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 Showing TPL Denial with NPI	02/2012
	Sample Remittance Advice (four pages)	04/2014
	Allied Professional Registration Form	04/2017
	LISW Allied Professional Registration Form	06/2017
	Mental Health Form	04/2013
	Corrective Action Plan	05/2021

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,

Prov.,der Name: (Please use blacl orblue ink when oompletng form)

Prowder Addre-ss:

ProviderCity. Siaie, Zip:

Total paid amount on the orig nal claim:

Original CCN:

?rovider ID:

NP I:

Recipèn:1D:

Adjustmen: Type:

Q Void Q Void/Replace

Originato:

Q DHHS Q MCCS Q Provider Q MIVS

Reason For Ad.ustment:(Fill One Only)

0 Insurance payment different than original claim
0 Keying errors
0 Incorrect recipient billed
O Voluntary provider refund due to health insurance
O Voluntary provider refund due to casualty
O Voluntary provider refund due to Medicare
O Medicaid paid twice - void only
O Incorrect provider paid
O Incorrect dates of service paid
O Provider filing error
O Medicare adjusted the claim
O Other

For Agency Use Only

Analyst ID:

O Hospital/Office Visit included in Surgical Package
O Independent lab should be paid for service
O Assistant surgeon paid as primary surgeon
O Multiple surgery claims submitted for the same DOS
O MMIS claims processing error
0 Rate change
O Web Tool error
0 Reference File error
0 MCCS processing error
0 Claim review by Appeals

Comments:

Signature: _____ Date: _____

Phone: _____

Form 130 Revision date: 03-1S-2007

South Carolina Department of Health and Human Services
Form for Medicaid Refunds

Purpose: This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. **Attach appropriate document(s) as listed in item 8.**

1. Provider Name: _____

2. Medicaid Legacy Provider # ☐☐☐☐☐☐
(Six Characters)

OR

3. NPI# ☐☐☐☐☐☐☐☐☐☐ **& Taxonomy** ☐☐☐☐☐☐☐☐☐☐

4. Person to Contact: _____ **5. Telephone Number:** _____

6. Reason for Refund: [check appropriate box]

☐ Other Insurance Paid (please complete **a – f** below and attach insurance EOMB)
- **a** Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
- **b** Insurance Company Name _____
- **c** Policy #: _____
- **d** Policyholder: _____
- **e** Group Name/Group: _____
- **f** Amount Insurance Paid: _____

☐ Medicare
( ) Full payment made by Medicare
( ) Deductible not due
( ) Adjustment made by Medicare

☐ Requested by DHHS (please attach a copy of the request)

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

7. Patient/Service Identification:

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

8. Attachment(s): [Check appropriate box]

☐ Medicaid Remittance Advice (required)
☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)
☐ Explanation of Benefits (EOMB) from Medicare (if applicable)
☐ Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

DHHS Form 205 (01/08)

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)-ALLOW25 DAYS

Beneficiary Name:_____ Date Referral Completed:_____

Medicaid ID#:_____ PolicyNumber:_____

Insurance Company Name:_____ Group Number:_____

Insured's Name: _____ Insured SSN: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Employer'sName/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 1vCMIS for subscriber or other family member.

(name) _____

ATTACHACOPYOFTHEAPPROPRIATEDOCUMENTATIONTOTHISFORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER_____ **DOS** _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

_____

(SIGNATURE AND DATE)

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

Revised 04/2014

South Carolina Department of Health and Human Services
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 -070 9 or submit an online inquiry at http :f/ www .scdhhs.gov/conta ct-us for instructions on submission of your request.

1. Provider Name: _____

2. Medicaid Legacy Provider#_____(Six Characters)

   NPI#_____ Taxonomy_____

3. Person to Contact:_____ Telephone Number: _____

4. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:

   _____
   _____
   _____
   _____
   _____

   Note : Remitta nce advices are available electronically through the Web Tool. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

5. Street Address for delivery of request:

   Street: _____

   City: _____
   State:_____
   Zip Code: _____

6. Charges for duplicate remittance advice(s) are as follows:

   Request Processing Fee - $20.00

   Page(s) copied - .20 per page

I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.

