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 Claim Showing Medicaid and Medicare with NPI	02/2012
CMS-1500 (02/12)	Sample Claim Showing Medicaid Only with NPI	02/2012
CMS-1500 (02/12)	Sample Claim Showing Medicaid and Private Pay with NPI and Medicaid Provider ID	02/2012
CMS-1500 (02/12)	Sample Claim Showing Medicare, Medicaid, Private Pay with NPI and Medicaid Provider ID	02/2012
	Sample Remittance Advice	04/2014
DME 001	Medicaid Certificate of Medical Necessity Equipment/Supplies	04/2018
DME 003	Medicaid Certificate of Medical Necessity Power/Manual Wheelchairs and/or Accessories	04/2018
DME 004	Medicaid Certificate of Medical Necessity Orthotics, Prosthetics, and Diabetic Shoes	04/2018
DME 005	Medicaid Certificate of Medical Necessity Enteral Nutrition	04/2018
DME 006	Medicaid Certificate of Medical Necessity Parenteral Nutrition	04/2018
DME 007	Medicaid Certificate of Medical Necessity Oxygen	04/2018
DME 008	Certificate of Repair and Labor Cost	02/2010

FORMS

Number	Name	Revision Date
	Justification for Home Uterine Activity Monitor/Supplies (HUAM) for Subcutaneous Tocolytic Therapy	02/2013

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

Durable Medical Equipment
Sample Claim Showing Medicaid Only
With NPI

PICA

1. MEDICARE ( ) (Medicare#) MEDICAID (X) (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): 1234567890

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

3. PATIENT'S BIRTH DATE: 01 01 1947 SEX: M (X) F ( )

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

5. PATIENT'S ADDRESS (No., Street): 123 Windy Lane

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other ( )

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

CITY: Anytown STATE: sc

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 29999 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (Include Area Code): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

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? YES ( ) NO ( ) PLACE (State):

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): 1

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Signature on File DATE

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

SIGNED

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. 846 0 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	20	14	01	20	14			AA4253	00		90 00	2		ZZ	1212121212
															NPI	1234567890
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 SSN ( ) EIN (X)

26. PATIENT'S ACCOUNT NO.: DOE1234

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

28. TOTAL CHARGE: $ 90 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use: 90 00

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #: (555)555-5555
ABC Medical Supply
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Durable Medical Equipment
Sample Claim Showing Medicaid and Private Pay
with NPI and Medicaid Provider ID

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Doe, John A.	01 01 1947 M[X] F[ ]	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
123 Windy Lane	Self[ ] Spouse[ ] Child[ ] Other[ ]	
CITY: Anytown / STATE: SC	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE: 299999 / 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
		01200000A
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES[ ] NO[X]	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M[ ] F[ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES[ ] NO[X] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC): 22 00
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES[ ] NO[X]	c. INSURANCE PLAN NAME OR PROGRAM NAME: 401
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES[ ] NO[X] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

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

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 / MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / MM DD YY TO
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.		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. 846 0 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY / To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 01 20 14 / 01 20 14	12		A4253	00		90 00	2		1D	ABC123
									NPI	1234567890
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)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
555555555	[ ]	[X]	DOE1234	YES[X] NO[ ]	$ 90 00	$ 22 00	68 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (555)5555555
SIGNED DATE	a. NPI b.	ABC Medical Supply 111 Main Street Anytown, SC 22222-2222 a. 1234567890 b. 1DABC123

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Durable Medical Equipment
Sample Claim Showing Medicare, Medicaid and
Private Pay with NPI and Medicaid Provider ID

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [X] (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): 1234567890

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

3. PATIENT'S BIRTH DATE: 01 01 1947 SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 123 Windy Lane

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY: Anytown STATE: SC

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 299999 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: 01200000A

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 012345678

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

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

b. RESERVED FOR NUCC USE

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

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

c. RESERVED FOR NUCC USE: 50.00

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: 400

d. INSURANCE PLAN NAME OR PROGRAM NAME: 620

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: Signature on File DATE:

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

SIGNED:

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. 846 0 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	20	14	01	20	14	12		A4253	00		90 00	2		1D	ABC123
															NPI	1234567890
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

