# FORMS

| Number | Name | Revision Date |
|---|---|---|
| DHHS 126 | Confidential Complaint | 06/2007 |
| DHHS 130 | Claim Adjustment Form 130 | 03/2007 |
| DHHS 205 | Medicaid Refunds | 01/2008 |
| DHHS 931 | Health Insurance Information Referral Form | 02/2018 |
| | Reasonable Effort Documentation | 04/2014 |
| | Electronic Funds Transfer (EFT) Authorization Agreement | 08/2017 |
| | Duplicate Remittance Advice Request Form | 09/2017 |
| | Claim Reconsideration Form | 11/2018 |
| CMS-1500 (02/12) | Sample Health Insurance Claim Form | 02/2012 |
| | Sample Remittance Advice (four pages) | 04/2014 |
| | Allied Professional Registration Form | 04/2017 |
| | LISW Allied Professional Registration Form | 04/2017 |
| | Mental Health Form | 04/2013 |

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

# CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

## PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

| | |
|---|---|
| SUSPECTED INDIVIDUAL OR INDIVIDUALS: | |
| NPI or MEDICAID PROVIDER ID: (if applicable) | MEDICAID RECIPIENT ID NUMBER: (if applicable) |
| ADDRESS OF SUSPECT: | LOCATION OF INCIDENT: |
| | DATE OF INCIDENT: |
| COMPLAINT: | |

| | | |
|---|---|---|
| NAME OF PERSON REPORTING: (Please print) | SIGNATURE OF PERSON REPORTING: | DATE OF REPORT |

| | |
|---|---|
| ADDRESS OF PERSON REPORTING: | TELEPHONE NUMBER OF PERSON REPORTING: |
| | SIGNATURE: (SCDHHS Representative Receiving Report) |

# South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Provider ID:

NPI:

Recipient ID:

Adjustment Type:

◯ Void ◯ Void/Replace

Originator:

◯ DHHS ◯ MCCS ◯ Provider ◯ MIVS

Reason For Adjustment: (Fill One Only )

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

For Agency Use Only

Analyst ID:

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

Comments:

Signature:_____ Date:_____

Phone:_____

DHHS Form 130 Revision date: 03-13-2007

**South Carolina Department of Health and Human Services**
**Form for Medicaid Refunds**

**Purpose:** This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

**Items 1, 2 or 3, 4, 5, 6, & 7 must be completed.** **Attach appropriate document(s) as listed in item 8.**

**1. Provider Name:** _____

**2. Medicaid Legacy Provider #** ☐☐☐☐☐☐
(Six Characters)

**OR**

**3. NPI#** ☐☐☐☐☐☐☐☐☐☐ **& Taxonomy** ☐☐☐☐☐☐☐☐☐☐

**4. Person to Contact:** _____ **5. Telephone Number:** _____

**6. Reason for Refund:** [check appropriate box]

☐ Other Insurance Paid (please complete **a – f** below and attach insurance EOMB)
- **a** Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
- **b** Insurance Company Name _____
- **c** Policy #:_____
- **d** Policyholder: _____
- **e** Group Name/Group: _____
- **f** Amount Insurance Paid:_____

☐ Medicare
- ( ) Full payment made by Medicare
- ( ) Deductible not due
- ( ) Adjustment made by Medicare

☐ Requested by DHHS (please attach a copy of the request)

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

**7. Patient/Service Identification:**

| Patient Name | Medicaid I.D.# (10 digits) | Date(s) of Service | Amount of Medicaid Payment | Amount of Refund |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**8. Attachment(s):** [Check appropriate box]

☐ Medicaid Remittance Advice (required)

☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)

☐ Explanation of Benefits (EOMB) from Medicare (if applicable)

☐ Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

# SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
# MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

**I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS**

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

**II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS**

_____ a. beneficiary has never been covered by the policy – close insurance.

_____ b. beneficiary coverage ended - terminate coverage (date) _____

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

**ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.**

Submit this information to Medicaid Insurance Verification Services (MIVS).

