

FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 140	Medicaid Provider Inquiry	06/2007
DHHS 142	Request for Medicaid Forms and Publications	06/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	Reasonable Effort Documentation	06/2007
	Authorization Agreement for Electronic Funds Transfer	01/2009
CMS-1500	Sample Claim Form Showing TPL Denial with NPI	08/2005
	Sample Edit Correction Form	10/2008
	Sample Remittance Advice	06/2007
DAODAS Form PE	Physical Examination	11/2001
	Medical Necessity Statement for Children's Behavioral Health Services	
	Medical Necessity Statement for Therapeutic Behavioral Health Services	07/2005
DHHS 254	Referral Form/Authorization for Services-Children's Behavioral Health Services	09/2009
	Consumer Satisfaction Survey	
DHHS 560	Therapeutic Behavioral Services Assessment (two pages)	09/2005
DHHS 561	Therapeutic Behavioral Services Weekly Progress Summary Notes	02/2005
DHHS 562	Therapeutic Behavioral Services Individual Treatment Plan-Attachment G	02/2005
	Residential Treatment Facility Admission/Discharge Notification for HCK Beneficiaries	01/2010



**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:

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Provider ID:

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NPI:

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Recipient ID:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Adjustment Type:

- Void Void/Replace

Originator:

- DHHS MCCS Provider MIVS

Reason For Adjustment: (Fill One Only)

- | | |
|---|---|
| <input type="radio"/> Insurance payment different than original claim | <input type="radio"/> Medicaid paid twice - void only |
| <input type="radio"/> Keying errors | <input type="radio"/> Incorrect provider paid |
| <input type="radio"/> Incorrect recipient billed | <input type="radio"/> Incorrect dates of service paid |
| <input type="radio"/> Voluntary provider refund due to health insurance | <input type="radio"/> Provider filing error |
| <input type="radio"/> Voluntary provider refund due to casualty | <input type="radio"/> Medicare adjusted the claim |
| <input type="radio"/> Voluntary provider refund due to Medicare | <input type="radio"/> Other |

For Agency Use Only

Analyst ID:

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

Comments:

Signature: _____ Date: _____

Phone: _____



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

MEDICAID PROVIDER INQUIRY

MAIL TO: ATTENTION _____ UNIT S.C. DEPT. OF HEALTH AND HUMAN SERVICES POST OFFICE BOX 8206 COLUMBIA, SOUTH CAROLINA 29202-8206	TODAY'S DATE:
	NPI or MEDICAID PROVIDER ID:
	TELEPHONE:
PROVIDER NAME AND ADDRESS:	TYPE OF PROVIDER (i.e., Dentist, Group, etc.)
	DATE CLAIM FILED:

-----FOLD HERE-----

PATIENT'S NAME (First, Initial, Last)	MEDICAID NUMBER (10 Digits)	DATE OF SERVICE
HAS THE CLAIM APPEARED ON THE PROVIDER'S REMITTANCE ADVICE? (CHECK ONE) <input type="checkbox"/> YES <input type="checkbox"/> NO		IS MEDICARE COVERAGE INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO
CLAIMS STATUS ON REMITTANCE ADVICE	PAYMENT DATE	17-DIGIT CLAIM REFERENCE NUMBER
STATEMENT OF PROBLEM OR QUESTION		
SIGNATURE OF PROVIDER		
RESPONSE		
AGENCY REPRESENTATIVE		DATE



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

**REQUEST FOR MEDICAID
FORMS AND PUBLICATIONS**

WHEN COMPLETED PLEASE FORWARD TO:

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUPPLY
POST OFFICE BOX 8206
COLUMBIA, SOUTH CAROLINA 29202-8206

-OR- FAX TO: (803) 898-4528

NPI or MEDICAID PROVIDER ID:

TYPE OF PROVIDER:

TELEPHONE: - -

CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY (PLEASE PRINT OR TYPE)

