FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
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-1450	UB-04 (blank; sample only)	
	Sample Remittance Advice	
	Abortion Statement	
	Abortion Statement-sample version	
	Alcohol and Drug Medical Assessment (two pages)	09/1990
DHHS 185	Community Long-Term Care Level of Care Certification Letter (two pages)	11/2003
	Community Long-Term Care Notification Form	12/2004
DHHS 218	ESRD Enrollment	06/2007
DHHS 687	Consent for Sterilization (two pages)	07/2022
	Notice of Termination of Administrative Days	09/2010
	Notification of Administrative Days Coverage	05/2012
	Referral Request Form for Out-of-State Services (three pages)	10/2022
DHHS 1716ME	Request for Medicaid ID Number	04/2017
	Request for Prior Approval Review By KEPRO	06/2012
	Surgical Justification Review for Hysterectomy	08/2017
	Surgical Justification Review for Hysterectomy (sample version)	08/2017
	Transplant Prior Authorization Request Form & Instructions (two pages)	05/2022

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
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.

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 1-888-289-0709 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**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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)

- ☐ 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: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature: _____ Date: _____

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c	d	e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a															a
b															b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS		81CC			
		a			
		b			
		c			
		d			

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

PROVIDER ID. 000099999 — IN/OUT-PATIENT SERVICES — PAYMENT DATE — PAGE

7777777777 **A** DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 02/28/2014 **B** — 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED PERIOD MMDDYY-MMDD	DAYS	AMOUNT BILLED **G**	TITLE 19 PAYMENT MEDICAID **H**	S|T|S **I**	RECIPIENT ID. NUMBER **J**	RECIPIENT NAME F M I I LAST NAME **K**	CO PY **L**	LV CL **M**	POS IND **M**	TYP REM **N**	**O**
V99999 **C**	999999 **D** 999999Z	0213 **E** 213	1 **F** 0	3,015.88	675.00	P	2222222222	B B JACKSON	C	1		1	
V99999999	99999999999999Z	021414-0214	1 0	3,690.88	0.00	S	1111111111	A B SMITH					
V99999999	99999999999999Z	021414-0214	1 0	3,690.88	0.00	R	1111111111	A B SMITH					
								EDITS: L00 758 **AA** L00 990					
								EDITS: L06 714					
	TOTALS	CLAIMS 3 **P**	0 **Q**	10,397.64 **R**	675.00 **S**								

T $0.00 — SCHAP PG TOT

U $0.00 — SCHAP TOTAL

V $675.00 — MEDICAID PG TOT

W $675.00 — MEDICAID TOTAL

X $675.00 — * CHECK TOTAL

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

9999999 **Y** — CHECK NUMBER

PROVIDER NAME AND ADDRESS

Z

PROVIDER ID. 000099999 — IN/OUT-PATIENT SERVICES — PAYMENT DATE — PAGE

7777777777 **A** DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

REMITTANCE ADVICE

02/28/2014 **B**

1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED PERIOD MMDDYY-MMDD	DAYS	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S|T|S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	CO PY	LV CL	POS IND	TYP REM	XOV IND
V99999 **C**	999999 **D** 999999Z	0213 **E** 213	**F** 0	3,015.88 **G**	675.00 **H**	P **I**	2222222222 **J**	B B JACKSON **K**	C **L**	1 **M**	1 **N**		**O**
V99999999	99999999999999Z	021414-0214	1 0	3,690.88	0.00	R	1111111111	A B SMITH					
							EDITS: L00 758	L00 990					
							EDITS: L06 714						
V99999999	99999999999999Z	021414-0214	1 0	3,690.88	0.00	R	1111111111	A B SMITH					
							EDITS: L00 758 **AA**	L00 990					
							EDITS: L06 714						
	TOTALS	CLAIMS 3 **P**	0 **Q**	10,397.64 **R**	675.00 **S**								