_____ _____
Authorizing Signature Date

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Healthy Connections MEDICAID

Submit your daim Reconsideration request to:

Fax: 1-855-563-7086

or

Mail: South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

CLAIM RECONSIDERATION FORM

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. A separate SCDHHS CR form is required for each claim control number (CCN). Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709. **Note:** Timely filing guidelines apply.

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____ Medicaid Beneficiary ID: _____

Section 2: Provider Information

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

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

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

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

Section 3: Claim Information *(Only one CCN allowed per request.)*

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

Section 4: Claim Reconsideration Information

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

- ☐ Ambulance Services
- ☐ Autism Spectrum Disorder (ASD) Services
- ☐ Clinic Services
- ☐ Community Long Term Care (CLTC)
- ☐ Community Mental Health Services
- ☐ Department of Disabilities and Special Needs (DDSN) Waivers
- ☐ Durable Medical Equipment (DME)
- ☐ Early Intervention Services
- ☐ Enhanced Services
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Home Health Services
- ☐ Hospice Services
- ☐ Hospital Services
- ☐ Licensed Independent Practitioner's Rehabilitative Services (LIPS)
- ☐ Local Education Agencies (LEA)
- ☐ Medically Complex Children's (MCC) Waivers
- ☐ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- ☐ Optional State Supplementation (OSS)
- ☐ Pharmacy Services
- ☐ Physicians Laboratories, and Other Medical Professionals Specify: _____
- ☐ Private Rehabilitative Therapy and Audiological Services
- ☐ Psychiatric Hospital Services
- ☐ Rehabilitative Behavioral Health Services (RBHS)
- ☐ Rural Health Clinic (RHC)
- ☐ Targeted Case Management (TCM)
- ☐ Other: _____

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signat ure: _____ Date _____

Sample Claim Showing TPL Denial with NPI

HEALTH INSURANCE CLAIM FORM

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

PICA PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Anytown STATE: SC

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 29999 TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: A123450A

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE: 0.00

d. INSURANCE PLAN NAME OR PROGRAM NAME: 401

YES

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. 295 32 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	11		90804			60 00	2		ZZ	1212121212
														NPI	123456 8
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

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

26. PATIENT'S ACCOUNT NO.: DOE1234

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

28. TOTAL CHARGE: $ 60 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use: 60 00

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

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #: 555 5555555
Jane Smith, MD
11 Main Street
Anytown, SC 22222-2222

SIGNED DATE

a. 1234567890 b. zz1212 121212

Sample Remittance Advice (page 1)

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

PROVIDER ID. AB00080000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE 02/14/2014

PAGE 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S/T	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB1AA	1403004803012700A 01	101713		71010	27.00	6.72	P	1112233333	M CLARK	026		0.00	0.00
ABB2AA	1403004804012700A 01	101713		74176	259.00	0.00	S	1112233333	M CLARK	026		0.00	0.00
ABB3AA	1403004805012700A 01	071913		A5120	24.00	0.00	R	1112233333	M CLARK	000		0.00	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							

SAMPLE ONLY

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT: $0.00
MEDICAID PG TOT: $286.46
CERTIFIED AMT
MEDICAID TOTAL: 0.00
CHECK TOTAL

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

CHECK NUMBER

PROVIDER NAME AND ADDRESS
ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 2)

This page of the sample Remittance Advice shows a paid claim, as well as a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle.

