

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
	Electronic Funds Transfer (EFT) Authorization Agreement	08/2017
	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



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:

Grid for Original CCN (15 boxes)

Provider ID:

Grid for Provider ID (6 boxes)

NPI:

Grid for NPI (10 boxes)

Recipient ID:

Grid for Recipient ID (10 boxes)

Adjustment Type:

- Void, Void/Replace

Originator:

- DHHS, MCCS, Provider, MIVS

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:

Grid for Analyst ID (6 boxes)

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

Comments:

Signature: _____ Date: _____

Phone: _____

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

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

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed.

Attach appropriate document(s) as listed in item 8.

1. Provider Name: _____

2. Medicaid Legacy Provider #
(Six Characters)

OR

3. NPI#

& Taxonomy

4. Person to Contact: _____

5. Telephone Number: _____

6. Reason for Refund: [check appropriate box]

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

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

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

Other, describe in detail reason for refund:

7. Patient/Service Identification:

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

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

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

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



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM**

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

- _____ a. beneficiary has never been covered by the policy – close insurance.
- _____ b. beneficiary coverage ended - terminate coverage (date) _____
- _____ c. subscriber coverage lapsed - terminate coverage (date) _____
- _____ d. subscriber changed plans under employer - new carrier is _____
- new policy number is _____
- _____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.
(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

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

Fax:
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.**

**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

By signing this form, I 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 the checking or savings account indicated above at the financial institution identified above. Credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the Department of Health and Human Services to make an adjusting debit entry to the account up to the amount of the excess payment. Credit entries to the above account 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 certify that the information shown is correct and 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: _____ Telephone Number: _____
4. 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.

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

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 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)

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Ambulance Services <input type="checkbox"/> Autism Spectrum Disorder (ASD) Services <input type="checkbox"/> Clinic Services <input type="checkbox"/> Community Long Term Care (CLTC) <input type="checkbox"/> Community Mental Health Services <input type="checkbox"/> Department of Disabilities and Special Needs (DDSN) Waivers <input type="checkbox"/> Durable Medical Equipment (DME) <input type="checkbox"/> Early Intervention Services <input type="checkbox"/> Enhanced Services <input type="checkbox"/> Federally Qualified Health Center (FQHC) <input type="checkbox"/> Home Health Services <input type="checkbox"/> Hospice Services <input type="checkbox"/> Hospital Services | <ul style="list-style-type: none"> <input type="checkbox"/> Licensed Independent Practitioner's Rehabilitative Services (LIPS) <input type="checkbox"/> Local Education Agencies (LEA) <input type="checkbox"/> Medically Complex Children's (MCC) Waivers <input type="checkbox"/> Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) <input type="checkbox"/> Optional State Supplementation (OSS) <input type="checkbox"/> Pharmacy Services <input type="checkbox"/> Physicians Laboratories, and Other Medical Professionals Specify: _____ <input type="checkbox"/> Private Rehabilitative Therapy and Audiological Services <input type="checkbox"/> Psychiatric Hospital Services <input type="checkbox"/> Rehabilitative Behavioral Health Services (RBHS) <input type="checkbox"/> Rural Health Clinic (RHC) <input type="checkbox"/> Targeted Case Management (TCM) <input type="checkbox"/> Other: _____ |
|---|--|