**Fax:** 803-252-0870 **or** **Mail:** Post Office Box 101110, Columbia, SC 29211-9804

## SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
## REASONABLE EFFORT DOCUMENTATION

**PROVIDER** _____ **DOS** _____

**NPI or MEDICAID PROVIDER ID** _____

**MEDICAID BENEFICIARY NAME** _____

**MEDICAID BENEFICIARY ID#** _____

**INSURANCE COMPANY NAME** _____

**POLICYHOLDER** _____

**POLICY NUMBER** _____

**ORIGINAL DATE FILED TO INSURANCE COMPANY** _____

**DATE OF FOLLOW UP ACTIVITY** _____

**RESULT:**

**FURTHER ACTION TAKEN:**

**DATE OF SECOND FOLLOW UP** _____

**RESULT:**

**I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.**

_____

**(SIGNATURE AND DATE)**

**ATTACH A COPY OF THE FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.**

**Revised 04/2014**

**South Carolina Department of Health 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.

## South Carolina Department of Health and Human Services
## Duplicate Remittance Advice Request Form

**Purpose: This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.**

**Please contact the SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for instructions on submission of your request.**

1. Provider Name: _____

2. Medicaid Legacy Provider # _____ (Six Characters)

   NPI# _____ Taxonomy _____

3. Person to Contact: _____ Telephone Number: _____

4. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:
   _____
   _____
   _____
   _____
   _____

   **Note: Remittance advices are available electronically through the Web Tool. Please check the Web Tool for the availability of the remittance advice date before submitting your request.**

5. Street Address for delivery of request:

   Street: _____

   City: _____

   State: _____

   Zip Code: _____

6. Charges for duplicate remittance advice(s) are as follows:

   Request Processing Fee - $20.00

   Page(s) copied - .20 per page

**I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.**

_____ _____

**Authorizing Signature** **Date**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

*Submit your Claim Reconsideration request to:*

**Fax:** 1-855-563-7086

or

**Mail:** South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

# CLAIM RECONSIDERATION FORM

**Instructions:** Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. A separate SCDHHS CR form is required for each claim control number (CCN). Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709. **Note:** Timely filing guidelines apply.

**Section 1: Beneficiary Information**

Name (Last, First, MI): _____

Date of Birth: _____ Medicaid Beneficiary ID: _____

**Section 2: Provider Information**

Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other (DME, Lab, Home Health Agency, etc.): _____

NPI: _____ Medicaid Provider ID: _____ Facility/Group/Provider Name: _____

Return Mailing Address: _____
*Street or Post Office Box* *State* *ZIP*

Contact: _____ Email: _____ Telephone #: _____ Fax #: _____

**Section 3: Claim Information** *(Only one CCN allowed per request.)*

Communication ID: _____ CCN: _____ Date(s) of Service: _____

**Section 4: Claim Reconsideration Information**

What area is your denial related to? (Please select below)

- ☐ Ambulance Services
- ☐ Autism Spectrum Disorder (ASD) Services
- ☐ Clinic Services
- ☐ Community Long Term Care (CLTC)
- ☐ Community Mental Health Services
- ☐ Department of Disabilities and Special Needs (DDSN) Waivers
- ☐ Durable Medical Equipment (DME)
- ☐ Early Intervention Services
- ☐ Enhanced Services
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Home Health Services
- ☐ Hospice Services
- ☐ Hospital Services
- ☐ Licensed Independent Practitioner's Rehabilitative Services (LIPS)
- ☐ Local Education Agencies (LEA)
- ☐ Medically Complex Children's (MCC) Waivers
- ☐ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- ☐ Optional State Supplementation (OSS)
- ☐ Pharmacy Services
- ☐ Physicians Laboratories, and Other Medical Professionals Specify: _____
- ☐ Private Rehabilitative Therapy and Audiological Services
- ☐ Psychiatric Hospital Services
- ☐ Rehabilitative Behavioral Health Services (RBHS)
- ☐ Rural Health Clinic (RHC)
- ☐ Targeted Case Management (TCM)
- ☐ Other: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

**Section 5: Desired Outcome**

**Request submitted by:**

Print Name: _____

Signature:_____ Date: _____

# HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | NPI | |
| 2 | | | | | | | | NPI | |
| 3 | | | | | | | | NPI | |
| 4 | | | | | | | | NPI | |
| 5 | | | | | | | | NPI | |
| 6 | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

# Sample Remittance Advice (page 1)

This page of the sample Remittance Advice shows a paid claim, suspended claim and rejected claim.