PROVIDER ID. AB00080000 | DEPT OF HEALTH AND HUMAN SERVICES | SOUTH CAROLINA MEDICAID PROGRAM | PROFESSIONAL SERVICES REMITTANCE ADVICE | PAYMENT DATE 02/28/2014 | PAGE 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	T	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	1405200415812200A				1192.00	243.71	P	1112233333	M CLARK			0.00	
	01		021814	S0315	800.00	117.71	P			000			0.00
	02		021814	S9445	392.00	126.00	P			000			0.00
	VOID OF ORIGINAL CCN 13283002244813300A PAID 20131018												
ABB222222	1405200077700000U				1412.00-	273.71-	P	1112233333	M CLARK				
	01		100213	S0315	1112.00-	143.71-	P			000			
	02		100213	S9445	300.00-	130.00-	P			000			
	REPLACEMENT OF ORIGINAL CCN 13047112536704 30A PAID 20131018												
ABB222222	1405200414812200A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		100213	S0315	142.50	42.75	P			000			0.00
	02		100313	S9445	859.00	0.00	R			000			0.00
												0.00	0.00

$286.46

CERT. PG TOT $0.00 | MEDICAID PG TOT $286.46

CERTIFIED AMT | MEDICAID TOTAL 0.00

CHECK TOTAL | CHECK NUMBER

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 3)

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

PROVIDER ID. AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE 02/28/2014

PAGE 2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	ORG O D	CHECK DATE	ORIGINAL CCN
ABB222222	14052000777000000U				513.00-	197.71-	P	1112233333	CLARK		M	000	131018	1328300224813300A
	01		100213	S0315	453.00	160.71-	P					000		
	02		100213	S9445	60.00	33.00-	P					000		
	TOTALS	1			513.00-	193.71-								

PROVDER INCENTIVE CREDIT AMOUNT: 0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 0.00

MEDICAID TOTAL: $243.71

ADJUSTMENTS: $193.71-

CHECK TOTAL: $50.00

CERTIFIED AMT: 0.00

CHECK NUMBER: 4197304

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 4)

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

PROVIDER ID.: AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE: 02/28/2014

PAGE: 3

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

PROVDER INCENTIVE CREDIT AMOUNT: 0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 0.00

MEDICAID TOTAL: 0.00

ADJUSTMENTS: -4338.95

CHECK TOTAL: 0.00

CERTIFIED AMT: 0.00

CHECK NUMBER:

0.00

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Please return signed original Attestation to:

Mailing Address:

SC Dept. of Health and Human Services c/o
Division of Family Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Fax: (803) 255-8204

Section I: Demographic Information

Please Print:

Physician or APRN Name	
Address:	
Facility:	
Telephone:	
National Provider Identifier Number (NPI)	
Fax:	
Email:	

Section II: Allied Professional Update Form

The Allied Professional(s) listed below are under my supervision and services rendered and billed to South Carolina Medicaid will be in compliance with the guidelines as provided in the South Carolina Medicaid FQHC or RHC Standard. All allied professionals must be listed and a maximum of three allied professionals are permitted.

Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage and Family Therapist

Name (as it appears on their license):	
License Number & Expiration Date:	
Name (as it appears on their license):	
License Number & Expiration Date:	
Name (as it appears on their license):	
License Number & Expiration Date:	

If there are any changes to this list, i.e. the allied professional's qualifications, physician or APRN information, I will notify South Carolina Medicaid utilizing this form within thirty days (30). Failure to comply shall result in the recoupment for services rendered. My signature and signature date certifies, that the information provided in the Attestation is correct.

_____ _____

Physician or APRN Signature Date

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Please return signed original Attestation to:

Mailing Address:

SC Dept. of Health and Human Services c/o
Division of Family Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Fax: (803) 255-8204

Section I: Demographic Information

Please Print:

LISW-CP Name	
Address:	
Facility:	
Telephone:	
National Provider Identifier Number (NPI)	
Fax:	
Email:	

Section II: Allied Professional LMSW Update Form

The Allied Professional(s) LMSW listed below are under my LISW-CP (licensed Independent social worker-clinical practice) supervision and services rendered and billed to South Carolina Medicaid w ill be in compliance w ith the guidelines as provided in the South Carolina Medicaid FQHC or RHC Standard. All allied professional(s) LMSW must be listed and a maximum of three LMSW(s) are permitted to be supervised by the LISW-CP.

