

Healthy Connections

PROVIDER MANUAL



Provider Enrollment

Established December 3, 2012
Updated January 1, 2019

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Healthy Connections
MEDICAID



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AGREEMENTS AND FORMS

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
01-01-19	1	7	Updated Application Fee
11-01-18	Appendix 1	55-56	Updated edit codes 906 and 907
11-01-18	Forms	-	Updated Claim Reconsideration Form
10-01-18	Change Control Record	1	Updated Forms section to change descriptions for dates 01-01-18, 03-01-18, 04-01-17, and 06-01-17
03-01-18	Forms	-	Updated SCDHHS letterhead on Hardship Waiver Exception Request
01-01-18	1	7	Updated Application Fee
01-01-18	Forms	-	Updated SCDHHS letterhead on Hardship Waiver Exception Request
08-02-17	Forms	-	Updated Electronic Funds Transfer (EFT)
08-01-17	Forms	-	Updated Participation and Payment Agreement
07-01-17	2	8 16	<ul style="list-style-type: none"> • Updated Criminal Background Checks • Updated Adding Provider Location
06-01-17	Forms	-	Updated SCDHHS letterhead on Hardship Waiver Exception Request
04-01-17	Forms	-	Updated SCDHHS letterhead on Hardship Waiver Exception Request
03-01-17	Forms	-	Added Preceptor-Protocol Agreement Form
01-01-17	1	7	Updated Application Fee
11-01-16	1	5	Updated Provider Enrollment Updates
08-01-16	1	7	Updated Application Fee
08-01-16	2	9-10 12	<ul style="list-style-type: none"> • Updated Federal/State Database Checks • Updated Provider Screening Level – Limited
02-01-16	1	9	Corrected typo

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-16	2	18	Updated Provider Appeals
02-01-16	3	1-10	Updated Program Integrity
02-01-16	Forms	-	Updated Participation and Payment Agreement
01-01-16	1	7	Updated Application Fee
12-01-15	Cover	-	December 1, 2015 - Replaced manual cover
09-01-15	1	4	Updated Provider Enrollment Notification
08-01-15	1	1 4 4 5 6 6 9	Updated the following sections: <ul style="list-style-type: none"> • Provider Participation • Enrollment Types • Provider Enrollment Notification • Interactive Web Application • SC Gov Enterprise Payment Systems • Application Fee • Requesting A Hardship Exception
08-01-15	Forms		<ul style="list-style-type: none"> • Renamed section heading to Agreements and Forms • Added Participation and Payment Agreement
04-01-15	Forms		Updated the following forms: <ul style="list-style-type: none"> • Hardship Waiver Exception Request • Request for Taxpayer Identification Number and Certification
01-01-15	1	6	Updated Application
01-01-15	Forms		Updated Hardship Waiver Exception Request form
12-01-14	1	1	Updated Provider Participation to reflect Medicaid Bulletin dated October 31, 2014 – Update to Section 1 of All Provider Manuals
04-01-14	3	1 2	Updated the following sections: <ul style="list-style-type: none"> • Fraud • Referrals to the Medicaid Fraud Control Unit
03-01-14	General Table of	1	Removed Appendices entries

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
	Contents		
01-01-14	1	5 10-11	Updated the following sections: <ul style="list-style-type: none"> • Application Fee • Electronic Funds Transfer (EFT)
01-01-14	Forms		Updated the following forms <ul style="list-style-type: none"> • Electronic Funds Transfer (EFT) • Trading Partner Agreement forms
09-01-13	Forms		<ul style="list-style-type: none"> • Revised Trading Partner Agreement and Trading Partner Enrollment form • Add Trading Partner Agreement for Vendor and Clearinghouses form
07-01-13	1	4 4 -	<ul style="list-style-type: none"> • Updated the following sections: <ul style="list-style-type: none"> ○ Enrollment Types ○ Interactive Web Application • Added the following sections: <ul style="list-style-type: none"> ○ Provider Enrollment Notification ○ Provider Enrollment Updates • Formatting/style changes throughout document
07-01-13	2	6 7 8 9-10	<ul style="list-style-type: none"> • Added “Rehabilitative Behavioral Health” to services provided by LIP • Added “Behavioral” to all occurrence of Rehabilitative Health Services • Changed Provider License, Certifications and/or Credentials heading to Verification of Provider License, Certifications and/or Credentials • Updated Federal/State Database Checks
02-01-13	2	8	Removed the following professionals from the list of approved LEA LPHAs for school-based rehabilitative therapy services: Licensed Practical Nurse and Licensed Psycho-educational Specialist
01-01-13	1	5	Updated application fee for calendar year 2013

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

PROVIDER PARTICIPATION

The Medicaid program administered by the South Carolina Department of Health and Human Services (SCDHHS) is considered to be a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

Provider participation in the Medicaid program is voluntary. To participate in the Medicaid program, a provider must meet the following requirements:

- Complete and submit an online provider enrollment application and submit any necessary supporting documentation. Certain provider types, depending on the type of service provided, are required to sign a contractual agreement in addition to the provider enrollment agreement.
- Accept the terms and conditions of the online application by electronic signature, indicating the provider's agreement to the contents of the participation and payment agreement, the Electronic Funds Transfer Agreement, W-9 and Trading Partner Agreement.
- Be licensed by the appropriate licensing body, certified by the standard-setting agency, and/or other pre-contractual approval processes established by SCDHHS.
- If eligible, obtain a National Provider Identifier (NPI) and share it with SCDHHS. Refer to <https://nppes.cms.hhs.gov> for additional information about obtaining an NPI.
- Be enrolled in the South Carolina Medicaid program and receive official notification of enrollment. This also applies to providers wanting to contract with one or all of the South Carolina Medicaid managed care organizations.
- Continuously meet South Carolina licensure and/or certification requirements of their respective professions or boards in order to maintain Medicaid enrollment.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

PROVIDER PARTICIPATION (CONT'D.)

- Comply with all federal and state laws and regulations currently in effect as well as all policies, procedures, and standards required by the Medicaid program.
- Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside the United States

All rendering providers must be enrolled in the Medicaid program. Enrolled providers are prohibited from allowing non-enrolled providers use of their Medicaid ID number/NPI number in order for non-participating providers to be reimbursed for services. Claims for Medicaid reimbursement submitted under a Medicaid ID number or NPI number other than that of the ordering, referring or rendering provider will be considered invalid and may result in a program integrity investigation and/or recoupment of the Medicaid payment. As required by 42 CFR 455.440, all claims submitted for payment for items and services that were ordered or referred must contain the NPI of the physician or other professional who ordered or referred such items or services.

A provider must immediately report any change in enrollment or contractual information (*e.g.*, mailing or payment address, physical location, telephone number, specialty information, change in group affiliation, ownership, etc.) to SCDHHS Provider Service Center (PSC) within thirty (30) days of the change. Failure to report this change of information promptly could result in delay of payment and/or termination of enrollment. Mailing information is located in the Correspondence and Inquiries section.

NON-DISCRIMINATION

All Medicaid providers are required to comply with the following laws and regulations:

- Title VI of the Civil Rights Act of 1964 that prohibits any discrimination due to race, color, or national origin (45 CFR Part 80)
- Title V, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 that prohibits discrimination on the basis of handicap (45 CFR Part 84)

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

NON-DISCRIMINATION (CONT'D.)

- The Americans with Disabilities Act of 1990 that prohibits discrimination on the basis of disability (28 CFR Parts 35 & 36)
- The Age Discrimination Act of 1975 that prohibits discrimination on the basis of age (45 CFR Parts 90 and 91)

ENROLLMENT TYPES

Individuals, atypical individuals, organizations, atypical organizations, ordering/referring providers as well as providers adding a new location can enroll in Medicaid.

Individual Provider is a person who provides health services to Medicaid beneficiaries. An individual may bill independently for services or may have an affiliation with an organization. Individuals enrolling in SCDHHS' Medicaid program are required to submit their Social Security Number (SSN) and NPI upon enrollment.

Individual/Sole Proprietor Provider is a person who provides health services to Medicaid beneficiaries. An individual may bill independently for services or may have an affiliation with an organization. Individual/Sole Proprietors enrolling in SCDHHS' Medicaid program are required to submit their Social Security Number (SSN), Employer Identification Number (EIN) and NPI upon enrollment.

Atypical Individual Provider is a person who provides non-health related services to Medicaid beneficiaries. An atypical individual provider may bill independently for services or may have an affiliation with an organization. Atypical Individuals enrolling in SCDHHS' Medicaid program are required to submit their Social Security Number (SSN). **Note:** This person may or may not be eligible for an NPI and NPI is not required.

Organizations are any entities, agencies, facilities, institutions, clinics or group of providers that provide health services to Medicaid beneficiaries. An organization may bill independently for services performed or may be an affiliation of individual providers. Organizations enrolling in SCDHHS' Medicaid program are required to submit their EIN and NPI.

Atypical Organizations are any entities, agencies, facilities, institutions, clinics or group of providers that

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

ENROLLMENT TYPES (CONT'D.)

provide non-health related services to Medicaid beneficiaries. An organization may bill independently for services performed or may be an affiliation of individual providers. Organizations enrolling in SCDHHS' Medicaid program are required to submit their EIN and may or may not be eligible for an NPI and NPI is not required.

Note: During the online enrollment process, organizations cannot affiliate individuals to their group. It is the responsibility of the individual provider to affiliate with a group. An affiliation cannot occur until the organization is enrolled.

Ordering/Referring Providers order services and/or refer Medicaid beneficiaries for services. Ordering/Referring only providers do not submit claims to SCDHHS for payment. However, the rendering provider will be required to include the ordering/referring NPI on all claims.

Add a Location is for entities, agencies, facilities, institutions, clinics or group of providers enrolled with a unique combination of an EIN and NPI and need to add a location to a previously existing enrollment. The location being added must operate under the same EIN/NPI as the previously enrolled location. When the EIN/NPI is not the same as the previously enrolled location, the provider must complete a new enrollment for that location.

Revalidation Request is for participating providers that must have their enrollment information revalidated upon notification. The enrolled information will be verified and screened to ensure compliance according to the Affordable Care Act of the provider enrollment and screening regulations published by the Centers for Medicare and Medicaid services.

PROVIDER ENROLLMENT NOTIFICATION

Enrollment applications will be processed within thirty (30) business days from the date of receipt. The thirty (30) business day timeframe may be exceeded for enrollment applications that: require additional information, a site visit, a contractual agreement or submitted with sanction information. SCDHHS will notify the provider upon approval, denial or rejection of an enrollment application. The provider will also be notified if additional information is required. A provider that is

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

PROVIDER ENROLLMENT NOTIFICATION (CONT'D.)

Terminated for Cause will receive notification via certified mail. Please refer to Section 2 of this manual for additional information regarding denials, rejections and terminations for cause.

PROVIDER ENROLLMENT UPDATES

SCDHHS requires a provider to report any change in enrollment or contractual information (*e.g.*, mailing or payment address, physical location, telephone number, specialty information, change in group affiliation, ownership, etc.) to PSC within thirty (30) days of the change. This updated information must be submitted on business letterhead with an authorized printed name and signature. Updates can be submitted via fax or mail. The provider will not be able to make any updates over the telephone. Updates will be processed within ten (10) days of receipt. Please refer to Correspondence and Inquiries for Provider Enrollment contact information.

INTERACTIVE WEB APPLICATION

Providers enrolling in South Carolina Medicaid will enroll utilizing an interactive web application. This application is an automated provider enrollment web-based application that will enable prospective South Carolina Medicaid providers to utilize a paperless application process. This new process will ensure the security of provider's information and is accessible from any computer that has internet access. The web-based application will enable:

- New enrollment for individuals and organizations
- Ordering/referring provider enrollment
- Add a new location(s) to an existing enrollment
- Revalidation for individuals and organizations

Refer to <http://provider.scdhhs.gov> to access the web-based application online. Once you have completed minimal required information, you will receive a Reference ID number. Emails containing the Reference ID number will be sent to both the authorized individual and the provider. Use this Reference ID number to retrieve and complete an in-process application. The in-process application must be submitted within thirty (30) days. After thirty (30) days, the in-process application will be purged and you must start the enrollment process over and be assigned another Reference ID number.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**PROVIDER ENROLLMENT****INTERACTIVE WEB
APPLICATION (CONT'D.)**

For an enrollment status update, contact the Provider Service Center (PSC) at 1-888-289-0709, option 4 for Provider Enrollment.

**SC.GOV ENTERPRISE
PAYMENT SYSTEM**

SCDHHS has contracted with SC.GOV Enterprise Payment System to facilitate collection of the application fee. SCDHHS will collect the applicable application fee prior to executing a provider agreement whether upon an initial enrollment, reactivation, revalidation or enrollment to add a new practice location.

SC.GOV is operated by South Carolina Interactive, LLC (SCI) and is a web-based application that allows you to make online payments to SCDHHS by electronic check, credit card, or by debit from your checking or savings account. SC. GOV accepts Visa, MasterCard, American Express and Discover. Paper checks are not accepted.

