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	01/2008
	Reasonable Effort Documentation	04/2014
	Authorization Agreement for Electronic Funds Transfer	01/2014
	Duplicate Remittance Advice Request Form	04/2014
	Claim Reconsideration Form	12/2016
CMS-1500 (02/12)	Sample Claim Form Showing NPI and Medicaid Provider ID	02/2012
CMS-1500 (02/12)	Sample Claim Form Showing NPI Only	02/2012
	Sample Edit Correction Form	06/2007
	Sample Remittance Advice	04/2014
DHHS 945	Verification of Retroactive Medicaid	05/2004
DHEC 1050	DHEC Ambulance Run Report (two pages)	01/2004

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:_____

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 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

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 above and the financial institution named above, 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.

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: _____ 4. Telephone Number: _____

5. Requesting:

   ☐ Remittance Advice Pages ☐ Edit Correction Form (ECF) Pages Only*

   (*) ECFs are available only for Remittance Advice dates prior to January 17, 2014. Please note that SCDHHS no longer accepts ECFs for processing as of April 1, 2014.

6. 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.

7. Street Address for delivery of request:

   Street: _____

   City: _____

   State: _____

   Zip Code: _____

8. 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

Nikki R. Haley GOVERNOR
Christian L. Soura DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

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. 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.

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____ . ŜyŜŦλŎλI·ℕẽ Medicaid ID:

_____ψψψψψψψ

Section 2: Provider Information

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

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

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

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

Section 3: Claim Information

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

Section 4: Claim Reconsideration Information

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

- ☐ Ambulance Services
- ☐ Clinic Services
- ☐ Community Long Term Care (CLTC)
- ☐ Community Mental Health Services
- ☐ Durable Medical Equipment (DME)
- ☐ Early Intervention Services
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Enhanced Services
- ☐ Home Health Services
- ☐ Hospice Services
- ☐ Hospital Services
- ☐ Licensed Independent Practitioner's Rehabilitative Services (LIPS)
- ☐ Local Education Agencies (LEA)
- ☐ Nursing Facility Services
- ☐ Optional State Supplementation (OSS)
- ☐ Pharmacy Services
- ☐ Physicians Laboratories, and Other Medical Professionals
  Specify: _____ψψ
- ☐ Private Rehabilitative Therapy and Audiological Services
- ☐ PRTF CHANCE Waiver
- ☐ 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

Nikki R. Haley GOVERNOR
Christian L. Soura DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature: _____ Date: _____

Ambulance Services
Sample Claim Showing
NPI and Medicaid Provider ID

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

3. PATIENT'S BIRTH DATE MM 01 DD 01 YY 1999 SEX M ☒ 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): (803) 898-2590

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)

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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. 250.91 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	07	14	01	07	14	41		A0428	NH					117 71	1		1D NPI	ABC123 1234567890
2	01	07	14	01	07	14	41		A0999	HN					79 65	1		1D NPI	ABC123 1234567890
3	01	07	14	01	07	14	41		A0425	NH					25 00	5		1D NPI	ABC123 1234567890
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 222 36

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use 222 36

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 Ambulance Company
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. 1DABC123

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

HEALTH INSURANCE CLAIM FORM

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

Ambulance Services
Sample Claim Showing
NPI Only

PICA

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

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

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

3. PATIENT'S BIRTH DATE MM 01 DD 01 YY 1999 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): (803) 898-2590

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)

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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. 250.91 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	07	14	01	07	14	41		A0428	NH					117 71	1		1D NPI	ABC123 1234567890
2	01	07	14	01	07	14	41		A0999	HN					79 65	1		1D NPI	ABC123 1234567890
3	01	07	14	01	07	14	41		A0425	NH					25 00	5		1D NPI	ABC123 1234567890
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 222 36

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use 222 36

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 Ambulance Company
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

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

SAMPLE

SIGNED DATE a. NPI b. a. 1234567890 b. 1DABC123
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

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.                                          PROFESSIONAL SERVICES            PAYMENT DATE                 PAGE
+--------------+  DEPT OF HEALTH AND HUMAN SERVICES                                    +------------+                +----+
| AB00080000   |                                          REMITTANCE ADVICE            | 02/28/2014 |                |  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|
+---------+-----------------+------+---------+------+--------+--------+-+----------+-------------------+---+-------+-------+-------+
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|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|
                                          +------------+   +------------+    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 3)