SCHAP PG TOT **T** $0.00 — MEDICAID PG TOT **V** $675.00

SCHAP TOTAL **U** $0.00 — MEDICAID TOTAL **W** $675.00

* CHECK TOTAL **X** $675.00

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

9999999 **Y** CHECK NUMBER

PROVIDER NAME AND ADDRESS

Z

PROVIDER ID. 000099999 — IN/OUT-PATIENT SERVICES — PAYMENT DATE — PAGE

A: 7777777777

DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

REMITTANCE ADVICE

B: 02/28/2014

2

PROVIDERS OWN REF. NUMBER (C)	CLAIM REFERENCE NUMBER (D)	SERVICE RENDERED PERIOD MMDDYY-MMDD (E)	DAYS (F)	AMOUNT BILLED (G)	TITLE 19 PAYMENT MEDICAID (H)	STS (I)	RECIPIENT ID. NUMBER (J)	RECIPIENT NAME F M I I LAST NAME (K)	COPY (L)	DRG (M)	TYPE REIM (N)	XOV IND (O)
L0000000	99999999999999900Z	021314-0213	1 1	1,339.25	429.37	P	1234567890	A B SMITH		391	A	
L0000000	99999999999999900Z	101513-1027	12 12	24,536.78	7,162.25	P	1234567890	C B JONES	D	138	C	
L0000000	99999999999999900Z	102213-1026	4 4	3,088.25	429.37	P	1234567890	J Q DOE		391	A	
L0000000	99999999999999900Z	102213-1026	4 4	13,085.84	3,720.97	P	1234567890	R R ROE	D	370	A	
L0000000	99999999999999900Z	101813-1021	3 3	13,152.95	3,438.85	P	1234567890	C D SMITH	D	336	A	
L0000000	99999999999999900Z	102813-1030	2 2	4,672.75	1,394.10	P	1234567890	A B JOHNSON		373	A	
L0000000	99999999999999900Z	102913-1030	1 0	2,873.00	0.00	R	1234567890	J Q PUBLIC		143	U	
								EDITS: L06 761 (AA)				
	TOTALS	CLAIMS 27 (P)	74 (Q)	317,236.27 (R)	50,011.83 (S)							

T: $0.00 — SCHAP PG TOT

V: $44,539.54 — MEDICAID PG TOT

U: $0.00 — SCHAP TOTAL

W: $50,011.83 — MEDICAID TOTAL

X: $50,011.83 — * CHECK TOTAL

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

Y: 9999999 — CHECK NUMBER

PROVIDER NAME AND ADDRESS

Z

PROVIDER ID. 000097427

7777777777 **A**

DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE

02/28/2014 **B**

PAGE 3

PROVIDERS OWN REF. NUMBER **C**	CLAIM REFERENCE NUMBER **D**	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
A999999999999	99999999999999900U	-									DEBIT	-27.00	
										PAGE TOTAL:		27.00	0.00

PROVDER INCENTIVE CREDIT AMOUNT **CC**: 0.00

BB

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 91430.19

MEDICAID TOTAL: 0.00

CERTIFIED AMT: 0.00

TO BE REFUNDED IN THE FUTURE: 0.00

$0.00

ADJUSTMENTS: -27.00

0.00

YOUR CURRENT DEBIT BALANCE: 0.00

* CHECK TOTAL: 91403.19

CHECK NUMBER: 9999999

PROVIDER NAME AND ADDRESS

* FUNDS AUTOMATICALLY DEPOSITED TO:
BANK NAME: BRANCH BANK & TRUST BANK NUMBER: ACCOUNT #:
NOTIFY MEDICAID PROVIDER ENROLLMENT BEFORE CLOSING OR CHANGING YOUR BANK ACCOUNT.

ABORTION STATEMENT

This certification meets FFP requirements and must include all of the aforementioned criteria.

Patient's Name:_____

Patient's Medicaid ID#:_____

Patient's Address:_____

_____

Physician Certification Statement

I, _____ certify that it was necessary to terminate the pregnancy of_____

_____ for the following reason:

a. ( ) Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition:

_____

b. ( ) The patient has certified to me the pregnancy was a result of rape or incest and the police report is attached.

c. ( ) The patient has certified to me the pregnancy was a result of rape or incest and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

_____ _____

Physician's Signature Date

****

The patient's certification statement is only required in cases of rape or incest.

Patient's Certification Statement

I, _____certify that my pregnancy was the result of an act of rape or incest.

(Patient's Name)

_____ _____

Patient's Signature Date

Both the completed Abortion Statement and appropriate medical records must be submitted with the claim form.

ABORTION STATEMENT

This certification meets FFP requirements and must include all of the aforementioned criteria.

Patient's Name: Jane Doe

Patient's Medicaid ID#: 1234567891

Patient's Address: 111 Maple Drive
Anytown, SC 29999

Physician Certification Statement

I, John Brown certify that it was necessary to terminate the pregnancy of Jane Doe for the following reason:

a. ( ) Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition: End Stage Renal Failure and Cancer

b. ( ) The patient has certified to me the pregnancy was a result of rape or incest and the police report is attached.

c. ( ) The patient has certified to me the pregnancy was a result of rape or incest and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

John Brown — Physician's Signature

12/12/04 — Date

****

The patient's certification statement is only required in cases of rape or incest.