SC.GOV uses RSA encryption to protect your transaction information. At the end of submitting your payment, you will see a confirmation screen indicating your payment was successfully submitted. This confirmation screen is your receipt and should be printed for your records. You will also receive a copy of this receipt in your email account if you provided an email address along with your cardholder and provider information. SC.GOV transactions will appear on your statement with the description "SC.GOV" to help identify the payment.

Refer to <http://provider.scdhhs.gov> and search for Online Application Fee Payment to access the SC.GOV Enterprise Payment System online.

APPLICATION FEE

The enrollment application fee must be collected prior to executing a provider agreement whether upon an initial enrollment, reactivation, revalidation or an enrollment to add a new practice location. The enrollment application fee is applicable to providers that the Centers for Medicare & Medicaid Services (CMS) has identified as institutional providers. South Carolina Healthy Connections Medicaid recognizes and enrolls the following institutional providers: Ambulatory Surgery Centers, Community Mental Health Centers, Comprehensive Outpatient Rehabilitation Facilities, Durable Medical Equipment, End Stage Renal Disease

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**PROVIDER ENROLLMENT****APPLICATION FEE
(CONT'D.)**

Facilities, Federally Qualified Health Centers, Home Health Agencies, Hospices, Hospitals, Independent Clinical Laboratories, Pharmacies, Skilled Nursing Facilities, and Rural Health Clinics.

A provider will be exempt from the fee if they have submitted and received approval for a Hardship Waiver request or they can demonstrate they are enrolled or have paid the application fee to Medicare and/or another state's Medicaid or CHIP for the same enrollment location jurisdiction. A different enrollment jurisdiction means "a new enrollment with an address different from a currently enrolled location."

Individual physicians (sole proprietors enrolling with an EIN and Social Security Number (SSN) are considered individuals), non-physician practitioners and non-physician practitioner organizations are exempted from paying the enrollment application fee.

The amount of the application fee is \$586.00 in calendar year 2019. The provider enrollment application fee is required with any applicable provider enrollment application submitted on or after January 1, 2019, and on or before December 31, 2019. The application fee increases each calendar year based on the consumer price index for all urban consumers and the amount is calculated by the CMS. In future years, the amount of the application fee will be the amount published by CMS in the Federal Register. To make payment, visit <http://provider.scdhhs.gov> and search for Online Application Fee Payment to access the SC.GOV Enterprise Payment System online.

Application Fee:

- The application fee is non-refundable, except under the following circumstances:
 - A request for hardship exception that is subsequently approved.
 - An application that is rejected prior to initiation of screening processes.
 - An application that is subsequently denied as a result of the imposition of a temporary moratorium.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**PROVIDER ENROLLMENT****APPLICATION FEE
(CONT'D.)**

Applicants are required to submit either or both of the following at the time of filing a SCDHHS enrollment application:

- The application fee; and/or
- A request for a hardship exception to the application fee.

**REQUESTING A HARDSHIP
EXCEPTION**

Applicants that do not submit the application fee because they requested a hardship exception that was not granted by CMS must pay the fee within thirty (30) days of the denial of the hardship waiver request.

Requesting a Hardship Exception:

- Business organizations and entities enrolling with an EIN may submit both an application fee and hardship exception waiver to avoid delays in the processing of the application. Business organizations and entities that believe they are entitled to a hardship exception from the application fee must submit a letter to SCDHHS explaining the nature of the hardship. To submit a hardship waiver exception request, see the Hardship Exception Letter in the Forms section of this manual.
 - The provider must submit sufficient documentation to support the request, including providing comprehensive documentation such as historical cost reports, recent financial reports, income statements, cash flow statement and/or tax returns.
 - CMS will notify the provider or supplier by letter approving or denying the request for a hardship exception. CMS will provide the reason(s) for denying any hardship exception.
 - Processing of the enrollment application will not begin until CMS determines whether to grant the exception.

A provider may appeal CMS' denial to grant a hardship exception from the application fee in accordance with the Appeals procedures established under the South Carolina Code Annotated, Regulations, 126-150, *et.seq.*

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**PROVIDER ENROLLMENT****REQUESTING A HARDSHIP
EXCEPTION (CONT'D.)**

SCDHHS will reject any initial enrollment or reactivation request when:

- The provider does not furnish the applicable application fee
- The provider does not furnish the applicable application fee in the appropriate amount
- The provider does not furnish the application fee or a hardship exception request at the time of submission, or
- SCDHHS is not able to deposit the full application amount into the SCDHHS account or the funds cannot be credited to SCDHHS.

SCDHHS will reject any initial enrollment or reactivation request and retain the application fee if the provider does not timely furnish SCDHHS with requested applicable supporting documentation or information necessary to complete its review and verification of the enrollment application information.

SCDHHS will deny any initial enrollment application and retain the application fee if funds have been expended for some or all of the required screening involved in processing the application.

SCDHHS will, upon revalidation request, revoke billing privileges of any enrolled provider if:

- The provider does not submit an application fee or a hardship exception request
- The hardship exception request is not granted
- SCDHHS is not able to deposit the full application amount into the SCDHHS account,
- The funds cannot be credited to SCDHHS
- The enrollment application is denied based on non-compliance with a provider enrollment requirement, or
- The provider does not meet the conditions of participation for their provider type.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**PROVIDER ENROLLMENT****ELECTRONIC FUNDS
TRANSFER (EFT)**

During enrollment, South Carolina Medicaid providers must register for an Electronic Funds Transfer (EFT) in order to receive reimbursement. SCDHHS will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside the United States.

Enrolled providers will receive reimbursement for paid claims via a direct deposit to the financial institution noted in their EFT Authorization Agreement. If there are any verification issues encountered during the enrollment process, a paper check will be issued. The provider will be notified and will be required to submit a revised EFT Authorization Agreement, along with verification of the electronic deposit information on the financial institutions letterhead, confirming the financial information contained within the EFT Authorization Agreement.

**Changes to EFT
Authorization Agreement**

Prior to revoking or revising the EFT Authorization Agreement, the provider must provide thirty (30) days written notice to:

Medicaid Provider Enrollment
PO Box 8809
Columbia, SC 29202-8809

The provider is required to submit a completed and signed EFT Authorization Agreement Form to confirm new and/or updated banking information. A copy of this EFT Authorization Agreement can be found in the Forms section of this manual.

All EFT requests are subject to a fifteen (15) day pre-certification period in which all accounts are verified by the qualifying financial institution before direct deposits are made to your account. During the pre-certification period, the provider will receive reimbursement via hard copy checks.

If the financial information cannot be verified during the pre-certification period, the provider will be notified and will be required to submit an EFT Authorization Agreement, along with verification of the electronic deposit information on the financial institution's letterhead confirming the financial information contained within the EFT Authorization Agreement. This new EFT

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION**PROVIDER ENROLLMENT****Changes to EFT
Authorization Agreement
(Cont'd.)**

authorization submission will be subject to the pre-certification process described above.

Upon completion of the pre-certification period, reimbursement will be deposited directly into the provider's designated bank account.

When SCDHHS is notified that the provider's bank account is closed or the routing number and/or bank account number is no longer valid, the provider will be notified and will be required to submit a revised EFT Authorization Agreement, along with verification of the electronic deposit information on the financial institutions letterhead. This new EFT authorization submission will be subject to the pre-certification process described above.

Questions regarding changes to EFT information, the status of EFT enrollment, missing or late EFTs should be directed to the Provider Service Center at 1-888-289-0709.

Remittance Advice

A Remittance Advice (RA) contains the provider's payment information and can be viewed and/or printed via the South Carolina Medicaid Web Tool. For Security purposes, only the last four digits of the provider's financial account number are reflected on their Remittance Advice.

Along with the financial account number information, providers also have the capability to link their Remittance Advice with their EFT payment transaction via a matching EFT Reassociation Trace Number. The EFT Reassociation Trace Number will automatically be included in your Remittance Advice. In order for the matching EFT Reassociation Number to appear in your EFT Notification, you must contact your financial institution and request the addition of this information.

Questions regarding the Remittance Advice, including missing or late RAs and/or the EFT Reassociation Trace Number, please contact the Provider Service Center at 1-888-289-0709.

**INTERDEPARTMENTAL
TRANSFER (IDT)**

IDT is the process used by SCDHHS to transfer funds to enrolled SC State Agencies for reimbursement for services rendered to Medicaid beneficiaries. Upon enrollment of a State Agency provider, the enrollment

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

INTERDEPARTMENTAL TRANSFER (IDT) (CONT'D.)

record is coded with the appropriate State Agency ownership code that initiates the IDT reimbursement. EFT is not required when payment is via IDT.

ELECTRONIC SIGNATURE

SCDHHS will rely on the use of an electronic signature for all provider enrollment electronic submissions.

- An electronic signature certifies that all data associated with a provider enrollment or update to a provider record (individual provider or organization) is accurate.
- Only the enrolling provider or authorized individual representing the enrolling provider may submit an electronic enrollment or record update.
- The individual provider/provider organization understands that checking the electronic signature box on any Terms, Conditions, Trading Partner Agreement, Electronic Funds Transfer (EFT), Language Assistance Attestation (LAA), etc., included with the provider enrollment application or update constitutes a signed contract with SCDHHS.
- All electronically signed enrollment applications have the same force and effect as paper enrollment applications that are signed non-electronically.
- The enrolling provider or authorized representative shall allow access to a traditional signature for inspection if SCDHHS so requests.
- The enrolling provider shall notify SCDHHS immediately in the event of any suspicion of an unauthorized person submitting an electronic signature on behalf of the provider.

CORRESPONDENCE AND INQUIRIES

Provider Enrollment inquiries to South Carolina Medicaid should be directed as follows:

Mail: Medicaid Provider Enrollment
PO Box 8809
Columbia, SC 29202-8809
Phone: 1-888-289-0709, Option 4
FAX: 803-870-9022

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SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES**PROVIDER
ENROLLMENT /
SCREENING
POLICIES****TEMPORARY MORATORIA****Federally Mandated
Moratoria**

SCDHHS will impose temporary moratoria on enrollment of new providers or provider types identified by the Secretary of the United States Department of Health and Human Services (“the Secretary”) as posing an increased risk to the Medicaid program.

SCDHHS will not impose a temporary moratorium on the enrollment of new providers or provider types, identified by the Secretary as posing an increased risk to the Medicaid program if SCDHHS determines that the imposition of such a moratorium would adversely affect beneficiaries’ access to medical assistance. If such a determination is made, SCDHHS will notify the Secretary in writing.

State-Initiated Moratoria

SCDHHS may impose temporary moratoria on enrollment of new providers, or impose numerical caps or other limits that SCDHHS identifies as having a significant potential for fraud, waste, or abuse and the Secretary has identified as being at high risk for fraud, waste, or abuse.

SCDHHS, before implementing the moratoria, caps, or other limits, will determine that its action would not adversely impact beneficiaries’ access to medical assistance.

SCDHHS will notify the Secretary in writing in the event SCDHHS seeks to impose such moratoria, including all details (rationale and justification) of the moratoria; and obtain the Secretary’s concurrence with imposition of the moratoria.

**Temporary Moratoria
Requirements**

The temporary moratorium is for an initial period of 6 months. If SCDHHS determines that it is necessary, the temporary moratorium may be extended in 6-month increments. SCDHHS will document in writing the necessity for extending the moratoria each time. At the

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES

Temporary Moratoria Requirements (Cont'd.)

time a moratorium is imposed, any pending Provider application subject to the moratorium will be denied.

DENIAL OF ENROLLMENT

Denial of Provider Enrollment

Denial of enrollment means that SCDHHS has reviewed the information provided in a completed enrollment application, and if applicable, a contract, and the Medicaid program takes action to deny enrollment. Approval to enroll in the Medicaid program is not automatic.

SCDHHS will deny the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under 42 CFR Subpart E – Provider Screening and Enrollment.

SCDHHS will deny the enrollment of any provider that was terminated on or after January 1, 2011, by Medicare or another State's Medicaid or Children's Health Insurance Program.

Unless SCDHHS first determines that termination is not in the best interest of the State Medicaid program and documents that determination in writing, SCDHHS will deny enrollment for the following reasons:

- Any person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, or Children's Health Insurance Program (CHIP) program in the past 10 years.
- The provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information.
- Any person with a 5 percent or greater direct or indirect ownership interest in the provider fails to submit sets of fingerprints in the form and manner required by SCDHHS within 30 days of a CMS or SCDHHS request.
- The provider fails to permit access to provider location for any site visit under 42 CFR §455.432.
- SCDHHS has determined that the provider has falsified information provided on the application

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES

Denial of Provider Enrollment (Cont'd.)

- SCDHHS cannot verify the identity of the provider / applicant.
- The provider’s license to practice has been suspended and/or revoked, or there are restrictions placed on his or her license such that the provider would not be able to adequately serve Medicaid beneficiaries.
- The provider fails to meet all screening requirements as specified by SCDHHS policy.