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

26. PATIENT'S ACCOUNT NO.: DOE1234

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

28. TOTAL CHARGE: $ 90 00

29. AMOUNT PAID: $ 50 00

30. Rsvd for NUCC Use: 40 00

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

a. 1234567890 b. 1DABC123

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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
+--------------+  DEPT OF HEALTH AND HUMAN SERVICES                                                     +------------+              +----+
| AB00080000   |                                                            REMITTANCE ADVICE           | 02/14/2014 |              |  1 |
+--------------+   SOUTH CAROLINA MEDICAID PROGRAM                                                      +------------+              +----+
+---------+-----------------+------+---------+------+--------+--------+-+---------+--------------------+---+-------+-------+-------+
|PROVIDERS|      CLAIM      |      |SERVICE RENDERED|  AMOUNT|TITLE 19|S|RECIPIENT |RECIPIENT NAME      |M  |TLE. 18| COPAY | TITLE |
| OWN REF.|   REFERENCE     |      | DATE(S) |      |  BILLED| PAYMENT|T|   ID.    |F M                 | O |ALLOWED| AMT   |  18   |
|  NUMBER |      NUMBER     |PY IND|MMDDYY   | PROC.|        |MEDICAID|S|  NUMBER  |I I LAST NAME       |  D|CHARGES|       |PAYMENT|
+---------+-----------------+------+---------+------+--------+--------+-+---------+--------------------+---+-------+-------+-------+
|         |                 |      |         |      |        |        | |         |                    |   |       |       |       |
|ABB1AA   |1403004803012700A|      |         |      | 27.00  |    6.72|P|1112233333|M   CLARK         |   |       |       |       |
|         |               01 |     |101713   |71010 | 27.00  |    6.72|P|         |                    |026|       |   0.00|   0.00|
|         |                 |      |         |      |        |        | |         |                    |   |       |       |       |
|ABB2AA   |1403004804012700A|                |      | 259.00 |    0.00|S|1112233333|M   CLARK         |   |       |       |       |
|         |               01 |     |101713   |74176 | 259.00 |    0.00|S|         |                    |026|       |   0.00|   0.00|
|         |                 |      |         |      |        |        | |         |                    |   |       |       |       |
|ABB3AA   |1403004805012700A|      |         |      |   24.00|    0.00|R|1112233333|M   CLARK         |   |       |   0.00|       |
|         |               01 |     |071913   |A5120 |   12.00|    0.00|R|         |                    |000|       |       |   0.00|
|         |               02 |     |071913   |A4927 |   12.00|    0.00|R|         |                    |000|       |       |   0.00|
|         |                 |      |         |      |        |        | |         | Edits:  L00  946  L02  852 08/30/13        |
|         |                 |      |         |      |        |        | |         |                    |   |       |       |       |
|         |           TOTALS|      |        3|      |  310.00|        | |         |                    |   |       |   0.00|   0.00|
|         |                 |      |         |      |        |        | |         |                    |   |       |       |       |
+---------+-----------------+------+---------+------+--------+--------+-+-+---------+--------------------+---+-------+-------+-------+
                                            |            |   |     $6.72|
                                            +------------+   +------------+   STATUS CODES:       PROVIDER NAME AND ADDRESS
FOR AN EXPLANATION OF THE                    CERT. PG TOT    MEDICAID PG TOT                     +--------------------------------+
ERROR CODES LISTED ON THIS                 +-------------+  +-------------+   P = PAYMENT MADE  |ABC HEALTH PROVIDER             |
FORM REFER TO:  "MEDICAID                  |       $0.00 |  |     $286.46|   R = REJECTED      |                                |
PROVIDER MANUAL".                          +-------------+  +-------------+   S = IN PROCESS    |PO BOX 000000                   |
                                            CERTIFIED AMT   MEDICAID TOTAL    E = ENCOUNTER     |FLORENCE           SC 00000    |
IF YOU STILL HAVE QUESTIONS+-------------+ +-------------+  +-------------+   +---------+       |                                |
PHONE THE D.H.H.S. NUMBER  |             | |             |  |         0.00|   |         |       +--------------------------------+
SPECIFIED FOR INQUIRY OF   +-------------+ +-------------+  +-------------+   +---------+
CLAIMS IN THAT MANUAL.                                         CHECK TOTAL      CHECK NUMBER
```

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	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

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 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	M O D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	1405200077700000U				513.00-	197.71-	P			1112233333	CLARK		M		131018	1328300224813300A
