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 Health Insurance Claim Form	02/2012
	Sample Remittance Advice (four pages)	04/2014

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 8355Columbia, 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: _____

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)

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? 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 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. 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											NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

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-|    |             |   +--------------------------------+
                                  YOUR CURRENT        +-------------+    +-------------+   |ABC HEALTH PROVIDER             |
                                  DEBIT BALANCE       CHECK TOTAL       CHECK NUMBER      |                                |
                                 +-------------+     +-------------+    +---------+       |PO BOX 000000                   |
                                 |        0.00 |     |       $50.00|    |  4197304|       |FLORENCE            SC 00000    |
                                 +-------------+     +-------------+    +---------+       +--------------------------------+
```

Sample Remittance Advice (page 4)

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

PROVIDER ID.: AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE: 02/28/2014

PAGE: 3

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

PROVDER INCENTIVE CREDIT AMOUNT: 0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 0.00

MEDICAID TOTAL: 0.00

ADJUSTMENTS: -4338.95

CHECK TOTAL: 0.00

CERTIFIED AMT: 0.00

CHECK NUMBER:

0.00

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000