Provider Appeal

Providers have the right to appeal a denial of enrollment in the Medicaid program, in accordance with the appeals policy established under State Regulations Chapter 126 Article 1, Subarticle 3.

PROVIDER TERMINATION

“Termination” means SCDHHS has taken an action to revoke a provider’s Medicaid billing privileges, the provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and there is no expectation on the part of the provider or SCDHHS that the revocation is temporary.

A terminated provider will be required to reapply and be reenrolled with the Medicaid program if they wish billing privileges to be reinstated.

Provider Termination for Cause

SCDHHS will terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under 42 CFR Subpart E – Provider Screening and Enrollment.

SCDHHS will terminate the enrollment of any provider that was terminated on or after January 1, 2011, by Medicare or another State’s Medicaid or Children’s Health Insurance Program.

Unless SCDHHS first determines that termination is not in the best interest of the State Medicaid program and documents that determination in writing, SCDHHS will terminate a provider’s enrollment for any of the following reasons:

- Any person with a 5 percent or greater direct or indirect ownership interest in the provider has been

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES

Provider Termination for Cause (Cont'd.)

convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, or title XXI program in the last 10 years.

- The provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information and/or does not cooperate with nay screening methods required by SCDHHS.
- The provider fails to permit access to provider locations for any site visit under 42 CFR §455.432.
- The provider fails to provide access to Medicaid patient records.
- Any person with a 5 percent or greater direct or indirect ownership interest in the provider fails to submit sets of fingerprints in the form and manner required by SCDHHS within 30 days of a CMS or SCDHHS request.

SCDHHS may terminate a provider's enrollment for any of the following reasons:

- It is determined that the provider has falsified any information provided on the application.
- The identity of any provider/applicant cannot be verified.
- The provider fails to comply with the terms of the enrollment agreement.
- The provider fails to comply with the terms of contract with SCDHHS.
- The provider has not repaid an outstanding debt or recoupment identified through a program integrity review.
- The provider's license to practice has been suspended and/or revoked, or there are restrictions placed on his or her license.
- The provider has been terminated by a Medicaid Managed Care Organization for reasons due to fraud or quality of care.
- The provider allows a non-enrolled rendering provider to use an enrolled provider's number, except where otherwise allowed by policy.

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES

Provider Termination for Cause (Cont'd.)

- The provider continues to bill Medicaid after the suspension or revocation of their medical license.
- The provider is under a State and/or Federal exclusion.
- The provider falsifies medical records to support services billed to Medicaid.
- The provider is sanctioned under State Regulation 126-403.
- The provider or any person with a 5 percent or greater direct or indirect ownership interest in the provider fails to submit sets of fingerprints within 30 days when required to do so.

Provider Appeal

Providers have the right to appeal a denial of enrollment in the Medicaid program, in accordance with the appeals policy established under State Regulations Chapter 126 Article 1, Subarticle 3.

ORDERING/REFERRING

SCDHHS requires all ordering/referring physicians or other professionals providing services, under the State plan or under a waiver of the plan, to be enrolled as participating providers.

This includes all health care providers who are HIPAA-covered individuals (e.g., physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists).

- Enrollment and NPI of Ordering or Referring Providers—Medicaid and CHIP Section 1902(kk)(7) of the Social Security Act provides that States must require all ordering or referring physicians or other professionals to be enrolled under a Medicaid State plan or waiver of the plan as a participating provider.
- Further, the NPI of such ordering or referring provider or other professional must be included on any Medicaid claim for payment based on an order or referral from that physician or other professional.

Qualified individuals must be enrolled in SC Medicaid to order or refer services for Medicaid beneficiaries and/or to bill Medicaid for said services.

SC Medicaid will reimburse for items or services for Medicaid beneficiaries that have been ordered or referred

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES

ORDERING/REFERRING (CONT'D.)

by a SC Medicaid enrolled physician or other qualified professional.

- Orders must be provided by an individual physician or other qualified non-physician (identified by an NPI number with an entity type code of “1”). Organizations cannot order or refer.

Residents or interns practicing under the supervision of a licensed professional may utilize the NPI of the supervising physician for reimbursement purposes.

ORDERING/REFERRING PHYSICIANS OR OTHER PROFESSIONALS PROVIDING MEDICAID SERVICES

An order or referral is required for the following SC Medicaid services:

- Services provided to beneficiaries participating in a Medical Home Network (MHN)
- Laboratory/Radiology Services
- Services provided as the result of an Early and Periodic Screening Diagnosis and Treatment (EPSDT) screening/evaluation
- Eyeglasses
- Ambulatory Surgical Center (ASC)
- Pharmacy Services
- Durable Medical Equipment (DME)
- Private Rehabilitative Therapy Services
- Rehabilitative Behavioral Health Services provided by a Licensed Independent Practitioner (LIP)
- Adult Day Care Services
- Institutional Respite
- Children’s Personal Care Aid
- Telemonitoring
- Incontinence Supplies
- Nutritional Supplement
- Private Duty Nursing
- Respite in a Community Residential Care Facility
- Medicaid Nursing Services
- Psychiatric Residential Treatment Facility (PRTF)/ Inpatient Psychiatric Hospital Services for Children Under 21

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES

ORDERING/REFERRING PHYSICIANS OR OTHER PROFESSIONALS PROVIDING MEDICAID SERVICES (CONT'D.)

- Services provided outside the South Carolina Medicaid Service Area (SCMSA)
- Hospice Services
- Home Health Services
- Hospital Services
- School Based Rehabilitative Therapy Services
- Local Educational Agency Rehabilitative Behavioral Health Services
- Rehabilitative Behavioral Health Services

The following provider types are authorized to order or refer services for a Medicaid beneficiary:

- Licensed Physician
- Licensed Nurse Practitioner
- Certified Mid-Wife
- Licensed Optometrist
- Licensed Practitioner of the Healing Arts for Rehabilitative Behavioral Health Services (Licensed Psychiatrist, Licensed Physician, Licensed Psychologist, Licensed Advanced Practice Registered Nurse, Licensed Independent Social Worker-Clinical Practice, Licensed Master Social Worker, Licensed Physician Assistant, Licensed Professional Counselor, Licensed Marriage and Family Therapist).
- Licensed Practitioner of the Healing Arts for Local Education Agency School Based Rehabilitative Therapy Services (Licensed Physician Assistant, Licensed Advanced Practice Registered Nurse, Licensed Registered Nurse, Licensed Audiologist, Licensed Occupational Therapist, Licensed Physical Therapist, Licensed Speech Language Pathologist, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Licensed Psychologist, Licensed Independent Social Worker, Licensed Master Social Worker, Licensed Baccalaureate Social Worker).
- Licensed Practitioner of the Healing Arts for Local Education Agency Rehabilitative Behavioral Health (Licensed Psychiatrist, Licensed Physician, Licensed Psychologist, Licensed Advanced Practice

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES

ORDERING/REFERRING PHYSICIANS OR OTHER PROFESSIONALS PROVIDING MEDICAID SERVICES (CONT'D.)

Registered Nurse, Licensed Independent Social Worker-Clinical Practice, Licensed Master Social Worker, Licensed Physician Assistant, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Licensed Psycho-educational Specialist).

CRIMINAL BACKGROUND CHECKS

As a condition of enrollment in Medicaid, SCDHHS requires that providers consent to criminal background checks, including National and State criminal record checks when they:

- Have a 5 percent or more direct or indirect ownership interest in the provider
- Are listed in the high categorical risk level

Failure to consent to a criminal back ground check is cause for application denial or termination of enrollment in the Medicaid program.

REVALIDATION OF ENROLLMENT

All SCDHHS providers, other than Durable Medical Equipment (DME) providers, must have their enrollment information revalidated every five years regardless of their provider type.

DME providers must revalidate their enrollment information every 3 years.

When revalidating a provider's enrollment, the provider must submit a new application and pay the applicable application fee.

Providers failing to resubmit a new application when required to revalidate will be terminated from Medicaid.

Providers failing to submit an application fee or hardship waiver request at the time of revalidation will be terminated from Medicaid.

VERIFICATION OF PROVIDER LICENSE, CERTIFICATIONS AND/OR CREDENTIALS

SCDHHS requires that all providers:

- Are compliant with Federal and/or State licensure and regulatory requirements for licenses, certifications and/or credentials.
- Operate within the appropriate standards of conduct as established by the laws and standards of their profession and/or business.

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES

VERIFICATION OF PROVIDER LICENSE, CERTIFICATIONS AND/OR CREDENTIALS (CONT'D.)

- A valid license, certification and/or credential means an established State and/or Federal authorizing board has granted the provider approval to practice within that profession or operate a business.
- SCDHHS will verify all licenses, certifications and/or credentials that they have not expired and have no restrictions in place such that the provider would not be able to adequately serve Medicaid beneficiaries.
- The provider must continuously meet South Carolina licensure, certification and/or credentialing requirements of their respective professions or boards in order to maintain SC Medicaid enrollment.

Failure to comply with this policy will result in termination or denial of enrollment.

FEDERAL/STATE DATABASE CHECKS

SCDHHS will confirm the identity and determine the exclusion status of:

- Providers to include medical professionals and any other eligible professionals.
- Any person with an ownership or control interest.
- An agency or managing employee of the provider.

SCDHHS will check the following databases to verify the identity and determine the exclusion status of the persons referenced above:

- Social Security Administration's Death Master File
- National Plan and Provider Enumeration System (NPPES)
- Health and Human Services (HHS) Office of the Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE)
- System for Award Management (SAM)
- SCDHHS Excluded Provider Listing
- Termination for Cause (formerly MCSIS)
- Any other databases as prescribed by CMS and/or SCDHHS

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES

FEDERAL/STATE DATABASE CHECKS (CONT'D.)

SCDHHS will refer to appropriate databases to confirm identity upon enrollment and provider re-enrollment.

SCDHHS will check LEIE and SAM no less frequently than monthly.

An enrolling provider or Medicaid provider that fails a Federal/State Database check is subject to denial or termination.

SCREENING OF PROVIDERS

Prospective and Re- enrollment Provider Screening

All providers are required to be screened by SCDHHS prior to enrollment in the SC Medicaid program.

All individuals and organizations will be screened upon submission of:

- An initial application for enrollment as a provider in SC Medicaid
- An application(s) for a new practice location(s)
- An application(s) to be an ordering and/or referring provider(s)
- An application for re-activation or revalidation

SCDHHS will rely, in part, on the results of the provider screening performed by the external provider enrollment programs of:

- Medicare Contractors
- Medicaid agencies or CHIP's of other States.

SCDHHS will conduct certain database checks of providers that have been screened by one of the above programs.

PROVIDER SCREENING LEVELS

The level and type of provider screening conducted will be based on a categorical risk level of "limited", "moderate" or "high".

A provider that fits in multiple categorical risk levels will be elevated to the highest level of screening.

SCDHHS will conduct all required provider screenings and verifications prior to making an enrollment determination.

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES

Provider Screening Level – Limited

Screening for providers designated as **“limited”** categorical risk will include the following verifications:

- That the provider meets all provider-specific requirements, including those in SCDHHS policy, and any applicable Federal or State requirements for the provider type.
- That the provider is licensed in good standing with his or her respective licensing board, including verification of any licenses in States other than South Carolina.

SCDHHS requires that all providers:

- Be compliant with Federal and/or State licensure and regulatory requirements for licenses, certifications and/or credentials.
- Operate within the appropriate standards of conduct as established by the laws and standards of their profession and/or business.

Verification of Licenses, Certifications and/or Credentials:

- A valid license, certification and/or credential means an established State and/or Federal authorizing board has granted the provider approval to practice within that profession or operate a business.
- SCDHHS will verify all licenses, certifications and/or credentials that they have not expired and have no restrictions in place such that the provider would not be able to adequately serve Medicaid beneficiaries.
- The provider must continuously meet South Carolina licensure, certification and/or credentialing requirements of their respective professions or boards in order to maintain SC Medicaid enrollment.
- Failure to comply with this policy will result in termination or denial of enrollment.

Federal/State Database Checks:

- SCDHHS will conduct checks to verify the identity and determine the exclusion status of:

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES

Provider Screening Level – Limited (Cont'd.)

- o Providers to include medical professionals and any other eligible professionals
- o Any person with an ownership or control interest
- o An agent or managing employee of the provider.
- o Medical directors
- o Supervising Physicians
- SCDHHS will check the following databases to verify the identity and determine the exclusion status of the persons referenced above:
 - o Social Security Administration’s Death Master File
 - o NPPES
 - o LEIE
 - o SAM
 - o SCDHHS Excluded Provider Listing
 - o Termination for Cause (formerly MCSIS)
 - o Any other databases as prescribed by CMS and/or SCDHHS.
- SCDHHS will refer to appropriate databases to confirm identity upon enrollment and provider re-enrollment.
- SCDHHS will check LEIE and SAM no less frequently than monthly.
- An applicant or Medicaid provider that fails a Federal/State Database check is subject to denial or termination
- SCDHHS will conduct these database checks on a pre and post-enrollment basis to ensure that providers meet and continue to meet the enrollment criteria for their provider type.