	01		100213	S0315	453.00	160.71-	P							000		
	02		100213	S9445	60.00	33.00-	P							000		
	TOTALS		1		513.00-	193.71-										

PROVDER INCENTIVE CREDIT AMOUNT: 0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 0.00

MEDICAID TOTAL: $243.71

ADJUSTMENTS: $193.71-

CHECK TOTAL: $50.00

CERTIFIED AMT: 0.00

CHECK NUMBER: 4197304

TO BE REFUNDED IN THE FUTURE: 0.00

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
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR EQUIPMENT/SUPPLIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: _____ **Medicaid # (10 digits):** _____

(2) DOB: ___/___/_____ **Sex:** ___ **HT:** _____ **(in) WT:** _____ **Date of Service:** _____/_____/_____

(3) Provider's name: _____ **Provider's DME #:** _____**NPI #:**_____

(4) Street address: _____ **City:** _____ **State:** ____ **Zip:** _____**Local telephone #:** _____

(5) Provider's signature: _____**Date:** _____

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT/SUPPLIES:

_____

_____

NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD) _____ **Description(s):**_____

_____ _____

_____ _____

(8) Indicate patient's ambulatory status while performing activities of daily living: ___Non-ambulatory ___Ambulatory, without assistance

___Ambulatory with the aid of a walker or cane, ____Ambulatory, with other assistance as described

_____

_____

Does the patient have decubitus ulcers? ___ Yes ___ No. If yes, circle stage(s): I, II, III, or IV. Indicate the wound size(s): _____

Please describe how this equipment / supply is medically necessary, the benefits to the recipient and how long will it take for the benefit to be evident:

_____

_____

_____

(9) For supplies, please indicate the dressing change required per day, week, month, etc.

_____

_____

Is additional information attached on separate sheet? _____Yes _____No (If "yes," enter recipient's name & I.D. Medicaid number on attachment

(10) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____

(11) Please indicate the prescription date: _____

(12)Duration of need (maximum of 12 months): _____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(13) PHYSICIAN'S NAME:_____ PHYSICIAN'S NPI #:_____

PHYSICIAN'S SIGNATURE _____DATE___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR EQUIPMENT/SUPPLIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #:	**Indicate the patient's name and his/her Medicaid # (10 digits).**
PATIENT DOB, SEX, HEIGHT, WEIGHT:	**Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.**
DATE OF SERVICE:	**Indicate the date of service (DOS). The date of service must be the same as the delivery date.**
PROVIDER'S NAME, DME # AND NPI #:	**Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.**
PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:	**Indicate the provider's physical address (provider's location) and telephone number.**
PROVIDER SIGNATURE AND DATE:	**Signature of DME provider representative and date.**
HCPCS CODES:	**List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.**

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES:	**In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).**
QUESTION SECTION:	**These fields are used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.**
DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:	**Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.**
PRESCRIPTION DATE:	**Indicate the prescription date. The prescription date must be within 90 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.**
EST. LENGTH OF NEED:	**Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.**
PHYSICIAN ATTESTATION:	**The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.**
PHYSICIAN SIGNATURE AND DATE:	**After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR POWER/MANUAL WHEELCHAIRS AND/OR ACCESSORIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: _____ **Medicaid # (10 digits)** _____

(2) DOB ____/____/____ **Sex:** ___ **HT:** _____**(in) WT:** _____**Date of Service:** _____

(3) Provider's name: _____ **Provider's DME #:** _____ **NPI#:** _____

(4) Street address: _____**City:** _____ **State:** _____ **Zip:** _____**Local telephone #:**_____

(5) Provider's signature: _____**Date:** _____

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN ON: _____

_____

_____

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

I ATTEST THAT THE PT/OT THERAPIST AND/OR THE TREATING /ORDERING PHYSICIAN HAS NO FINANCIAL RELATIONSHIP WITH MY COMPANY.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD): _____ **Diagnosis(s):** _____

_____ _____

(8) Indicate the patient's mobility limitation & explain how it interferes with the performance of activities of daily living (ADLs):

_____

_____

- **Explain why a cane or walker is not sufficient to meet the patient's mobility needs in the home:**

_____

- **Explain why a manual wheelchair is not sufficient to meet the patient's mobility needs in the home:**

