

**South Carolina**  
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**Post Office Box 8206**  
**Columbia, South Carolina 29202-8206**  
[www.scdhhs.gov](http://www.scdhhs.gov)

December 9, 2010

ALL

## MEDICAID BULLETIN

**TO: Providers Indicated**

**SUBJECT: Requests for Duplicate Remittance Packages**

Effective immediately, the South Carolina Department of Health and Human Services (SCDHHS) will begin charging for requests of duplicate remittance advice(s) including Edit Correction Forms (ECF).

Currently, providers have access to their remittance advice(s) and associated ECFs through the South Carolina Medicaid Web Based Claims Submission Tool (Web Tool). Through the Web Tool, providers can view, save, and print their own remittance advice(s) but not a remittance advice belonging to another provider. Remittance advices and ECFs for the most recent twenty five (25) weeks are available.

For a remittance advice greater than 25 weeks, providers must use the Remittance Advice Request form. Providers will have the option of requesting the complete remittance package, the remittance pages only, or the ECF pages only. The charges associated with the request will be deducted from a future remittance advice and will appear as a debit adjustment. Charges for a duplicate remittance package are as follows:

Request Processing Fee		\$20.00__
Pages copied at .20 per page	_____ Pages	\$_____
Total Amount Due SCDHHS:		\$_____

Attached to this bulletin is a copy of the Duplicate Remittance Request form. This form can also be found in the Forms Appendix of all Program Manuals on our website at [www.scdhhs.gov](http://www.scdhhs.gov).

Please contact your respective Program Manager if you have questions regarding this policy. Thank you for your continued support and participation in the South Carolina Medicaid Program.

/S/  
Emma Forkner  
Director

### Attachment

**Note:** To receive Medicaid bulletins by email, please register at <http://bulletin.scdhhs.gov/>. To sign up for Electronic Funds Transfer of your Medicaid payment, please go to <http://www.dhhs.state.sc.us/dhhsnew/hipaa/index.asp> and select " Electronic Funds Transfer (EFT)" for instructions

# South Carolina Department of Health and Human Services Duplicate Remittance 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 your South Carolina Medicaid program manager for instructions on submission of your request via program facsimile number or mailing address.

**1. Provider Name:** \_\_\_\_\_

**2. Medicaid Legacy Provider #** \_\_\_\_\_ (Six Characters)

**NPI#** \_\_\_\_\_ **& Taxonomy** \_\_\_\_\_

**3. Person to Contact:** \_\_\_\_\_ **4. Telephone Number:** \_\_\_\_\_

**5. Requesting:**

**Complete  
Remittance  
Package**

**Remittance Pages  
Only**

**Edit Correction  
Pages Only**

**6. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**7. Street Address for delivery of request:**

**Street:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

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**