## FORMS

<table>
<thead>
<tr>
<th>Number</th>
<th>Name</th>
<th>Revision Date</th>
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<tbody>
<tr>
<td>DHHS 126</td>
<td>Confidential Complaint</td>
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</tr>
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<td>DHHS 205</td>
<td>Medicaid Refunds</td>
<td>01/2008</td>
</tr>
<tr>
<td>DHHS 931</td>
<td>Health Insurance Information Referral Form</td>
<td>02/2018</td>
</tr>
<tr>
<td>DHHS 931</td>
<td>Reasonable Effort Documentation</td>
<td>04/2014</td>
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<tr>
<td></td>
<td>Electronic Funds Transfer (EFT) Authorization Agreement</td>
<td>08/2019</td>
</tr>
<tr>
<td></td>
<td>Duplicate Remittance Advice Request Form</td>
<td>09/2017</td>
</tr>
<tr>
<td></td>
<td>Claim Reconsideration Form</td>
<td>11/2018</td>
</tr>
<tr>
<td>CMS-1450</td>
<td>UB-04 (blank; sample only)</td>
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<tr>
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<td>Sample Remittance Advice</td>
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<td></td>
<td>Abortion Statement-sample version</td>
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<td></td>
<td>Alcohol and Drug Medical Assessment (two pages)</td>
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<tr>
<td>DHHS 185</td>
<td>Community Long-Term Care Level of Care Certification Letter (two pages)</td>
<td>11/2003</td>
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<td>DHHS 185</td>
<td>Community Long-Term Care Notification Form</td>
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<td>DHHS 218</td>
<td>ESRD Enrollment</td>
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<td>DHHS 687</td>
<td>Consent for Sterilization (two pages)</td>
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<td>Notice of Termination of Administrative Days</td>
<td>09/2010</td>
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<td>Notification of Administrative Days Coverage</td>
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<td>Referral Request Form for Out-of-State Services (three pages)</td>
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<tr>
<td>DHHS 1716ME</td>
<td>Request for Medicaid ID Number</td>
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<td>Request for Prior Approval Review By KEPRO</td>
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<td>Surgical Justification Review for Hysterectomy</td>
<td>08/2017</td>
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<td>Surgical Justification Review for Hysterectomy (sample version)</td>
<td>08/2017</td>
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<tr>
<td></td>
<td>Transplant Prior Authorization Request Form &amp; Instructions (two pages)</td>
<td>06/2012</td>
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</table>
**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.

<table>
<thead>
<tr>
<th>SUSPECTED INDIVIDUAL OR INDIVIDUALS:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NPI or MEDICAID PROVIDER ID: (if applicable)</th>
<th>MEDICAID RECIPIENT ID NUMBER: (if applicable)</th>
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<tbody>
<tr>
<td>ADDRESS OF SUSPECT:</td>
<td>LOCATION OF INCIDENT:</td>
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<td></td>
<td>DATE OF INCIDENT:</td>
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COMPLAINT:

<table>
<thead>
<tr>
<th>NAME OF PERSON REPORTING: (Please print)</th>
<th>SIGNATURE OF PERSON REPORTING:</th>
<th>DATE OF REPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS OF PERSON REPORTING:</td>
<td>TELEPHONE NUMBER OF PERSON REPORTING:</td>
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</tr>
<tr>
<td></td>
<td>SIGNATURE: (SCDHHS Representative Receiving Report)</td>
<td></td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Medicaid I.D.# (10 digits)</th>
<th>Date(s) of Service</th>
<th>Amount of Medicaid Payment</th>
<th>Amount of Refund</th>
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<tbody>
<tr>
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</table>

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

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

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

DHHS Form 205 (01/08)
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: ___________________________ Provider ID or NPI: _______________________

Contact Person: ___________________________ Phone #: ___________________________ Date: _____________

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

DHHS 931 – Updated February 2018
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
# Electronic Funds Transfer (EFT) Authorization Agreement

**Reason for Submission**
- [ ] Change to Current EFT (i.e. account or bank changes)
- [ ] Individual
- [ ] Organization

**Individual/Provider/Organization Information**

<table>
<thead>
<tr>
<th>Doing Business as Name (DBA)</th>
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</tbody>
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<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code/Postal Code</th>
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<table>
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<table>
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<tr>
<th>Designate Tax Identification Number (TIN)</th>
<th>SSN (individual)</th>
<th>EIN (organization)</th>
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<table>
<thead>
<tr>
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<th>EIN</th>
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**Organizational/Individual Provider EFT Contact Information**