_____

- **How long has the condition been present and what is the patient's clinical progression:**

_____

_____

- **Indicate any related diagnosis and all other interventions tried and the results:**

_____

_____

- **Has the patient ever used a walker, manual or power wheelchair and what were the results?**

_____

_____

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____
(10) Prescription Date: _____

(11) Duration of need (Maximum of 12 months): _____

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) PRINT PHYSICIAN'S NAME: _____ PHYSICIAN'S NPI #_____

PHYSICIAN'S SIGNATURE: _____ DATE ____/____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR POWER/MANUAL WHEELCHAIRS AND/OR ACCESSORIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #:	**Indicate the patient's name and his/her Medicaid # (10 digits).**
PATIENT DOB, SEX, HEIGHT, WEIGHT:	**Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.**
DATE OF SERVICE:	**Indicate the date of service (DOS). The date of service must be the same as the delivery date.**
PROVIDER'S NAME, DME # AND NPI#:	**Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.**
PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:	**Indicate the provider's physical address (provider's location) and telephone number.**
PROVIDER SIGNATURE AND DATE:	**Signature of DME provider representative and date.**
HCPCS CODES:	**List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.**

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES:	**In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).**
QUESTION SECTION:	**This information is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.**
DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:	**Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.**
PRESCRIPTION DATE:	**Indicate the prescription date. The prescription date must be within 90 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.**
EST. LENGTH OF NEED:	**Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.**
PHYSICIAN ATTESTATION:	**The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.**
PHYSICIAN SIGNATURE AND DATE:	**After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM FOR ORTHOTICS, PROSTHETICS AND DIABETIC SHOES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: _____ **Medicaid # (10 digits):** _____

(2) DOB: _____/____/_____**Sex:** ___ **HT:** _____ **(in) WT:** _____ **Date of Service:** _____

(3) Provider's name: _____**Provider's DME #:** _____**NPI #:** _____

(4) Street address: _____ **City:** _____**State:** _____ **Zip:** _____ **Local telephone #:** _____

(5) Provider's signature: _____**Date:** _____

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR ORTHOTICS, PROSTHETICS, AND/OR DIABETIC SHOES. _____

_____

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD): _____ **Diagnosis (s):** _____

_____ _____

_____ _____

(8) Give a detailed description of the severity of the recipient's condition(s) as related to orthotics, prosthetics, and/or diabetic shoes.

Orthotics and/or Prosthetics:

_____

_____

_____

Diabetic Shoes: Does the patient have one or more of the following conditions? Check all that apply:

____History of previous foot ulcerations ____Peripheral neuropathy with evidence of callus formation _____Foot deformity

____Poor circulation ____History of partial or complete amputation of the foot _____History of pre-ulcerative callus

Is additional information attached on a separate sheet? _____Yes _____No (If "yes," enter recipient's name and Medicaid I.D. number on attachment)

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____

(10) Prescription Date: _____

(11) Duration of need (Maximum of 12 months): _____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) PRINT PHYSICIAN'S NAME: _____ PHYSICIAN'S NPI # _____

PHYSICIAN'S SIGNATURE: _____ DATE ____/____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR ORTHOTICS, PROSTHETICS AND DIABETIC SHOES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #:	**Indicate the patient's name and his/her Medicaid # (10 digits).**
PATIENT DOB, SEX, HEIGHT, WEIGHT:	**Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.**
DATE OF SERVICE:	**Indicate the date of service (DOS). The date of service must be the same as the delivery date.**
PROVIDER'S NAME, DME # AND NPI#:	**Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.**
PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:	**Indicate the provider's physical address (provider's location) and telephone number.**
PROVIDER SIGNATURE AND DATE:	**Signature of DME provider representative and date.**
HCPCS CODES:	**List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.**

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES:	**In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).**
QUESTION SECTION:	**This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.**
DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:	**Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.**
