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
	Duplicate Remittance Advice Request Form	09/2017
	Claim Reconsideration Form	11/2018
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



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 NUMBI	ER: (if applicable)							
ADDRESS OF SUSPECT:		LOCATION OF INCIDENT:								
		DATE OF INCIDENT:								
COMPLAINT:										
NAME OF PERSON REPORTING: (Please print)	SIGNATU	IRE OF PERSON REPORTING:	DATE OF REPORT							
ADDRESS OF PERSON REPORTING:	<u>'</u>	TELEPHONE NUMBER OF PERS	ON REPORTING:							
		SIGNATURE: (SCDHHS Representative	Receiving Report)							

SCDHHS Form 126 (revised 06/07)

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: Total paid amount on the original claim: Provider City, State, Zip: Original CCN: Provider ID: NPI: Recipient ID: Adjustment Type: Originator: ○Void/Replace () DHHS ○ MCCS Provider () Void Reason For Adjustment: (Fill One Only) Insurance payment different than original claim Medicaid paid twice - void only Keying errors Incorrect provider paid Incorrect recipient billed Incorrect dates of service paid Voluntary provider refund due to health insurance Provider filing error Voluntary provider refund due to casualty Medicare adjusted the claim Voluntary provider refund due to Medicare Other For Agency Use Only Analyst ID: Hospital/Office Visit included in Surgical Package Independent lab should be paid for service Web Tool error Reference File error Assistant surgeon paid as primary surgeon. Multiple surgery claims submitted for the same DOS MCCS processing error MMIS claims processing error Claim review by Appeals Rate change Comments: _____ Date: Signature:__ 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, 5, 6, & 7 must	be completed.	Attach ap	propriate document(s)) as listed in item 8.
1. Provider Nan	ne:				
2. Medicaid Leg OR 3. NPI#	•	x Characters)	& Taxon		
4. Person to Con				hone Number:	
6. Reason for R		onronriate hoxl	_ 3. Telepi	none Number:	
a b c d e f Me () () () Rec	Type of Insurance Insurance Compa Policy #:Policyholder:Group Name/Gro Amount Insurance dicare Full payment made Deductible not de Adjustment made quested by DHHS er, describe in de	te: () Accident/Auto any Name Dup: the Paid: de by Medicare ue the by Medicare (please attach a copy tail reason for refund:	Cof the request)		<u> </u>
	tient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund
□ E □ E □ R	ledicaid Remittan	ce Advice (required) nefits (EOMB) from Interest (EOMB) from M	Medicare (if appli	icable)	



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		EDICAID BENEFICIARY WITH N TON SYSTEM (MMIS) – ALLOW	O INSURANCE IN THE MEDICAID 25 DAYS
	Beneficiary Name:	Date	e Referral Completed:
	Medicaid ID#:	Police	cy Number:
	Insurance Company Name:	Gro	up Number:
	Insured's Name:	Insu	ared SSN:
	Employer's Name/Address:		
	b. beneficiary	coverage lapsed - terminate coverage c	carrier is
	e. beneficiary	to add to insurance already in MMIS	for subscriber or other family member.
	(name)		
	Submit th	nis information to Medicaid Insurance	ail:



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 PAFROM THE PRIMARY INSURER.	AYMENT OR SUFFICIENT RESPONSE
(SIGNATURE AND DATI	E)

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

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 remitta	ince advice for which you are requesting a duplicate copy:
		vailable electronically through the Web Tool. Please check lity of the remittance advice date before submitting your
5.	Street Address for delivery of reques	st:
	Street:	
	City:	. <u> </u>
	State:	
	Zip Code:	
6.	Charges for duplicate remittance ad	vice(s) are as follows:
	Request Processing Fee - \$20.00	
	Page(s) copied - <u>.20 per page</u>	
		charge is associated with this request and will be deducted djustment on a future remittance advice.
Auth	norizing Signature	Date



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 BeneficiaryID:	
Section 2: Provider Information		
Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other	(DME, Lab, Home Health Agency, et	c.):
NPI: Medicaid Provider ID:	Facility/Group/Provide	r 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) AmbulanceServices AutismSpectrum Disorder (ASD) Services ClinicServices Community Long Term Care (CLTC) Community Mental Health Services Department of Disabilities and Special Needs (DDSN) Waivers Durable Medical Equipment (DME) Early InterventionServices Enhanced Services Federally Qualified Health Center (FQHC) Home Health Services Hospice Services Hospital Services	☐ Local Education Agencies (LEA)☐ Medically Complex Children's	(MCC) Waivers rmediate Care Facility for Individual: CF/IID) on (OSS) Other Medical Professionals and AudiologicalServices th Services (RBHS)

SCDHHS-CR Form (11/18) Page 1 of 2



Healthy Connections	
Section 5: Desired Outcome	
Request submitted by:	
Print Name:	•
Signature:	Date:

SCDHHS-CR Form (11/18) Page 2 of 2



HEALTH INSURANCE CLAIM FORM

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

Ambulance Services Sample Claim Showing NPI and Medicaid Provider ID

PICA	OTHE ODELIN COMM	1112 (4000) 0212						PICA T
1. MEDICARE MEDICAL	D TRICARE	CHAMPY	A GROUP	PLAN PLK LUNG	ОТНЕЯ	1a. INSURED'S I.D. NUMBE	ER .	(For Program in Item 1)
(Medicares) X (Medicald	9) (IDM/DoD#)	1234567890						
2. PATIENT'S NAME (Last Name	, First Name, Middle	initial)	3. PATIENT'S B		EX	4. INSURED'S NAME (Last	Name, First Name,	, Middle Initial)
Doe, John A.			01 01		F			
5. PATIENT'S ADDRESS (No., 8 123 Windy Lane	treet)			LATIONSHIP TO INSU	777	7. INSURED'S ADDRESS (I	No., Street)	
CITY		CTATT		ouse Child	Other	CITY	-	-
Anytown		SC STATE	6. RESERVED	FOR NUCC USE		CITY		STATE
ZIP CODE	TELEPHONE (Incl.	ide Area Code)				ZIP CODE	TELEPHON	NE (Include Area Code)
29999	(803) 898	-2590						1
8. OTHER INSURED'S NAME (L			10. IS PATIENT	'S CONDITION RELAT	ED TO:	11. INSURED'S POLICY GE	ROUP OR FECA N	UMBER
R. OTHER INSURED'S POLICY	OR GROUP NUMBER	3	a. EMPLOYMEN	NT? (Current or Previou	s)	a. INSURED'S DATE OF BI		SEX
				YES NO			M	F
b. RESERVED FOR NUCC USE			b. AUTO ACCID		ACE (State)	b. OTHER CLAIM ID (Desig	nated by NUCC)	
c. RESERVED FOR NUCC USE			c. OTHER ACC	YES NO		c. INSURANCE PLAN NAM	F OR PROGRAM	NAME
A THESERVED I ON NOOD USE			W OTHER ACC	YES NO		WHOOLDINGE PLAN NAM	L ON FROGRAM I	IV UNE
IL INSURANCE PLAN NAME OF	PROGRAM NAME		10d. CLAIM CO	DES (Designated by N	JCC)	d. IS THERE ANOTHER HE	ALTH BENEFIT P	LAN?
			\ \		* \	YES NO	8 yes, comple	ete Items 9, 9a, and 9d.
READ 12. PATIENT'S OR AUTHORIZE to process this claim. I also re-	BACK OF FORM BE	FORE COMPLETIN	A SIGNING THE	B FORM.		13. INSURED'S OR AUTHO	RIZED PERSONS	S SIGNATURE I authorize
to process this claim. I also re	quest payment of gove	mment benefits either	to myself or to the	party who accepts assig	nment	services described below	anta to the Uniderat v.	gned physician or supplier for
below.	. C:L-							
Signature or			DATE			\$IGNED_		
14. DATE OF CURRENT ILLNE	BS, INJURY, OF PREG	INANCY (LMP) 15.	OTHER DATE	MM DD	YY	18. DATES PATIENT UNAB MM DD FROM	LE TO WORK IN C	
17. NAME OF REFERRING PRO	المشاخة	1. 1.				18. HOSPITALIZATION DAT		
		27	o. NPI			FROM DD	YY TO	
19. ADDITIONAL CLAIM INFOR	WATION (Designated					20. OUTSIDE LAB?	80	CHARGES
			>			YES NO		
21. DIAGNOSIS OR NATURE O	FILLNESS OF INJUF	TY Relate A-L to sen	rice line below (24)	E) ICD Ind.		22. FIESUBMISSION CODE	ORIGINAL F	REF. NO.
250 91	В	c. 1		D				boundary and any and any
E.L	F.	G. L	-	н. Ц		23. PRIOR AUTHORIZATIO	N NUMBER	
I. DATE(S) OF SERVICE	J. B.	C. D. PROCE	DURES SERVIC	ES, OR SUPPLIES	E.	F. (3. H. I.	4
From	TO PLACE OF	F (Expli	ain Unusual Circun		DIAGNOSIS	\$ CHARGES U	3. H. I. IYS EPSOT ID. ITS Plan QUAL	RENDERING PROVIDER ID. #
	JO 11 GUING	Line Of Info	00	MODIFIER	TOMILIT	g of thirdLo	1D	ABC123
01 07 14 01 0	7 14 41	A0428	3 NH			117 71	1 NPI	1234567890
	į.	1	1			I .	1D	ABC123
01 07 14 01 0	7 14 41	A0999) HN			79 65	1 NPI	1234567890
01 07 14 04 0	7 14 40	10000	1 800	1 1		25/00/	1D	ABC123 1234567890
01 07 14 01 0	7 14 41	A042	5 NH			25 00	5 NPI	1234307690
		1	1			T E 1	NPI	
							THE C	
							NPI	
	6 8					V - V - 2		
							NPI	
25. FEDERAL TAX I.D. NUMBER	88N EIN	28. PATIENT'S	ACCOUNT NO.	27. ACCEPT ASS		28. TOTAL CHARGE	29. AMOUNT PA	The state of the s
31. SIGNATURE OF PHYSICIAN	I OD ÉLIGIPIES	93 SERVINE E	ACILITY LOCATIO	YES	NO	\$ 222 36 39. BILLING PROVIDER IN	V.	222 36
INCLUDING DEGREES OR	CREDENTIALS	SZ. SCHVIUE H	WILLIT LOUATIO	INTONIA I KIN		ABC Ambulance C	100	55)5555555
(I certify that the statements of apply to this bill and are made						111 Main Street		
						Anytown, SC 2222	2-2222	
RIANED	DATE	a.	b.			1 234567890	□ 1DABC1	23