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature: _____

Date: _____



HEALTH INSURANCE CLAIM FORM

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

Sample Claim Showing TPL Denial with NPI

CARRIER

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#DoD#) (Member ID#) (ID#) (ID#)</small>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John A.					3. PATIENT'S BIRTH DATE MM DD YY 01 01 1947			SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)		8. RESERVED FOR NUCC USE											
CITY Anytown			STATE SC		8. RESERVED FOR NUCC USE			CITY		STATE											
ZIP CODE 29999		TELEPHONE (Include Area Code) ()			8. RESERVED FOR NUCC USE			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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>											
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME											
c. RESERVED FOR NUCC USE 0.00					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, complete items 9, 9a, and 9d.											
d. INSURANCE PLAN NAME OR PROGRAM NAME 401					10d. CLAIM CODES (Designated by NUCC) 1			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, complete items 9, 9a, and 9d.													
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				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. <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (State A-L to service line below (24E) ICD Incl.) A. 295.32 B. C. D. E. F. G. H. I. J. K. L.												22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER MM DD YY MM DD YY EMB CPT/HCCPCS MODIFIER												F. \$ CHARGES		G. DAYS OR UNITS	H. FROST Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #				
1	01		07		14		01		07		14		11	90804		60.00		2	ZZ	1212121212	
2	NPI																				
3	NPI																				
4	NPI																				
5	NPI																				
6	NPI																				
25. FEDERAL TAX I.D. NUMBER 555555555				SBN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. DOE1234				27. ACCEPT ASSIGNMENT? For spec. servs. see back <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 60.00		29. AMOUNT PAID \$ 0.00		30. Paid for NUCC Use 60.00					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE 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 a. NPI b.				33. BILLING PROVIDER INFO & PH # (555) 5555555 Jane Smith, MD 11 Main Street Anytown, SC 22222-2222 a. 1234567890 b. ZZ1212121212					
SIGNED DATE												SIGNED									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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		
+-----+ AB00080000 +-----+	DEPT OF HEALTH AND HUMAN SERVICES				REMITTANCE ADVICE				+-----+ 02/14/2014 +-----+		+-----+ 1 +-----+		
+-----+													
+-----+ PROVIDERS	+-----+ CLAIM	+-----+ 	+-----+ SERVICE RENDERED	+-----+ AMOUNT	+-----+ TITLE 19	+-----+ S	+-----+ RECIPIENT	+-----+ RECIPIENT NAME	+-----+ M	+-----+ TLE. 18	+-----+ COPAY	+-----+ TITLE	
+-----+ OWN REF.	+-----+ REFERENCE	+-----+ PY IND	+-----+ DATE(S)	+-----+ BILLED	+-----+ PAYMENT	+-----+ T	+-----+ ID.	+-----+ F M	+-----+ O	+-----+ ALLOWED	+-----+ AMT	+-----+ 18	
+-----+ NUMBER	+-----+ NUMBER	+-----+ 	+-----+ MMDDYY	+-----+ PROC.	+-----+ 	+-----+ S	+-----+ NUMBER	+-----+ I I LAST NAME	+-----+ D	+-----+ CHARGES	+-----+ 	+-----+ PAYMENT	
+-----+ ABB1AA	+-----+ 1403004803012700A	+-----+ 	+-----+ 101713	+-----+ 71010	+-----+ 27.00	+-----+ 6.72 P	+-----+ 1112233333	+-----+ M CLARK	+-----+ 026	+-----+ 	+-----+ 0.00	+-----+ 0.00	
+-----+ ABB2AA	+-----+ 1403004804012700A	+-----+ 	+-----+ 101713	+-----+ 74176	+-----+ 259.00	+-----+ 0.00 S	+-----+ 1112233333	+-----+ M CLARK	+-----+ 026	+-----+ 	+-----+ 0.00	+-----+ 0.00	
+-----+ ABB3AA	+-----+ 1403004805012700A	+-----+ 	+-----+ 071913	+-----+ A5120	+-----+ 12.00	+-----+ 0.00 R	+-----+ 1112233333	+-----+ M CLARK	+-----+ 000	+-----+ 	+-----+ 0.00	+-----+ 0.00	
+-----+ 	+-----+ 01	+-----+ 	+-----+ 071913	+-----+ A4927	+-----+ 12.00	+-----+ 0.00 R	+-----+ Edits: L00 946 L02 852 08/30/13 +-----+					+-----+ 0.00	+-----+ 0.00
+-----+ 	+-----+ 02	+-----+ 	+-----+ 	+-----+ 	+-----+ 24.00	+-----+ 0.00 R	+-----+ 					+-----+ 0.00	+-----+ 0.00
+-----+ 	+-----+ TOTALS	+-----+ 	+-----+ 3	+-----+ 	+-----+ 310.00	+-----+ 	+-----+ 					+-----+ 0.00	+-----+ 0.00
+-----+													

\$6.72

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	MEDICAID PG TOT
\$0.00	\$286.46
CERTIFIED AMT	MEDICAID TOTAL
0.00	0.00
CHECK TOTAL	CHECK NUMBER

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

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S	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 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	

\$286.46

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	MEDICAID PG TOT
\$0.00	\$286.46
CERTIFIED AMT	MEDICAID TOTAL
	0.00
	CHECK TOTAL

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

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.	DEPT OF HEALTH AND HUMAN SERVICES	CLAIM ADJUSTMENTS	PAYMENT DATE	PAGE
AB11110000	SOUTH CAROLINA MEDICAID PROGRAM		02/28/2014	2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME I I	M F M O	ORG CHECK DATE	ORIGINAL CCN
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-						

SAMPLE ONLY

PROVDER INCENTIVE CREDIT AMOUNT	DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	TO BE REFUNDED IN THE FUTURE
0.00	0.00	\$243.71	0.00	0.00
		ADJUSTMENTS		
		\$193.71-		
	YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PROVIDER NAME AND ADDRESS
	0.00	\$50.00	4197304	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.	DEPT OF HEALTH AND HUMAN SERVICES	ADJUSTMENTS	PAYMENT DATE	PAGE
AB11110000	SOUTH CAROLINA MEDICAID PROGRAM		02/28/2014	3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME F M LAST NAME I I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	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

SAMPLE ONLY

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

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



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 will be in compliance with 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

- | | | | |
|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> 90833 | <input type="checkbox"/> 90846 | <input type="checkbox"/> 90853 | <input type="checkbox"/> 90837 |
| <input type="checkbox"/> 90836 | <input type="checkbox"/> 90847 | <input type="checkbox"/> 90832 | <input type="checkbox"/> H0002 |
| <input type="checkbox"/> 90838 | <input type="checkbox"/> 96101 | <input type="checkbox"/> 90834 | |

Current Medications	Name	Dose	Frequency	Side Effects
<input type="checkbox"/> New	1. _____	_____	_____	_____
<input type="checkbox"/> New	2. _____	_____	_____	_____
<input type="checkbox"/> New	3. _____	_____	_____	_____
<input type="checkbox"/> New	4. _____	_____	_____	_____
Compliance	<input type="checkbox"/> >90%	<input type="checkbox"/> 50-90%	<input type="checkbox"/>	<input type="checkbox"/> <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