Patient's Certification Statement

I, _____ certify that my pregnancy was the result of an act of rape or incest.

(Patient's Name)

_____ — Patient's Signature

_____ — Date

Both the completed Abortion Statement and appropriate medical records must be submitted with the claim form.

Alcohol and Drug Medical Assessment

Patient's Name (Last, First, MI) and I.D. #	
Medicaid Client #	Date of Medical Assessment
Physician's Name and Address	

1. Brief medical history to include hospital admissions, surgeries, allergies. present medications, information (where appropriate) about shared needles, sexual activity/orientation and history of hepatitis and liver disease.

2. History of patient /family involvement with alcohol/drugs.

3. Assessment of patient nutritional status.

ADMA 9/20/90
SCCADA FORM

4. Physical examination to include, but not be limited to, vital signs, inspection of ears, nose, mouth, teeth and gums. Also, inspection of skin for recent and/or old needle marks/tracking, abscesses or scarring from healed abscesses.

5. General assessment of patient cardiovascular system, respiratory system, gastro-intestinal system abd neurological status.

6. Screening for anemia (hematocrit or hemoglobin may be used when physician has machinery available in office).

7.

It is ordered that _____ receive alcohol/drug rehabilitative services.

Physician's Signature and Date

SOUTH CAROLINA COMMUNITY LONG TERM CARE
LEVEL OF CARE CERTIFICATION LETTER
FOR
MEDICAID-SPONSORED NURSING HOME CARE

NAME: _____ COUNTY OF RESIDENCE: _____

SOCIAL SECURITY #: _____ MEDICAID #: _____

LOCATION AT ASSESSMENT:

South Carolina Community Long Term Care has evaluated your application and has determined that:

☐ According to Medicaid criteria, you do not meet requirements for skilled or intermediate care. This does not mean that you do not need personal or other medical care, and does not mean that you cannot be admitted to a long term care facility. It does mean that the Medicaid program will not be responsible to pay for your care in a long term care facility. Please do not hesitate to contact this office if there is a change in your health status or you become more limited in your ability to care for yourself.

☐ According to Medicaid criteria, you meet the requirements to receive long term care at the following level:

☐ SKILLED ☐ INTERMEDIATE

This Certification Letter is not an approval for financial eligibility for Medicaid. You must establish financial eligibility with the County Department of Social Services.

This letter must be presented to the long term care facility to which you are admitted. IF YOU HAVE NOT ENTERED A FACILITY BY THE EXPIRATION DATE BELOW, YOU MUST CONTACT THE CLTC OFFICE AT _____ TO REAPPLY.
Telephone No.

If you change locations from where your assessment was made (i.e., hospital to home) your assessment must be updated and a new effective period established.

Medicaid certification is automatically cancelled when a client enters a facility with a payment source other than Medicaid; you must again be certified before a Medicaid conversion will be allowed.

☐ ADMINISTRATIVE DAYS ☐ SUBACUTE CARE

☐ **If the location of care is hospital, your assessment must be re-evaluated and a new effective period established PRIOR TO TRANSFER TO A LONG TERM CARE FACILITY.**

FOR LONG TERM CARE FACILITY USE

☐ TIME-LIMITED CERTIFICATION. LTC FACILITY STAFF MUST SUBMIT AN ASSESSMENT AT LEAST FIVE WORKING DAYS BEFORE THE EXPIRATION DATE DUE. (See Expiration Date Below)

☐ THIS CLIENT HAS BEEN RECEIVING HOME AND COMMUNITY-BASED SERVICES FROM CLTC. CONTACT THE DSS OFFICE IN THE CLIENT'S COUNTY OF RESIDENCE TO DETERMINE IF THE 30 CONSECUTIVE DAYS REQUIREMENT HAS BEEN MET.

Effective Date: _____ Expiration Date: _____

Nurse Consultant Signature: _____ Date: _____

☐ CLIENT ☐ CO. DSS ☐ LTC FACILITY ☐ PHYSICIAN ☐ HOSPITAL ☐ OTHER

SENT: Date: _____ Initials: _____

APPEALS

As a Medicaid nursing home or home and community-based wiaver applicant/recipient, you have the right to a fair hearing regarding this decision. To initiate the appeal process, you or your representative must submit a written request to the following address no later than thirty (30) days from the receipt of this notification.

Division of Appeals and Fair Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

You may be eligible to receive continued benefits pending a hearing decision. If you are interested in continued benefits you must contact your CLTC representative before the effective date of the action indicated above. If the hearing decision is not in your favor, you may be required to repay Medicaid benefits received pending the decision to the South Carolina Department of Health and Human Services.