Provider Screening Level – Moderate

Screening for providers designated as “**moderate**” categorical risk will include the following verifications:

- That the provider meets the “limited” screening requirements described above and

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES

Provider Screening Level – Moderate (Cont’d.)

- An on-site visit to verify that information submitted to SCDHHS is accurate and to determine compliance with Federal and State enrollment requirements.

SCDHHS will conduct pre-enrollment and post-enrollment site visits of providers designated as “moderate” or “high” categorical risks to the Medicaid program.

- The purpose of the site visit by SCDHHS will be to:
 - o Verify the information submitted to SCDHHS for accuracy.
 - o Determine compliance with Federal and State enrollment requirements.
- Any enrolling and/or enrolled provider must permit SCDHHS, its agents or its designated contractors, to conduct unannounced on-site inspections of any and all provider locations.
- Any enrolling and/or enrolled provider that fails to permit access for site visits will be denied or terminated from Medicaid.

Provider Screening Level – High

Screening for providers designated as a “**high**” categorical risk will include the following verifications:

- That the provider meets all “limited” and “moderate” screening requirements described above.
- Criminal background checks, including National and State criminal record checks, for the provider and individuals with a 5 percent or more direct or indirect ownership interest in the provider.
- Submission of a set of fingerprints in accordance with 42 CFR §455.434 (b)(2).

Provider Screening Level Adjustment

SCDHHS will adjust the categorical risk level from “limited” or “moderate” to “high” when any of the following occurs:

- Imposition of a payment suspension on a provider based on credible allegation of fraud, waste or abuse
- The provider has an existing Medicaid overpayment

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES

Provider Screening Level Adjustment (Cont'd.)

- The provider has been excluded by the OIG, SCDHHS, or another State's Medicaid program within the previous ten years
- If CMS or SCDHHS, in the previous six months, has lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment at any time within six months from the date the moratorium was lifted

Provider Screening Mandates

All providers must meet these screening requirements.

SCDHHS will deny enrollment or terminate the enrollment in the Medicaid program of any provider for the following reasons:

- Any person with a 5 percent or greater direct or indirect ownership interest in the provider did not submit timely an accurate information and cooperate with any screening methods
- Provider was terminated on or after January 1, 2011, by Medicare or another State's Medicaid or Children's Health Insurance Program
- Any person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, or title XXI program in the last 10 years
- The provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit accurate information and/or does not cooperate with any screening methods required by SCDHHS within ten (10) calendar day timeframe
- Any person with a five (5) percent or greater direct or indirect ownership interest in the provider fails to submit sets of fingerprints in the form and manner required by SCDHHS within 30 days of a CMS or SCDHHS request
- Fails to permit access to provider locations for any site visit under 42 CFR §455.432
- Fails to provide access to Medicaid patients records

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES**Provider Screening
Mandates (Cont'd.)**

- The provider falsified information on the application
- SCDHHS cannot verify the identity of the provider
- Fails to comply with the terms and conditions of the provider enrollment agreement
- Fails to comply with the terms of SCDHHS contract
- The provider's license to practice has been suspended and/or revoked, or there are restrictions placed on his or her license
- Fails to meet all screening requirements as specified by SCDHHS policy
- Imposition of a temporary moratorium
- The provider did not re-submit the Return for Additional Information within the requested ten (10) calendar day timeframe
- The provider has not repaid an outstanding debt or recoupment identified through a program integrity review
- The provider has been terminated by a Managed Care Organization for reasons due to fraud or quality of care
- The provider allowed a non-enrolled rendering provider to use an enrolled provider's number, except where otherwise allowed by policy
- The provider continues to bill Medicaid after suspension or revocation of his or her medical license
- The provider is under a State and/or Federal exclusion
- The provider falsified medical records to support services billed to Medicaid
- The provider is sanctioned under State Regulation 126-403
- The provider fails to submit an application fee within 30 days after Hardship Request was denied
- The provider fails to submit an application fee or Hardship Waiver Request at the time of revalidation

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES

Provider Screening Mandates (Cont'd.)

- Does not meet any of the required licensure, certification or other screening requirements as set forth in this policy
- Fails to submit timely and accurate information needed for screening
- Fails to consent to a criminal background check

REACTIVATION OF ENROLLMENT

Providers whose enrollment with SCDHHS has been denied, terminated, or deactivated for any reason must follow normal provider enrollment and screening to have their enrollment reactivated.

Reactivation includes re-screening based on the categorical risk level of the provider and requiring, if necessary, payment of associated application fees.

ADDING PROVIDER LOCATION

SCDHHS requires providers to complete a new provider enrollment application when adding a new location. The location being added must operate under the same EIN/NPI as the previously enrolled location. The location being added is subject to an enrollment application fee. When the EIN/NPI combination is not the same as a previously enrolled location, providers must complete a new enrollment for that location.

Processing the new location enrollment application will include:

- Screening for the new location based on the provider's categorical risk level of "limited", "moderate" or "high".
- SCDHHS will rely on the results of a screening performed by:
 - Medicare contractors
 - Other State Medicaid Programs or CHIP
- Payment of the applicable application fee is required unless:
 - The provider is already enrolled in Medicare or another State's Medicaid program or CHIP.
 - The provider already paid the fee to Medicare or another State Medicaid program or CHIP.
 - The applicant is an individual physician or non-physician practitioner.

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES

ADDING PROVIDER LOCATION (CONT'D.)

- o The provider wishes to request a hardship exception to the application fee by:
 1. Submitting a hardship exception waiver request to SCDHHS providing justification that the provider is not required to pay the application fee.
- o Processing the new location enrollment application will not begin until the provider has been notified if the hardship exception has been granted.

PRE AND POST ENROLLMENT SITE VISITS

SCDHHS will conduct pre-enrollment and post-enrollment site visits of providers designated as “moderate” or “high” categorical risks to the Medicaid program.

The purpose of the site visit by SCDHHS will be to:

- Verify the information submitted to SCDHHS for accuracy.
- Determine compliance with Federal and State enrollment requirements.

Any enrolling and/or enrolled provider must permit SCDHHS, its agents or its designated contractors, to conduct announced and unannounced on-site inspections of any and all provider locations.

- Any enrolling and/or enrolled provider that fails to permit access for site visits will be denied or terminated from Medicaid.

REJECTION OF ENROLLMENT

Rejection of enrollment means SCDHHS has reason to reject the initial enrollment application submitted by the provider, without further review as to whether the provider or supplier qualifies to enroll in SC Medicaid.

SCDHHS may reject an enrollment application for the following reasons:

- Errors or omissions are found in the application.
- If The Medicaid agency is not able to deposit the full amount into the State-owned account or the funds are not able to be credited to the State-owned account.
- The provider does not submit the applicable application fee within 30 days of notification that the hardship exception request was not approved.

SECTION 2 PROVIDER ENROLLMENT / SCREENING POLICIES

REJECTION OF ENROLLMENT (CONT'D.)

- Imposition of a Temporary Moratorium.
- The provider submitted an application while a temporary moratorium was in place for that provider type and/or specialty.

PROVIDER APPEALS

In accordance with SCDHHS regulations an appeal hearing may be requested by a provider when:

- A prospective provider is denied enrollment as a Medicaid provider.
- An enrolled provider is terminated for cause.

In accordance with regulations of SCDHHS, a provider wishing to file an appeal must request a hearing in writing and submit a copy of the notice of adverse action. Appeals may be filed:

Online: www.scdhhs.gov/appeals

By Fax: (803) 255-8206

By Mail to:

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

The request for an appeal hearing must be made within 30 days of the date of receipt of the notice of adverse action. Hearings will be held in Columbia unless otherwise arranged. The appellant or appellant's representative must be present at the appeal hearing.

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SECTION 3 PROGRAM INTEGRITY

PROGRAM INTEGRITY

The South Carolina Department of Health and Human Services ensures the integrity of the Medicaid Program and seeks to identify and reduce waste, fraud, and abuse in the use of Medicaid funds through the activities carried out by the Division of Program Integrity and the Division of Audits. The purposes of program oversight are to safeguard against unnecessary, inappropriate, and/or fraudulent use of Medicaid services, identify excessive or inaccurate payments to providers, and ensure compliance with the applicable Medicaid laws, regulations, and policies.

The Division of Program Integrity conducts post-payment reviews of all health care provider types including but not limited to hospitals (inpatient and outpatient) rural health clinics, Federally-qualified health clinics, pharmacies, ASCs, ESRD clinics, physicians, dentists, other health care professionals, speech, PT and OT therapists, CLTC providers, durable medical equipment providers, transportation providers, and behavioral and mental health care providers. Program Integrity uses several methods to identify areas for review:

- The toll-free Fraud and Abuse Hotline and the Fraud and Abuse email for complaints of provider and beneficiary fraud and abuse. The hotline number is 1-888-364-3224, and the email address is fraudres@scdhhs.gov.
- Each complaint received from the hotline or email is reviewed, and if the complaint is determined to involve either a Medicaid beneficiary or provider, a preliminary investigation is conducted to identify any indications of fraud and abuse.
- Referrals from other sources as well as ongoing provider monitoring that identify aberrant or excessive billing practices.
- The automated Surveillance and Utilization Review System (SURS) to create provider profiles and

SECTION 3 PROGRAM INTEGRITY

PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

exception reports that identify excessive or aberrant billing practices.

A Program Integrity review can cover several years' worth of paid claims data. (See "Records/Documentation Requirements" in this section for the policy on Medicaid record retention.) The Division conducts payment reviews, analysis of provider payments, and review of provider records, using statistical sampling and overpayment estimation when feasible, to determine the following:

- Medical reasonableness and necessity of the service provided
- Indications of fraud or abuse in billing the Medicaid program
- Compliance with Medicaid program coverage and payment policies
- Compliance with state and federal Medicaid laws and regulations
- Compliance with accepted medical coding conventions, procedures, and standards
- Whether the amount, scope, and duration of the services billed to Medicaid are fully documented in the provider's records

The Division of Program Integrity ("Program Integrity") or its authorized entities, as described under Records Documentation/Requirements, General Information of Section 1, conduct both announced and unannounced desk and field reviews, on-site inspections, and/or investigations of providers to determine whether the provider is complying with all applicable laws, rules, regulations, and agreements. Program Integrity may conduct reviews, investigations, or inspections of any current or former enrolled provider, agency-contracted provider, or agent thereof, at any time and/or for any time period. During such reviews, Program Integrity staff will request medical records and related documents ("the documentation"). Record means any document or electronically stored information including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations, stored in any medium from which information can be obtained either directly or, if necessary,

SECTION 3 PROGRAM INTEGRITY

PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

after translation by the entity into a usable form that allows authorized entities, described under Records Documentation/Requirements, General Information of Section 1, the ability to review the record. Program Integrity or its designee(s) may either copy, accept a copy or may request original records. Program Integrity may evaluate any information relevant to validating that the provider received only those funds to which it is legally entitled. This includes interviewing any person Program Integrity believes has information pertinent to its review, investigation or inspection. Interviews may consist of one or more visits.

Program Integrity staff will thoroughly review the records to determine whether the documentation accurately represents paid claims and rendered services, and whether the provider is in compliance with its obligations to the state Medicaid program. The documentation must sufficiently disclose the extent of services delivered, medical necessity, appropriateness of treatment, quality of care, and the documentation adheres to all applicable policy requirements. The provider, therefore, must submit a copy of all requested records by the date requested by Program Integrity. Providers must not void, replace, or tamper with any claim records or documentation selected for a Program Integrity review activity, until the activity is finalized.

An overpayment arises when Program Integrity denies the appropriateness or accuracy of a claim. Reasons for which Program Integrity may deny a claim include, but are not limited to the following:

- The Program Integrity review finds excessive, improper, or unnecessary payments have been made to a provider
- The Provider fails to provide medical records as requested
- The provider refuses to allow access to records

In each scenario Medicaid must be refunded for the denied claims.

The provider is notified via certified letter of the post-payment review results, including any overpayment

SECTION 3 PROGRAM INTEGRITY

PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

findings. If the Provider disagrees with the findings, the provider will have the opportunity to discuss and/or present evidence to Program Integrity to support any disallowed payment amounts. If the parties remain in disagreement following these discussions, the Provider may exercise its right to appeal to the Division of Appeals and Hearings.

If the provider does not contest Program Integrity's finding, or the appeal process has concluded, the provider will be required to refund the overpayment by issuing payment to SCDHHS or by having the overpayment amount deducted from future Medicaid payments. Termination of the provider enrollment agreement or contract with SCDHHS does not absolve the provider of liability for any penalties or overpayments identified by a Program Integrity review or audit.

