

## FORMS

<b>Number</b>	<b>Name</b>	<b>Revision Date</b>
DHHS 126	<a href="#">Confidential Complaint</a>	06/2007
DHHS 130	<a href="#">Claim Adjustment Form 130</a>	03/2007
DHHS 205	<a href="#">Medicaid Refunds</a>	01/2008
DHHS 931	<a href="#">Health Insurance Information Referral Form</a>	02/2018
	<a href="#">Reasonable Effort Documentation</a>	04/2014
	<a href="#">Duplicate Remittance Advice Request Form</a>	09/2017
	<a href="#">Claim Reconsideration Form</a>	11/2018
CMS-1500 (02/12)	<a href="#">Sample Claim Showing Medicare Denial with NPI</a>	02/2012
CMS-1500 (02/12)	<a href="#">Sample Claim Showing Medicare Denial with NPI and Medicaid Provider ID</a>	02/2012
	<a href="#">Sample Remittance Advice</a>	04/2014
DHHS 168IS	<a href="#">Physician Certification of Incontinence Form</a>	11/2021



**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

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, 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:

Grid for Analyst ID (5 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:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

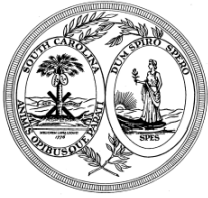
**7. Patient/Service Identification:**

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



**Section 5: Desired Outcome**

**Request submitted by:**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# HEALTH INSURANCE CLAIM FORM

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

Home Health Service  
Sample Claim Showing Medicare Denial  
with NPI

CARRIER

<input type="checkbox"/> PIGA										<input type="checkbox"/> PIGA							
1. MEDICARE <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK (LUNG) <input type="checkbox"/> OTHER <input type="checkbox"/>										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)		CITY STATE							
CITY Anytown			STATE SC			8. RESERVED FOR NUCC USE			CITY STATE								
ZIP CODE 29999			TELEPHONE (Include Area Code) ( )			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)			11. INSURED'S POLICY GROUP OR FECA NUMBER 2222222222B			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>								
a. OTHER INSURED'S POLICY OR GROUP NUMBER			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC) 0 00			c. INSURANCE PLAN NAME OR PROGRAM NAME 618								
b. RESERVED FOR NUCC USE			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.			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.								
c. RESERVED FOR NUCC USE			d. INSURANCE PLAN NAME OR PROGRAM NAME			READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			SIGNED								
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.						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE											
SIGNED Signature on File						SIGNED											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.						15. OTHER DATE MM DD YY QUAL.											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. NPI											
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						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. Flalets A-L to service line below (24E) ICD Ind.						22. RESUBMISSION CODE ORIGINAL REF. NO.											
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____						23. PRIOR AUTHORIZATION NUMBER											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. PROCEDURE, SERVICE, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. FROST Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1		01 07 14 01 07 14 12		T1030				100 00		1		ZZ		1212121212		1234567890	
2		01 07 14 01 07 14 12		A9900				25 00		1		ZZ		1212121212		1234567890	
3		02 05 14 02 05 14 12		T1030				100 00		1		ZZ		1212121212		1234567890	
4		02 05 14 02 05 14 12		T1021				50 00		1		ZZ		1212121212		1234567890	
5		02 05 14 02 05 14 12		A9900				25 00		1		ZZ		1212121212		1234567890	
6																	
25. FEDERAL TAX I.D. NUMBER 555555555				26. PATIENT'S ACCOUNT NO. DOE1234		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 300 00		29. AMOUNT PAID \$ 0 00		30. Paid for NUCC Use 300 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											
SIGNED DATE						33. BILLING PROVIDER INFO & PH # (555) 5555555 ABC Home Health 111 Main Street Anytown, SC 22222-2222											
a. NPI						b. ZZ1212121212											
SIGNED DATE						a. 1234567890 b. ZZ1212121212											