PRESCRIPTION DATE:	**Indicate the prescription date. The prescription date must be within 90 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.**
EST. LENGTH OF NEED:	**Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.**
PHYSICIAN ATTESTATION:	**The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.**
PHYSICIAN SIGNATURE AND DATE:	**After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR ENTERAL NUTRITION

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: _____ Medicaid # (10 digits): _____

(2) DOB: _____/____/_____ Sex: __ HT: _____ (in) WT: _____ Date of Service: _____

(3) Provider's name: _____Provider's DME #: _____NPI #: _____

(4) Street address: _____ City: _____State: _____ Zip: _____ Local telephone #: _____

(5) Provider's signature: _____Date: _____

(6) LIST ALL PROCEDURE CODES ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR ENTERAL NUTRITION.

_____

_____

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: IF FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD): _____ Diagnosis (s): _____

_____ _____

_____ _____

(8) Does the patient have permanent non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel? Yes _____ No _____.

Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's over all health status? Yes _____ No _____.

Product name (s): _____

Total calories Per Day: _____

The method of administration: Syringe _____ Gravity _____ Pump _____Does not apply _____.

Does the patient have a documented allergy or intolerance to semi-synthetic nutrients? Yes _____ No ____.

Is additional information attached on separate sheet? ___Yes ___No (If "yes," enter recipient's name & Medicaid I.D. number on attachment)

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____

(10) Enter the prescription date: _____

(11) Duration of need (Maximum of 12 months): _____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify the requested equipment/supplies are appropriate for the patient.

(12) PRINT PHYSICIAN'S NAME: _____ PHYSICIAN'S NPI # _____

PHYSICIAN'S SIGNATURE _____DATE____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR ENTERAL NUTRITION

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #:	**Indicate the patient's name and his/her Medicaid # (10 digits).**
PATIENT DOB, SEX, HEIGHT, WEIGHT:	**Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.**
DATE OF SERVICE:	**Indicate the date of service (DOS). The date of service must be the same as the delivery date.**
PROVIDER'S NAME, DME # AND NPI #:	**Indicate the name of the DME company (Provider name), Provider's DME # and NPI #.**
PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:	**Indicate the provider's physical address (provider's location) and telephone number.**
PROVIDER SIGNATURE AND DATE:	**Signature of DME provider representative and date.**
HCPCS CODES:	**List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.**

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES:	**In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).**
QUESTION SECTION:	**This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.**
DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:	**Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.**
PRESCRIPTION DATE:	**Indicate the prescription date. The prescription date must be within 90 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.**
EST. LENGTH OF NEED:	**Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.**
PHYSICIAN ATTESTATION:	**The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.**
PHYSICIAN SIGNATURE AND DATE:	**After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR PARENTERAL NUTRITION

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: _____ **Medicaid # (10 digits):** _____

(2) DOB: _____/____/_____ **Sex:** __ **HT:** _____ **(in) WT:** _____ **Date of Service:** _____

(3) Provider's name: _____**Provider's DME #:** _____**NPI #:** _____

(4) Street address: _____ **City:** _____**State:** _____ **Zip:** _____ **Local telephone #:** _____

(5) Provider's signature: _____**Date:** _____

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR PARENTERAL NUTRITION:

_____

_____

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD): _____ **Diagnosis (s):** _____

_____ _____

_____ _____

(8) Does the patient have severe permanent disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength commensurate with the patient's overall health status? Yes_____ No _____.

Formula components:

Amino Acid. _____ **(ml/day)** _____**concentration%** _____**gms protein/day**

Dextrose. _____ **(ml/day)** _____**concentration%**

Lipids. _____ **(ml/day)** _____**days/weeks** _____**concentration%.**

Check the method of administration: Central line _____**Hemodialysis access line** _____ **Peripherally inserted catheter (PIC)** ____

Is additional information attached on separate sheet? ___Yes ___No (If "yes", enter recipient's name & Medicaid I.D. number on attachment)

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____

(10) Enter the prescription date: _____