Sanctions including but not limited to suspension, termination, or exclusion from the Medicaid program may result upon the failure of the provider to:

- Allow immediate access to records
- Repay in full the identified overpayment
- Make arrangements for the repayment of identified overpayments
- Abide by repayment terms
- Make payments which are sufficient to remedy the established overpayment

In addition, failure to provide requested records may result in one or more of the following actions by SCDHHS:

- Immediate suspension of future payments
- Denial of future claims
- Recoupment of previously paid claims

Any provider terminated for cause, suspended, or excluded will be reported to the Centers for Medicare and Medicaid Services (CMS) and U.S. Department of Health and Human (HHS) Office of Inspector General (OIG).

PREPAYMENT REVIEW

In order to ensure that claims presented by a provider for payment meet the requirements of federal and state laws and regulations, a provider may be required to undergo

SECTION 3 PROGRAM INTEGRITY**PROGRAM INTEGRITY****PREPAYMENT REVIEW
(CONT'D.)**

prepayment claims review. Grounds for being placed on prepayment claims review shall include, but shall not be limited to identification of aberrant billing practices as a result of reviews, investigations, or data analysis performed by Program Integrity/SUR, or other grounds as determined by Program Integrity/SUR.

Parameters are developed for prepayment review based on the specific areas of concern identified in each case. As part of the prepayment review process, providers are required to submit paper claims, rather than electronic claims, along with supporting medical record documentation (*e.g.*, clinical notes, progress notes, diagnostic testing results, other reports, superbills, X-rays, and any related medical record documentation) attached to each claim for all services billed. This documentation is used to ascertain that the services billed were billed appropriately, and according to South Carolina Medicaid policies and procedures. Services inconsistent with South Carolina Medicaid policies and procedures are adjudicated accordingly. Claims submitted initially without the supporting medical record documentation will be denied.

Additional medical record documentation submitted by the provider for claims denied as a result of the prepayment review process is not considered at a later time. A provider is removed from prepayment review only when determined appropriate by Program Integrity/SUR. Once removed from prepayment review, a follow-up assessment of the provider's subsequent practice patterns may be performed to monitor and ensure continued appropriate use of resources. Noncompliant providers are subject to administrative sanctions as defined in the rules in South Carolina Regulations at Chapter 126, Article 4, Subarticle 1.

**RECOVERY AUDIT
CONTRACTOR**

The South Carolina Department of Health and Human Services, Division of Program Integrity, has contracted with a Recovery Audit Contractor to assist in identifying and collecting improper payments paid to providers as a result of billing errors as referenced in 42 CFR 476.71. Section 6411(a) of the Affordable Care Act, Expansion of the Recovery Audit Contractor (RAC) Program amends section 1902(a) (42) of the Social Security Act and requires

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RECOVERY AUDIT CONTRACTOR (CONT'D.)

States to establish a RAC program to enable the auditing of claims for services furnished by Medicaid providers. Pursuant to the statute, these Medicaid RACs must: (1) identify overpayments; (2) recoup overpayments; and (3) identify underpayments. The Centers for Medicare & Medicaid Services (CMS) published the final rule implementing this provision, with an effective date of January 1, 2012. States are required to contract with Medicaid RACs “in the same manner as the Secretary enters into contracts” with the Medicare Recovery Auditors. For example, the contingency fee paid to the Medicaid RAC may not exceed that of the highest fee paid to a Medicare Recovery Auditor.

Under this rule, State contracts with Medicaid Recovery Audit Contractors must include the following requirements (or the State must obtain an exemption from CMS for the requirement):

- That each Medicaid RAC hires a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy licensed to practice in that State.

Note: SCDHHS has an approved State Plan Amendment to allow the RAC to have a part-time, in-state medical director who is also a practicing physician, in lieu of a 1.0 FTE medical director.

- That each Medicaid RAC also hires certified coders (unless the State determines that certified coders are not required for the effective review of Medicaid claims)
- An education and outreach program for providers, including notification of audit policies and protocols
- Minimum customer service measures such as a toll-free telephone number for providers and mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers' request
- Notifying providers of overpayment findings within 60 calendar days
- A 3 year maximum claims look-back period and

SECTION 3 PROGRAM INTEGRITY

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**RECOVERY AUDIT
CONTRACTOR (CONT'D.)**

- A State-established limit on the number and frequency of medical records requested by a RAC.

Note: SCDHHS has an approved State Plan Amendment to allow the RAC to review claims that are older than three years. The RAC will only be allowed to review claims older than three years upon written permission of the agency.

HMS (Health Management Systems, Inc.) is the current Recovery Audit Contractor for the SCDHHS Division of Program Integrity.

**BENEFICIARY
EXPLANATION OF
MEDICAL BENEFITS
PROGRAM**

The Beneficiary Explanation of Medical Benefits Program allows Medicaid beneficiaries the opportunity to participate in the detection of fraud and abuse. Each month the Division of Program Integrity randomly selects several hundred beneficiaries for whom claims for services were paid. These beneficiaries are provided with an Explanation of Medical Benefits that lists all non-confidential services that were billed as having been delivered to them and which were paid during the previous 45-day period. Beneficiaries are requested to verify that they received the services listed. The Division of Program Integrity investigates any provider when the beneficiary denies having received the services.

BENEFICIARY OVERSIGHT

The Division of Program Integrity performs preliminary investigations on allegations of beneficiary fraud and abuse. This includes, but is not limited to, beneficiaries who are alleged to have:

- Submitted a false application for Medicaid
- Provided false or misleading information about family group, income, assets, and/or resources and/or any other information used to determine eligibility for Medicaid benefits
- Shared or lent their Medicaid card to other individuals
- Sold or bought a Medicaid card
- Diverted for re-sale prescription drugs, medical supplies, or other benefits

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BENEFICIARY OVERSIGHT (CONT'D.)

- Obtained Medicaid benefits that they were not entitled to through other fraudulent means
- Other fraudulent or abusive use of Medicaid services

Program Integrity reviews the initial application and other information used to determine Medicaid eligibility, and makes a fraud referral to the State Attorney General's Office or other law enforcement agencies for investigation as appropriate. Beneficiary cases will also be reviewed for periods of ineligibly not due to fraud but which still may result in the unnecessary payment of benefits. In these cases the beneficiary may be required to repay the Medicaid services received during a period of ineligibility.

Complaints pertaining to beneficiaries' misuse of Medicaid services can be reported using the Fraud and Abuse Hotline (1-888-364-3224) or fraud email at fraudres@scdhhs.gov.

MEDICAID BENEFICIARY LOCK-IN PROGRAM

The Division of Program Integrity manages a Beneficiary Lock-In Program that screens all Medicaid members against clinically-vetted criteria designed to identify drug-seeking behavior and inappropriate use of prescription drugs. The Beneficiary Lock-In Program addresses issues such as coordination of care, patient safety, quality of care, improper or excessive utilization of benefits, and potential fraud and abuse associated with the use of multiple pharmacies and prescribers. The policy implements SC Code of Regulations R 126-425. The Division of Program Integrity reviews beneficiary claims data in order to identify patterns of inappropriate, excessive, or duplicative use of pharmacy services. If beneficiaries meet the lock-in criteria established by SCDHHS, they will be placed in the Medicaid Lock-In Program to monitor their drug utilization and to require them to utilize one designated pharmacy. Beneficiaries who are enrolled in the Lock-In Program with an effective date of October 1, 2014 and forward will remain in the program for two years. The beneficiary has the opportunity to select a pharmacy and has the right to appeal. The program also has provisions that allow the beneficiary to obtain emergency medication and/or go to another pharmacy should the first pharmacy provider be unable to provide the needed services.

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DIVISION OF AUDITS

Medicaid providers, who contract with SCDHHS for services, including state agencies, may be audited by the SCDHHS Division of Audits. The SCDHHS Division of Audits was formed to assist the agency in the management, assessment, and improvement of agency programs, services, and operations. The Division of Audits accomplishes these goals by reviewing and evaluating programs administered by SCDHHS to determine the extent to which fiscal, administrative, and programmatic objectives are met in a cost-effective manner.

In performing its audits, the Division of Audits follows generally accepted auditing standards (GAGAS). The Division of Audits performs different types of audits of Medicaid providers and programs, including:

- Performance audits that provide an independent assessment of the program outcomes and the management of resources. These audits address the effectiveness, efficiency, and adequacy of program results.
- Audits of contracts with health care providers and other state agencies to ensure compliance with contract terms and conditions for Medicaid service delivery and administration
- Audits to confirm the accuracy and allowability of costs and other financial information reported to SCDHHS.

PAYMENT ERROR RATE MEASUREMENT

The South Carolina Medicaid program, along with the Medicaid programs in other states, is required to comply with the CMS Payment Error Rate Measurement (PERM) program, which was implemented in federal fiscal year 2007. Each state will be reviewed every three years. PERM requires states to submit a statistically valid sample of paid Medicaid claims to a federal contractor, which will review for compliance with payment rates and state Medicaid policies, and will determine whether medical necessity for the service is adequately documented in the medical record. Providers who are chosen for the sample will be required to submit all applicable medical records for review; however, for most providers only one claim will be chosen for the sample. Providers who fail to send in the

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PAYMENT ERROR RATE MEASUREMENT CONT'D.)

requested documentation will face recoupment of the Medicaid payment for the claim in question. In addition if the CMS PERM contractor determines that a Medicaid claim was paid in error, SCDHHS will be required to recoup the payment for that claim. PERM will combine the errors found in each state in order to establish a national Medicaid error rate.

FRAUD

The South Carolina Medicaid program operates under the anti-fraud provisions of 42 US Code §1320a-7b. This federal law relates to both fraud and abuse of the program and identifies illegal acts, penalties for violations, and the individuals and/or entities liable under this section.

The Division of Program Integrity carries out SCDHHS responsibilities concerning suspected Medicaid fraud as required by 42 CFR Part 455, Subpart A. Program Integrity will conduct a preliminary investigation and cooperate with the state and federal authorities in the referral, investigation, and prosecution of suspected fraud in the Medicaid program. Suspicion of fraud can arise from any means, including but not limited to fraud hotline tips, provider audits and program integrity reviews, RAC audits, data mining, and other surveillance activities. SCDHHS refers suspected cases of Medicaid fraud by health care providers to the Medicaid Fraud Control Unit (MFCU) of the State Attorney General's Office for investigation and possible prosecution. SCDHHS also makes referrals to the Bureau of Drug Control for suspected misuse or overprescribing of prescription drugs, especially controlled substances. If a provider suspected of fraud or abuse is also enrolled in a Medicaid Managed Care Organization (MCO), Program Integrity will coordinate the investigation with the MCO(s) involved. Suspected Medicaid fraud on the part of a beneficiary is referred to a Medicaid Recipient Fraud Unit in the State Attorney General's Office for investigation.

PAYMENT SUSPENSION

Medicaid payments to a provider may be withheld upon credible allegation of fraud, in accordance with the requirements in 42 CFR §455.23.

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Suspension of Provider Payments for Credible Allegation of Fraud

SCDHHS will suspend payments in cases of a credible allegation of fraud. A “credible allegation of fraud” is an allegation that has been verified by SCDHHS and that comes from any source, including but not limited to the following:

- Fraud hotline complaints
- Claims data mining
- Patterns identified through provider audits, civil false claims cases, and law enforcement investigations

SCDHHS has flexibility in determining what constitutes a “credible allegation of fraud.” Allegations are considered to be credible when they have indications of reliability based upon SCDHHS’ review of the allegations, facts, and evidence on a case-by-case basis.

Notice of Suspension

SCDHHS will suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity. Payments may be suspended without first notifying the provider of the intention to suspend payments. SCDHHS will send notice of its suspension of program payments within the following timeframes:

- Within five business days of suspending the payment, unless requested in writing by a law enforcement agency to temporarily withhold such notice
- Within 30 calendar days of suspending the payment, if requested by law enforcement in writing to delay sending such notice

The Notice of Payment Suspension will include all information required to be provided in accordance with 42 CFR §455.23.

All suspension of payment actions will be temporary and will not continue after either of the following:

- SCDHHS or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider

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Notice of Suspension (Cont'd.)

- Legal proceedings related to the provider's alleged fraud are completed

Referrals to the Medicaid Fraud Control Unit

Whenever an investigation leads to the initiation of a payment suspension in whole or part, SCDHHS will make a fraud referral to the South Carolina Medicaid Fraud Control Unit.

Good Cause not to Suspend Payments or to Suspend Only in Part

SCDHHS may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed on an individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation
- Other available remedies implemented by SCDHHS will more effectively or quickly protect Medicaid funds
- SCDHHS determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed
- SCDHHS determines that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons:
 - An individual or entity is the sole community physician or the sole source of essential specialized services in a community
 - The individual or entity serves a large number of beneficiary's within a medically underserved area, as designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services
- Law enforcement declines to certify that a matter continues to be under investigation

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Good Cause not to Suspend Payments or to Suspend Only in Part (Cont'd.)

