectives	Frequency	Completion Date*

* A Progress Report must be sent to the Primary Care Physician when services are completed.

This ICP will be reviewed on (6 months from ICP date): _____________________________

Participant's Signature:____ **Date:** _______________

Parent/Legal Guardian's Signature:______________________________ **Date:** _______________

Provider of Service: ____ **Date:** _______________
(Licensed/Certified Signature and Title)

Units: ______________

Date Reviewed: ________________________________ (Review case plan during Individual Session)

Progress Report prepared by: ____ **Date:** ______________

Mailed to: ____ **Date:** ______________
(Primary Care Physician)

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES

Individual or Group Session Form

Participant's Name: ____

Date of Service: ____________________ **DOB**: ________________ **Age**: _______

Medicaid Number: _______________________ ☐ **Individual** ☐ **Group**

Place: **Units of Service:** ______________________

☐ Participant's Home ☐ Office ☐ School ☐ Other

Risk Factors: (Check All That Apply)

☐ Participant is a Teen Parent ☐ Peer Pressure to engage in sexual activity is identified as a problem by the adolescent

☐ Participant is sexually and/or has a history of sexual abuse

A narrative description of services must be provided. Documentation of session must support time billed and points discussed. Check the Documentation Points discussed:

☐ 1. Discussion of adolescent development as it relates to human growth, development, sexuality, and pregnancy prevention

☐ 2. Information on the importance of family planning, responsible sexual behavior, and its affect on overall reproductive health

☐ 3. Discussion of the benefits of abstinence as it relates to normal growth and development for teens and pregnancy prevention

☐ 4. Discussion of the benefits of delaying sexual activity as it relates to healthier birth outcomes and pregnancy prevention

☐ 5. Discussion of the benefits of delaying pregnancy

☐ 6. Discussion of the long and short-term health risks related to early sexual activity

☐ 7. Discussion of birth control methods, including abstinence, and the options available

☐ 8. Instruction on the proper and appropriate use of birth control methods

☐ 9. Importance of compliance with prescribed family planning methods and follow up medical visits

☐ 10. Information on the benefits and risks of long term birth control methods

☐ 11. Identification of family planning problems

☐ 12. Discussion of the availability of other health care resources related to family planning

☐ 13. Information on STDs and prevention of STDs as it relates to reproductive health and family planning

PATIENT EDUCATION

☐ Individual **☐ Group**

Participant's Name: ____

Date of Service: ____________________ **Medicaid Number**: ______________________

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Service Provider

SIGNATURE (and credentials): ______________________________________ Date: ____________

Supervisor

CO-SIGNATURE (and credentials) ____________________________________ Date: ____________

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

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

FAX COVER SHEET

CONFIDENTIAL INFORMATION ENCLOSED

DATE:________________

TO: SCDHHS – Division of Behavioral Health

Attn: LEA RBHS Exceptions

Fax # 803-255-8204

FROM: ________________________________

Telephone #: __________________________

Contact Person: ______________________________________

Total Number of Pages Transmitted: ______ (Including Cover Sheet)

COMMENTS:

Confidentiality Note

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

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

Request for Service Limit Exception—Local Education Agencies RBHS

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 (If applicable)	# of Additional Units Requested

LPHA Name: ______________________________________

Credentials: ______________________________________

Signature: ______________________________________

Date: ____________________