(11) Duration of need (Maximum of 12 months): _____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) PRINT PHYSICIAN'S NAME: _____ PHYSICIAN'S NPI # _____

PHYSICIAN'S SIGNATURE _____DATE____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN SECTION 2 OF THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR PARENTERAL NUTRITION

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #:	**Indicate the patient's name and his/her Medicaid # (10 digits).**
PATIENT DOB, SEX, HEIGHT, WEIGHT:	**Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.**
DATE OF SERVICES:	**Indicate the date of service (DOS). The date of service must be the same as the delivery date.**
PROVIDER 'S NAME, DME # AND NPI #:	**Indicate the name of the DME company (Provider name), Provider's DME # and NPI #.**
PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:	**Indicate the provider's physical address (provider's location) and telephone number.**
PROVIDER SIGNATURE AND DATE:	**Signature of DME provider representative and date.**
HCPCS CODES:	**List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.**

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES:	**In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).**
QUESTION SECTION:	**This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.**
DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:	**Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.**
PRESCRIPTION DATE:	**Indicate the prescription date. The prescription date must be within 90 days of the date of treating /ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.**
EST. LENGTH OF NEED:	**Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.**
PHYSICIAN ATTESTATION:	**The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.**
PHYSICIAN SIGNATURE AND DATE:	**After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR OXYGEN

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: _____ **Medicaid # (10 digits):** _____

(2) DOB ____/___/_____ **Sex:** ___ **HT:** _____**(in) WT**_____ **Date of service:** _____/____/_____

(3) Provider's name: _____ **Provider's DME #:** _____**NPI #:**_____

(4) Street address: _____**City:** _____**State:**____ **Zip:** _____**Local telephone #:** _____

(5) Provider's signature: _____**Date:** _____

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT:

_____

_____

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD) _____ **(Descriptions):** _____

_____ _____

_____ _____

(8) ANSWERS	**ANSWER QUESTIONS 1-9. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted)**
a) _____mm Hg b) _____% c) ____/____/____	1. Enter the result of most recent test taken **on or before** the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test, Enter date of test (c)
Y N	2. Was the test in Question 1 performed **EITHER** with the patient in a chronic stable state as an outpatient **OR** within two days prior to discharge from an inpatient facility to home?
1 2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
XXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXXXXX	4. Physician/provider performing test in Question 1 (and, if applicable, Question 7) Print/type name and address below NAME: ADDRESS:
Y N D	5. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D
_____LPM	6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a**"X**"

IF PO2 = 56-60 OR OXYGEN SATURATION = < 89%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.

Y N 7	7. Does the patient have dependent edema due to congestive heart failure?
Y N D	8. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?
Y N D	9. Does the patient have a hematocrit greater than 56%?

NAME OF PERSON ANSWERING SECTION C QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____

(10) Please indicate the Prescription date: _____

(11) Duration of need (maximum of 12 months): _____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) PRINT PHYSICIAN'S NAME _____ PHYSICIAN'S NPI # _____

PHYSICIAN'S SIGNATURE _____ DATE___/___/___ **(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)**

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR OXYGEN

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #:	**Indicate the patient's name and his/her Medicaid # (10 digits).**
PATIENT DOB, SEX, HEIGHT, WEIGHT:	**Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.**
DATE OF SERVICE:	**Indicate the date of service (DOS). The date of service must be the same as the delivery date.**
PROVIDER'S NAME, DME # AND NPI#:	**Indicate the name of the DME company (Provider name), Provider's DME # and NPI #.**
PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:	**Indicate the provider's physical address (provider's location) and telephone number.**
PROVIDER SIGNATURE AND DATE:	**Signature of DME provider representative and date.**
HCPCS CODES:	**List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.**

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES:	**In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).**