<table>
<thead>
<tr>
<th>Provider Contact Name</th>
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<table>
<thead>
<tr>
<th>Telephone Number</th>
<th>Extension</th>
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<table>
<thead>
<tr>
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**Financial Institution Information**

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<table>
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<tr>
<th>City</th>
<th>State</th>
<th>Zip Code/Postal Code</th>
</tr>
</thead>
<tbody>
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</table>

**Provider’s Account Number with Financial Institution**

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<th>Financial Institution Routing Number (Nine digits)</th>
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<table>
<thead>
<tr>
<th>Provider’s Account Number with Financial Institution (Up to 17 digits)</th>
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<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Type of Account at Financial Institution (TRANSIT CODE)</th>
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</thead>
<tbody>
<tr>
<td>22 – Checking Account or 32 – Savings Account</td>
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</table>

By signing this form, I authorize the SCDHHS to initiate credit entries, if necessary, debit entries for any credits in error to the checking or savings account at the financial institution identified above. Credit entries will pertain only to the SCDHHS payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the SCDHHS 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 30 days written notice to the address shown below prior to revoking or revising this authorization.

I acknowledge that I have read and understand that payments will be issued only to the bank account of the provider designated to receive payments beginning July 2019 with the transition of Medicaid claims payments to the South Carolina Enterprise Information System (SCeIS). For more information, please visit [https://sc.eis.hhs.gov/seis/en](https://sc.eis.hhs.gov/seis/en) or contact 888-289-0709.

**ALL EFT REQUESTS ARE SUBJECT TO A 10-DAY PRENOTICE PERIOD IN WHICH ALL ACCOUNTS ARE VERIFIED BY THE QUALIFYING FINANCIAL INSTITUTION BEFORE ANY MEDICAID DIRECT DEPOSITS ARE MADE.**

<table>
<thead>
<tr>
<th>Signature of Person Submitting Form</th>
<th>Printed Name of Person Submitting Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>(print to sign)</td>
<td></td>
</tr>
</tbody>
</table>

**Submission Date**

**SPECIAL INSTRUCTIONS**: For questions regarding the status of your EFT update, please contact the Provider Service Center at 888-289-0709. Please refer to the EFT section of the provider enrollment manual found at [https://www.scdhhs.gov/provider](https://www.scdhhs.gov/provider) for instructions on how to complete updates to your EFT information.

Effective Jan 01, 2013, providers can link their EFT with their electronic remittance advice (ERA) by a matching EFT Reassociation Trace Number. This trace number will automatically be included in your electronic remittance advice. In order for this trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding the EFT Reassociation Trace Number and ERA can be directed to the Provider Service Center at 888-289-0709.

To process EFT updates, please return this completed form along with verification of your electronic deposit information on your financial institution’s letterhead to:

SDCHHS, Medicaid Provider Enrollment • PO BOX 8809 • Columbia, South Carolina 29202-8809 • FAX 803-870-9022
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

SCDHHS (Revised 09/01/17)
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, Laboratory, and Other Medical Professionals Specify: __________________________
☐ Private Rehabilitative Therapy and Audiology Services
☐ Psychiatric Hospital Services
☐ Rehabilitative Behavioral Health Services (RBHS)
☐ Rural Health Clinic (RHC)
☐ Targeted Case Management (TCM)
☐ Other: __________________________
Section 5: Desired Outcome

Request submitted by:

Print Name: ________________________________

Signature: ________________________________ Date: __________
<table>
<thead>
<tr>
<th>PROVIDERS OWN REF. NUMBER</th>
<th>CLAIM REFERENCE NUMBER</th>
<th>SERVICE RENDERED PERIOD</th>
<th>AMOUNT</th>
<th>TITLE 19</th>
<th>MEDICAID PAYMENT</th>
<th>RECIPIENT ID.</th>
<th>RECIPIENT NAME</th>
<th>EDIT: L00 758</th>
<th>EDIT: L00 990</th>
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<td>3,015.88</td>
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<td>0.00</td>
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<td>675.00</td>
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</tbody>
</table>

**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

**CHECK TOTAL**

<table>
<thead>
<tr>
<th>SCHAP TOTAL</th>
<th>MEDICAID TOTAL</th>
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**CHECK NUMBER**