Please attach a copy of this notification with your request. You or your representative will be notified of the date, time and place the hearing will take place.

In your request for a fair hearing you must state with specificity which issues(s) you with to appeal.

Unless a request is made within thirty (30) calendar days of receipt of this notification, this decision will be final and binding.

A request for a fair hearing is considered filed if postmarked by the thirtieth (30th) calendar day following receipt of this notification.

COMMUNITY LONG TERM CARE NOTIFICATION FORM

TO:

FROM: CLTC Central Office
Post Office Box 8206
Columbia, SC 29202-8206

CLIENT NAME: SS# MA#

- Client's level of care appears to be skilled. (THIS IS NOT A CERTIFIED LEVEL OF CARE. CLIENT INFORMATION MUST AGAIN BE REVIEWED PRIOR TO CERTIFICATION.)

- Client has been referred to you for case follow-up and services, as appropriate.

IF YOU DISAGREE WITH THIS DETERMINATION, PLEASE READ THE APPEALS NOTICE BELOW:

APPEALS

As a Medicaid recipient, you have the right to a fair hearing regarding this decision. To initiate the appeals process, you or your representative must submit a written request to the following address no later than thirty (30) days from the receipt of this notification.

Division of Appeals and Fair Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Please attach a copy of this notification with your request. You or your representative will be notified of the date, time, and place the hearing will take place. In your request for a fair hearing, you must state with specificity which issue(s) you wish to appeal.

Unless a request is made within thirty (30) calendar days of receipt of this notification, this decision will be final and binding.

A request for a fair hearing is considered filed if postmarked by the thirtieth (30^{th}) calendar day following receipt of this notification.

Signature: Date:

Copies sent to:

CLIENT [ ] HOSPITAL [ ] LTC FACILITY [ ] COUNTY DSS [ ]
PHYSICIAN [ ] CAREGIVER/RESPONSIBLE PARTY [ ] OTHER [ ]

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
ESRD ENROLLMENT FOR MEDICAID BENEFICIARIES

PART I – PATIENT INFORMATION

Name:	Date of Birth:	Social Security No:

Address:	Medicaid ID No:	Medicare Eligible?
STREET OR RFD CITY STATE ZIP CODE	Medicare Application Submitted? Yes Date:	

County:	Medicare No:	Effective Date:	Medicare Denied? ☐ Yes ☐ No

REASON FOR DENIAL: _____

_____

PART II – TREATMENT INFORMATION – DIALYSIS

Date of First Treatment:	Transplant Candidate? ☐ Yes ☐ No
Name of Facility Transferred From:	
Mode of Treatment: ☐ HEMODIALYSIS ☐ PERITONEAL DIALYSIS ☐ SELF DIALYSIS	Home Dialysis: TYPE: _____ SUPPLIER: _____

PART III – MEDICAL TRANSPORTATION

Reimbursed by DSS? ☐ Yes ☐ No	Provider of Transportation:

ESRD PROVIDER INFORMATION	DHHS USE ONLY
Clinic Name:	ESRD Enrolled:
NPI or Medicaid Provider ID:	Code:
Physician's Name:	Effective Date:
Form Completed By: NAME TELEPHONE NO. TITLE DATE	Approved By: Date Approved:
Mail To: ESRD SERVICES SCDHHS PO BOX 8206 COLUMBIA, SC 29202-8206	Comments:

Form Approved: OMB No. 0937-0166
Expiration date: 4/30/2022

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZEDWILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (*Doctor or Clinic*). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____ (*Specify Type of Operation*). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____ (*Date*)

I, _____, hereby consent of my own free will to be sterilized by _____ (*Doctor or Clinic*) by a method called _____ (*Specify Type of Operation*). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ (*Signature*) _____ (*Date*)

_____ (*Medicaid ID*)

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ (*Interpreter's Signature*) _____ (*Date*)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation _____ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ (*Signature of Person Obtaining Consent*) _____ (*Date*)

_____ (*Facility*)

_____ (*Address*)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (*Name of Individual*) on _____ (*Date of Sterilization*)

I explained to him/her the nature of the sterilization operation _____ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraph**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery *(describe circumstances)*:

_____

_____

_____ (*Physician's Signature*) _____ (*Date*)

*****The sterilization consent form is codified in federal regulations as an Appendix to 42 CFR 441 Subpart F. Because the form is codified in federal regulation it never expires and must be used regardless of whether there is a current OMB date. While the expiration date now on the sterilization form is expected to continue to be renewed with new dates, for Medicaid purposes the form does not require an expiration date to be valid. This is the only form that can be used, and it may not be altered in any way. The lack of a current form is not a valid reason to deny a claim providing the form has not been altered and is compliant with regulations. *****

