

ATTACHMENT A

**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Request for Approval of Non-Covered Medical Expenses**

FROM:

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

(Name & Address of Facility)

TO:

South Carolina Department of Health and Human Services  
Division of Medicaid Policy and Planning  
Post Office Box 8206  
Columbia, South Carolina 29202-8206

Regarding:

\_\_\_\_\_  
(Beneficiary's Name)

\_\_\_\_\_  
(Medicaid ID#)

**Part I**

(To be completed by facility)

Description of item/service received:

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

Reason item/service is a questionable deduction or needs prior approval:

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

Cost of item/service:

\_\_\_\_\_

**Part II**

(To be completed by SCDHHS)

Item/Service approved for deduction:

Yes       No (check one)

If Yes, \$ \_\_\_\_\_ may be deducted.

Signature: \_\_\_\_\_  
Division of Medicaid Policy and Planning

Date: \_\_\_\_\_