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<th>MEDICAID PG TOT</th>
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<tbody>
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<tr>
<td>PROVIDERS</td>
<td>CLAIM REFERENCE NUMBER</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------</td>
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TOTALS | 3 | 0 | 10,397.64 | 675.00 |

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

IF YOU STILL HAVE QUESTIONS SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.
<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>000999999</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
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**PROVIDERS**

<table>
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<tr>
<th>PROVIDER ID.</th>
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<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
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<tbody>
<tr>
<td></td>
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**CLAIMS**

<table>
<thead>
<tr>
<th>PROVIDERS</th>
<th>CLAIM</th>
<th>SERVICE RENDERED</th>
<th>AMOUNT</th>
<th>TITLE 19</th>
<th>MEDICAID</th>
<th>NUMBER</th>
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**TOTALS**

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**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.**
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DEBIT BALANCE PRIOR TO THIS REMITTANCE $0.00 ADJUSTMENTS

YOUR CURRENT DEBIT BALANCE * CHECK TOTAL CHECK NUMBER

| 0.00 | 91403.19 | 9999999 |

* 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, ______________________________ 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: ______________________________

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.

______________________________
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.
## Alcohol and Drug Medical Assessment

<table>
<thead>
<tr>
<th>Patient's Name (Last, First, Mi) and I.D. #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Medicaid Client #</th>
<th>Date of Medical Assessment</th>
</tr>
</thead>
</table>

### 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.
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 and 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 waiver 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: [Blank]
FROM: CLTC Central Office
Post Office Box 8206
Columbia, SC 29202-8206

CLIENT NAME: [Blank] SS# [Blank] MA# [Blank]

- 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 (30th) calendar day following receipt of this notification.

Signature: [Blank] Date: [Blank]

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? Yes □ No □  
STREET OR RFD  Medicare Application Submitted? Yes □ Date: ___________  
CITY  STATE  ZIP CODE  Medicare Denied? □ Yes □ No  
County: ___________________________  Medicare No: ___________  Effective Date: ___________  

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  
Clinic Name: ___________  ESRD Enrolled: ___________  

NPI or Medicaid Provider ID: ___________  Code: ___________  

Physician’s Name: ___________  Effective Date: ___________  

Form Completed By: ___________  Approved By: ___________  

NAME ___________  TELEPHONE NO. ___________  Date Approved: ___________  
TITLE ___________  DATE ___________  

Mail To:  
ESRD SERVICES  
SCDHHS  
PO BOX 8206  
COLUMBIA, SC 29202-8206  

DHHS 218 (June 2007)  
Comments:  

Replaces HHSFC 218 (Apr 1986), which is obsolete.
CONSENT FOR STERILIZATION

Notice: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

[Box: CONSENT TO STERILIZATION]

I have asked for and received information about sterilization from ________________________. When I first asked ________________________, 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 ___________________________________________________________. The discomforts, risks and benefits associated with this 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 ________________________, ________________________, ________________________.

I, ________________________, hereby consent of my own free will to be sterilized by ________________________, a doctor or clinic.

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: ________________________

Race (mark one or more): ________________________

Hispanic or Latino ________________________

Not Hispanic or Latino ________________________

American Indian or Alaska Native ________________________

Asian ________________________

Black or African American ________________________

Native Hawaiian or Other Pacific Islander ________________________

White ________________________

[Box: PHYSICIAN’S STATEMENT]

Shortly before I performed a sterilization operation upon ________________________, ________________________, I explained to him/her the nature of the sterilization 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: ________________________

Name of Individual: ________________________ Date of Sterilization: ________________________

Signature: ________________________ Date: ________________________

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
   - Individuals’ expected date of delivery: ________________________
   - Emergency abdominal surgery (describe circumstances)

   Signature: ________________________ Date: ________________________

HHS-687 (04/22)
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; 88 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).
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
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)
Referral Request Form for Out of State Services
To be completed by the referring physician

<table>
<thead>
<tr>
<th>Send to:</th>
<th>From</th>
<th># of pages (including this cover page)</th>
</tr>
</thead>
</table>
| SCDHHS Claims and Provider Services  
ATTN: Out of State Coordinator  
FAX: (803) 255-8255 |      |                                        |

<table>
<thead>
<tr>
<th>Point of Contact Information</th>
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<tbody>
<tr>
<td>Name</td>
<td></td>
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<tr>
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<tr>
<td>Email</td>
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Please complete the following checklist prior to submission:

- Out-Of-State Provider has been contacted and has confirmed in writing that they are enrolled or have begun to enroll in the South Carolina Medicaid program and will accept the Medicaid reimbursement as payment in full (see Form B)
- Completed and signed Form A: Beneficiary and Referring Physician Information
- Completed and signed Form B: Out-of-State Provider Information (submit one per out-of-state Provider from whom the beneficiary is to receive services)
- One year of medical records/clinical notes supporting the decision to refer out of state are attached
- If Medicaid is not the primary insurance, Prior Authorization from Primary Insurance is attached (if applicable)
- Valid points of contact are provided for referring and out-of-state physicians
- Brief explanation of services to be rendered is provided below

Please provide a brief explanation of why the beneficiary requires services outside the South Carolina Medicaid Service Area (SCMSA). The service area includes all of South Carolina and regions of North Carolina and Georgia within 25 miles of the South Carolina border. All service performed outside the SCMSA require prior approval.

Please Note
Incomplete requests will not be processed.
Form A: Beneficiary and Referring Provider Information

To be completed by the referring Provider.

Please complete all fields.

Beneficiary Information

Name: ____________________________________________

SC Medicaid Number: ___________________________ Date of Birth: _______________________

Name of Guardian: ____________________________________________

Contact Number: ____________________________________________

Will the Beneficiary Require Lodging, Meal Reimbursement and Transportation Assistance?

☐ Yes  ☐ No

The Medicaid member being referred for out of state services and one (1) escort may be provided transportation assistance, where applicable. Adequate advanced notice and prior approval from SCDHHS, are mandatory prior to the Broker preparing travel arrangements. NOTE: Reimbursement is not an option for transportation and lodging; prior approval is required.

Referring Provider (In State Provider)

Only referrals requested by Providers within the South Carolina Medical Services Area (SCMSA) will be processed.

Name: ____________________________________________

Contact Number: ____________________________________________

NPI Number: ___________________________ SC Medicaid Number: ___________________________

Patient Is Being Referred To: ____________________________________________

Name of Facility and Physician

Condition Requiring Treatment: ____________________________________________

Diagnosis Code(s):

Procedure Code(s):

(Please identify any services considered experimental and/or investigational, sponsored under a research program, or performed in few medical centers across the United States.)

Date(s) of Service: ___________________________ Date of Return: ___________________________

(If no appointment is scheduled, enter “tentative”)

I certify communication has been established with the Out of State Provider. I certify the aforementioned services are not available, nor provided within the South Carolina Medical Services Area (SCMSA), defined as South Carolina and twenty-five (25) miles from its borders into Georgia and North Carolina.

__________________________________________  ______________________________
Signature of Referring Provider  Date
Form B: Out-of-State Physician Information

To be completed by the out-of-state Provider.

If the beneficiary will receive services from multiple out-of-state Providers, please submit a copy of Form B for each. Please complete all fields.

Out of State Provider

☐ Physician  ☐ Facility

Name: ________________________________

Name of Facility or Physician

NPI Number: ________________________ SC Medicaid Number: ________________________

Telephone Number: ____________________ Fax Number: ________________________

By Signing below, the Out of State Facility and Physician certifies the following:

- Enrolled or have begun to enroll in South Carolina Medicaid (if enrolling, please provide a communication ID or a screen shot of the in-process application)
- Accepting South Carolina 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, referrals will not be processed or reviewed.

For information concerning enrollment and claims submission for out-of-state hospital providers, see “Out-of-State Hospitals” in the Hospital Services Provider Manual.

When a beneficiary is in one of the Managed Care Organizations (MCO) the request for out-of-state services needs to be completed through the MCO.

For a complete copy of the Out-of-State (OOS) Services policy, please refer to the Physicians Services Provider Manual. The most current version of the provider manual is maintained on the SCDHHS web site at www.scdhhs.gov. If you have additional questions, please contact the Provider Service Center at 1-888-289-0709, submit an only inquiry at http://www.scdhhs.gov/contact-us, or contact your MCO representative at (803) 898-4614.
# Request for Medicaid ID Number - Infant

## I. Provider Information

<table>
<thead>
<tr>
<th>Provider Name / Hospital Name</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider Street Address</th>
<th>City</th>
<th>County</th>
<th>State</th>
<th>ZIP code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider Representative (First, Last Name)</th>
<th>Phone</th>
</tr>
</thead>
</table>