PAPERWORK REDUCTION ACT STATEMENT

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, SW., Washington, DC 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations. [43 FR 52165, Nov. 8, 1978, as amended at 58 FR 33343, June 17, 1993; 68 FR 12308, Mar. 14, 2003]

Instructions for Completing DHHS Form 1723

(Consent for Sterilization)

Consent to Sterilization

1. Name of the physician or group scheduled to do the sterilization procedure. If the name of the physician or group is unknown, enter the phrase "OB on call."
2. Name of the sterilization procedure (*e.g.*, bilateral tubal ligation)
3. Birth date of the beneficiary. The beneficiary must be 21 years old when he or she signs the consent form, which would be 30 days prior to the procedure being performed.
4. Beneficiary's name
5. Name of the physician or group scheduled to do the sterilization or the phrase "OB on call"
6. Name of the sterilization procedure
7. Beneficiary's signature and date. If the beneficiary signs with an "X," an explanation must accompany the consent form.
8. Beneficiary's 10-digit Medicaid ID number

Interpreter's Statement

If the beneficiary had an interpreter translate the consent form information into a foreign language, the interpreter must complete this section. If an interpreter was not necessary, put an "N/A" in these blanks.

Statement of Person Obtaining Consent

1. Beneficiary's name
2. Name of the sterilization procedure
3. Signature and date of the person who counseled the beneficiary on the sterilization procedure. This date should be the same as the date of the beneficiary's signature date. Also complete the facility address. An address stamp is acceptable if legible.

Physician's Statement

1. Beneficiary's name
2. Date of the sterilization procedure (must match date billed on claim)
3. Name of the sterilization procedure
4. EDC date is required if sterilization is within the 30-day waiting period and the beneficiary was pregnant. At least 72 hours must pass before the sterilization procedure may be performed.
5. An explanation must be attached if an emergency abdominal surgery was performed within the 30-day waiting period. At least 72 hours must pass before the sterilization. The sterilization cannot be the reason for the emergency surgery.
6. Physician signature and date. A physician stamp is acceptable. The physician's date must be the same as the sterilization date or after. In the license number field, put the Medicaid Provider ID (either the group or individual physician's Medicaid number).

ADMISSION DATE

DATE

MEDICAID ID NUMBER

ATTENDING PHYSICIAN'S NAME

NOTICE OF TERMINATION OF ADMINISTRATIVE DAYS

This is to inform you that a nursing home bed has been found for you at _____ _____ in _____, South Carolina. The bed will be available to you on _____. If you elect to remain in the hospital after this date, you will be responsible for payment of all services provided to you by _____ _____ Hospital beginning on _____.

You may appeal this Notice of Termination with a written request to:

SCDHHS
Division of Appeals and Hearings
P. O. Box 8206
Columbia, SC 29202-8206

The appeal request must be received by SHHSFC within 30 calendar days from receipt of this letter. If the appeal rules in your favor, you will not be responsible for additional charges. However, if the appeal upholds the Notice of Termination, you are responsible for all charges beginning on the date the nursing home bed was located.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of non-coverage of services from the _____ _____ at _____ on _____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of this notice.

(Signature of recipient or person acting on behalf of the recipient) (Time) (Date)

cc: Division of Hospital Services
DHHS

ADMISSION DATE

DATE

MEDICAID ID NUMBER

ATTENDING PHYSICIAN'S NAME

NOTIFICATION OF ADMINISTRATIVE DAYS COVERAGE

This notice is to inform you that the hospital's Utilization Review Committee has determined that beginning _____ further acute hospital care is no longer necessary. Your condition, however, qualifies you for nursing home care.

Limited additional days in the hospital may be approved subject to Medicaid coverage regulations while you and your family actively seek a nursing home bed.

Once an available bed is located, Medicaid payment of your hospital bill will stop. If you refuse to accept an available nursing home bed and remain in the hospital, you will be personally responsible for the additional expense in the hospital.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of the Administrative Day Program from the _____ on _____.
I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of this notice.

(Signature of recipient or person acting on behalf of the recipient)

(Date)

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

Send to:	Date:	# of Pages (including cover):
SCDHHS Bureau of Provider and Support Services Attn: Out-of-State Coordinator Fax: 803-255-8255	**Point of Contact Information**	
	Name	
	Phone	
	Fax	
	Email	

Please ensure all items on the checklist are included prior to submitting the packet.

Incomplete requests will not be processed. Please allow up to two weeks for processing.