ITEMS REQUESTED

FORM/PUBLICATION NO.	TITLE OF FORM OR PUBLICATION	QUANTITY

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

III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN (SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax:	or	Mail:
803-255-8225		Post Office Box 8206, Attention TPL Columbia, SC 29202-8206



**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 FORM TO THE APPROPRIATE CLAIM OR ECF AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

South Carolina
Department of Health and Human Services
Electronic Funds Transfer (EFT) Authorization Agreement

PROVIDER INFORMATION

Provider Name _____
Medicaid Provider Number _____
Provider NPI Number _____
Provider Address _____
City _____ State _____ Zip _____

BANKING INFORMATION (Please include a copy of the electronic deposit information on bank letterhead. This is required and the information will be used to verify your bank account information).

Financial Institution Name _____
Financial Institution Address _____
City _____ State _____ Zip _____
Routing Number (nine digit) _____
Account Number _____
Type of Account (check one) Checking Savings

I (we) hereby 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 my account indicated below and the financial institution named below, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.

I (we) understand that credit entries to the account of the above named payee 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 (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

Contact Name: _____ Phone Number: _____

Signed _____ (Signature)
_____ (Print)

Title _____ Date _____

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.

RETURN COMPLETED FORM TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 699-8637

1500

Alcohol & Drug Rehabilitation Services
Sample Claim Form Showing TPL Denial
with NPI

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS; 22. MEDICAID RESUBMISSION; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; B. PLACE OF SERVICE; C. EMG; D. PROCEDURES, SERVICES, OR SUPPLIES; E. DIAGNOSIS POINTER; F. \$ CHARGES; G. DAYS OR UNITS; H. EPSDT Family Plan; I. I.D. QUAL; J. RENDERING PROVIDER ID.#; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

Sample Only

REPORT NUMBER CLM3500

EDIT CORRECTION FORM

ANALYST ID

HIC - 76 PRAC SPEC -

EMC Y

SIGNON ID

DOC IND N

ORIGINAL CCN:

TAXONOMY:

SFL ZIP:

PRV ZIP:

ADJ CCN:

1 2

3 4

5 6

7 8 9

EDITS

PROV/XWALK RECIPIENT

P AUTH TPL

INJURY

EMERG PC COORD

---- DIAGNOSIS ----

INSURANCE EDITS

ID ID

NUMBER

CODE

PRIMARY SECONDARY

CLAIM EDITS

ABC123 1111111111

v71.02

NPI: 1234567890

LINE EDITS

01) 712 951

10 RECIPIENT NAME - DOE, JANE

11 DATE OF BIRTH 01/25/1992

12 SEX F

13

14

LN

15 DATE OF

16 PLACE

17 PROC

18 MOD

19 INDIVIDUAL CHARGE

20 PAY

21 UNITS

22

** AGENCY USE ONLY **

** APPROVED EDITS **

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ALLOWED

NO

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! CLAIMS/LINE PAYMENT INFO !

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! EDIT PAYMENT DATE !

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7 / /

NPI:

TAXONOMY:

8 / /

NPI:

TAXONOMY:

24

25

26

INS CARR

POLICY

INS CARR

27 TOTAL CHARGE

836.00

NUMBER

NUMBER

PAID

.00

01

28 AMT REC'D INS

02

29 BALANCE DUE

836.00

03

30 OWN REF #

012345

RESOLUTION DECISION _R_

ADDITIONAL DIAG CODES:

RETURN TO: MEDICAID CLAIMS RECEIPT P. O. BOX 1412 COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER: ABC PROVIDER PO BOX 00000 ANYWHERE XO 00000-0000

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"

* INDICATES A SPLIT CLAIM

Sample Remittance Advice (page 1)

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.

# AB0008 ABC PROVIDER .121212121234. PROVIDER ID.	Y	PO BOX 000000 FLORENCE SC000000000	PAGE
DEPT OF HEALTH AND HUMAN SERVICES		PROFESSIONAL SERVICES	1
AB00080000		REMITTANCE ADVICE	1
SOUTH CAROLINA MEDICAID PROGRAM		PAYMENT DATE	
		03/26/2007	

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
2212345	0406001089000400A				1192.00	243.71	P	1112233333	M CLARK				
	01		021507	H2020	800.00	117.71	P			0TF	0.00	0.00	
	02		021507	H2019	392.00	126.00	P			000	0.00	0.00	
VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04													
ABB222222	0406001089000400U				1412.00-	273.71-		1112233333	M CLARK				
	01		012107	H2020	1112.00-	143.71-				0TF			
	02		012107	H2019	300.00-	130.00-				000			
REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04													
ABB222222	0407701389002500A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		012107	H2020	142.50	42.75	P			0TF		0.00	
	02		012107	H2019	859.00	0.00	R			000		0.00	
	TOTALS			2	2193.50	286.46					0.00	0.00	

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 \$0.00 CERTIFIED AMT \$0.00 FEDERAL RELIEF	MEDICAID PG TOT \$286.46 MEDICAID TOTAL 0.00 MAXIMUS AMT	\$286.46 CHECK TOTAL	STATUS CODES: P = PAYMENT MADE R = REJECTED S = IN PROCESS E = ENCOUNTER CHECK NUMBER	PROVIDER NAME AND ADDRESS ABC PROVIDER PO BOX 000000 ANYWHERE XO 00000-0000
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Sample Remittance Advice (page 2)

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

PROVIDER ID.	DEPT OF HEALTH AND HUMAN SERVICES	CLAIM ADJUSTMENTS	PAYMENT DATE	PAGE
AB00080000	SOUTH CAROLINA MEDICAID PROGRAM		03/26/2007	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 I I	M F M O I I D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	0406001089000400U				513.00-	197.71-		1112233333	CLARK	M	022807	0404711253670430A
	01		012107	H2020	453.00	160.71-	P				0TF	
	02		012107	H2019	60.00	33.00-	P				000	
	TOTALS		1		513.00-	193.71-						

DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
	\$243.71	0.00	0.00	0.00
0.00	ADJUSTMENTS	MAXIMUS AMT	PROVIDER NAME AND ADDRESS	
	\$193.71		ABC PROVIDER	
YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PO BOX 000000 ANYWHERE XO 00000-0000	
0.00	\$50.00	4197304		

Sample Remittance Advice (page 3)

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.	DEPT OF HEALTH AND HUMAN SERVICES	ADJUSTMENTS	PAYMENT DATE	PAGE
AB00080000	SOUTH CAROLINA MEDICAID PROGRAM		03/26/2007	3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME F M LAST NAME I I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	0408600003700000U	-						DEBIT	-2389.05	
TPL 4	0408600004700000U	-						DEBIT	-1949.90	
TPL 5	0408600005700000U	-						DEBIT	-477.25	
TPL 6	0408600006700000U	-						DEBIT	-477.25	
PAGE TOTAL:									5293.45	0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
0.00	0.00	0.00	0.00	0.00
0.00	ADJUSTMENTS	MAXIMUS AMT	PROVIDER NAME AND ADDRESS	
0.00	0.00	0.00	ABC PROVIDER	
YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PO BOX 000000 ANYWHERE XO 00000-0000	
5293.45	0.00			

Physical Examination

Client Name (Last, First, MI) _____ ID# _____

Medicaid Client # _____ Date of
Physical Examination _____

Physician Name and Address _____

1. Brief medical history to include hospital admissions, surgeries, allergies, present medications (include names and telephone numbers of prescribing physicians), information (where appropriate) about shared needles, sexual activity/orientation, and history of hepatitis and liver disease
2. History of patient/family involvement with alcohol/drugs
3. Assessment of patient nutritional status

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL NECESSITY STATEMENT
FOR
CHILDREN'S BEHAVIORAL HEALTH SERVICES**

Child's Name: _____ Social Security Number: _____

Date of Birth: _____ Medicaid Number: _____

Based on professional staffing recommendations, review of treatment history and/or personal observation or evaluation, I recommend that the above-named Medicaid recipient receive _____

(Specific Rehabilitative Service)

for maximum reduction of physical or mental disability and restoration of the recipient to his/her highest level of functioning. This recipient meets the medical necessity criteria for this level of care.

(Signature of Physician or other Licensed Practitioner of the Healing Arts) _____ (Professional Title)

(Please print name signed above) _____ (Phone Number)

Date of Signature: _____ (Services must be initiated within 90 days)

Diagnosis and Diagnosis Code: _____

In the absence of a full clinical assessment and evaluation, use of a V-Code may be appropriate. A more thorough diagnosis and the corresponding diagnosis code should replace the V-Code when available.

- | | | | |
|--------|--|--------|--|
| V61.20 | Parent-child relational problem | V62.81 | Interpersonal problems, not elsewhere classified |
| V61.21 | Neglect/Abuse of Child | V62.82 | Bereavement |
| V61.9 | Relational Problem Related to a
Mental Disorder | V71.02 | Child or Adolescent Antisocial Behavior |

Child's identified problems areas or needs. These may be based on professional staffing recommendations, review of treatment history and/or personal observation or evaluation.

**S. C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL NECESSITY STATEMENT
FOR
THERAPEUTIC BEHAVIORAL SERVICES**

Recipient's Name: _____

Recipient's Date of Birth: ____ / ____ / ____

Recipient's Social Security Number: ____ / ____ / ____

Recipient's Medicaid Number: _____

Diagnosis Code: _____ ICD-9 CM or Acceptable V-Code

I recommend that the above named Medicaid recipient receive Therapeutic Behavioral Services for maximum reduction of physical or mental disability and restoration of the recipient to his/her best possible functional level. The recipient meets the medical necessity criteria for this service as evidenced by

1. The attached developmental and emotional screening tool used. (Must be comparable to the Denver Developmental Screening Test II as used in Early and Periodic Screening Diagnosis and Treatment (EPSDT) screenings), and
2. Meeting one of the following criteria: (circle the appropriate criteria(s))
 - 2.1 The child is unable to attend regular child care due to substantiated developmental or behavioral problems,
 - 2.2 The child exhibits developmental or behavioral problems as a result of substantiated cases of abuse /neglect with behavior problems, or
 - 2.3 The child is in imminent danger of being removed from the home due to substantiated developmental or behavioral problems.

(Signature of Physician or Licensed Practitioner of the Healing Arts)

(Professional Title)

Date of Signature: ____/____/____ (Service must be initiated within 90 days)

Consumer Satisfaction Survey

Please help us improve this program by answering some questions about the services you have gotten over the past several months. We are interested in your honest opinions, good or bad. Please answer all the questions. Thank you very much. We appreciate your help.

(Circle your answer)

1. How would you rate the quality of service you and your child received?

Excellent Good Fair Poor

2. Did your child get the kind of service you wanted?

No, definitely not Not really Yes, generally Yes, definitely

3. Have these services met your child's needs?

Almost all of his/her needs have been met. Most of his/her needs have been met. Only a few of his/her needs have been met. None of his/her needs have been met.

4. How satisfied are you with the amount of help you and your child received?

Quite dissatisfied Indifferent or Mildly dissatisfied Mostly satisfied Very satisfied

5. Have the services your child has received helped you to deal with your child's problems?

Yes, they helped a great deal. Yes, they helped somewhat. No, they didn't really help. No, they seemed to make things worse.