HEALTH INSURANCE CLAIM FORM

Ambulance Services Sample Claim Showing NPI Only

PROVED BY NATIONAL UNII	ORM CLAIM	COMMIT	TEE (N	UCC) 02/12									NPI C	
PICA			26.	- 199										PICA
MEDICARE MEDICAL		CARE	_	CHAMPVA	GROUP	PLAN FECA	ING OTHER			JER .			(For Pro	gram in Item 1)
(Medicare#) X (Medicald		#/DoD#)		(Member IDII)	(ILNO)	(11.78)	(IDW)	12345678						
ATIENT'S NAME (Last Nam	, First Name	, Middle in	nittel)	a. i	ATIENT'S BIF		SEX	4. INSURED'S N	IAME (Las	t Name	, First N	lame, l	Middle Initi	al)
oe, John A.					01 01	1999 MX								
ATIENT'S ADDRESS (No., 8 23 Windy Lane	treet)			1,000	And the second	ATIONSHIP TO IN		7. INSURED'S A	DDHE88	(No., 8	itraet)			
SA-SELECTION OF THE PROPERTY.				the state of the s	Self Spo		Other				4		- 5/	
y nytown				SC 8.1	RESERVED F	OR NUCC USE		CITY						STATE
CODE	TELEPHO	AIP Analu	de Aven	370070				717 0005				u ima ii		241
9999				Codel				ZIP CODE			IELE!	HUN	= (include /	Area Code)
		898-									_ \)	
THER INSURED'S NAME (I	ast Name, FI	ret Neme,	, MICKES	initiau) 10.	IS PAHENTS	CONDITION RE	AIED TO:	11. INSURED'S	POLICY	HUUP	OHFE	CA NU	WHEH	. 200
THER INSURED'S POLICY	OD GDOLID	MINDED			EMDI OVMEN	T7 (Current or Pre	utes en	> INCLIDENCE	ATE OF	שדמו		-	0	EX
THEN INSONED S POLICY	JH GHOOF	HOMBEN			- MIT LOT INC. IN		10	a. INSURED'S D	DD T	"TYP"	-	M		F
ESERVED FOR NUCC USE		-		b.	AUTO ACCIDE			b. OTHER CLAIR	M ID Man	anned a	I box BII II			
				100000			PLACE (State)	D. OINER CLAIR	m in (mas	Service (ay mul			
ESERVED FOR NUCC USE				6.6	OTHER ACCID			a. INSURANCE	PLAN NA	WE OR	PROGE	N MAF	AME	
					A		ю	300		1900				
SURANCE PLAN NAME OF	PROGRAM	NAME		100	L CLAIM COD	ES (Designated b		d. IS THERE AN	OTHER H	EALTH	BENE	FIT PL	AN7	
					1		1	YES	NC.					9a, and 9d.
REAL	BACK OF F	ORM BEI	FORE C	ONPLETING & S	IGNING THIS	FORM.		13. INSURED'S	OR AUTH	ORIZE	D PERS	ONS	SIGNATUR	RE I authorize
READ PATIENT'S OR AUTHORIZE o process this claim. I also re	D PERSONS	SIGNAT	URE 19	authorize the releasements at the re-	se of any medi self or to the p	cal or other informs	ttlen necessary	payment of n	nedical be	nefita to	the un	deralgr	ned physici	ian or supplier for
elow.														
Signature or	ı File 🤍				DATE_		A	SIGNED						
ATE OF CURRENT ILLNE	S, INJURY,	or PREGI	NANCY	(LMP) 15. OTH	ER DATE	MM DD	w	16. DATES PATI	ENT UNA	BLEJO) WOR	(IN C	URRENT C	CCUPATION
	IUAL			QUAL				FROM				TO	CONTRACT OF STREET	100
AME OF REFERRING PRO	VIDER OR C	OTHER S	OURCE	179.				18. HOSPITALIZ	ATION D	TES P	ELATE	DTO	CURRENT	SERVICES DD YY
				17b. N	મ ્			FROM				то		
ADDITIONAL CLAIM INFOR	NATION (De	signated b	by NUCC	2)				20. OUTSIDE LA				\$ CI	HARGES	
		M	200					YES	NO)				
NAGNOSIS OR NATURE O	- ILLNESS C	H INJUH	Y 1-184808	9 W-L to service II	ne Delow (24E)	ICD Ind.	· I	22. FIESUBMISS	HON	17	ORIGIN	VAL PI	EF. NO.	
250.91	В			C	-	D		23. PRIOR AUTI	LODIZAT	ONIAMI	A APPEN			
	F.	-		G		н. 📖		23. PHION AUTI	HUHIZATI	ON NO	MOCH			
A. DATE(S) OF SERVI	J.		_	K.	EO OFFINADE	L L S, OR SUPPLIES	1 -	F.	-					
From	To	B. PLACE OF	C.	(Explain U	nusual Circum	stances)	E. DIAGNOSIS			OAYS OA OA INITS	H. EPSOT Family Plan (I. ID.		RENDERING
DD YY MM	DD YY	SERVICE	EMG	CPT/HCPCS	1 1	MODIFIER	POINTER	\$ CHARGES	3 1	INTS		1D	ABC12	ROVIDER ID. #
07 14 01 4	7 14	41	1	A0428	NH	1 1		117	71	1	-	NPI	12345	
07 14 01 (7 14	41		710-120	1411			117				1D	ABC12	
07 14 01 0	7 14	41	-	A0999	HN	1 1	1	79	65	1		NPI	12345	
07 14 01 0	14	41		710333	LIIN			19	55		- 5	760000	ABC12	
		41		A0425	NH	1 1	1	III aci	00	5	-	NPI	12345	
07 14 01 0	7 14								()()		1 1 2	100	1000	
07 14 01 0	7 14	41						25	00	-				
07 14 01 0	7 14	41						25	00	,		NPI		
07 14 01 0	7 14	41		Ţ				25				NPI		
07 14 01 0	7 14	41						25				NPI NPI		
07 14 01 0	7 14	41						25		3.				
07 14 01 0	7 14	41												
		N EIN	28. F	PATIENT'S ACCX	DUNT NO.	27. ACCEPT.	SSIGNMENT?	28. TOTAL CHA	RGE	29.		NPI NPI	ID 30). Ravel for NUCC
			28. F	PATIENT'S ACCO	DUNT NO.	27. ACCEPT. ACCEPT. YES	SSIGNMENT?	28. TOTAL CHA		29.		NPI NPI NT PA	D 30	0. Ravel for NUCC 222 36
EDERAL TAX I.D. NUMBER	R SSI	N EIN		PATIENT'S ACC		YES		28. TOTAL CHA \$ 39. BILLING PRO	RGE 222 36	29. \$	AMOUR PH #	NPI NT PAI	00	
EDERAL TAX LD. NUMBE	R SSI	N EIN				YES		28. TOTAL CHA \$ 39. BILLING PRI ABC Ambu	RGE 222 36 OVIDER II	29. \$	AMOUR PH #	NPI NT PAI	00	222 36
EDERAL TAX LD. NUMBE	R SSI	N EIN				YES		28. TOTAL CHA \$ 33. BILLING PR ABC Ambu 111 Main S	RGE 222 36 OVIDER II Ilance Street	29. \$ NFO & Com	AMOUN PH # pany	NPI NT PAI	00	222 36
07 14 01 C	R SSI	N EIN				YES		28. TOTAL CHA \$ 39. BILLING PRI ABC Ambu	RGE 222 36 OVIDER II Ilance Street	29. \$ NFO & Com	AMOUN PH # pany	NPI NT PAI 0	00	222 36

Sample Remittance Advice (page 1)
This page of the sample Remittance Advice shows a paid claim, suspended claim and rejected claim.

PROVIDER +	+ DEPT OF HE			REMITTANCE ADVICE						PAYMENT DATE ++ 02/14/2014 ++			PAGE ++ 1 ++
PROVIDERS OWN REF. NUMBER	REFERENCE	+ PY IND	DATE(S)	+ ENDERED PROC.	BILLED	+ TITLE 19 PAYMENT MEDICAID	Т	ID.	+	0	TLE. 18 ALLOWED CHARGES		TITLE 18 PAYMENT
ABB1AA	 1403004803012700A 01		101713	 71010	27.00	6.72 6.72		 11122333333 	M CLARK	026		0.00	0.00
ABB2AA	 1403004804012700A 01		 101713	 74176	259.00 259.00	0.00		 1112233333 	 M CLARK 	026		0.00	0.00
ABB3AA 	 1403004805012700A 01 02	İ	 071913 071913 	 A5120 A4927 	24.00 12.00 12.00	0.00	R	!	M CLARK	 000 000 6 L02	852 08/3	0.00	0.00
	 TOTALS 	 	 3 		 310.00 	İ	 		 			0.00	0.00
ERROR CODES LISTED ON THIS + FORM REFER TO: "MEDICAID PROVIDER MANUAL". +					G TOT 1	# \$6. #EDICAID \$28	72 PG 6.4	+ STAT TOT + P = 46 R = + S = FAL E =	PAYMENT MADE AB REJECTED IN PROCESS PO		NAME AND		+
	FOR INQUIRY OF + THAT MANUAL.		+ +-		+ +	CHECK TO			' K 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				DIII GEG		PROFESS	IOI	NAL SERVICE	-	PAYMENT D			PAGE
AB0008000	+ DEPT OF HE 00 + SOUTH CAR					REMIT	TAI	NCE ADVICE		02/28/20	14		1 1
PROVIDERS OWN REF. NUMBER	REFERENCE		SERVICE REDATE(S)		BILLED	PAYMENT	Т	ID.	RECIPIENT NAME F M I LAST NAME	0	TLE. 18	AMT	TITLE 18 PAYMENT
 ABB222222	 1405200415812200A 01 02		 021814 021814	 S0315 S9445	 1192.00 800.00 392.00	117.71	P		 M CLARK 	00		0.00	0.00
 ABB222222 	 VOID OF ORIGINAL (1405200077700000U 01 02		100213	 S0315	 AID 20131 1412.00- 1112.00- 300.00-	273.71- 143.71-	P	1	 M CLARK 	00			
 ABB222222 	REPLACEMENT OF OR. 1405200414812200A 01 02		 100213		1001.50 142.50	42.75 42.75	P P	!	 M CLARK 	00		 0.00 	0.00
				 	 	 	 	 	 			0.00	0.00
+	+	·	+	+	+	+ \$28 +			+ US CODES:	DBOMINE	-+	+	++
ERROR CODES					G TOT I	MEDICAID \$28	PG	TOT + P = 1	PAYMENT MADE REJECTED	PROVIDER NAME AND ADDRESS + ABC HEALTH PROVIDER		, + 	
PROVIDER MA	ANUAL". LL HAVE QUESTIONS+:			CERTIFI	ED AMT 1	MEDICAID	TO:	TAL E =	IN PROCESS ENCOUNTER	PO BOX 0		SC 000	000
PHONE THE I	D.H.H.S. NUMBER FOR INQUIRY OF +-						0.0	00	+	+			+
	THAT MANUAL.					CHECK TO	TAI	L CHEC	K NUMBER				

Sample Remittance Advice (page 3)
This page of the sample Remittance Advice shows a claim-level Void without a corresponding Replacement claim.