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

```
PROVIDER ID.                                                  +----------------+              PAYMENT DATE                  PAGE
+--------------+  DEPT OF HEALTH AND HUMAN SERVICES            |     CLAIM      |              +------------+                 +----+
|  AB11110000  |                                               |  ADJUSTMENTS   |              | 02/28/2014 |                 |  2 |
+--------------+   SOUTH CAROLINA MEDICAID PROGRAM             |                |              |            |                 +----+
                                                              +----------------+              +------------+

+---------+-----------------+---+---------+------+--------+--------+-+-+-+----------+----------+---+------+------------------------+
|PROVIDERS|       CLAIM     |   |SERVICE RENDERED|  AMOUNT|TITLE 19|S|RECIPIENT |RECIPIENT NAME|M  | ORG  |                        |
| OWN REF.|   REFERENCE     |PY | DATE(S) |      |  BILLED| PAYMENT|T|    ID.   |          F  M| O |CHECK |    ORIGINAL CCN        |
|  NUMBER |      NUMBER     |IND|MMDDYY   | PROC.|        |MEDICAID|S|  NUMBER  |LAST NAME I  I|  D| DATE |                        |
+---------+-----------------+---+---------+------+--------+--------+-+----------+--------------+---+----  |------------------------+
|         |                 |   |         |      |        |        | |          |              |   |      |                        |
|         |                 |   |         |      |        |        | |          |              |   |      |                        |
|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-| |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
+---------+-----------------+-------------+------+--------+--------+-+----------+--------------+---+------+------------------------+
                                                          MEDICAID TOTAL     CERTIFIED AMT                          TO BE REFUNDED
 PROVDER                    DEBIT BALANCE               +-------------+    +-------------+    +-------------+     IN THE FUTURE
 INCENTIVE                  PRIOR TO THIS               |     $243.71|    |     0.00|   |    |         0.00|       +----------+
 CREDIT AMOUNT              REMITTANCE                  +-------------+    +-------------+    +-------------+       |      0.00|
+-------------+            +-------------+                                                                          +----------+
|         0.00|            |         0.00|              ADJUSTMENTS
+-------------+            +-------------+            +-------------+    +-------------+      PROVIDER NAME AND ADDRESS
                                                        |    $193.71-|    |             |    +--------------------------------+
                                                        +-------------+    +-------------+    |ABC HEALTH PROVIDER             |
                            YOUR CURRENT                CHECK TOTAL        CHECK NUMBER       |                                |
                            DEBIT BALANCE              +-------------+    +---------+        |PO BOX 000000                   |
                           +-------------+             |       $50.00|    |  4197304|        |FLORENCE            SC 00000    |
                           |        0.00 |             +-------------+    +---------+        +--------------------------------+
                           +-------------+
```

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.                                                  +----------------+            PAYMENT DATE                 PAGE
+--------------+  DEPT OF HEALTH AND HUMAN SERVICES              |                |            +------------+               +----+
|  AB11110000  |                                                 |  ADJUSTMENTS   |            | 02/28/2014 |               |  3 |
+--------------+   SOUTH CAROLINA MEDICAID PROGRAM               |                |            |            |               +----+
                                                                 +----------------+            +------------+

+---------+-----------------+-------------+-----------+----------+--------------+------+----------+---------+-----------+----------+
|PROVIDERS|      CLAIM      |   SERVICE   |PROC / DRUG|RECIPIENT |RECIPIENT NAME|ORIG. |  ORIGINAL|         |DEBIT /    |    EXCESS|
| OWN REF.|    REFERENCE    |   DATE(S)   |           |   ID.    |          F M |CHECK |   PAYMENT|  ACTION |CREDIT     |          |
|  NUMBER |      NUMBER     |   MMDDYY    |   CODE    | NUMBER   |LAST NAME I I |DATE  |          |         |     AMOUNT|    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|
+---------+-----------------+-------------+-----------+----------+--------------+------+----------+---------+-----------+----------+

                                                   MEDICAID TOTAL     CERTIFIED AMT                        TO BE REFUNDED
          PROVDER                   DEBIT BALANCE  +-------------+    +-------------+   +-------------+     IN THE FUTURE
          INCENTIVE                 PRIOR TO THIS  |         0.00|    |         0.00|   |         0.00|       +----------+
          CREDIT AMOUNT             REMITTANCE     +-------------+    +-------------+   +-------------+       |      0.00|
         +-------------+           +-------------+                                                           +----------+
         |         0.00|           |         0.00|     ADJUSTMENTS
         +-------------+           +-------------+    +-------------+    +-------------+    PROVIDER NAME AND ADDRESS
                                                      |     -4338.95|    |         0.00|   +--------------------------------+
                                    YOUR CURRENT      +-------------+    +-------------+   |  ABC HEALTH PROVIDER           |
                                    DEBIT BALANCE       CHECK TOTAL     CHECK NUMBER     |  PO BOX 000000                 |
                                   +-------------+    +-------------+   +---------+       |  FLORENCE            SC 00000  |
                                  |         0.00|    |         0.00|   |         |      |                                |
                                   +-------------+    +-------------+   +---------+       +--------------------------------+
```

South Carolina Department of Health and Human Services

Verification of Retroactive Medicaid

Date: _____

To: _____

_____

_____

Re: _____

Medicaid Number: _____

Retroactive Medicaid coverage was entered into the Department of Health and Human Services computer system for the above-named individual on the following date:

_____.

The retroactive period began on the following date: _____.

The retroactive period ended on the following date: _____.

Please be reminded that all bills must be submitted within six (6) months of the individual's eligibility determination or one (1) year from the date of service delivery, whichever is later.

_____	_____
Medicaid Eligibility Worker	Telephone Number

DHHS Form 945 (May 2004)

DHEC Ambulance Run Report (page 1)

DHEC PATIENT CARE FORM

Q.A. NO.

TRIP NO.

PATIENT IDENTIFICATION (Please Print)

LAST NAME (10–29) FIRST NAME (30–45) MI (46)

STREET (47–71) APT. #

CITY (72–87) STATE (88–89) ZIP CODE (90–94)

SSN (95-103)

SEX (104)
1 ☐ Male
2 ☐ Female
3 ☐ Undetermined

RACE (105)
1 ☐ White
2 ☐ Black
3 ☐ Am. Indian
4 ☐ Hispanic
5 ☐ Asian
6 ☐ Other

AGE (106–109)
CHECK ONE
1 ☐ YRS.
2 ☐ MOS.
3 ☐ DAYS

DISPOSITION (110–111)
01 ☐ TREAT/NO TRANS.
02 ☐ DOA AT SCENE
03 ☐ HOSPITAL ER
04 ☐ HOSP. DIR. ADMIT.
06 ☐ PATIENT'S HOME
07 ☐ NURSING HOME
08 ☐ DR.'S OFFICE
09 ☐ OUTPATIENT
10 ☐ PT. REFUSED TREAT.
13 ☐ EMS TRANSFER

TYPE OF INCIDENT

TRAUMA (112)
1 ☐ MVA
2 ☐ MC
3 ☐ BIKES
4 ☐ PED
5 ☐ ASSAULT
6 ☐ FALL
7 ☐ FIRE
8 ☐ INTERFAC
9 ☐ OTHER

MEDICAL (113)
1 ☐ ENVIRON
2 ☐ BEHAV
3 ☐ OB/GYN
4 ☐ RESP
5 ☐ CARDIAC
6 ☐ INTERFAC
7 ☐ OTHER

CALL TYPE

TO SCENE (114)
1 ☐ EMERGENT
2 ☐ NONEMERGENT
CODE

PATIENT STATUS

ON SCENE (115)
1 ☐ URGENT
2 ☐ NON URGENT
CODE

FROM SCENE (116)
1 ☐ URGENT
2 ☐ NON URGENT

INCIDENT LOCATION

ST. OR HWY. NAME OR NO.

CITY

County (117-118) Zip Code (119-123)

SAFETY EQP (124)
1 ☐ Seatbelts 4 ☐ Child Seat
2 ☐ Helmets 5 ☐ None
3 ☐ Airbags 6 ☐ Unkn.

SITE OF INCIDENT (125)
1 ☐ ROADWAY 4 ☐ RECREATIONAL
2 ☐ RESIDENCE 5 ☐ AGRICULTURAL
3 ☐ INDUSTRIAL 6 ☐ OTHER

PRELIMINARY IMPRESSIONS (MARK NO MORE THAN 4) (126–137)

003 ☐ Seizure
004 ☐ Diabetic
011 ☐ Abrasion/Contusions
013 ☐ Laceration
023 ☐ Fracture
024 ☐ Multitrauma/Shock
030 ☐ Head Injury
032 ☐ Spinal Injury
084 ☐ Stroke
051 ☐ G.I. Problems
074 ☐ Respiratory Distress
080 ☐ Coronary Problems
083 ☐ Cardiac Arrest
Other
Other

PRIMARY IMPRESSION (138–140)

TREATMENT PROCEDURES (141–174)

01 ☐ Dressing Applied
02 ☐ Limb Splinted
03 ☐ Spine Immobilized
04 ☐ Neck Immobilized
05 ☐ OB Assistance
06 ☐ Oral Airway Used
07 ☐ Oxygen Given
08 ☐ Suction Used
09 ☐ Antishock Trousers
10 ☐ Airway Maintained
11 ☐ Antishock Treatment
12 ☐ Artificial Resp.
13 ☐ Cardiac Massage
14 ☐ Bleeding Controlled
15 ☐ Cold Application
16 ☐ Patient Restrained
17 ☐ Other (Use Comments)
18 ☐ Ventilator

HCFA CODES (175–180)

SITE OF TRAUMA (181–189)
1 ☐ Head
2 ☐ Face
3 ☐ Neck
4 ☐ Chest
5 ☐ Abdomen
6 ☐ Hip/Pelvis
7 ☐ Upper Extr.
8 ☐ Lower Extr.
9 ☐ Back

ADVANCED PROCEDURES (190–223)

1. ☐ EKG Monitored Rhythm ____ Time ____
2. ☐ First Defib Attempted Watt Sec. ____ Time ____
   Post Defib Rhythm ____
3. ☐ Second Defib Attempted Watt Sec. ____ Time ____
   Post Defib Rhythm ____
4. ☐ Third Defib Attempted Watt Sec. ____ Time ____
   Post Defib Rhythm ____

INTUBATED 5. ☐ ET Size ____ Total # Attempts ☐ (224)
15 ☐ RSI 16 ☐ LMA 17 ☐ Crico

6. ☐ EXTERNAL PACING
7. ☐ BLOOD DRAWN DEXTROSE BGL ____
8. ☐ IV STARTED/GAUGE SOLUTION ____
   RATE ____ IV TIME IV VOLUME
9. ☐ IV STARTED/GAUGE SOLUTION ____
   RATE ____ IV TIME IV VOLUME
14 ☐ IV ATTEMPTED Total # ☐ (225)
10. ☐ PLEURAL DECOMPRESSION Time ____
11. ☐ INTRAOSSEOUS INF. ____
12. ☐ AUTOMATIC DEFIB
13. ☐ PATIENT ASSISTED MEDS. ____

Ordering Physician ____ (Name) (Signature)

DRUGS USED (226–241)

DRUG	DOSE	TIME	DRUG	DOSE	TIME

REVISED TRAUMA SCORE

GCS: (242) EYES ____ (247–249) SBP ____ RTS (254–255) ☐
(243) VERBAL ____ (250–252) RR ____
(244) MOTOR ____
(245–246) GLASGOW ____ (253) ANATOMICAL INJ. 1 ☐ YES 2 ☐ NO

VITAL SIGNS

BP	PULSE		RESPIRATONS		PUPIL		LEVEL OF CONSC.		TIME
/	RATE	☐ REG. ☐ IRREG.	RATE	☐ REG. ☐ IRREG.					
/		☐ REG. ☐ IRREG.		☐ REG. ☐ IRREG.	E U N C D		A V P U		
/		☐ REG. ☐ IRREG.		☐ REG. ☐ IRREG.					
/		☐ REG. ☐ IRREG.		☐ REG. ☐ IRREG.					
/		☐ REG. ☐ IRREG.		☐ REG. ☐ IRREG.					

EXPOSURE TO PT's BODY FLUIDS? (256) 1. ☐ YES 2. ☐ NO

1st Responder (257) 1. ☐ YES Name ____ 2. ☐ NO

COMMENTS (INCLUDE CHIEF COMPLAINTS, OBSERVATIONS AT SCENE, RESPONSE TO STIMULI)

Patient Care Form Left In (258): 1. ☐ ED 2. ☐ ICU 3. ☐ OTHER ____ ☐ See Page 2

TIME RECORD

RUN DATE (259–266) MONTH DAY YEAR

Call Received: (267–270)	
Call Dispatched: (271–274)	
Departed Base: (275–278)	
Arrive Scene: (279–282)	
Departed Scene: (283–286)	
Arrive Destination: (287–290)	

CAUSE OF DELAY ____

DHEC PERMIT NO. (291–295)

RECEIVING AGENCY (296–299)

SENDING AGENCY (300–303)

PROVIDER TIME (OPTIONAL)

ATTENDANT'S SIGNATURE & CERTIFICATION NO.

PRIMARY PATIENT ATTENDANT (304–308)

2ND ATTENDANT/DRIVER (309–313)

3RD ATTENDANT/DRIVER (314–318)

(RECEIVING NURSE OR PHYSICIAN)

DHEC 1050 REV. (01/2004) EMS PROVIDER COPY REPORT NO. (1-9) 898388

DHEC Ambulance Run Report (page 2)

PATIENT COMPLAINT SIGNALS

Type of Incident

TRAUMA
011 ABRASION/CONTUSION
012 AVULSION
013 LACERATION
014 PUNCTURE/STAB
015 GUNSHOT WOUND
016 BURN
017 HEMORRHAGE
018 ELECTROCUTION
019 CHEST INJURY
020 CRUSHING
021 AMPUTATION
022 DISLOCATION
023 FRACTURE
024 MULTITRAUMA/SHOCK
025 PATIENT TRAPPED
026 EYE INJURY
029 SPRAIN/STRAIN
030 HEAD INJURY
031 PARALYSIS
032 SPINAL INJURY
037 ANIMAL BITE
038 SNAKE BITE

CARDIAC/STROKE
080 CORONARY PROBLEM
081 CONGESTIVE HEART FAILURE
082 HYPERTENSION
083 CARDIAC ARREST
084 CVA/TIA/STROKE
085 HYPOTENSION
086 CHEST PAIN

RESPIRATORY
070 APNEA
071 AIRWAY OBSTRUCTION/ CHOKING
072 HYPERVENTILATION
073 PULMONARY EDEMA
074 RESPIRATORY DISTRESS
075 ANAPHYLACTIC/TOXIN SHOCK
076 NEAR DROWNING

ENVIRONMENTAL
001 HEAT EXHAUSTION
002 HEAT STROKE
101 COLD EXPOSURE/ HYPOTHERMIA

BEHAVIORAL
040 HYSTERIA
041 FAINTING
043 PSYCHIATRIC/ BEHAVIORAL
044 OVERDOSE
045 IMPAIRMENT SIMILAR TO ALCOHOL
046 ALTERED MENTAL STATUS

OB/GYN
060 OB PRENATAL
061 OB POSTNATAL
062 OB EMERGENCY
063 OB ABORTION
064 GYN PROBLEM
065 OB DELIVERY

OTHER
003 SEIZURE
004 DIABETIC REACTION
005 INSULIN SHOCK
006 POISONING
007 COMMUNICABLE DISEASE
008 UNCONSCIOUS
009 DEAD ON ARRIVAL-NO TRANS.
010 DEAD ON ARRIVAL- TRANS.
050 VOMITING
051 G.I. PROBLEMS
052 G.U. PROBLEMS
090 UNKNOWN COMPLAINT
091 TRANSPORT FOR EXAM
092 NONEMERGENCY TRANSPORT
093 NO TRANSPORT
094 CANCELLED CALL
095 FALSE CALL
102 SEXUAL ASSAULT
103 COLD/FLU
104 HEADACHE
105 WEAKNESS/DIZZNESS
106 PAIN
107 CANCER
108 DIALYSIS
109 MEDICAL DEVICE FAILURE
110 POST OPERATIVE COMPLICATIONS
111 BED CONFINED
112 ALS MONITORING REQUIRED
113 BLS MONITORING REQUIRED
114 SPECIALTY CARE MONITORING

CORE DRUGS

28 Activated Charcoal USP
29 Adenosine
31 Albuterol
43 Amiodarone
37 Ativan
04 Atropine Sulfate
83 Atrovent
34 Calcium Gluconate
15 Dextrose 50%
10 Diazepam
08 Diphenhydramine
24 Dopamine HCL
03 Epinephrine IV
02 Epinephrine SQ
06 Furosemide
30 Glucagon USP
05 Lidocaine HCL
45 Magnesium Sulfate
22 Morphine Sulfate
11 Naloxone
13 Nitroglycerin Spray
14 Nitroglycerin Sublingual
25 Procainamide HCL
42 Racemic Epinephrine
01 Sodium Bicarbonate
27 Syrup of Ipecac
26 Terbutaline Sulfate SQ
35 Thiamine
46 Vasopressin
84 Xopenex

SPECIAL PURPOSE / LOCAL OPTION DRUGS

44 Acetaminophen
36 Aspirin
38 Diltiazem
69 Dobutamine
39 Flumazenil
09 Heparin Lock Flush
40 Ibuprofen
41 Labetalol
19 Nalbuphine HCL
16 Nitrous Oxide
23 Oxytocin
68 Promethazine
33 Proparacaine HCL

Toxicology
71 Amyl Nitrite
77 Calcium Gluconate (tox)
72 Methylene Blue
73 Pralidoxime Chloride (2-PAM)
74 Propranolol (Inderal)
82 Pyridoxine HCL
75 Sodium Nitrite
76 Sodium Thiosulfate

Rapid Seq Intubation
81 Etomidate
78 Midazolam HC (Versed)
79 Succinylcholine (Anectine)
80 Vecuronium Bromide (Norcuron)

GLASGOW

EYE OPENING:		VERBAL:		MOTOR:	
SPONTANEOUS	4	ORIENTED	5	OBEYS COMMANDS	6
TO VOICE	3	CONFUSED	4	LOCALIZES PAIN	5
TO PAIN	2	INAPPROPRIATE WORDS	3	WITHDRAW (Pain)	4
NONE	1	INCOMPREHENSIBLE	2	FLEXION (Pain)	3
		NONE	1	EXTENSION (Pain)	2
				NONE	1

REVISED TRAUMA SCORE

GLASGOW COMA SCORE	SYSTOLIC BP	RESPIRATORY RATE	CODE VALUE
13–15	>89	10–29	4
9–12	76–89	>29	3
6–8	50–75	6–9	2
4–5	1–49	1–5	1
3	0	0	0

SELECTED ANATOMICAL INJURIES

1. ALL PENETRATING INJURIES TO HEAD, NECK, TORSO AND EXTREMITIES PROXIMAL TO ELBOW AND KNEE.
2. FLAIL CHEST.
3. COMBINATION TRAUMA WITH BURNS.
4. TWO OR MORE PROXIMAL LONG BONE FRACTURES.
5. PELVIC FRACTURES.
6. LIMB PARALYSIS.
7. AMPUTATION PROXIMAL TO WRIST AND ANKLE.

VITAL SIGNS

PUPILS	LEVEL OF CONSC.
E = EQUAL	A = ALERT
U = UNEQUAL	V = VERBAL ST.
N = NO RESP.	P = PAINFUL ST.
C = CONSTR.	U = UNRESP.
D = DILATED	

LIST OF CODE NUMBERS OF S.C. COUNTIES

01 Abbeville
02 Aiken
03 Allendale
04 Anderson
05 Bamberg
06 Barnwell
07 Beaufort
08 Berkeley
09 Calhoun
10 Charleston
11 Cherokee
12 Chester
13 Chesterfield
14 Clarendon
15 Colleton
16 Darlington
17 Dillon
18 Dorchester
19 Edgefield
20 Fairfield
21 Florence
24 Greenwood
25 Hampton
26 Horry
27 Jasper
28 Kershaw
29 Lancaster
30 Laurens
31 Lee
32 Lexington
33 McCormick
34 Marion
35 Marlboro
36 Newberry
37 Oconee
38 Orangeburg
39 Pickens
40 Richland
41 Saluda
42 Spartanburg
43 Sumter
44 Union