- SCDHHS determines that payment suspension is not in the best interests of the Medicaid program

SCDHHS may also find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, on any individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- SCDHHS determines that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons:
 - An individual or entity is the sole community physician or the sole source of essential specialized services in a community
 - The individual or entity serves beneficiaries within a medically underserved area, as designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services
- SCDHHS determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such suspension should be imposed only in part
- SCDHHS determines the following:
 - The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and
 - A payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid. If this determination is made by SCDHHS, it will be documented in writing.
- Law enforcement declines to certify that a matter continues to be under investigation
- SCDHHS determines that payment suspension is not in the best interest of the Medicaid program

SECTION 3 PROGRAM INTEGRITY

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Good Cause not to Suspend Payments or to Suspend Only in Part (Cont'd.)

Even if SCDHHS exercises the good cause exceptions set forth above, this does not relieve the agency of its obligation to refer a credible allegation of fraud to the Medicaid Fraud Control Unit.

TEMPORARY MORATORIA

Federally-Mandated Moratoria

SCDHHS will impose a Temporary Moratorium when such a moratorium is issued by CMS on enrollment of new providers or provider types identified as posing an increased risk to the Medicaid program.

SCDHHS will take action upon notification by CMS regarding the imposition of the temporary moratorium in advance of the imposition of the moratorium.

SCDHHS will impose the temporary moratorium on the enrollment of new providers or provider types, identified by CMS as posing an increased risk to the Medicaid program, with the following exception:

- SCDHHS is not required to impose such a moratorium if it determines that the imposition of a temporary moratorium would adversely affect beneficiaries' access to medical assistance
- If SCDHHS makes such a determination, CMS will be notified in writing.

State-Initiated Moratoria

SCDHHS may impose temporary moratoria on enrollment of new providers, or impose numerical caps or other limits, that SCDHHS identifies as having a significant potential for fraud, waste, or abuse and has identified as being a high risk for fraud, waste, or abuse.

SCDHHS, before implementing the moratoria, caps, or other limits, will determine that its action would not adversely impact beneficiaries' access to medical assistance.

SCDHHS will notify CMS in writing in the event the Medicaid program seeks to impose such moratoria, including all details (rationale and justification) of the moratoria; and obtain CMS' concurrence with imposition of the moratoria

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Temporary Moratoria Requirements

The temporary moratorium is for an initial period of 6 months.

If SCDHHS determines that it is necessary, the temporary moratorium may be extended in 6-month increments.

SCDHHS will document in writing the necessity for extending the moratoria each time.

SCDHHS will obtain CMS' concurrence with any moratoria extension.

Provider applications pending at the time of imposition of a moratorium will be denied.

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AGREEMENTS AND FORMS

Number	Name	Revision Date
	Hardship Waiver Exception Request	03/2018
	Authorization Agreement For Electronic Funds Transfer	08/2017
1514	Disclosure of Ownership and Control Interest Statement Form	12/2011
	Trading Partner Agreement Instructions and Enrollment Form for Providers	01/2014
	Trading Partner Agreement Instructions and Enrollment Form for Vendors and Clearinghouses	01/2014
W-9	Request for Taxpayer Identification Number and Certification	12/2014
	Participation and Payment Agreement	07/2017
	Preceptor/Protocol Agreement Form	01/2017

Hardship Waiver Exception Request

Date: _____

Contact Name: _____

Organization Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: () _____ - _____

NPI: _____

EIN: _____

Provider Type/Specialty: _____

Application Reference ID: _____

Reason for Waiver Request:

This request must document the basis for the waiver request including a discussion of the impact on beneficiary access to care if the fee is imposed. Include any comments on the financial or legal records that might be needed to make a determination of hardship. Examples of sufficient documentation to support the request may include historical cost reports, recent financial reports, bank statements, income statements, cash flow statement and/or tax returns.

If you have any questions or need additional information, please contact Medicaid Provider Enrollment at (888) 289-0709, Option 4.

Please return the completed Hardship Waiver Exception Request to SC Medicaid via fax at (803) 870-9022.

Hardship Exception Waiver Request
March 2018

**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.

**INSTRUCTIONS TO APPLICANTS FOR MEDICAID PROVIDER ENROLLMENT
REGARDING REQUIRED DISCLOSURES
Part 1**

1. If you are an individual practitioner or in a group of practitioners that is not organized as a business proprietorship, limited liability corporation, partnership, or corporation, whether it be for profit or not for profit, you are not required to complete Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514). Please indicate if you are enrolling only as an individual practitioner and are exempt from these disclosure requirements.

Yes No

By answering "Yes", you are enrolling as an individual only and therefore exempt from disclosure requirements as required by Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514). Please complete all of Part 1. If "No" is checked, proceed to Part 2.

2. Provide the following information about yourself (individual practitioner only).
PLEASE NOTE: If you are not required to have a National Provider Identifier (NPI), please indicate "NA" in the NPI Field below.

*Full Name:				
First	M.I.	Last	Suffix	Title (MD, etc.)
*SSN:		*Date of Birth (mm/dd/ccyy): / /		*Gender:
Provider Number: (If Known)	*NPI:		Email address:	
*Primary Practice Location Name and Address:			*Telephone Number:	

Name Street Address City State Zip + 4
Fields marked with an * must be completed.

3. Have you ever been convicted of a criminal offense in relation to Medicaid, Medicare, or the State Children's Health Insurance Program (SCHIP)? Yes No

If "Yes", list the charge(s), where convicted, the date, and disposition status of the conviction.
(Attach additional page(s) if necessary.)

Charge(s)	City/State of Conviction	Conviction Date	Disposition Status
		/ /	
		/ /	

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE IN MEDICAID, OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF THE AGREEMENT OR CONTRACT WITH the SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES (SCDHHS).

*Print or Type Full Name: _____
*Signature: _____ *Date: _____

Please send this page (Part 1) with your completed Medicaid enrollment application. Do not send Part 2 of the Disclosure form if you are exempt from Disclosure requirements. All other applicants for Medicaid enrollment must complete and submit only Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514).

**DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT
PART 2**

General Instructions

Federal Medicaid regulations (42 CFR 455.100 – .106) require that all Medicaid providers disclose the name, address, and other identifying information for each person with an ownership or control interest in the provider and any subcontractor in which the provider has a 5% or more interest. All applicants, except an individual practitioner or group of practitioners as defined in 42 CFR 455.101, must complete this form in order to enroll as a provider in the Medicaid program. The provider must also screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the State Children’s Health Insurance Program (SCHIP) and/or all federal health care programs. Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider.

Please answer all questions as of the **current date**. If the "Yes" block for an item is checked, list the requested additional information in the area provided; attach additional pages and/or documentation as needed, referencing the item number to which the information corresponds. Return the original to the South Carolina Department of Health and Human Services (SCDHHS); retain a copy for your files. Failure to provide this form and/or incomplete information will result in a refusal by SCDHHS to enter into an agreement or contract with any such provider or institution or in termination of existing agreements.

This form is to be completed for all programs established by Title XIX and Title XXI and **must be submitted within 35 days of any changes to provider information**. Completion and submission of this form is a condition of approval or renewal of a contract or agreement between the disclosing entity and SCDHHS. Any substantial delay in completing the form should be reported to SCDHHS.

Disclosure of Social Security Number (SSN): Disclosure of a SSN is used for the purpose of determining whether persons and entities named in an application are federally excluded parties and to verify licensure. **Refusal to provide a SSN will result in rejection of the provider’s application to participate in the Medicaid program or termination of any existing provider agreement or contract.**

I. Instructions / Definitions: Providers that must have a National Provider Identifier (NPI) must include the NPI. If currently enrolled in South Carolina Medicaid with multiple NPI numbers, a separate Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514) must be completed for each NPI number.

I. Identifying Information			
[a] Name of Provider (Disclosing Entity):			
Doing Business As (trade or company name):			
Street Address		City, State, Zip + 4	
County	Provider Number (If Known)	NPI	Telephone Number
[b] Federal Employer Identification Number (FEIN):			
[c] Type of Entity (Applies to either For Profit or Non-Profit)			
<input type="checkbox"/> Limited Liability Corporation (LLC)			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> Business Proprietorship or Company			
<input type="checkbox"/> Sole Proprietor			
<input type="checkbox"/> Governmental Unit			
<input type="checkbox"/> Other (Please specify) _____			

II. Instructions / Definitions:

Providers must disclose ownership and control information as required by 42 CFR 455.101 - 104.

Ownership interest is defined as the possession of equity in the capital, the stock or the profits of the disclosing entity. **A disclosing entity** is a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Control interest is defined as the direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e. joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Therefore, **a person with an ownership or control interest** is a **person or corporation** that –

- (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
- (b) Has an indirect ownership interest totaling 5 percent or more in a disclosing entity;
- (c) Has a combination of direct and indirect ownership interest equal to 5 percent or more in a disclosing entity;
- (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
- (e) Is an officer or director of a disclosing entity that is organized as a corporation; or
- (f) Is a partner in a disclosing entity that is organized as a partnership.

Subcontractor means (a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, (b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

II. Individuals and Organizations with Ownership or Control Interest

[a] List names, addresses, date of birth and SSN for individuals, or list names, addresses and the FEIN for organizations, having direct or indirect ownership or control interest, **as defined on pg. 2**, in the entity listed in Section I. Attach additional pages, if needed, for any additional names and addresses. **If Sole Proprietor or Business Proprietorship or company is checked in Section I, skip this section.**

Name	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

[b] Are any persons / entities with ownership or control interest in the provider also owners of other Medicare / Medicaid providers? If yes, list name of the owner from Section II [a] and the name and NPI and/or FEIN for each facility or SSN if an individual provider.

Yes No

Name of Owner from Section II [a]	Name of Other Provider or Entity	NPI/SSN	FEIN

III. Subcontractors

[a] Please list any subcontractors of the disclosing entity (provider), **as defined on pg. 2**, in which the disclosing entity has a direct or indirect ownership of 5% or more.

Not Applicable

Name of Subcontractor	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

[b] List the following information for individuals or organizations having direct or indirect ownership or a control interest, **as defined on pg. 2**, in any subcontractor in which the disclosing entity (provider) has a direct or indirect ownership of 5% or more. Attach additional pages, if needed, for additional names.

Name	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

IV. Relationships

Are any of the individuals identified in Sections I, II or III related to each other? Yes No
If yes, list the individuals identified and the relationship to each other (spouse, sibling, parent, child, etc).

Name of Person 1	Name of Person 2	Relationship

V. Managing Employees

[a] List current managing employees as indicated below. "Managing employee" means general manager, office or business manager, administrator, director, or other individual who exercises operational or managerial control over the institution, agency, or organization, or who directly or indirectly conducts the day-to-day operations. Attach additional pages, if needed, for additional names.

Name/Title	Address	SSN	Date of Birth

[b] Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?

Yes No

If Yes, give date for change: Date / / . List names, titles, and SSN of the prior Administrator, Director of Nursing, or Medical Director.

Name	Title	SSN

VI. Management Company

A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility. If the answer is yes, list the name of the management firm as well as the managing employees of the firm (i.e., CEO, CFO, etc). Attach additional pages, if needed, for additional names.

Is the provider/entity/facility operated by a management company?

Yes No

If Yes, what is the term of the agreement?

Beginning Date / / to Ending Date / /

Name of Management Co.	Address	FEIN

Name(s) of Managing Employee(s)	SSN	Date of Birth

VII. Instructions / Definitions: Criminal Offenses related to the delivery of services or items under Medicare or Medicaid programs include convictions relating to patient neglect or abuse in connection with the delivery of a health care item or service; felony and/or misdemeanor convictions related to health care fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; and felony and/or misdemeanor convictions related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

VII. Criminal Offenses

If any of the questions are answered "Yes", list names, addresses, and SSNs for individuals and names, addresses, and FEINs for organizations, or attach documentation or additional pages if needed.

[a] As listed in **Sections II or III**, have any individuals and organizations with a direct or indirect ownership of 5% or more in the disclosing entity (provider), or any subcontractor(s) in which the provider has a direct or indirect ownership of 5% or more, been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX, or XXI (Medicare, Medicaid, or SCHIP)?

Yes No

[b] As listed in **Sections V or VI**, have any directors, officers, agents, or managing employees of the disclosing entity (provider) ever been convicted of a criminal offense related to their involvement in such program established by Titles XVIII, XIX, or XXI (Medicare, Medicaid, or SCHIP)? Yes No

Name	Address	SSN/FEIN

VIII. Instructions / Definitions: Sanctions and other adverse actions include any revocation or suspension of a license to provide health care by any State licensing authority; any revocation or suspension of accreditation; and/or any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

VIII. Sanctions and Other Adverse Actions

Has your organization, under any current or former name or business identity, or any individuals and organizations listed in **Sections II, III, V, or VI**, ever had a final adverse action imposed against it? If yes, report the individual(s) or organization(s) involved, each final adverse action, when it occurred, and the Federal or State agency or the court/administrative body that imposed the action. Yes No

Individual/Organization	Adverse Action	Date	Taken by

IX. Instructions/ Definitions: Changes in provider status are defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the ownership, including changes in any partnership arrangement, or any changes of ownership.

IX. Changes in Provider Status

If there has been a change in ownership /partnership within the last year or if you anticipate a change, indicate the date in the appropriate space. If there are no owners (i.e., the provider is a sole proprietorship), check Not Applicable.

[a] Has there been a change in ownership or controlling interest within the last year? If Yes, give date.
 Yes - Date: / / No Not Applicable

X. Instructions / Definitions: A chain affiliate is any free-standing health care facility that is owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other devices, control and direction of a private, charitable or propriety. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

X. Chain Affiliation

[a]. Is this facility chain-affiliated? If Yes, list name, address and FEIN of parent Corporation below.
 Yes No

Name	Address	FEIN

[b]. If the answer to part [a] of this item was "No", was the facility ever affiliated with a chain? If Yes, list name, address and FEIN of parent Corporation.
 Yes No

Name	Address	FEIN

Certification Statement

You MUST sign and date the certification statement below in order to be enrolled in the Medicaid program. In doing so, you are attesting to meeting and maintaining the Medicaid requirements stated below.

I, the undersigned, certify to the following:

- 1. I have read the contents of this form, and the information contained herein is true, correct, and complete. If I become aware that any information listed on this form is not true, correct, or complete, I agree to notify Medicaid of this fact within thirty-five (35) days of discovery.
- 2. I authorize Medicaid to verify the information contained herein. I agree to notify Medicaid of a change in ownership, practice location and/or Final Adverse Action within 35 days of the reportable event. In addition, I agree to notify Medicaid of any other changes to the information on this form within 35 days of the effective date of change. I understand that any change in business structure of this provider may require the submission of a new application.
- 3. I understand that any deliberate omission, misrepresentation, or falsification of any information contained on this form or contained in any communication supplying information to Medicaid, or any deliberate alteration of any text on this form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicaid billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
- 4. I agree to abide by the Medicaid laws, regulations and program instructions that apply to me or to the organization. The Medicaid laws, regulations, and program instructions are available through SCDHHS. I understand that payment of a claim by Medicaid is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions, and on the provider's compliance with all applicable conditions of participation in Medicaid.
- 5. Neither I, nor any managing employee listed on this form, is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicaid or other Federal program beneficiaries.
- 6. I agree that any existing or future overpayment made to me or to the organization(s) listed on this form, by the Medicaid program, may be recouped by Medicaid through the withholding of future payments.
- 7. I understand that the Medicaid identification number issued to me can only be used by me or by a provider to whom I have reassigned my benefits under current Medicaid regulations, when billing for services rendered by me.
- 8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicaid, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

Name of Authorized Representative (Printed or Typed):	Title:
Signature:	Date:

Trading Partner Agreement Enrollment Instructions for Providers

The Trading Partner Agreement (TPA) Enrollment form may be found in the “Forms” section under “Provider Quick Links” on the SCDHHS website, <http://provider.scdhhs.gov>.

Please use the instructions outlined below to complete the TPA. Incomplete or incorrect TPAs will not be processed.

Field	Instructions
Reason for Submission	Select the appropriate transaction type being submitted: New Enrollment, Change Enrollment, or Cancel Enrollment. <i>(Select only one)</i>
Provider Name	Enter the complete legal name of institution, corporate entity, practice, or individual provider.
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it. Enter this information, if applicable.
Street	Enter the number and street name where a person or organization can be found.
City	Enter the city associated with the provider address field.
State/Province	Enter the ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable country.
Zip Code/Postal Code	Enter the 5 digit or the 5 digit + 4 codes associated with the provider’s add The zip code/postal code is part of the system of postal-zone codes (Zip stand for “zone improvement plan” introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.
National Provider Identifier (NPI)	Enter the unique 10-digit identification number issued to healthcare providers by the Centers for Medicare and Medicaid Services.
Provider Federal Tax Identification Number (TIN)	Enter a Federal Tax Identification Number, also known as an Employer Identification Number (EIN), which is used to identify a business entity. A Social Security Number (SSN) may also be used for Individual provider enrollments.
Trading Partner ID	Enter the provider’s submitter ID assigned by the health plan or the provider’s clearinghouse or vendor. Leave this field blank if you have an X12 Submitter ID.
SC Medicaid Provider ID	Enter the 6-digit alphanumeric SC Medicaid Provider number assigned to the provider by SCDHHS. This will not be completed for new Trading Partner Agreement enrollments.
Type of Business	Select “Medicaid Provider”.
Provider Contact Name	Enter the name of the contact in the provider’s office for handling ERA issues.
Telephone Number	Enter the 10-digit telephone number associated with the contact person.
Telephone Number Extension	Enter the contact person’s telephone number extension, if applicable.
Fax Number	Enter a 10-digit number at which the provider can be sent facsimiles.
Email Address	Enter an electronic email address at which the health plan might contact the provider.
Preference for Aggregation of Remittance Data	Select either the “National Provider Identifier (NPI)” or the “Provider Tax Identification Number (TIN)” checkbox to indicate the provider’s preference for grouping (bulking) claim payment remittance advice. Enter the provider’s NPI or TIN (EIN or SSN) in the space provided. Only one type may be selected. (Note: In most cases, this will be the NPI unless the provider is atypical and does not have an NPI.)
Using a clearinghouse, billing agent, or vendor to submit claims	Indicate if you are using a clearinghouse, billing agent, or vendor to submit your claims. If you select “Yes”, enter the name of this entity. (If you will only be using the South Carolina Medicaid Web-based Submission Tool, enter “Web Tool” in this space.) If you select “No”, please indicate the protocol(s) you will use to submit claims. (multiple selections are allowed)
South Carolina Medicaid Web-based Claims Submission Tool (Select Only One)	If you would like to access the SC Medicaid Web Tool, check the “Requesting Access” checkbox and indicate the number of IDs you require. (Individual IDs are required). If you bill as part of an existing group, leave this section blank. If you have an existing Web tool ID and you would like the NPI on this TPA linked, select the “Link to Existing ID” checkbox and indicate the Web Tool ID.
Transactions Requested	Leave blank unless you have an X12 Submitter ID.
TPA Authorization Agreement	Select the checkbox if you have read, understand, and are in agreement with TPA terms and conditions. (The TPA will not be processed if this is not checked)
Authorized Signature	Enter the signature of the individual authorized by the provider or its agent to initiate, modify, or terminate an enrollment.
Printed name of Person Submitting Enrollment	Print the name of the person signing the form.
Submission Date	Enter the date on with the enrollment or modification is being submitted.
Requested Effective Date	Enter the date the provider wishes to begin receiving/end an electronic remittance advice (ERA).

SC Trading Partner Agreement/Remittance Advice Enrollment

Fax to (803)870-9021 or mail to SC Medicaid TPA, PO Box 17, Columbia, SC 29202

Reason for Submission: New Enrollment Change Enrollment Cancel Enrollment

Trading Partner Information

Provider Name: _____

Doing Business As Name (DBA): _____

Street: _____

City: _____ State/Province: _____ Zip Code/Postal Code: _____

National Provider Identifier (NPI): _____ Provider Federal Tax Identification Number (TIN): _____

Trading Partner ID: _____ SC Medicaid Provider ID: _____

Type of Business: Medicaid Provider Billing Service Clearinghouse Software Vendor

Other (please specify): _____

Provider Contact Information

Provider Contact Name: _____

Telephone Number: _____ Telephone Number Extension: _____

Fax Number: _____ Email Address: _____

Preference for Aggregation of Remittance Data Provider Tax Identification Number (TIN): _____

(e.g., Account number linkage to provider identifier): National Provider Identifier (NPI): _____

Claims Submission/Retrieval Information

Are you using a clearinghouse, billing agent, or vendor to submit your claims? Yes No

If Yes, please enter the name of the clearinghouse, billing agent, or vendor here: _____

If No, please indicate below which protocol(s) is/are used: (multiple selections are allowed)

Secure FTP WS_FTP Pro CD Diskette

South Carolina Medicaid Web-Based Claims Submission Tool (Select One)

Requesting Access: Number of IDs Requested _____ No Access Needed

Link to Existing IDs: _____

(If you submit X12 claims directly to SC Medicaid, you must complete the "linked" Submitter ID Information found on the second page of this application)

Transactions Requested

Yes No 270 – Eligibility IN Yes No 820 – Premium Payments Yes No 837P – Professional Claims

Yes No 271 – Eligibility OUT Yes No 834 – Benefit Enrollment Yes No 837D – Dental Claims

Yes No 276 – Claim Status IN Yes No 835 – Electronic Remittance Advice*

Yes No 277 – Claim Status OUT Yes No 837I – Institutional Claims

TPA Authorization Agreement

I have read, understand, and agree with the conditions set forth in the South Carolina Trading Partner Agreement for Electronic Claims and Related transactions.

Authorized Signature: _____

Printed Name of Person Submitting Enrollment: _____

Submission Date: _____ Requested Effective Date: _____

*Please contact the Provider Service Center at 1-888-289-0709 for any questions regarding the electronic remittance advice enrollment process or the status of your enrollment.

*Please refer to the "Your Remittance Advice" area in 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 Electronic Remittance Advice.

For assistance completing this form, please contact the EDI Support Center at 1-888-289-0709.

If you submit X12 files directly to SC Medicaid, please complete this page to indicate providers to link to your Submitter ID.

Do not use this page if you are submitting claims through a vendor or clearinghouse.

Individual providers who are a part of a Medicaid group ***must*** have a separate Trading Partner Agreement.

PROVIDER NAME	MEDICAID ID	NPI	STATE	ADD/REMOVE

For assistance completing this form, please contact the EDI Support Center at 1-888-289-0709.

Trading Partner Agreement Enrollment Instructions for Vendors and Clearinghouses

The Trading Partner Agreement (TPA) Enrollment form may be found in the “Forms” section under “Provider Quick Links” on the SCDHHS website, <http://provider.scdhhs.gov>.

Please use the instructions outlined below to complete the TPA. Incomplete or incorrect TPAs will not be processed.

Field	Instructions
Reason for Submission	Select the appropriate transaction type being submitted: New Enrollment, Change Enrollment, or Cancel Enrollment. (<i>Select only one</i>) Select “New Enrollment” to request a new SC Medicaid Submitter ID. Select “Change” or “Cancel” to add or remove providers on an existing Submitter ID.
Trading Partner Name	Enter the complete legal name of institution, corporate entity, practice, or individual provider.
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it. Enter this information, if applicable.
Street	Enter the number and street name where a person or organization can be found.
City	Enter the city associated with the provider address field.
State/Province	Enter the ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable country.
Zip Code/Postal Code	Enter the 5 digit or the 5 digit + 4 codes associated with the provider’s add The zip code/postal code is part of the system of postal-zone codes (Zip stand for “zone improvement plan” introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.
National Provider Identifier (NPI)	Enter the unique 10-digit identification number issued to healthcare providers by the Centers for Medicare and Medicaid Services. (<i>For future use</i>)
Provider Federal Tax Identification Number (TIN)	Enter a Federal Tax Identification Number, also known as an Employer Identification Number (EIN), which is used to identify a business entity. A Social Security Number (SSN) may also be used for Individual provider enrollments. (<i>For future use</i>)
Trading Partner ID	Enter the provider’s submitter ID assigned by the health plan or the provider’s clearinghouse or vendor. Enter the X12 Submitter ID for the clearinghouse or vendor.
SC Medicaid Provider ID	Enter the 6-digit alphanumeric SC Medicaid Provider number assigned to the provider by SCDHHS. This will not be completed for new Trading Partner Agreement enrollments.
Type of Business	Select the appropriate type for your company.
Trading Partner Contact Name	Enter the name of the contact in the provider’s office for handling ERA issues.
Telephone Number	Enter the 10-digit telephone number associated with the contact person.
Telephone Number Extension	Enter the contact person’s telephone number extension, if applicable.
Fax Number	Enter a 10-digit number at which the provider can be sent facsimiles.
Email Address	Enter an electronic email address at which the health plan might contact the provider.
Protocol	Select the appropriate submission or retrieval method for X12 transactions.
South Carolina Medicaid Web-based Claims Submission Tool (Select Only One)	If you would like to access the SC Medicaid Web Tool, check the “Requesting Access” checkbox and indicate the number of IDs you require. (Individual IDs are required). If you would like to link providers, select the “Link to Existing ID” checkbox and complete Page 2 of the application. (<i>Note: Linked providers must have a TPA on file for the Submitter ID listed on Page 1</i>)
Transactions Requested	Select the transaction types you wish to send and receive.
TPA Authorization Agreement	Select the checkbox if you have read, understand, and are in agreement with TPA terms and conditions. (The TPA will not be processed if this is not checked)
Authorized Signature	Enter the signature of the individual authorized by the provider or its agent to initiate, modify, or terminate an enrollment.
Printed name of Person Submitting Enrollment	Print the name of the person signing the form.
Submission Date	Enter the date on with the enrollment or modification is being submitted.
Requested Effective Date	Enter the date the provider wishes to begin receiving/end an electronic remittance advice (ERA).

SC Trading Partner Agreement Enrollment

Fax to (803)870-9021 or mail to SC Medicaid TPA, PO Box 17, Columbia, SC 29202

Reason for Submission: New Enrollment Change Enrollment Cancel Enrollment

Trading Partner Information

Trading Partner Name: _____

Doing Business As Name (DBA): _____

Street: _____

City: _____ State/Province: _____ Zip Code/Postal Code: _____

National Provider Identifier (NPI): _____ Provider Federal Tax Identification Number (TIN): _____

Trading Partner ID: _____ SC Medicaid Provider ID: _____

Type of Business: Billing Service Clearinghouse Software Vendor

Other (please specify): _____

Trading Partner Contact Information

Trading Partner Contact Name: _____

Telephone Number: _____ Telephone Number Extension: _____

Fax Number: _____ Email Address: _____

Claims Submission/Retrieval Information

Indicate below which protocol(s) is/are used: (Multiple selections are allowed)

Secure FTP WS_FTP Pro CD Diskette

South Carolina Medicaid Web-Based Claims Submission Tool (Select One)

Requesting Access: Number of IDs Requested _____ No Access Needed

Link to Existing IDs: _____

(If you submit X12 claims directly to SC Medicaid, you must complete the "linked" Submitter ID Information found on the second page of this application)

Transactions Requested

Yes No 270 – Eligibility IN Yes No 820 – Premium Payments Yes No 837P – Professional Claims
 Yes No 271 – Eligibility OUT Yes No 834 – Benefit Enrollment Yes No 837D – Dental Claims
 Yes No 276 – Claim Status IN Yes No 835 – Electronic Remittance Advice
 Yes No 277 – Claim Status OUT Yes No 837I – Institutional Claims

TPA Authorization Agreement

I have read, understand, and agree with the conditions set forth in the South Carolina Trading Partner Agreement for Electronic Claims and Related transactions.

Authorized Signature: _____

Printed Name of Person Submitting Enrollment: _____

Submission Date: _____ Requested Effective Date: _____

For assistance completing this form, please contact the EDI Support Center at 1-888-289-0709.

If you submit X12 files directly to SC Medicaid, please complete this page to indicate providers to link to your Submitter ID.

Do not use this page if you are submitting claims through a vendor or clearinghouse.

Individual providers who are a part of a Medicaid group *must* have a separate Trading Partner Agreement.

PROVIDER NAME	MEDICAID ID	NPI	STATE	ADD/REMOVE

For assistance completing this form, please contact the EDI Support Center at 1-888-289-0709.

Request for Taxpayer Identification Number and Certification

**Give Form to the
requester. Do not
send to the IRS.**

Print or type See Specific Instructions on page 2.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.		
	2 Business name/disregarded entity name, if different from above		
	3 Check appropriate box for federal tax classification; check only one of the following seven boxes: <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner. <input type="checkbox"/> Other (see instructions) ▶ _____		4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts maintained outside the U.S.)</i>
	5 Address (number, street, and apt. or suite no.)		Requester's name and address (optional)
	6 City, state, and ZIP code		
	7 List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> </tr> </table>												
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Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at www.irs.gov/fw9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)

- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding? on page 2.

By signing the filled-out form, you:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
- Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

- 1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)
- 2—The United States or any of its agencies or instrumentalities
- 3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities
- 4—A foreign government or any of its political subdivisions, agencies, or instrumentalities
- 5—A corporation
- 6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession
- 7—A futures commission merchant registered with the Commodity Futures Trading Commission
- 8—A real estate investment trust
- 9—An entity registered at all times during the tax year under the Investment Company Act of 1940
- 10—A common trust fund operated by a bank under section 584(a)
- 11—A financial institution
- 12—A middleman known in the investment community as a nominee or custodian
- 13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 5 ²
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

- A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)
- B—The United States or any of its agencies or instrumentalities
- C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities
- D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)
- E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)
- F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state
- G—A real estate investment trust
- H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940
- I—A common trust fund as defined in section 584(a)
- J—A bank as defined in section 581
- K—A broker
- L—A trust exempt from tax under section 664 or described in section 4947(a)(1)
- M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN below*.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship or disregarded entity owned by an individual	The owner ³
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor ⁴
For this type of account:	Give name and EIN of:
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity ⁴
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: sparr@uce.gov or contact them at www.ftc.gov/idtheft or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

PARTICIPATION AND PAYMENT AGREEMENT

AS A CONDITION OF PARTICIPATION AND PAYMENT, I UNDERSTAND AND AGREE;

- That this agreement shall not be assigned or transferred.
- That upon acceptance of this agreement, the South Carolina Department of Health and Human Services (SCDHHS) will issue a Medicaid provider number.
- That services shall be provided to Medicaid recipients in compliance with Section 504 of the Rehabilitation Act of 1973, as amended, and the Age Discrimination Act of 1975, as amended; the Omnibus Budget Reconciliation Act of 1981, as amended; the Americans with Disabilities Act of 1990 (ADA), as amended; and any regulations promulgated pursuant to any of these Acts.
- In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 et seq.) and regulations pursuant thereto, (45 CFR Part 80, 2014, as amended), the provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement.
- That provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR 489 Subpart I and 42 CFR §417.436(d).
- That adequate and correct fiscal and medical records shall be kept to disclose the extent of services rendered and to assure that claims for funds are in accordance with all applicable laws, regulations, and policies.
- That for Medicaid purposes all fiscal and medical records shall be retained for a minimum period of five (5) years after last payment was made for services rendered, except that hospitals and nursing homes are required to retain such records for six (6) years after last payment was made for services rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the appropriate retention period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the appropriate retention period, whichever is later.
- That, for the purposes of reviewing, copying, and reproducing documents, access shall be allowed to all records concerning services and payment under this agreement to SCDHHS, the State Auditor's Office, the South Carolina Attorney General's Office, the United States Department of Health and Human Services, Government Accountability Office and/or their designee during normal business hours. Failure of the provider to comply with this provision may result in the immediate termination of this agreement. SCDHHS may, upon good cause shown by the provider, and within the discretion of SCDHHS, allow the provider a reasonable amount of time to provide the documents requested. SCDHHS will notify the provider of any termination under this provision by Certified Mail, Return Receipt Requested, or nationally recognized overnight carrier.
- That upon request, information must be furnished regarding any claim for payment to the SCDHHS.
- That requests for reimbursement for services shall reflect any third party payment received and that any payment received subsequent to claims filing shall be reported.
- That Medicaid will reimburse the co-insurance and/or deductible portions (cost sharing) of Medicare claims for recipients with both coverages only if the provider accepts Medicare assignment. Cost sharing is in accordance with the South Carolina State Plan for Medical Assistance.
- That Medicaid reimbursement is always made to the provider of services and that the recipient shall not be billed pending receipt of such payment.
- That Medicaid reimbursement is payment in full and that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient or any other person, family member, relative, organization or entity for care or services to a recipient/patient except as may otherwise be allowed under Federal regulations or in accordance with SCDHHS policy. That this statement applies only to those recipients for whom Medicaid claims are filed and that it in no way requires that the provider render services to any Medicaid recipient.
- The provider may terminate this agreement upon providing SCDHHS with thirty (30) days written notice of termination. SCDHHS may terminate this agreement for good cause upon providing the provider with thirty (30) days written notice of termination. Notices of termination shall be sent by Certified Mail, Return Receipt Requested or nationally recognized overnight carrier, and be effective thirty (30) days after the date of receipt. For the purposes of this agreement, 'good cause' shall be a failure of the provider to abide by the terms of this agreement.
- That the provider shall disclose full and complete information as to ownership, business transactions, and criminal activity in accordance with 42 CFR 455 Subpart B (2014, as amended). Furthermore, the provider shall disclose any felony convictions under federal or state law in accordance with 42 CFR 1001 Subparts B and Subpart C (2014, as amended).
- That the provider shall comply with all applicable screening and enrollment requirements in accordance with 42 CFR 455 Subpart E (2014, as amended).
- That, for any dispute arising under this agreement, the provider shall have as his sole and exclusive remedy the right to request a hearing from SCDHHS within thirty (30) calendar days of the SCDHHS action which he believes himself aggrieved. Such proceedings shall be in accordance with SCDHHS appeals procedures and S.C. Code Ann. 1-23-310 et seq. (1976, as amended). Judicial review of any final agency administrative decision shall be in accordance with S.C. Code Ann. 1-23-380 (1976, as amended).
- That the provider shall safeguard the use and disclosure of information concerning applicants for or recipients of Title XIX (Medicaid) services in accordance with 42 CFR Part 431 Subpart F (2014, as amended), SCDHHS regulation §§126-170, et seq., South Carolina Code of State Regulations (2012) Volume 10, as amended, and all applicable State laws and regulations.
- That none of the funds provided under this agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for political office, or otherwise in violation of the "Hatch Act".
- That participation, all services rendered, and claims submitted shall be in compliance with all applicable federal and state laws and regulations and in accordance with the South Carolina Plan for Medical Assistance, bulletins, SCDHHS policies, procedures, and Medicaid Provider Manuals.
- That all information provided on the Medicaid enrollment form is incorporated as a part of this agreement.
- That the provider shall be held personally liable for all claims submitted by him or on his behalf as evidenced by his endorsement of his Medicaid reimbursement check or acceptance of an electronic deposit.
- That Medicaid reimbursement (payment of claims) is from state and federal funds and that any falsification (false claims, statement or documents) or concealment of material fact may be prosecuted under applicable state and federal laws.
- That the provider shall comply with all applicable standards of Title VII of the Civil Rights Act of 1964, as amended; the Clean Air Act of 1970, as amended; the Federal Water Pollution Control Act, as amended; Section 6002 of the Solid Waste Disposal Act of 1965 as amended by the Resource Conservation and Recovery Act of 1976; and any regulations promulgated pursuant to any of these Acts.
- That the provider shall comply with all terms and conditions of the Drug Free Workplace Act, S.C. Code Ann. Section 44-107-10 et seq. (1976, as amended) if this agreement is for a stated or estimated value of Fifty Thousand Dollars or more.
- That the provider shall comply with all terms and conditions of the Iran Divestment Act of 2014, S.C. Code Ann. §§11-57-10 et seq. (Supp. 2014, as amended).
- That in accordance with 31 U.S.C. 1352, funds received through this agreement may not be expended to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. This restriction is applicable to all contractors and subcontractors.
- The Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification: Standard Unique Health Identifier for Health Care Providers regulations (45 CFR 162 Subparts A & D), states that all covered entities: health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a standard transaction must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES).
- Pursuant to the Standard Unique Health Identifier regulations (45 CFR 162 Subparts A & D), and if the provider is a covered health care provider as defined in 45 CFR §162.402, the provider agrees to disclose its National Provider Identifier (NPI) to SCDHHS once obtained from the NPPES. Provider also agrees to use the NPI it obtained from the NPPES to identify itself on all standard transactions that it conducts with SCDHHS.
- That the provider shall comply with all applicable provisions of 2 CFR Part 180 (2014, as amended) as supplemented by 2 CFR Part 376 (2014, as amended), pertaining to debarment and/or suspension. As a condition of participation, the provider should screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program, and/or all federal health care programs. Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider.
- That if the provider receives annual Medicaid payments of at least Five Million Dollars, the provider must comply with Section 6032 of the Deficit Reduction Act of 2005, Employee Education about False Claims Recovery.

State of South Carolina
Department of Health and Human Services

PRECEPTOR/PROTOCOL AGREEMENT FORM

1. A Nurse Practitioner, Nurse Midwife, Clinical Nurse Specialist, or Physician Assistant practicing in an extended role shall perform delegated medical acts pursuant to an approved written protocol between the nurse or physician assistant and the physician.
2. The approved written protocol shall include the following information at a minimum:
 - A. General Data:
 1. Name, address, and license number of the nurse or physician assistant.
 2. Name, address, and license number of the physician preceptor/collaborator.
 3. Nature of practice and practice location(s) of the nurse or physician assistant and the physician.
 4. Date the protocol was developed and dates reviewed and amended.
 5. Description of how consultation with the physician is provided and if a provision for backup consultation has been established in the physician's absence.
 - B. Delegated Medical Acts:
 1. The medical conditions for which therapies may be initiated, continued or modified.
 2. The treatments that may be initiated continued or modified.
 3. The drug therapies that may be prescribed.
 4. Situations that require direct evaluation by or referral to the physician.
3. The original protocol and any amendments to the protocol, dated and signed by the nurse or physician assistant and the physician, shall be available for review within 72 hours of request.
4. Individuals, who change practice settings or physicians, shall notify the Department of Health and Human Services (DHHS) in writing within 15 days. Individuals who discontinue their practice shall notify DHHS in writing within 15 days.

I, the undersigned, agree to serve as the physician preceptor/collaborator for _____
_____. My preceptorship is to extend to the limits described in the
above written protocol.

Physician Printed Name

Enrollee Printed Name

Physician Signature

Enrollee Signature

Physician License #

Physician Assistant or Nurse License #

Physician NPI #

Physician Assistant or Nurse NPI #

Date _____

PLEASE FAX THIS COMPLETED FORM TO: Medicaid Provider Enrollment (803) 870-9022

01/2017