PROVIDER II	O. + DEPT OF HE	אוידע אאר עוואאא	CEDVICEC	+ CLAIM		PAYMENT DATE	PAGE
AB111100		OLINA MEDICAID	PROGRAM	ADJUSTMENTS	 +	02/28/2014	
PROVIDERS OWN REF. NUMBER	REFERENCE	SERVICE R		TITLE 19 S RECIPIENT D PAYMENT T ID. MEDICAID S NUMBER	F M	M ORG OCHECK	ORIGINAL CCN
 ABB222222 	1405200077700000U 01 02 TOTALS	!!	S0315 453.00 S9445 60.00		į į	000	1328300224813300A
+	PROVDER INCENTIVE CREDIT AMOUNT	PR RE	H++ BIT BALANCE IOR TO THIS MITTANCE				. 0.00
	0.00	+ +	0.00	ADJUSTMENTS	+	PROVIDER 1	+
			UR CURRENT BIT BALANCE	·	 + CHECK NUMBER		
		+	0.00	++ \$50.00		 PO BOX 0000 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.

PROVIDE	R ID. + DEPT OF HEA	ו מאווע מווא מידי	CEDVITCEC		+		+		YMENT DATE		PAGE
AB111100					 ADJUSTM +	MENTS	+		02/28/2014		3
PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG	RECIPIENT ID. NUMBER	+ RECIPIENT LAST NAME	F M	CHECK	+ ORIGINAL PAYMENT 	+ ACTION 	DEBIT / CREDIT AMOUNT	EXCESS
 TPL 2	1404900004000100U	-	 		 		 	 	 DEBIT	-2389.05	
TPL 4	14055000760004000	-					 		DEBIT	-1949.90	
TPL 5	14049000040001000	-					 		DEBIT	-477.25	
TPL 6	14055000760004000	-	 	 			 	 	 CREDIT 	477.25	
 +	 		 +	 +	 +		 +	PAGE TOTAL	: +	4338.95	0.00 ++
	PROVDER	DE	BIT BALANCE		AID TOTAL		ERTIFIE			TO 1	BE REFUNDED THE FUTURE
	INCENTIVE CREDIT AMOUNT		IOR TO THIS	 +	0.00	+-		0.00		.00	++
	++	+	0.00	ADJU	STMENTS						++
	++	+	+	•	+ -4338.95			0.00 +		NAME AND ADDI	
		DE	UR CURRENT BIT BALANCE	+ CHEC	+ K TOTAL	+- CI	HECK NU	+ MBER	PO BOX 00		
			0.00	1	0.00			T I	FLORENCE		SC 00000

South Carolina Department of Health and Human Services Verification of Retroactive Medicaid