## II. Mother’s Information

<table>
<thead>
<tr>
<th>First Name, Middle Name, Last Name</th>
<th>Date of Birth (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>County</th>
<th>State</th>
<th>ZIP code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Medicaid ID#</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>First Name, Middle Name, Last Name (If not yet named, enter “Baby Boy” or “Baby Girl”)</th>
<th>Date of Birth (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address (If same as mother’s, enter “Same”)</th>
<th>City</th>
<th>County</th>
<th>State</th>
<th>ZIP code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Birth Facility</th>
<th>County of Birth Facility</th>
</tr>
</thead>
</table>

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 ____________________   *
MONTH/DAY/YEAR

MEDICAID# _______________________

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 ________________________________________ NPI
LAST FIRST MI
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 Doe
MEDICAID # 1234567891
LAST FIRST MI
BIRTHDATE 09/09/1970 GRAVITY 2 PARITY 2
MONTH/DAY/YEAR

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 Mary Z 1234567890
LAST FIRST MI NPI
ADDRESS 101 East Street Anywhere, SC 22222

CONTACT PERSON John Brown TELEPHONE (803) 123-4567
FAX (803) 123-4568

SIGNATURE ___Mary Brown, MD DATE 06/01/07
ATTENDING PHYSICIAN

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

Revised: 08/01/17
TRANSPLANT PRIOR AUTHORIZATION REQUEST FORM

INSTRUCTIONS

In determining whether to provide Prior Authorization, 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.

When submitting a completed Transplant Prior Authorization Request Form:

1. The referring South Carolina (SC) Medicaid provider must complete the form.

2. All fields on the form must be completed.

3. Include supporting clinical documentation (e.g., clinical notes, diagnostic studies, lab results)

4. This is not an authorization for payment. Payments are made subject to the beneficiary’s eligibility and benefits on the day of service.

5. Providers seeking reimbursement for services must be credentialed with SC Medicaid.

6. You must provide sufficient information to allow us to make a decision regarding your request.

7. 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.

8. Requests for prior authorizations from KePRO may be submitted using one of the following methods.

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

SCDHHS reserves the right to make recommendations to a center that has provided transplant services to Medicaid beneficiaries in the past. You must identify any services that are considered experimental and/or investigational, sponsored under a research program, as these services are non-covered by SC Medicaid. In addition, a copy of the beneficiary’s medical records, relating to the transplant, for up to the past year must be included.

All transplant prior authorization requests require at least 10 days advance notice.
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.

NAME OF BENEFICIARY: ____________________________________________ DATE OF BIRTH: ____________________________________________

SC MEDICAID ID#: ______________________________________________

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

REFERRING PHYSICIAN: _____________________________________________________________________________

NPI: ________________________________ _____                  SC MEDICAID #:   __________________________________

TYPE OF TRANSPLANT: ________________________________

Is the patient receiving a ______ living organ or a _____ cadaveric organ?

EXPECTED DATE OF SERVICE: ____________________________  EXPECTED DATE OF RETURN: ____________________________

WILL THE BENEFICIARY REQUIRE TRANSPORTATION? YES _______ NO _______

RECOMMENDED MODE OF TRANSPORTATION: ___________________________________________

Medicaid patients, as well as their escort, may be provided transportation when necessary. Prior approval is mandatory in order to make the necessary travel arrangements. Contact the Provider Service Center at 1-888-289-0709 to make travel arrangements.

RENDERING PHYSICIANS/FACILITY

PATIENT REFERRED TO: _______________________________________________________________

NAME OF FACILITY AND/OR PHYSICIAN (S)

ADDRESS: _______________________________________________________________________________________________________________

TELEPHONE: _______________________________________________________ FAX: ________________________________________________

NAME OF CONTACT PERSON/COORDINATOR: ______________________________________________________________________________

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

☐ Medical records, including physical exam, medical history, and family history

☐ 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.

PLEASE ANSWER THE FOLLOWING QUESTIONS

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient have any unresolved psychosocial concerns or a history of non-compliance with medical management?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the patient had active alcohol, tobacco, or substance abuse within the past 6 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient have any serious health conditions that create an inability to tolerate transplant surgery or post transplant care?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient have any uncontrolled/untreatable infections or diseases?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the answer is “Yes” to any of the above questions, please explain and provide medical documentation.

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 ____________________________