☐ Valid point of contact information is provided for referring and out-of-state providers

☐ Completed and signed Form A – To be completed by South Carolina referring provider

☐ Completed and signed Form B – To be completed by the out-of-state (OOS) provider. This form indicates that the provider has been contacted and has confirmed, in writing, that they are enrolled or have begun to enroll in the South Carolina Healthy Connections Medicaid program and will accept Healthy Connections Medicaid reimbursement as payment-in-full

☐ One year of medical records/clinical notes that support the decision to refer out-of-state

☐ If Medicaid is not the primary insurance, prior authorization (PA)/denial from primary insurance is attached
✹ If no PA is required from primary insurance, please advise: _____

FORM A

To be completed by the South Carolina referring provider.

All fields are required and failure to complete each section will cause a delay in processing.

Member Information				
Name	*Date of Birth*	*SC Medicaid Number*	*Name of Guardian*	*Contact Phone Number*
Will member require meals, lodging and transportation (ancillary) assistance? Yes ☐ No ☐				
Services are (Select one): ☐ *Inpatient* ☐ *Outpatient*				
Ancillary assistance is provided for the member and one (1) escort for approved services, where applicable. Adequate advanced notice and prior approval from SCDHHS are mandatory prior to the broker arranging travel. Hotel accommodations are for outpatient services *only*. Retroactive reimbursement will not be approved.				
Referring Provider Information				
Facility Name	*Provider Name*	*NPI | SC Medicaid Legacy ID #*	*Contact Phone Number*	
Clinical Information				
Condition requiring treatment				
REQUIRED *Brief explanation of medical need to receive services outside of the South Carolina Medicaid Service Area (SCMSA).* The SCMSA includes all of South Carolina and regions of North Carolina and Georgia within 25 miles of the South Carolina border.				
ICD-10 | Diagnosis Code(s)			*HCPCS/CPT | Procedure Code(s)*	
Patient is being referred to:				
Facility:		*Provider(s):*		
Date of service (if no appointment is scheduled, enter "tentative")			*Date of return (refers to length of stay for the service)*	

- I certify communication has been established with the out-of-state provider.
- I certify the aforementioned services are not available or provided within the South Carolina Medicaid Service Area (SCMSA).

_____ _____

Signature of Referring Provider Date

FORM B

To be completed by the out-of-state rendering provider. Separate form to be completed for each **individual** provider rendering/billing for services.

All fields are required.

Provider Information	
☐ Individual	☐ Facility
Provider Name	*NPI | SC Medicaid Legacy ID #*
Contact Phone Number	*Fax Number*
Member Name	*Member Date of Birth*

By signing below, the out-of-state facility and physician(s) certifies the following:

- Facility and physician(s) are enrolled or have initiated enrollment with South Carolina Healthy Connections Medicaid (if enrolling, please provide the 15-digit alpha-numeric Communication ID or a screenshot of the in-process application)

- Accepting South Carolina Healthy Connections Medicaid reimbursement as payment-in-full

_____ _____

Authorized Signature of Out-of-State Provider Date

_____

Printed Name of Authorized Representative

Please Note: If the out-of-state provider does not sign or indicates a reason for refusal, the referral request will not be processed or reviewed.
For information concerning enrollment and claims submission for out-of-state hospital providers, please see "**Out-of-State Hospitals**" in the *Hospital Services Provider Manual*. The most current version of the provider manual is maintained on the SCDHHS website at www.scdhhs.gov.

Services for members enrolled in managed care organizations (MCOs) are to be requested through the MCO using the entity's prior authorization process.

For a complete copy of the out-of-state services policy, please refer to the *Physicians Services Provider Manual*. The most current version of the provider manual is maintained on the SCDHHS website at www.scdhhs.gov. If you have additional questions, please contact the Provider Service Center at (888) 289-0709, submit an inquiry at http://www.scdhhs.gov/contact-us, or contact your MCO representative at (803) 898-4614.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Request for Medicaid ID Number - Infant

I. Provider Information

Provider Name / Hospital Name			Date	
Provider Street Address	City	County	State	ZIP code
Provider Representative (First, Last Name)			Phone	

II. Mother's Information

First Name, Middle Name, Last Name			Date of Birth (mm/dd/yyyy)	
Street Address	City	County	State	ZIP code
Social Security Number		Medicaid ID#		

Is the mother covered by other health insurance? ☐ Yes ☐ No

If yes, does the insurance cover Doctor Visits and Lab Tests? ☐ Yes ☐ No ☐ Unsure

Insurance Company: _____ Policy#: _____

III. Child's Information

First Name, Middle Name, Last Name (If not yet named, enter "Baby Boy" or "Baby Girl")			Date of Birth (mm/dd/yyyy)	
Street Address (If same as mother's, enter "Same")	City	County	State	ZIP code
Name of Birth Facility		County of Birth Facility		