	Date:
To:	_
	_
Re:	_
Medicaid Number:	_
Retroactive Medicaid coverage was entered Services computer system for the above-nan	
The retroactive period began on the following	ng date:
The retroactive period ended on the following	ng date:
Please be reminded that all bills must be sub-	mitted 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 PATH	ENT CAR	E FORM					Q.A. N		
										TRIP		
	TIDENTIFICATION		DISPOSITION (110–111)	TYPE OF	INCIDENT	CALL TYP	STATE OF THE PERSON			The state of the s	T STATUS	No. of Concession, Name of Street, or other
AST NAME (10-2			01 TREAT/NO TRANS.		MEDICAL (113)	1 EMERGE	ENT 1	N SC	RGENT		FROM S	ENT
TREET (47-71)		PT. #	03 HOSPITAL ER	1 MVA	1 ENVIRON 2 BEHAV	2 NONEME CODE	ERGENT 2	■ NO		GENT CODE	2 NO	URGENT
TY (72–87)	STATE (88	- 39) ZIP CODE (90–94)	04 HOSP. DIR. ADMIT.	3 BIKES	3 OB/GYN	ST. OR HWY.	IN	CIDE	NT LO	OCATIO	N	
SN (95-103)			06 PATIENT'S HOME	4 PED	4 RESP	NAME OR NO).					
SEX (104)	RACE (105)	AGE (106-109)	07 NURSING HOME 08 DR.'S OFFICE	5 ASSAULT	5 CARDIAC	County		Zin	Code			
Male	1 White 2 Black	CHECK ONE	09 OUTPATIENT	6 FALL	6 INTERFAC	(117-118)	(FOR (404	(11	9-123	3)	OF INCIDE	NT (105)
Female	3 Am. Indian	1 TYRS.	10 PT. REFUSED TREAT.	7 FIRE	7 OTHER	1 Seatbelts	y EQP (124) s 4 Child	-	1 🗐		OF INCIDE	- 0
Undetermined	4 Hispanic 5 Asian	2 MOS.	13 EMS TRANSFER	8 INTERFAC		2 Helmets	5 None				NCE 5	
2251 1111	6 Other	3 DAYS	THAN 4) (400 407)	PRIMARY		3 Airbags	6 Unkn	-	_	_	RIAL 6	OTHER
		S (MARK NO MORE itrauma/Shock 074	Respiratory Distress	IMPRESSION	01 Dressing A		7 Oxygen				(4) Cardiac	Maccana
3 Seizure	030 Hea		Coronary Problems	(138–140)	02 Limb Splin		8 Suction				Bleedin	
4 Diabetic					03 Spine Imm		9 Antishoo		eare		Cold Ap	
	ontusions 032 Spir		Cardiac Arrest		04 Neck Imm		0 Airway I				Patient	
3 Laceration	084 Stro		Other Other		05 OB Assista							
3 Fracture	051 G.I.	•					1 Antishoo		tment		Other (L	
HCFA COD (175-180			ROCEDURES (190-223)		06 Oral Airwa		2 Artificial		_		Ventilate	or
(175-160		G Monitored	Rhythm Time Watt Sec. Time				RUGS US					
	2. Fir	st Defib Attempted Post Defib	Watt Sec. Time Rhythm		DRUG	DOSE	TIME		DRUG		DOSE	TIN
	3. □ Se	cond Defib Attempted	Watt Sec. Time									
		Post Defib	Rhythm								•	
SITE OF TRA (181–189		ird Defib Attempted	Watt Sec. Time									
		Post Defib	Rhythm									
Head	INTU	BATED 5. ET Size				RE	EVISED TR	AUMA	scc	ORE		
Face	e D EV	15 RSI	16 LMA 17 Crico		GCS: (242) E			-249) 9				RTS (254
Neck		OOD DRAWN	DEXTROSE BGL			RBAL	(25	0-252)	RR _			
		STARTED/GAUGE	SOLUTION		(244) MC		/25	2) AMA	TOMIC	LIAL IAC	1 YE	200
Choct		RATE	IV TIME IV VOLUI	ME	(245–246) GLAS	IGOW	-	-	-	JAL INJ.	TEST TE	5 4
		HAIL										
	9. 🗆 IV	STARTED/GAUGE	SOLUTION				VITAL	SIGN	S			
Abdomen		STARTED/GAUGE RATE	IV TIME IV VOLUE	ME	BP	PULSE R	ESPIRATONS	-	UPIL	LEVEL	OF CONSC	. 1
Abdomen Hip/Pelvis	14 🗆 I	STARTED/GAUGE RATE V ATTEMPTED Total #	IV TIME IV VOLUI	ME				S PI		LEVEL	OF CONSC	1
Abdomen Hip/Pelvis Upper Extr.	14 🔲 I'	STARTED/GAUGE RATE V ATTEMPTED Total # EURAL DECOMPRESSIO	IV TIME IV VOLUI	ME .		REG. RA	ESPIRATONS ATE REG			LEVEL	OF CONSC	1
Abdomen Hip/Pelvis Upper Extr. Lower Extr.	14	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIO TRAOSSEOUS INF.	IV TIME IV VOLUI	ME		REG. RA	ESPIRATONS ATE REG	. E			OF CONSC	1
Abdomen Hip/Pelvis Upper Extr. Lower Extr.	14 I' 10. PL 11. IN 12. AL	STARTED/GAUGE RATE V ATTEMPTED Total # EURAL DECOMPRESSIO	IV TIME IV VOLUE (225) N Time	ME		REG. RA	ESPIRATONS ATE REG IRRE REG REG	G. E. E. G. U		A	OF CONSC	
Abdomen Hip/Pelvis Upper Extr. Lower Extr.	14 I' 10. PL 11. IN 12. AL	STARTED/GAUGE RATE RATE VATTEMPTED Total # EURAL DECOMPRESSIO TRAOSSEOUS INF. JITOMATIC DEFIB TIENT ASSISTED MEDS Physician	IV TIME IV VOLUI (225) IN Time			REG. RAG. RAG. REG. REG.	ESPIRATONS ATE REG REG REG REG	G. E. G. U. N		A V	OF CONSC	. 1
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back	14	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEGUS INF. ITOMATIC DEFIB TIENT ASSISTED MEDS 'hysician (Name)	IV TIME IV VOLUI (225) N Time (Signatur			REG. RA	ESPIRATONS ATE REG IRRE REG REG	G. E. G. U. N. G. C		A V P	OF CONSC	. 1
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back	14	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEGUS INF. ITOMATIC DEFIB TIENT ASSISTED MEDS 'hysician (Name)	IV TIME IV VOLUI (225) IN Time	10)		REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS ATE	6 PU G E G		A V	OF CONSC	
Abdomen Hip/Pelvis Upper Extr. Lower Extr. Back POSURE TO P Responder (25	14	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TIENT ASSISTED MEDS Physician (Name) 56) 1. YES	IV TIME IV VOLUI (225) N Time (Signatur	2. NO		REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS ATE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE	G. U. N. G. C. D. G		A V P	OF CONSC	
Abdomen Hip/Pelvis Upper Extr. Lower Extr. Back POSURE TO P Responder (25	14	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TIENT ASSISTED MEDS Physician (Name) 56) 1. YES	IV TIME IV VOLUI (225) N Time (Signatur	2. NO		REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS ATE	G. U. N. G. C. D. G		A V P	OF CONSC	
GADdomen GAD	14	STARTED/GAUGE RATE VATEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TIENT ASSISTED MEDS Physician (Name) 56) 1. YES	IV TIME IV VOLUI (225) N Time (Signatur	2. NO		REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS ATE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE	G. U. N. G. C. D. G		A V P	OF CONSC	