PROVIDER ID. PROFESSIONAL SERVICES PAYMENT DATE PAGE

AB00080000

DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

REMITTANCE ADVICE

02/14/2014

1

| PROVIDERS OWN REF. NUMBER | CLAIM REFERENCE NUMBER | PY IND | SERVICE RENDERED DATE(S) MMDDYY | PROC. | AMOUNT BILLED | TITLE 19 PAYMENT MEDICAID | T S | RECIPIENT ID. NUMBER | RECIPIENT NAME F M I I LAST NAME | M O D | TLE. 18 ALLOWED CHARGES | COPAY AMT | TITLE 18 PAYMENT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ABB1AA | 1403004803012700A | | | | 27.00 | 6.72 | P | 1112233333 | M CLARK | | | | |
| | 01 | | 101713 | 71010 | 27.00 | 6.72 | P | | | 026 | | 0.00 | 0.00 |
| ABB2AA | 1403004804012700A | | | | 259.00 | 0.00 | S | 1112233333 | M CLARK | | | | |
| | 01 | | 101713 | 74176 | 259.00 | 0.00 | S | | | 026 | | 0.00 | 0.00 |
| ABB3AA | 1403004805012700A | | | | 24.00 | 0.00 | R | 1112233333 | M CLARK | | | 0.00 | |
| | 01 | | 071913 | A5120 | 12.00 | 0.00 | R | | | 000 | | | 0.00 |
| | 02 | | 071913 | A4927 | 12.00 | 0.00 | R | | | 000 | | | 0.00 |
| | | | | | | | | | Edits: L00 946 L02 852 08/30/13 | | | | |
| | TOTALS | | 3 | | 310.00 | | | | | | | 0.00 | 0.00 |

$6.72

CERT. PG TOT $0.00

MEDICAID PG TOT $286.46

CERTIFIED AMT

MEDICAID TOTAL 0.00

CHECK TOTAL

CHECK NUMBER

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

STATUS CODES:

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

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

# Sample Remittance Advice (page 2)

This page of the sample Remittance Advice shows a paid claim, as well as a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle.

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

| PROVIDERS OWN REF. NUMBER | CLAIM REFERENCE NUMBER | PY IND | SERVICE RENDERED DATE(S) MMDDYY | PROC. | AMOUNT BILLED | TITLE 19 PAYMENT MEDICAID | S T S | RECIPIENT ID. NUMBER | RECIPIENT NAME F M I I LAST NAME | M O D | TLE. 18 ALLOWED CHARGES | COPAY AMT | TITLE 18 PAYMENT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ABB222222 | 1405200415812200A | | | | 1192.00 | 243.71 | P | 1112233333 | M CLARK | | | 0.00 | |
| | 01 | | 021814 | S0315 | 800.00 | 117.71 | P | | | 000 | | | 0.00 |
| | 02 | | 021814 | S9445 | 392.00 | 126.00 | P | | | 000 | | | 0.00 |
| | VOID OF ORIGINAL CCN 13283002244813300A PAID 20131018 | | | | | | | | | | | | |
| ABB222222 | 1405200077700000U | | | | 1412.00- | 273.71- | P | 1112233333 | M CLARK | | | | |
| | 01 | | 100213 | S0315 | 1112.00- | 143.71- | P | | | 000 | | | |
| | 02 | | 100213 | S9445 | 300.00- | 130.00- | P | | | 000 | | | |
| | REPLACEMENT OF ORIGINAL CCN 1304711253670430A PAID 20131018 | | | | | | | | | | | | |
| ABB222222 | 1405200414812200A | | | | 1001.50 | 42.75 | P | 1112233333 | M CLARK | | | 0.00 | |
| | 01 | | 100213 | S0315 | 142.50 | 42.75 | P | | | 000 | | | 0.00 |
| | 02 | | 100313 | S9445 | 859.00 | 0.00 | R | | | 000 | | | 0.00 |
| | | | | | | | | | | | | 0.00 | 0.00 |

$286.46

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

| CERT. PG TOT | MEDICAID PG TOT |
|---|---|
| $0.00 | $286.46 |
| CERTIFIED AMT | MEDICAID TOTAL |
| | 0.00 |
| | CHECK TOTAL |

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

CHECK NUMBER

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

# Sample Remittance Advice (page 3)

This page of the sample Remittance Advice shows a claim-level Void without a corresponding Replacement claim.

PROVIDER ID.: AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE: 02/28/2014

PAGE: 2

| PROVIDERS OWN REF. NUMBER | CLAIM REFERENCE NUMBER | PY IND | SERVICE RENDERED DATE(S) MMDDYY | PROC. | AMOUNT BILLED | TITLE 19 PAYMENT MEDICAID | S T S | RECIPIENT ID. NUMBER | RECIPIENT NAME LAST NAME | F I | M I | ORG CHECK O D | CHECK DATE | ORIGINAL CCN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ABB222222 | 1405200077700000U | | | | 513.00- | 197.71- | P | 1112233333 | CLARK | | M | 131018 | | 1328300224813300A |
| | 01 | | 100213 | S0315 | 453.00 | 160.71- | P | | | | | 000 | | |
| | 02 | | 100213 | S9445 | 60.00 | 33.00- | P | | | | | 000 | | |
| | TOTALS | 1 | | | 513.00- | 193.71- | | | | | | | | |



| PROVDER INCENTIVE CREDIT AMOUNT | DEBIT BALANCE PRIOR TO THIS REMITTANCE | MEDICAID TOTAL | CERTIFIED AMT | TO BE REFUNDED IN THE FUTURE |
|---|---|---|---|---|
| 0.00 | 0.00 | $243.71 | 0.00 | 0.00 |

| ADJUSTMENTS | YOUR CURRENT DEBIT BALANCE | CHECK TOTAL | CHECK NUMBER |
|---|---|---|---|
| $193.71- | 0.00 | $50.00 | 4197304 |

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

# Sample Remittance Advice (page 4)

This page of the sample Remittance Advice shows four gross-level adjustments.
Gross-level adjustments always appear on the final page of the Remittance Advice.

PROVIDER ID.: AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE: 02/28/2014

PAGE: 3

| PROVIDERS OWN REF. NUMBER | CLAIM REFERENCE NUMBER | SERVICE DATE(S) MMDDYY | PROC / DRUG CODE | RECIPIENT ID. NUMBER | RECIPIENT NAME LAST NAME F M I | ORIG. CHECK DATE | ORIGINAL PAYMENT | ACTION | DEBIT / CREDIT AMOUNT | EXCESS REFUND |
|---|---|---|---|---|---|---|---|---|---|---|
| TPL 2 | 1404900004000100U | - | | | | | | DEBIT | -2389.05 | |
| TPL 4 | 1405500076000400U | - | | | | | | DEBIT | -1949.90 | |
| TPL 5 | 1404900004000100U | - | | | | | | DEBIT | -477.25 | |
| TPL 6 | 1405500076000400U | - | | | | | | CREDIT | 477.25 | |
| | | | | | | | PAGE TOTAL: | | 4338.95 | 0.00 |



PROVDER INCENTIVE CREDIT AMOUNT: 0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 0.00

MEDICAID TOTAL: 0.00

ADJUSTMENTS: -4338.95

CHECK TOTAL: 0.00

CERTIFIED AMT: 0.00

CHECK NUMBER:

0.00

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

**Please return signed original Attestation to:**

**Mailing Address:**

**SC Dept. of Health and Human Services c/o**
**Division of Family Services**
**Post Office Box 8206**
**Columbia, South Carolina 29202-8206**

**Fax: (803) 255-8204**

## Section I: Demographic Information

**Please Print:**

| | |
|---|---|
| **Physician or APRN Name** | |
| **Address:** | |
| **Facility:** | |
| **Telephone:** | |
| **National Provider Identifier Number (NPI)** | |
| **Fax:** | |
| **Email:** | |

## Section II: Allied Professional Update Form

**The Allied Professional(s) listed below are under my supervision and services rendered and billed to South Carolina Medicaid will be in compliance with the guidelines as provided in the South Carolina Medicaid FQHC or RHC Standard. All allied professionals must be listed and a maximum of three allied professionals are permitted.**

**Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage and Family Therapist**

| | |
|---|---|
| **Name (as it appears on their license):** | |
| **License Number & Expiration Date:** | |
| **Name (as it appears on their license):** | |
| **License Number & Expiration Date:** | |
| **Name (as it appears on their license):** | |
| **License Number & Expiration Date:** | |

**If there are any changes to this list, i.e. the allied professional's qualifications, physician or APRN information, I will notify South Carolina Medicaid utilizing this form within thirty days (30). Failure to comply shall result in the recoupment for services rendered. My signature and signature date certifies, that the information provided in the Attestation is correct.**

_____ _____

Physician or APRN Signature Date

Allied Professional Registration Form (Revised 4/2017)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

**Please return signed original Attestation to:**

**Mailing Address:**

**SC Dept. of Health and Human Services c/o**
**Division of Family Services**
**Post Office Box 8206**
**Columbia, South Carolina 29202-8206**

**Fax: (803) 255-8204**

## Section I: Demographic Information

**Please Print:**

| | |
|---|---|
| **LISW-CP Name** | |
| **Address:** | |
| **Facility:** | |
| **Telephone:** | |
| **National Provider Identifier Number (NPI)** | |
| **Fax:** | |
| **Email:** | |

## Section II: Allied Professional LMSW Update Form

**The Allied Professional(s) LMSW listed below are under my LISW-CP (licensed Independent social worker-clinical practice) supervision and services rendered and billed to South Carolina Medicaid will be in compliance with the guidelines as provided in the South Carolina Medicaid FQHC or RHC Standard. All allied professional(s) LMSW must be listed and a maximum of three LMSW(s) are permitted to be supervised by the LISW-CP.**

**Licensed Master Social Worker (LMSW)**

| | |
|---|---|
| **Name (as it appears on their license):** | |
| **License Number & Expiration Date:** | |
| **Name (as it appears on their license):** | |
| **License Number & Expiration Date:** | |
| **Name (as it appears on their license):** | |
| **License Number & Expiration Date:** | |

**If there are any changes to this list, i.e. the allied professional's qualifications, LISW-CP information, I will notify South Carolina Medicaid utilizing this form within thirty days (30). Failure to comply shall result in the recoupment for services rendered. My signature and signature date certifies, that the information provided in the Attestation is correct.**

_____ _____

LISW-CP Signature Date

# South Carolina
# Department of Health and Human Services
# Mental Health Form

**FILL OUT COMPLETELY TO AVOID DELAYS**

| | | | |
|---|---|---|---|
| **Beneficiary's Name:** | | **Organization NPI:** | |
| **Medicaid ID #:** | | **Center's Name:** | |
| **Date of Birth:** | | **Service Location Address:** | |
| **Individual NPI:** | | **City & State:** | |

**DSM-IV TR Diagnosis**

Axis I _ _ _ _ _/_ _ _ _ _/ _ _ _ _ _ Axis II _ _ _ _ _/ _ _ _ _ _ Axis III _ _ _ _ _/ _ _ _ _ _

**Date first seen: _____ Date of last service: _____ # of additional visits requested: _____**

*Current Clinical Information:* (Circle each. Scale 0=None, 1=Mild, 2=Moderate, 3=Severe, 4=Extreme)

| | | | | | |
|---|---|---|---|---|---|
| Aggression | 0 1 2 3 4 | Depressions | 0 1 2 3 4 | Relationship Problems | 0 1 2 3 4 |
| Alcohol/Substance Use | 0 1 2 3 4 | Hallucinations | 0 1 2 3 4 | Side Effects | 0 1 2 3 4 |
| Anxiety/Panic | 0 1 2 3 4 | Impulsivity | 0 1 2 3 4 | Sleep Effects | 0 1 2 3 4 |
| Appetite Disturbance | 0 1 2 3 4 | Job/School Problems | 0 1 2 3 4 | Sleep Disturbance | 0 1 2 3 4 |
| Attention/Concentration | 0 1 2 3 4 | Mania | 0 1 2 3 4 | Weight Loss | 0 1 2 3 4 |
| Deficit in ADLs | 0 1 2 3 4 | Medical Illness | 0 1 2 3 4 | Other | 0 1 2 3 4 |
| Delusions | 0 1 2 3 4 | Memory | 0 1 2 3 4 | Current Stressors | 0 1 2 3 4 |

***Services***

| | | | |
|---|---|---|---|
| ◇ 90833 | ◇ 90846 | ◇ 90853 | ◇ 90837 |
| ◇ 90836 | ◇ 90847 | ◇ 90832 | ◇ H0002 |
| ◇ 90838 | ◇ 96101 | ◇ 90834 | |

| **Current Medications** | **Name** | **Dose** | **Frequency** | **Side Effects** |
|---|---|---|---|---|
| ◇ **New** | **1.**_____ | _____ | _____ | _____ |
| ◇ **New** | **2.**_____ | _____ | _____ | _____ |
| ◇ **New** | **3.**_____ | _____ | _____ | _____ |
| ◇ **New** | **4.**_____ | _____ | _____ | _____ |
| **Compliance** | ◇ **>90%** | ◇ **50-90%** | ◇ **<50%** | |

| | |
|---|---|
| **Reasons for Noncompliance:** | |

_____ (___)_____ (___)_____

Physician/Non physician Practitioner's Name Phone: Fax

_____ _____

Physician/Non physician Practitioner's Signature Date

**Clinical documentation must be submitted with this request and submitted to the QIO using one of the following methods:**

**KePRO FAX#: 1-855-300-0082, KePRO Customer Service Phone#: 1-855-326-5216, KePRO website: http://scdhhs.Kepro.com.**

**Disclaimer: Authorization indicates that SCDHHS determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary's eligibility and benefit limitations at the time services are rendered. The Physician Assistant is not authorized to sign this form.**

Behavioral Health Services
Post Office Box 8206
Columbia, South Carolina 29202-8206