Gender: ☐ Male ☐ Female

Has an application been made for a SSN for the child? ☐ Yes ☐ No

IV. Mail the Completed Form

Mail the completed form to:

SCDHHS - Central Mail
PO Box 100101
Columbia, SC
29202-3101

Fax:

(803) 255-8200

SOUTH CAROLINA MEDICAID PROGRAM
REQUEST FOR PRIOR APPROVAL REVIEW BY KePRO

PATIENT NAME _____
LAST FIRST MI

BIRTHDATE _____ ***MEDICAID#** _____
MONTH/DAY/YEAR

PROCEDURE _____ CODE _____

DX CODE: _____

FACILITY _____ _____
NAME NPI #

PLANNED SURGERY DATE _____

*TO AVOID THE RISK OF NON–PAYMENT, PROVIDERS SHOULD CHECK ELIGIBILITY OF RECIPIENT PRIOR TO REQUEST FOR PRIOR APPROVAL REVIEW. IF THE RECIPIENT IS MANAGED CARE, PRIOR APPROVAL MUST BE OBTAINED THROUGH THE MANAGED CARE PROVIDER.

PHYSICIAN'S NAME _____
LAST FIRST MI

ADDRESS _____

_____ NPI: _____

CONTACT PERSON _____ TELEPHONE (_____) _____

DATE _____ FAX NUMBER (_____) _____

- **OFFICE NOTES DOCUMENTING THE REQUESTED INFORMATION MUST BE ATTACHED**
- **ALL PERTINENT DOCUMENTATION FOR THE PROCEDURE SHOULD BE MAILED TOGETHER**
- **PROVIDERS WILL BE NOTIFIED OF DETERMINATION VIA MAIL**

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE

Revised: 06/01/12

SOUTH CAROLINA MEDICAID PROGRAM
SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY

THIS COMPLETED FORM AND A SIGNED "CONSENT FOR STERILIZATION" FORM MUST BE RECEIVED 30 DAYS PRIOR TO SCHEDULED SURGERY.

PATIENT

NAME _____ **MEDICAID #** _____
LAST FIRST MI

BIRTHDATE _____ **GRAVITY** _____ **PARITY** _____
MONTH/DAY/YEAR

PROCEDURE CODE: _____ **DX CODE:** _____

HOSPITAL _____ _____
NAME NPI (IF AVAILABLE)

PLANNED ADMISSION DATE _____ **PLANNED SURGERY DATE** _____

TYPE OF HYSTERECTOMY PLANNED_____

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:

_____
_____
_____
_____
_____
_____
_____
_____

HCT ____ **HGB** ____ **CHECK ONE: PREMENOPAUSAL** _____ **POSTMENOPAUSAL** _____

CONSERVATIVE TREATMENT/MEDICATION WITH DATES:

_____
_____
_____

PRIOR GYN SURGERY/DIAGNOSTIC PROCEDURES (INCLUDE COPIES OF ALL REPORTS):

_____
_____
_____

OFFICE NOTES AND ALL SUPPORTING DOCUMENTATION (e.g., ULTRASOUND, OPERATIVE AND PATH REPORTS, ETC.) ARE REQUIRED FOR APPROVAL AND SHOULD BE ATTACHED TO THIS FORM.

ATTENDING PHYSICIAN'S NAME _____ _____
LAST FIRST MI NPI

ADDRESS _____

CONTACT PERSON _____ **TELEPHONE (_____)** _____

FAX (_____) _____

SIGNATURE _____ **DATE** _____
ATTENDING PHYSICIAN

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

Revised: 08/01/17

SOUTH CAROLINA MEDICAID PROGRAM
SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY

THIS COMPLETED FORM AND A SIGNED "CONSENT FOR STERILIZATION" FORM MUST BE RECEIVED 30 DAYS PRIOR TO SCHEDULED SURGERY.

PATIENT

NAME Jane (LAST) Doe (FIRST) (MI) **MEDICAID #** 1234567891

BIRTHDATE 09/09/1970 (MONTH/DAY/YEAR) **GRAVITY** 2 **PARITY** 2

PROCEDURE CODE: _____ **DX CODE:** _____

HOSPITAL Memorial Hospital (NAME) 1234567890 (NPI (IF AVAILABLE))

PLANNED ADMISSION DATE 08/15/10 **PLANNED SURGERY DATE** 08/15/10

TYPE OF HYSTERECTOMY PLANNED Vaginal

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:

Dysfunctional uterine bleeding >3 mos and unresponsive to hormonal therapy x 3 consecutive cycles, bleeding, anemia with transfusion x 1. Neg. for endometrial lesion per biopsy 10/04.

HCT 26 **HGB** ___ **CHECK ONE: PREMENOPAUSAL** X **POSTMENOPAUSAL** ___

CONSERVATIVE TREATMENT/MEDICATION WITH DATES:

D&C 10/05/09 Dx Lap. 11/09

PRIOR GYN SURGERY/DIAGNOSTIC PROCEDURES (INCLUDE COPIES OF ALL REPORTS):

OFFICE NOTES AND ALL SUPPORTING DOCUMENTATION (e.g., ULTRASOUND, OPERATIVE AND PATH REPORTS, ETC.) ARE REQUIRED FOR APPROVAL AND SHOULD BE ATTACHED TO THIS FORM.

ATTENDING PHYSICIAN'S NAME Brown (LAST) Mary (FIRST) Z (MI) 1234567890 (NPI)

ADDRESS 101 East Street Anywhere, SC 22222

CONTACT PERSON John Brown **TELEPHONE** (803) 123-4567

FAX (803)123-4568

SIGNATURE Mary Brown, MD (ATTENDING PHYSICIAN) **DATE** 06/01/07

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

Revised: 08/01/17

TRANSPLANT PRIOR AUTHORIZATION REQUEST FORM INSTRUCTIONS

The South Carolina Department of Health and Human Services (SCDHHS) may use guidelines that include clinical standards, protocols, or criteria regarding the treatment of specific conditions in determining whether to provide prior authorization.

General Information

- All transplant prior authorization requests require at least 10 days advance notice.
- Ensure most recent version of the Transplant Prior Authorization Request form is submitted.
- The referring South Carolina (SC) Medicaid provider must complete the form.
- All fields on the form must be completed.
- Providers seeking reimbursement for services must be credentialed with SC Medicaid.
- Incomplete prior authorization requests are administratively denied. Requests are considered only when completed and received before the service is provided.
- Include supporting clinical documentation *(e.g.,* clinical notes, diagnostic studies, lab results)
- Authorization approval is not an authorization for payment. Payments are made based on the beneficiary's eligibility and benefits on the day of service.
- If the transplant service is available in state and this case is being referred outside of the South Carolina Medical Service Area (SCMSA), you must indicate why.

Requests for prior authorizations may be submitted to Kepro using one of the following methods.

Kepro Customer Service:	1-855-326-5219
Kepro Fax #	1-855-300-0082
For Provider Issues email:	atrezzoissues@Kepro.com

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Transplant Prior Authorization Request Form

Omissions, generalities, and illegibility will result in the form being returned for completion or clarification. Please note that the approval of a transplant evaluation does not guarantee the approval of the actual transplant.

BENEFICIARY INFORMATION

NAME OF BENEFICIARY: _____ SC MEDICAID #: _____DATE OF BIRTH: _____

NAME OF GUARDIAN (if applicable): _____ CONTACT NUMBER: _____

PROVIDER INFORMATION

REFERRING PHYSICIAN

NAME OF REFERRING PHYSICIAN: _____NPI: _____ SC MEDICAID #: _____

TYPE OF TRANSPLANT: _____ TYPE OF ORGAN BEING RECEIVED: Living _____ Cadaveric _____

EXPECTED DATE OF SERVICE: _____

RENDERING PHYSICIAN/FACILITY

NAME OF PHYSICIAN(S): _____ NAME OF FACILITY: _____

FACILITY NPI: _____ FACILITY SC MEDICAID #: _____

FACILITY ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

NAME OF CONTACT PERSON/COORDINATOR: _____

TELEPHONE: _____ FAX: _____

DIAGNOSIS/PROCEDURE CODES and DESCRIPTIONS

ICD-10 DIAGNOSIS CODE(S)	DESCRIPTION
PROCEDURE CODE(S)	**DESCRIPTION**

REQUIRED DOCUMENTATION

Letter of Medical Necessity for the transplant, including the following:

- Summary of course of illness, current medications, smoking, alcohol, and drug abuse history must be six months free from use.
- Medical records, including physical exam, medical history, family history and laboratory assessments including serologies
- Letter to support the need to have the transplant performed outside of the South Carolina Medical Service Area (SCMSA) - if applicable.

I certify that the above information is correct, and that contact has been made with the Rendering Facility/Physician. I also certify that if the request is to a provider and/or facility outside of the SCMSA, that the service is not available and cannot be provided within the SCMSA.

_____ _____

SIGNATURE OF REFERRING PHYSICIAN **DATE**