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P	14	STARTED/GAUGE RATE VATEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TIENT ASSISTED MEDS Physician (Name) 56) 1. YES	IV TIME IV VOLUI (225) N Time (Signatur	2. NO		REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS ATE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE	G. U. N. G. C. D. G		A V P	OF CONSC	
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P	14	STARTED/GAUGE RATE VATEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TIENT ASSISTED MEDS Physician (Name) 56) 1. YES	IV TIME IV VOLUI (225) N Time (Signatur	2. NO		REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS ATE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE	G. U. N. G. C. D. G		A V P	OF CONSC	. 1
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P	14	STARTED/GAUGE RATE VATEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TIENT ASSISTED MEDS Physician (Name) 56) 1. YES	IV TIME IV VOLUI (225) N Time (Signatur	2. NO		REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS ATE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE	G. U. N. G. C. D. G		A V P	OF CONSC	. 1
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P	14	STARTED/GAUGE RATE VATEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TIENT ASSISTED MEDS Physician (Name) 56) 1. YES	IV TIME IV VOLUI (225) N Time (Signatur	2. NO		REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS ATE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE	G. U. N. G. C. D. G		A V P	OF CONSC	. 1
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P	14	STARTED/GAUGE RATE VATEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TIENT ASSISTED MEDS Physician (Name) 56) 1. YES	IV TIME IV VOLUI (225) N Time (Signatur	2. NO		REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS ATE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE	G. U. N. G. C. D. G		A V P	OF CONSC	
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P	14	STARTED/GAUGE RATE VATEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TIENT ASSISTED MEDS Physician (Name) 56) 1. YES	IV TIME IV VOLUI (225) N Time (Signatur	2. NO		REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS ATE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE	G. U. N. G. C. D. G		A V P	OF CONSC	
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P	14	STARTED/GAUGE RATE VATEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TIENT ASSISTED MEDS Physician (Name) 56) 1. YES	IV TIME IV VOLUI (225) N Time (Signatur	2. NO		REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS ATE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE	G. U. N. G. C. D. G		A V P	OF CONSC	
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P	14	STARTED/GAUGE RATE VATEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TIENT ASSISTED MEDS Physician (Name) 56) 1. YES	IV TIME IV VOLUI (225) N Time (Signatur	2. NO		REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS ATE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE	G. U. N. G. C. D. G		A V P	OF CONSC	
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P	14	STARTED/GAUGE RATE VATEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TIENT ASSISTED MEDS Physician (Name) 56) 1. YES	IV TIME IV VOLUI (225) N Time (Signatur	2. NO		REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS ATE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE	G. U. N. G. C. D. G		A V P	OF CONSC	
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P	14	STARTED/GAUGE RATE VATEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TIENT ASSISTED MEDS Physician (Name) 56) 1. YES	IV TIME IV VOLUI (225) N Time (Signatur	2. NO		REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS ATE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE	G. U. N. G. C. D. G		A V P	OF CONSC	
GADdomen GAD	14	STARTED/GAUGE RATE VATEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TIENT ASSISTED MEDS Physician (Name) 56) 1. YES	IV TIME IV VOLUI (225) N Time (Signatur	2. NO		REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS ATE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE	G. U. N. G. C. D. G		A V P	OF CONSC	
Abdomen Hip/Pelvis Upper Extr. Lower Extr. Back POSURE TO P Responder (25	14	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TILENT ASSISTED MEDS Physician (Name) TO YES MPLAINTS, OBSERVAT	IV TIME IV VOLUI (225) NN Time (Signatur 2. NO	2. NO		REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS ATE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE REG IRRE	G. U. N. G. C. D. G		A V P	OF CONSC	
Abdomen Hip/Pelvis Upper Extr. Lower Extr. Back POSURE TO P Responder (25	14	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TILENT ASSISTED MEDS Physician (Name) S6) 1. YES MPLAINTS. OBSERVAT	IV TIME IV VOLUI (225) NN Time (Signatur 2. NO TIONS AT SCENE, RESPONS	2. NO	/ RATE / / / / / / /	REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS TE REG REG REG REG REG REG REG REG REG RE	S PO PO PO PO PO PO PO PO PO PO PO PO PO	UPIL	A V P U		See Pa
Abdomen Hip/Pelvis Upper Extr. Lower Extr. Back POSURE TO P Responder (25	14	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TILENT ASSISTED MEDS Physician (Name) S6) 1. YES MPLAINTS. OBSERVAT	IV TIME IV VOLUI (225) NN Time (Signatur 2. NO TIONS AT SCENE, RESPONS	2. NO	/ RATE / / / / / / /	REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS TE REG REG REG REG REG REG REG REG REG RE	S PO PO PO PO PO PO PO PO PO PO PO PO PO	UPIL	A V P U	OF CONSCI	See Pa
5- Abdomen 5 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P Responder (25 COMMENTS (14	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TILENT ASSISTED MEDS Physician (Name) S6) 1. YES MPLAINTS. OBSERVAT	IV TIME IV VOLUI (225) NN Time (Signatur 2. NO TIONS AT SCENE, RESPONS	2. NO	/ RATE / / / / / / /	REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS TE REG REG REG REG REG REG REG REG REG RE	S PO PO PO PO PO PO PO PO PO PO PO PO PO	UPIL	A V P U		See Pa
5 Abdomen 5 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P 12 Responder (25 COMMENTS (14	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TILENT ASSISTED MEDS Physician (Name) S6) 1. YES MPLAINTS. OBSERVAT	IV TIME IV VOLUI (225) NN Time (Signatur 2. NO TIONS AT SCENE, RESPONS	2. NO	/ RATE / / / / / / /	REG. RAG. RAG. RAG. REG. REG. REG. REG. REG. REG. REG. RE	ESPIRATONS TE REG REG REG REG REG REG REG REG REG RE	S PO PO PO PO PO PO PO PO PO PO PO PO PO	UPIL	A V P U		See Pa
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P 12 Responder (25 COMMENTS (14	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TILENT ASSISTED MEDS Physician (Name) S6) 1. YES MPLAINTS. OBSERVAT	IV TIME IV VOLUI (225) NN Time (Signatur 2. NO TIONS AT SCENE, RESPONS	2. NO	/ RATE / / / / / / / / / / / / / / / / / / /	REG. RA IRREG. REG. IRREG. IRREG. IRREG. IRREG. IRREG. IRREG. IRREG. IRREG.	ESPIRATONS TE REG REG REG REG REG REG REG REG REG RE	S P(G	UPIL	A V P U		See Pa
5 Abdomen 5 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P Responder (25 COMMENTS (14	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TILENT ASSISTED MEDS Physician (Name) S6) 1. YES MPLAINTS. OBSERVAT	IV TIME IV VOLUI (225) NN Time (Signatur 2. NO TIONS AT SCENE, RESPONS	2. NO E TO STIMULI) EC PERMIT NO	/ RATE / / / / / / / / / / / / / / / / / / /	REG. RA IRREG. REG. IRREG. IRREG. IRREG. IRREG. IRREG. IRREG. IRREG. IRREG.	ESPIRATONS TE REG REG REG REG REG REG REG REG REG RE	S P(G	UPIL	A V P U		See Pa
5 Abdomen 5 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P Responder (25 COMMENTS (14	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TILENT ASSISTED MEDS Physician (Name) S6) 1. YES MPLAINTS. OBSERVAT	IV TIME IV VOLUI (225) NN Time (Signatur 2. NO TIONS AT SCENE, RESPONS	2. NO E TO STIMULI) EC PERMIT NO	/ RATE / / / / / / / / / / / / / / / / / / /	REG. RAG. IRREG.	ESPIRATONS TE REGENTATIONS REGENTATIONS REGENTATIONS REGENTATIONS REGENTATIONS ATTENDAN	S PPC	UPIL SANT (3	A V P U U U U U U U U U U U U U U U U U U		See Pa
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P 12 Responder (25 COMMENTS (14 Telephone Comments (15 Telephone Comments (16 Telephone Comments (17 Telephone Comments (18 Telephone Comments	14	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TILENT ASSISTED MEDS Physician (Name) S6) 1. YES MPLAINTS. OBSERVAT	IV TIME IV VOLUI (225) NO Time (Signatur 2. NO TIONS AT SCENE, RESPONS 3. OTHER DH	2. NO E TO STIMULI) EC PERMIT NO EDIVING AGENCE	/ RATE / / / / / / / / / / / / / / / / / / /	REG. RAG. IRREG.	ESPIRATONS TE REG REG REG REG REG REG REG REG REG RE	S PPC	UPIL SANT (3	A V P U U U U U U U U U U U U U U U U U U		See Pa
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back (POSURE TO P tt Responder (25 COMMENTS (Comments (25 Comments	TIME RE MONTH DAY 267-270) 14	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TILENT ASSISTED MEDS Physician (Name) S6) 1. YES MPLAINTS. OBSERVAT	IV TIME IV VOLUI (225) NO Time (Signatur 2. NO TIONS AT SCENE, RESPONS 3. OTHER DH	2. NO E TO STIMULI) EC PERMIT NO	/ RATE / / / / / / / / / / / / / / / / / / /	REG. RAG. IRREG.	ESPIRATONS TE REGENTATIONS REGENTATIONS REGENTATIONS REGENTATIONS REGENTATIONS ATTENDAN	S PPC	UPIL SANT (3	A V P U U U U U U U U U U U U U U U U U U		See Pa
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back (POSURE TO P tt Responder (25 COMMENTS (Comments (25 Comments	TIME RE MONTH DAY (267–270) 14	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TILENT ASSISTED MEDS Physician (Name) S6) 1. YES MPLAINTS. OBSERVAT	IV TIME IV VOLUI (225) NO Time (Signatur 2. NO TIONS AT SCENE, RESPONS 3. OTHER DH	2. NO E TO STIMULI) EC PERMIT NO EDIVING AGENCE	/ RATE / / / / / / / / / / / / / / / / / / /	REG. RA IRREG. REG. IRREG.	ESPIRATONS TE REGENTATIONS REGENTATIONS REGENTATIONS REGENTATIONS REGENTATIONS ATTENDAN	S PPC	UPIL ANT (309-	A V P U U U U U U U U U U U U U U U U U U		See Pa
5 Abdomen 6 Hip/Pelvis 7 Upper Extr. 8 Lower Extr. 9 Back POSURE TO P tt Responder (25 COMMENTS (Patient Care Forn RUN DATE 259–266) Call Received: (Call Dispatched: Departed Base: Arrive Scene: (2 Departed Scene	TIME RE MONTH DAY (2675–278) (275–282) (283–286)	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TILENT ASSISTED MEDS Physician (Name) S6) 1. YES MPLAINTS. OBSERVAT	IV TIME IV VOLUE (225) Time (Signatur 2. NO TIONS AT SCENE, RESPONS 3. OTHER DH REC	2. NO E TO STIMULI) EC PERMIT NO EIVING AGENCY	/ RATE / / / / / / / / / / / / / / / / / / /	REG. RA IRREG. REG. IRREG.	ESPIRATONS ATTENDANT/D	S PPC	UPIL ANT (309-	A V P U U U U U U U U U U U U U U U U U U		See Pa
st Responder (25	TIME RE MONTH DAY (2675–278) (275–282) (283–286)	STARTED/GAUGE RATE VATTEMPTED Total # EURAL DECOMPRESSIC TRAOSSEOUS INF. ITOMATIC DEFIB TILENT ASSISTED MEDS Physician (Name) S6) 1. YES MPLAINTS. OBSERVAT	IV TIME IV VOLUI (225) NO Time (Signatur 2. NO TIONS AT SCENE, RESPONS 3. OTHER DH	2. NO E TO STIMULI) EC PERMIT NO EIVING AGENCY	/ RATE / / / / / / / / / / / / / / / / / / /	PRIMAR PRIMAR PRIMAR PRIMAR PRIMAR PRIMAR PRIMAR	ESPIRATONS ATTENDANT/D	S PU GG. U S GG. C C C GG. TTEND.	ANT (309-	A V P U U U U U U U U U U U U U U U U U U		See Pa