6. If you were to look for help again, would you use these same services?

No, definitely not No, not really Yes, generally Yes, definitely

Therapeutic Behavioral Services (formerly Therapeutic Child Treatment) Assessment

Attachment H

Client: _____ Birth Date: ____ / ____ / ____

DATES Admission: ____ / ____ / ____ Plan: ____ / ____ / ____

Participants	Initial Goals / Desired Outcomes	Strengths	Barriers
Primary Caregiver			
Secondary Caregiver			
Other Family			
TBS Child			
School / Day Care			
Neighborhood/Community			

Client: _____

DHHS Form 560 Page # 1 (09/2005 Version)

Lead Clinical Staff (LCS) Signature _____

Date _____

Supervising LCS Signature _____

Date _____

Genogram	Presenting Problem and the Impacting Issues

Lead Clinical Staff (LCS) Signature _____

Date _____

Supervising LCS Signature _____

Date _____

Therapeutic Behavioral Services

(formerly Therapeutic Child Treatment)

WEEKLY PROGRESS SUMMARY NOTES

Client: _____ / _____ / _____
 Birth Date: _____ / _____ / _____

	Mon	Tue	Wed	Thu	Fri
Date					

Number of Units: _____

Attachment DHHS Form 561

Page 1

Short Term Goals addressed this week <small>(These should complement the Overarching and Short Term Goals listed in the child's ITP)</small>	Intervention(s) used to address Short Term Goals	Barriers to Short Term Goals	Advancement in Treatment	Changes in Assessment	Short Term Goals for Next Week

Non-LCS Signature (When Required) _____ Date _____
 Lead Clinical Staff (LCS) Signature _____ Date _____
 Supervising LCS Signature: _____ Date _____

Therapeutic Behavioral Services

(formerly Therapeutic Child Treatment)

INDIVIDUAL TREATMENT PLAN

Attachment G

Client: _____

Birth Date: _____ / ____ / ____

DATES

Admission: _____ / ____ / ____

1st Review: _____ / ____ / ____

3rd Review: _____ / ____ / ____

Plan: _____ / ____ / ____

2nd Review: _____ / ____ / ____

Re-Development: _____ / ____ / ____

Reasons for Referral / Presenting Problems: _____

Overarching Goals	Criteria for Achievement	Target Date	Completion Date
1.		____ / ____ / ____	____ / ____ / ____
2.		____ / ____ / ____	____ / ____ / ____
3.		____ / ____ / ____	____ / ____ / ____
4.		____ / ____ / ____	____ / ____ / ____

Therapeutic Behavioral Services (formerly Therapeutic Child Treatment) Individual Treatment Plan

Client: _____

Page # 1
DHHS Form 562 (02/2005 Version)

Primary Caregiver Signature _____

Date _____

Lead Clinical Staff (LCS) Signature _____

Date _____

Other Caregiver Signature _____

Date _____

Supervising LCS Signature _____

Date _____



**RESIDENTIAL TREATMENT FACILITY
ADMISSION/DISCHARGE NOTIFICATION FOR HCK BENEFICIARIES**

Payment Category: _____
Provider must verify eligibility.
If Payment Category is not 99, do not complete this form.

TYPE OF NOTIFICATION
(check one)
 ADMISSION
 DISCHARGE

*If a child has HCK coverage and is being admitted to a residential treatment facility (Psychiatric Residential Treatment Facility or substance abuse), the facility or referring state agency must notify SCDHHS Eligibility, using this form, at the time of Admission and at the time of discharge.

HCK Beneficiary Information:
Name _____
DOB _____
HCK ID Number _____ Social Security Number _____

Facility Information:
Facility Name _____
Address _____
Phone: _____ Contact Person: _____

Date of Residential Admission: _____

Date of Residential Discharge: _____

COMMENTS: _____

Printed Name and Title of Authorized Staff

Authorized Staff Signature

Date

Mail or fax completed forms to:
SCDHHS – Eligibility-Constituent Services
Post Office Box 8206
Columbia, South Carolina 29202-8206
Fax: 803-255-8350