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   +-----+
+-----+   SOUTH CAROLINA MEDICAID PROGRAM   +-----+													
PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	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 27.00	6.72 6.72	P P	1112233333	M CLARK	026		0.00	0.00
ABB2AA	1403004804012700A 01		101713	74176	259.00 259.00	0.00 0.00	S S	1112233333	M CLARK	026		0.00	0.00
ABB3AA	1403004805012700A 01 02		071913 071913	A5120 A4927	24.00 12.00 12.00	0.00 0.00 0.00	R R R	1112233333	M CLARK	000 000		0.00 0.00	0.00 0.00
Edits: L00 946 L02 852 08/30/13													
TOTALS													
			3	310.00		\$6.72							
+-----+													
FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".				CERT. PG TOT	\$0.00	MEDICAID PG TOT	\$286.46	STATUS CODES:		PROVIDER NAME AND ADDRESS			
IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.				CERTIFIED AMT		MEDICAID TOTAL	0.00	P = PAYMENT MADE	ABC HEALTH PROVIDER				
								R = REJECTED	PO BOX 000000				
								S = IN PROCESS	FLORENCE SC 00000				
								E = ENCOUNTER					
						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				REMITTANCE ADVICE				02/28/2014				+-----+	
AB00080000	SOUTH CAROLINA MEDICAID PROGRAM												1	
+-----+	+-----+				+-----+				+-----+				+-----+	
PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T 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		
											0.00	0.00		
					\$286.46									
+-----+					+-----+	+-----+								
FOR AN EXPLANATION OF THE					CERT. PG TOT	MEDICAID PG TOT	STATUS CODES:						PROVIDER NAME AND ADDRESS	
ERROR CODES LISTED ON THIS					+-----+	+-----+	P = PAYMENT MADE						+-----+	
FORM REFER TO: "MEDICAID					\$0.00	\$286.46	R = REJECTED						ABC HEALTH PROVIDER	
PROVIDER MANUAL".					+-----+	+-----+	S = IN PROCESS						PO BOX 000000	
IF YOU STILL HAVE QUESTIONS					CERTIFIED AMT	MEDICAID TOTAL	E = ENCOUNTER						FLORENCE SC 00000	
PHONE THE D.H.H.S. NUMBER					+-----+	+-----+	+-----+						+-----+	
SPECIFIED FOR INQUIRY OF						0.00	+-----+						+-----+	
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.	CLAIM ADJUSTMENTS	PAYMENT DATE	PAGE
+-----+   AB11110000   +-----+	+-----+   CLAIM ADJUSTMENTS   +-----+	+-----+   02/28/2014   +-----+	+-----+   2   +-----+
DEPT OF HEALTH AND HUMAN SERVICES			
SOUTH CAROLINA MEDICAID PROGRAM			

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

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

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

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		
	0.00	-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

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

**PHYSICIAN CERTIFICATION OF INCONTINENCE**

TO: _____ (Name of Physician) _____ (Address) _____ (City, State)                      (ZIP) _____ (Phone) _____ (FAX)	FROM _____ (Name) _____ (Address) _____ (City, State)                      (ZIP) _____ (Phone) _____ (FAX)
---	---

BENEFICIARY'S NAME: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ DOB: # \_\_\_\_\_

Please complete the areas below and return to the "FROM" address above. This beneficiary is requesting incontinence supplies (includes diapers/briefs/pull-ups, wipes, and/or underpads) through the Medicaid Home Health benefit. Coverage of gloves for DDSN waiver clients is through the Medicaid DME benefit. In order to qualify the beneficiary must have one of the following conditions. Please check any that apply. The form must be fully completed.

- Incontinent of bladder
- Incontinent of bowel

Certifications for waiver and non-waiver beneficiaries are effective for the timeframe indicated below as certified by the prescriber signing the certification:

- |                                   |                                    |
|-----------------------------------|------------------------------------|
| <input type="checkbox"/> 3 months | <input type="checkbox"/> 9 months  |
| <input type="checkbox"/> 6 months | <input type="checkbox"/> 12 months |

What is the diagnosis related to incontinence?  
 \_\_\_\_\_

Does this beneficiary use any appliances (e.g., catheter, ostomy) to prevent incontinence? If so, please list:  
 \_\_\_\_\_

Comments (list incontinence supplies):  
 \_\_\_\_\_

Please indicate **one** of the following:

- Incontinence Supplies are **NOT** medically necessary.
- Incontinence Supplies are **MEDICALLY NECESSARY** for this Medicaid beneficiary.

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_ (Nurse Practitioner or Physician Assistant signatures are not acceptable)