. 6			53	

	PATIENT COMPLAIN	TSICNALS	CORE DRUGS	SPECIAL PURPOSE/
				LOCAL OPTION
	Type of Incider	nt	OO Astireted Charges I I CD	DRUGS
			28 Activated Charcoal USP	44 Acetaminophen
TRAUMA	RESPIRATORY	OTHER	29 Adenosine	36 Aspirin
11 ABRASION/CONTUSION		003 SEIZURE 004 DIABETIC REACTION	31 Albuterol	38 Diltiazem
12 AVULSION 13 LACERATION	071 AIRWAY OBSTRUCTION/ CHOKING	005 INSULIN SHOCK	43 Amiodarone	
14 PUNCTURE/STAB	072 HYPERVENTILATION	006 POISONING	37 Ativan	69 Dobutamine
15 GUNSHOT WOUND	073 PULMONARY EDEMA	007 COMMUNICABLE DISEASE	04 Atropine Sulfate	39 Flumazenil
16 BURN	074 RESPIRATORY DISTRESS	008 UNCONSCIOUS		09 Heparin Lock Flush
17 HEMORRHAGE	075 ANAPHYLACTIC/TOXIN SHOCK	009 DEAD ON ARRIVAL-NO TRANS. 010 DEAD ON ARRIVAL-TRANS.	83 Atrovent	40 Ibuprofen
18 ELECTROCUTION 19 CHEST INJURY	076 NEAR DROWNING	050 VOMITING	34 Calcium Gluconate	41 Labetalol
20 CRUSHING	OTO (VETA) DITOTO MITO	051 G.I. PROBLEMS	15 Dextrose 50%	19 Nalbuphine HCL
21 AMPUTATION	ENVIRONMENTAL	052 G.U. PROBLEMS	10 Diazepam	
22 DISLOCATION	001 HEAT EXHAUSTION	090 UNKNOWN COMPLAINT	08 Diphenhydramine	16 Nitrous Oxide
23 FRACTURE	002 HEAT STROKE	091 TRANSPORT FOR EXAM 092 NONEMERGENCY TRANSPORT	24 Dopamine HCL	23 Oxytocin
24 MULTITRAUMA/SHOCK 25 PATIENT TRAPPED	101 COLD EXPOSURE/ HYPOTHERMIA	093 NO TRANSPORT		68 Promethazine
26 EYE INJURY	HTFOTHERWIA	094 CANCELLED CALL	03 Epinephrine IV	33 Proparacaine HCL
29 SPRAIN/STRAIN	BEHAVIORAL	095 FALSE CALL	02 Epinephrine SQ	Toxicology
30 HEAD INJURY	040 HYSTERIA	102 SEXUAL ASSAULT	06 Furosemide	
031 PARALYSIS	041 FAINTING	103 COLD/FLU	30 Glucagon USP	71 Amyl Nitrite
032 SPINAL INJURY	043 PSYCHIATRIC/	104 HEADACHE		77 Calcium Gluconate (tox)
037 ANIMAL BITE 038 SNAKE BITE	BEHAVIORAL 044 OVERDOSE	105 WEAKNESS/DIZZNESS 106 PAIN		72 Methylene Blue
38 SNAKE BITE	045 IMPAIRMENT SIMILAR TO	107 CANCER	45 Magnesium Sulfate	73 Pralidoxime Chloride
	ALCOHOL ALCOHOL	108 DIALYSIS	22 Morphine Sulfate	
CARDIAC/STROKE	046 ALTERED MENTAL STATUS		11 Naloxone	(2-PAM)
80 CORONARY PROBLEM		110 POST OPERATIVE	13 Nitroglycerin Spray	74 Propranolol (Inderal)
81 CONGESTIVE HEART	OB/GYN 060 OB PRENATAL	COMPLICATIONS		82 Pyridoxine HCL
FAILURE	061 OB POSTNATAL	111 BED CONFINED	14 Nitroglycerin Sublingual	75 Sodium Nitrite
82 HYPERTENSION	062 OB EMERGENCY	112 ALS MONITORING REQUIRED 113 BLS MONITORING REQUIRED	25 Procainamide HCL	76 Sodium Thiosulfate
083 CARDIAC ARREST	063 OB ABORTION	114 SPECIALTY CARE MONITORING	42 Racemic Epinephrine	
084 CVA/TIA/STROKE	064 GYN PROBLEM		01 Sodium Bicarbonate	Rapid Seq Intubation
085 HYPOTENSION 086 CHEST PAIN	065 OB DELIVERY			81 Etomidate
OU OTLOT FAIN				78 Midazolam HC (Versed)
			26 Terbutaline Sulfate SQ	79 Succinylcholine (Anectin
			35 Thiamine	
			46 Vasopressin	80 Vecuronium Bromide
			84 Xopenex	(Norcuron)
	GLASGOW			
EYE OPENING:	VERBAL:	MOTOR:		
SPONTANEOUS 4	ORIENTED 5		LIST OF CODE	E NUMBERS OF
TO VOICE 3	CONFUSED 4		80.00	UNTIES
TO PAIN 2	INAPPROPRIATE WORDS 3		5.0.00	CIVILLES
NONE 1	INCOMPREHENSIBLE 2		01 Abbeville	24 Greenwood
	NONE 1	EXTENSION (Pain) 2	02 Aiken	25 Hampton
		NONE 1	03 Allendale	26 Horry
		CONTRACTOR OF STREET		27 Jasper
CHICAGO CON CONTRACTOR CONTRACTOR				
	REVISED TRAUMA	SCORE	04 Anderson	
	REVISED TRAUMA	SCORE	05 Bamberg	28 Kershaw
			05 Bamberg 06 Barnwell	28 Kershaw 29 Lancaster
GLASGOW	SYSTOLIC RESPIRA	ATORY CODE	05 Bamberg 06 Barnwell 07 Beaufort	28 Kershaw 29 Lancaster 30 Laurens
	SYSTOLIC RESPIRA BP RAT	ATORY CODE E VALUE	05 Bamberg 06 Barnwell 07 Beaufort 08 Berkeley	28 Kershaw 29 Lancaster 30 Laurens 31 Lee
GLASGOW COMA SCORE 13–15	SYSTOLIC RESPIRA BP RAT	ATORY CODE E VALUE 29 4	05 Bamberg 06 Barnwell 07 Beaufort	28 Kershaw 29 Lancaster 30 Laurens
GLASGOW COMA SCORE 13–15 9–12	SYSTOLIC RESPIRA BP RAT >89 10-2 76-89 >28	ATORY CODE E VALUE 29 4 9 3	05 Bamberg 06 Barnwell 07 Beaufort 08 Berkeley	28 Kershaw 29 Lancaster 30 Laurens 31 Lee
GLASGOW COMA SCORE 13–15 9–12 6–8	SYSTOLIC RESPIRA BP RAT >89 10-2 76-89 >28 50-75 6-8	ATORY CODE VALUE 29 4 9 3 9 2	05 Bamberg 06 Barnwell 07 Beaufort 08 Berkeley 09 Calhoun	28 Kershaw 29 Lancaster 30 Laurens 31 Lee 32 Lexington
GLASGOW <u>COMA SCORE</u> 13–15 9–12 6–8 4–5	SYSTOLIC RESPIRA BP RAT >89 10-2 76-89 >25 50-75 6-5 1-49 1-5	ATORY CODE VALUE 29 4 9 3 9 2 5 1	05 Bamberg 06 Barnwell 07 Beaufort 08 Berkeley 09 Calhoun 10 Charleston	28 Kershaw 29 Lancaster 30 Laurens 31 Lee 32 Lexington 33 McCormick
GLASGOW COMA SCORE 13–15 9–12 6–8	SYSTOLIC RESPIRA BP RAT >89 10-2 76-89 >28 50-75 6-8	ATORY CODE VALUE 29 4 9 3 9 2 5 1	05 Bamberg 06 Barnwell 07 Beaufort 08 Berkeley 09 Calhoun 10 Charleston 11 Cherokee	28 Kershaw 29 Lancaster 30 Laurens 31 Lee 32 Lexington 33 McCormick 34 Marion
GLASGOW <u>COMA SCORE</u> 13–15 9–12 6–8 4–5 3	SYSTOLIC RESPIRA BP RAT >89 10-2 76-89 >28 50-75 6-8 1-49 1-4 0 0	ATORY CODE E VALUE 29 4 9 3 9 2 5 1 0	05 Bamberg 06 Barnwell 07 Beaufort 08 Berkeley 09 Calhoun 10 Charleston 11 Cherokee 12 Chester 13 Chesterfield	28 Kershaw 29 Lancaster 30 Laurens 31 Lee 32 Lexington 33 McCormick 34 Marion 35 Marlboro 36 Newberry
GLASGOW <u>COMA SCORE</u> 13–15 9–12 6–8 4–5	SYSTOLIC RESPIRA BP RAT >89 10-2 76-89 >28 50-75 6-8 1-49 1-5 0 0 0 0	ATORY CODE VALUE 29 4 9 3 9 2 5 1	05 Bamberg 06 Barnwell 07 Beaufort 08 Berkeley 09 Calhoun 10 Charleston 11 Cherokee 12 Chester 13 Chesterfield 14 Clarendon	28 Kershaw 29 Lancaster 30 Laurens 31 Lee 32 Lexington 33 McCormick 34 Marion 35 Marlboro 36 Newberry 37 Oconee
GLASGOW COMA SCORE 13–15 9–12 6–8 4–5 3 SELECTED ANATO 1. ALL PENETRATING INJU	SYSTOLIC RESPIRA BP RAT >89 10-2 76-89 >28 50-75 6-8 1-49 1-5 0 0 0 0	ATORY CODE E VALUE 29 4 9 3 9 2 5 1 0	05 Bamberg 06 Barnwell 07 Beaufort 08 Berkeley 09 Calhoun 10 Charleston 11 Cherokee 12 Chester 13 Chesterfield 14 Clarendon 15 Colleton	28 Kershaw 29 Lancaster 30 Laurens 31 Lee 32 Lexington 33 McCormick 34 Marion 35 Marlboro 36 Newberry 37 Oconee 38 Orangeburg
GLASGOW COMA SCORE 13–15 9–12 6–8 4–5 3 SELECTED ANATO 1. ALL PENETRATING INJU TORSO AND EXTREMIT AND KNEE.	SYSTOLIC RESPIRA BP RAT >89 10-2 76-89 >22 50-75 6-5 1-49 1-5 0 0 DMICAL INJURIES JRIES TO HEAD, NECK, JIES PROXIMAL TO ELBOW	ATORY CODE E VALUE 29 4 9 3 9 2 5 1 0	05 Bamberg 06 Barnwell 07 Beaufort 08 Berkeley 09 Calhoun 10 Charleston 11 Cherokee 12 Chester 13 Chesterfield 14 Clarendon 15 Colleton 16 Darlington	28 Kershaw 29 Lancaster 30 Laurens 31 Lee 32 Lexington 33 McCormick 34 Marion 35 Marlboro 36 Newberry 37 Oconee 38 Orangeburg 39 Pickens
GLASGOW COMA SCORE 13–15 9–12 6–8 4–5 3 SELECTED ANATO 1. ALL PENETRATING INJUTORSO AND EXTREMITAND KNEE.	SYSTOLIC RESPIRA	ATORY CODE E VALUE 29 4 9 3 9 2 5 1 0 VITAL SIGNS	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	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
GLASGOW COMA SCORE 13–15 9–12 6–8 4–5 3 SELECTED ANATO 1. ALL PENETRATING INJU TORSO AND EXTREMIT AND KNEE.	SYSTOLIC	ATORY CODE E VALUE 29 4 9 3 9 2 5 1 0 VITAL SIGNS	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	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
GLASGOW COMA SCORE 13–15 9–12 6–8 4–5 3 SELECTED ANATO 1. ALL PENETRATING INJUITORSO AND EXTREMIT AND KNEE. 2. FLAIL CHEST. 3. COMBINATION TRAUMA	SYSTOLIC RESPIRA	ATORY CODE E	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	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
GLASGOW COMA SCORE 13–15 9–12 6–8 4–5 3 SELECTED ANATO 1. ALL PENETRATING INJULTORSO AND EXTREMIT AND KNEE. 2. FLAIL CHEST.	SYSTOLIC	ATORY CODE E	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	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

5. PELVIC FRACTURES.6. LIMB PARALYSIS.

AMPUTATION PROXIMAL TO WRIST AND ANKLE.