QUESTION SECTION:	**This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, circling "Y for yes, "N" for no, or "D" for does not apply.**
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	**If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the question of Section B, he/she must print his/her name, give his/her professional title and name of his/her employer where indicated. If the physician is answering the question, this space may be left blank.**
DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:	**Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.**
PRESCRIPTION DATE:	**Indicate the prescription date. The prescription date must be within 90 days of the date of treating /ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.**
EST. LENGTH OF NEED:	**Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.**
PHYSICIAN ATTESTATION:	**The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.**
PHYSICIAN SIGNATURE AND DATE:	**After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF DURABLE MEDICAL EQUIPMENT

CERTIFICATE OF REPAIR AND LABOR COST

TO BE COMPLETED BY ENROLLED DME PROVIDER										
(1) RECIPIENT'S NAME:										
(2) RECIPIENT'S MEDICAID # (10 DIGITS):										
(3) BRAND NAME OF EQUIPMENT:			(4) DATE OF REPAIR AND/OR LABOR:							
(5) SPECIFICALLY IDENTIFY EQUIPMENT TO BE REPAIRED:										
(6) ESTIMATED COST OF REPAIR:										
(7) GIVE A DETAILED DESCRIPTION OF THE TYPE OF REPAIR AND/OR LABOR TO BE PERFORMED ON EQUIPMENT:										
(8) PROVIDER'S NAME:			PROVIDER ID and/or NPI:							
(9) STREET ADDRESS:			CITY:							

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF REPAIR AND LABOR COST

LINE 1	**RECIPIENT'S NAME**	**Enter recipient's full name.**
LINE 2	**RECIPIENT'S MEDICAID #**	**Enter recipient's 10-digit Medicaid number.**
LINE 3	**BRAND OF EQUIPMENT**	**Enter the brand name of the equipment you are repairing.**
LINE 4	**DATE OF REPAIR AND/OR LABOR**	**Enter the date the repair and/or labor was performed.**
LINE 5	**SPECIFICALLY IDENTIFY EQUIPMENT TO BE REPAIRED**	**Specify equipment being repaired.**
LINE 6	**ESTIMATED COST OF REPAIRED**	**Enter estimated cost of repair. This cost must be itemized if you are repairing more than one item. Please use the additional space at the bottom of this form if needed.**
LINE 7	**GIVE A DETAILED DESCRIPTION OF THE TYPE OF REPAIR AND/OR LABOR TO BE PERFORMED ON EQUIPMENT**	**Give a detailed description of what type of repair was performed.**
LINE 8	**PROVIDER'S NAME & PROVIDER ID AND/OR NPI**	**Enter provider's name and Medicaid DME number and/or National Provider Identifier.**
LINE 9	**STREET ADDRESS AND CITY**	**Enter provider's street address and city.**

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

JUSTIFICATION FOR HOME UTERINE ACTIVITY MONITOR/SUPPLIES (HUAM) FOR SUBCUTANEOUS TOCOLYTIC THERAPY

PART I – (ALL INFORMATION MUST BE PRINTED)

Patient's Name	Medicaid #:
Date Telephone Order/Written Order Given:	
Patient's Expected Date of Delivery:	
Provider's NPI or Medicaid ID:	

PART II

The patient must have a gestational age of at least 24 weeks, but not more than 35 weeks AND meet AT LEAST ONE of the following criteria which necessitates a home uterine activity monitor/supplies and/or subcutaneous tocolytic therapy:

(AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE CHECKED)

- _____ Has experienced idiopathic pre-term labor that has required or will require hospitalization for IV tocolytic therapy.
- _____ Multiple gestation, three (3) or more fetuses, that has required or will require hospitalization for IV tocolytic therapy.
- _____ Patient has uterine anomalies or placenta previa that has required or will require hospitalization for IV tocolytic therapy.

PART III

Additionally, the patient must also meet ALL of the following criteria:

1) The patient has been diagnosed with pre-term labor based on uterine activity and/or cervical changes.
2) The patient has been stabilized by tocolytic medication.
3) There are no contraindications to the continuation of this pregnancy.
4) There is no fetal distress.
5) The patient's membranes are intact.
6) The patient is on homebound status and is agreeable to bed rest activities.
7) The patient has a telephone and is agreeable to daily phone contact and frequent physician follow-up.
8) The patient would have to be hospitalized for uterine activity monitoring and/or subcutaneous tocolytic therapy, if this service were not offered.
9) If the patient is hospitalized, this service will allow her to be discharged.
10) The patient is assigned to a delivering physician who has back up coverage in his/her absence.

PART IV — Physician Certification

I, _____, (Ordering/Treating Physician's Name) certify that _____ (Patient's Name), qualifies for Home Uterine Activity Monitoring/Supplies for Subcutaneous Tocolytic Therapy based on medical necessity and that the patient meets the above criteria.

Ordering/Treating Physician's Signature:	Date:
Physician UPIN/License #:	Phone #:

This form MUST be signed within 60 days of ordering service.

(Revised 02/13)