Licensed Master Social Worker (LMSW)

Name (as it appears on their license):	
License Number & Expiration Date:	
Name (as it appears on their license):	
License Number & Expiration Date:	
Name (as it appears on their license):	
License Number & Expiration Date:	

If there are any changes to this list, i.e. the allied professional's qualifications, LISW-CP information, I will notify South Carolina Medicaid utilizing this form within thirty days (30). Failure to comply shall result in the recoupment for services rendered. My signature and signature date certifies, that the information provided in the Attestation is correct.

_____ _____

LISW-CP Signature Date

South Carolina
Department of Health and Human Services
Mental Health Form

FILL OUT COMPLETELY TO AVOID DELAYS

Beneficiary's Name:		**Organization NPI:**	
Medicaid ID #:		**Center's Name:**	
Date of Birth:		**Service Location Address:**	
Individual NPI:		**City & State:**	

DSM-IV TR Diagnosis

Axis I _ _ _ _ _/_ _ _ _ _/ _ _ _ _ _ Axis II _ _ _ _ _/ _ _ _ _ _ Axis III _ _ _ _ _/ _ _ _ _ _

Date first seen:_____ **Date of last service:**_____**# of additional visits requested:** _____

Current Clinical Information: (Circle each. Scale 0=None, 1=Mild, 2=Moderate, 3=Severe, 4=Extreme)

Aggression	0 1 2 3 4	Depressions	0 1 2 3 4	Relationship Problems	0 1 2 3 4
Alcohol/Substance Use	0 1 2 3 4	Hallucinations	0 1 2 3 4	Side Effects	0 1 2 3 4
Anxiety/Panic	0 1 2 3 4	Impulsivity	0 1 2 3 4	Sleep Effects	0 1 2 3 4
Appetite Disturbance	0 1 2 3 4	Job/School Problems	0 1 2 3 4	Sleep Disturbance	0 1 2 3 4
Attention/Concentration	0 1 2 3 4	Mania	0 1 2 3 4	Weight Loss	0 1 2 3 4
Deficit in ADLs	0 1 2 3 4	Medical Illness	0 1 2 3 4	Other	0 1 2 3 4
Delusions	0 1 2 3 4	Memory	0 1 2 3 4	Current Stressors	0 1 2 3 4

Services

◇ 90833	◇ 90846	◇ 90853	◇ 90837
◇ 90836	◇ 90847	◇ 90832	◇ H0002
◇ 90838	◇ 96101	◇ 90834	

Current Medications	**Name**	**Dose**	**Frequency**	**Side Effects**
◇ **New**	**1.**_____	_____	_____	_____
◇ **New**	**2.**_____	_____	_____	_____
◇ **New**	**3.**_____	_____	_____	_____
◇ **New**	**4.**_____	_____	_____	_____
Compliance	◇ **>90%**	◇ **50-90%**	◇	**<50%**

Reasons for Noncompliance:	

_____ (___)_____ (___)_____

Physician/Non physician Practitioner's Name Phone: Fax

_____ _____

Physician/Non physician Practitioner's Signature Date

Clinical documentation must be submitted with this request and submitted to the QIO using one of the following methods:

KePRO FAX#: 1-855-300-0082, KEPRO Customer Service Phone#: 1-855-326-5216, KePRO website: http://scdhhs.Kepro.com.

Disclaimer: Authorization indicates that SCDHHS determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary's eligibility and benefit limitations at the time services are rendered. The Physician Assistant is not authorized to sign this form.

Behavioral Health Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Robert M. Kerr DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

The Division of Behavioral Health Corrective Action Plan

Provider Name			
Contact Person		**Phone Number**	
Contact Email		**Fax Number**	
Date Submitted to SCDHHS			

Item # on Summary	Opportunity for Improvement	Corrective Action Steps to be Implemented	Person(s) Responsible for Implementation	Target Date to Implement Corrective Action	Completion Date for Implementation
1					
2					
3					
4					
5					

Additional questions to be addressed: