

## FORMS

<b>Number</b>	<b>Name</b>	<b>Revision Date</b>
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	Reasonable Effort Documentation	04/2014
	Authorization Agreement for Electronic Funds Transfer	01/2014
	Duplicate Remittance Advice Request Form	04/2014
	Claim Reconsideration Form	12/2016
CMS-1500 (02/12)	Sample Health Insurance Claim Form	02/2012
	Sample Remittance Advice (four pages)	04/2014
	Freedom of Choice Form	10/2012
	Grievance and Appeals Notice (three pages)	02/2013
	Rights and Responsibilities Agreement (three pages)	01/2014
	Waiver Service Authorization Form	07/2012



**STATE OF SOUTH CAROLINA  
DEPARTMENT OF HEALTH  
AND HUMAN SERVICES**

# CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

## PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

NPI or MEDICAID PROVIDER ID: (if applicable)

MEDICAID RECIPIENT ID NUMBER: (if applicable)

ADDRESS OF SUSPECT:

LOCATION OF INCIDENT:

DATE OF INCIDENT:

COMPLAINT:

NAME OF PERSON REPORTING: (Please print)

SIGNATURE OF PERSON REPORTING:

DATE OF REPORT

ADDRESS OF PERSON REPORTING:

TELEPHONE NUMBER OF PERSON REPORTING:

SIGNATURE: (SCDHHS Representative Receiving Report)

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Grid for Original CCN (15 boxes)

Provider ID:

Grid for Provider ID (6 boxes)

NPI:

Grid for NPI (10 boxes)

Recipient ID:

Grid for Recipient ID (8 boxes)

Adjustment Type:

- Void, Void/Replace

Originator:

- DHHS, MCCS, Provider, MIVS

Reason For Adjustment: (Fill One Only )

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

For Agency Use Only

Analyst ID:

Grid for Analyst ID (6 boxes)

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

Comments:

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

Phone: \_\_\_\_\_

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

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

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

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

**1. Provider Name:** \_\_\_\_\_

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

**OR**

**3. NPI#**

**& Taxonomy**

**4. Person to Contact:** \_\_\_\_\_

**5. Telephone Number:** \_\_\_\_\_

**6. Reason for Refund:** [check appropriate box]

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

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

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

Other, describe in detail reason for refund:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**7. Patient/Service Identification:**

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

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

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

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



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

Provider or Department Name: \_\_\_\_\_ Provider ID or NPI: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ Date: \_\_\_\_\_

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

Beneficiary Name: \_\_\_\_\_ Date Referral Completed: \_\_\_\_\_

Medicaid ID#: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured SSN: \_\_\_\_\_

Employer's Name/Address: \_\_\_\_\_

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

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

**ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.**

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

<b>Fax:</b>	<b>or</b>	<b>Mail:</b>
803-252-0870		Post Office Box 101110
		Columbia, SC 29211-9804

**III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN  
(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)**

Medicaid Beneficiary ID: \_\_\_\_\_ SSN: \_\_\_\_\_

Carrier Name/Code: \_\_\_\_\_ New Unique Policy Number: \_\_\_\_\_

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

<b>Fax:</b>	<b>or</b>	<b>Mail:</b>
803-255-8225		Post Office Box 8206, Attention TPL
		Columbia, SC 29202-8206



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
REASONABLE EFFORT DOCUMENTATION**

**PROVIDER** \_\_\_\_\_ **DOS** \_\_\_\_\_

**NPI or MEDICAID PROVIDER ID** \_\_\_\_\_

**MEDICAID BENEFICIARY NAME** \_\_\_\_\_

**MEDICAID BENEFICIARY ID#** \_\_\_\_\_

**INSURANCE COMPANY NAME** \_\_\_\_\_

**POLICYHOLDER** \_\_\_\_\_

**POLICY NUMBER** \_\_\_\_\_

**ORIGINAL DATE FILED TO INSURANCE COMPANY** \_\_\_\_\_

**DATE OF FOLLOW UP ACTIVITY** \_\_\_\_\_

**RESULT:**

**FURTHER ACTION TAKEN:**

**DATE OF SECOND FOLLOW UP** \_\_\_\_\_

**RESULT:**

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

\_\_\_\_\_  
(SIGNATURE AND DATE)

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

**South Carolina Department of Health and Human Services  
Electronic Funds Transfer (EFT) Authorization Agreement**

**PROVIDER INFORMATION**

Provider Name \_\_\_\_\_  
Doing Business As Name (DBA) \_\_\_\_\_  
Provider Address \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State/Province \_\_\_\_\_  
Zip Code/Postal Code \_\_\_\_\_ Medicaid Provider Number \_\_\_\_\_  
Provider Federal Identification Number (TIN) or  
Employer Identification Number (EIN) \_\_\_\_\_  
National Provider Identifier (NPI) \_\_\_\_\_  
Provider EFT Contact Information  
Provider Contact Name \_\_\_\_\_  
Telephone Number \_\_\_\_\_ Telephone Number Extension \_\_\_\_\_  
Email Address \_\_\_\_\_

**FINANCIAL INSTITUTION INFORMATION**

Financial Institution Name \_\_\_\_\_  
Financial Institution Address \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State/Province \_\_\_\_\_  
Zip Code/Postal Code \_\_\_\_\_  
Financial Institution Routing Number \_\_\_\_\_

Type of Account at Financial Institution (select one)     Checking     Savings  
Provider's Account Number with Financial Institution \_\_\_\_\_  
Account Number Linkage to Provider Identifier (select one)  
 Provider Tax Identification Number (TIN)  
 National Provider Identifier (NPI)

REASON FOR SUBMISSION:     New Enrollment     Change Enrollment     Cancel Enrollment

I (we) hereby authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to my account indicated above and the financial institution named above, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.

I (we) understand that credit entries to the account of the above named payee 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 (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

**All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.**

Written Signature of Person Submitting Enrollment \_\_\_\_\_

Printed Name of Person Submitting Enrollment \_\_\_\_\_

Submission Date \_\_\_\_\_

*TO PROCESS YOUR EFT ENROLLMENT OR CHANGE EXISTING INFORMATION, PLEASE RETURN THIS COMPLETED FORM ALONG WITH VERIFICATION OF YOUR ELECTRONIC DEPOSIT INFORMATION ON YOUR FINANCIAL INSTITUTION'S LETTERHEAD TO:*

Department of Health and Human Services  
Medicaid Provider Enrollment  
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809  
FAX (803) 870-9022

**SPECIAL INSTRUCTIONS:** For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider web page for instructions on how to complete updates to your EFT information.  
Effective January 01, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDHHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching trace number and your ERA can be directed to the Provider Service Center at 1-888-289-0709.

**South Carolina Department of Health and Human Services  
Duplicate Remittance Advice Request Form**

**Purpose:** This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

**Please contact the SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us> for instructions on submission of your request.**

1. Provider Name: \_\_\_\_\_
2. Medicaid Legacy Provider # \_\_\_\_\_ (Six Characters)  
NPI# \_\_\_\_\_ & Taxonomy \_\_\_\_\_
3. Person to Contact: \_\_\_\_\_ 4. Telephone Number: \_\_\_\_\_
5. Requesting:  
 Remittance Advice Pages       Edit Correction Form (ECF)  
Pages Only\*

(\* ) ECFs are available only for Remittance Advice dates prior to January 17, 2014. Please note that SCDHHS no longer accepts ECFs for processing as of April 1, 2014.

6. 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.**

7. Street Address for delivery of request:  
Street: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_  
Zip Code: \_\_\_\_\_

8. 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**



Nikki R. Haley GOVERNOR  
 Christian L. Sours DIRECTOR  
 P.O. Box 8206 > Columbia, SC 29202  
 www.scdhhs.gov

**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. 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.

**Section 1: Beneficiary Information**

Name (Last, First, MI): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Beneficiary Medicaid 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**

Communication ID: \_\_\_\_\_ CCN: \_\_\_\_\_ Date(s) of Service: \_\_\_\_\_

**Section 4: Claim Reconsideration Information**

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

- |   |   |
|---|---|
| <input type="checkbox"/> Ambulance Services   | <input type="checkbox"/> Nursing Facility Services                                |
| <input type="checkbox"/> Clinic Services  | <input type="checkbox"/> Optional State Supplementation (OSS)                     |
| <input type="checkbox"/> Community Long Term Care (CLTC)                                    | <input type="checkbox"/> Pharmacy Services  |
| <input type="checkbox"/> Community Mental Health Services                                   | <input type="checkbox"/> Physicians Laboratories, and Other Medical Professionals |
| <input type="checkbox"/> Durable Medical Equipment (DME)                                    | Specify: _____  |
| <input type="checkbox"/> Early Intervention Services  | <input type="checkbox"/> Private Rehabilitative Therapy and Audiological Services |
| <input type="checkbox"/> Federally Qualified Health Center (FQHC)                           | <input type="checkbox"/> PRTF CHANCE Waiver                                       |
| <input type="checkbox"/> Enhanced Services  | <input type="checkbox"/> Psychiatric Hospital Services                            |
| <input type="checkbox"/> Home Health Services   | <input type="checkbox"/> Rehabilitative Behavioral Health Services (RBHS)         |
| <input type="checkbox"/> Hospice Services   | <input type="checkbox"/> Rural Health Clinic (RHC)                                |
| <input type="checkbox"/> Hospital Services  | <input type="checkbox"/> Targeted Case Management (TCM)                           |
| <input type="checkbox"/> Licensed Independent Practitioner's Rehabilitative Services (LIPS) | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Local Education Agencies (LEA)                                     |   |

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**Section 5: Desired Outcome**

**Request submitted by:**

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

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

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



# HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA <span style="float: right;"><input type="checkbox"/> PICA <input type="checkbox"/></span>														
1. MEDICARE <input type="checkbox"/> (Member ID#)            MEDICAID <input type="checkbox"/> (Medicaid#)            TRICARE <input type="checkbox"/> (ID#/DoD#)            CHAMPVA <input type="checkbox"/> (Member ID#)            GROUP HEALTH PLAN <input type="checkbox"/> (ID#)            FECA SIX LUNG <input type="checkbox"/> (ID#)            OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. CLAIM CODES (Designated by NUCC)		11. INSURED'S POLICY GROUP OR FECA NUMBER  a. INSURED'S DATE OF BIRTH MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> # yes, complete items 9, 9a, and 9d.							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED _____				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY    QUAL: _____					15. OTHER DATE QUAL: _____ MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY    B. PLACE OF SERVICE    C. EMG					D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER    F. \$ CHARGES    G. DAYS OR UNITS    H. FROST Family Plan    I. ID. QUAL    J. RENDERING PROVIDER ID. #							
25. FEDERAL TAX I.D. NUMBER    SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gross charges, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ _____		29. AMOUNT PAID \$ _____		30. Paid for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____					32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____					33. BILLING PROVIDER INFO & PH # ( ) a. NPI _____ b. _____				

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

# Sample Remittance Advice (page 1)

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

PROVIDER ID.	DEPT OF HEALTH AND HUMAN SERVICES	PROFESSIONAL SERVICES	PAYMENT DATE	PAGE
AB00080000	SOUTH CAROLINA MEDICAID PROGRAM	REMITTANCE ADVICE	02/14/2014	1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB1AA	1403004803012700A 01		101713	71010	27.00 27.00	6.72 P 6.72 P	1112233333	CLARK		026	0.00	0.00
ABB2AA	1403004804012700A 01		101713	74176	259.00 259.00	0.00 S 0.00 S	1112233333	CLARK		026	0.00	0.00
ABB3AA	1403004805012700A 01 02		071913 071913	A5120 A4927	24.00 12.00 12.00	0.00 R 0.00 R 0.00 R	1112233333	CLARK		000 000	0.00	0.00
TOTALS				3	310.00						0.00	0.00

\$6.72

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

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

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

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

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

CHECK NUMBER

# Sample Remittance Advice (page 2)

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

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

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	1405200415812200A				1192.00	243.71	P	1112233333	M CLARK			0.00	
	01		021814	S0315	800.00	117.71	P			000		0.00	
	02		021814	S9445	392.00	126.00	P			000		0.00	
VOID OF ORIGINAL CCN 13283002244813300A PAID 20131018													
ABB222222	1405200077700000U				1412.00-	273.71-	P	1112233333	M CLARK				
	01		100213	S0315	1112.00-	143.71-	P			000			
	02		100213	S9445	300.00-	130.00-	P			000			
REPLACEMENT OF ORIGINAL CCN 1304711253670430A PAID 20131018													
ABB222222	1405200414812200A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		100213	S0315	142.50	42.75	P			000		0.00	
	02		100313	S9445	859.00	0.00	R			000		0.00	
												0.00	0.00

\$286.46

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

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

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

STATUS CODES:

P = PAYMENT MADE  
R = REJECTED  
S = IN PROCESS  
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER  
PO BOX 000000  
FLORENCE SC 00000

CHECK NUMBER

# Sample Remittance Advice (page 3)

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

PROVIDER ID. -----+   AB11110000   +-----+	DEPT OF HEALTH AND HUMAN SERVICES -----+   CLAIM ADJUSTMENTS   +-----+	PAYMENT DATE -----+   02/28/2014   +-----+	PAGE -----+   2   +-----+
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PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME I I	M F M O	D D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	1405200077700000U				513.00-	197.71-	P	1112233333	CLARK	M		131018	1328300224813300A
	01		100213	S0315	453.00	160.71-	P				000		
	02		100213	S9445	60.00	33.00-	P				000		
	TOTALS		1		513.00-	193.71-							

PROVDER INCENTIVE CREDIT AMOUNT -----+   0.00   +-----+	DEBIT BALANCE PRIOR TO THIS REMITTANCE -----+   0.00   +-----+	MEDICAID TOTAL -----+   \$243.71   +-----+	CERTIFIED AMT -----+   0.00   +-----+	TO BE REFUNDED IN THE FUTURE -----+   0.00   +-----+
	YOUR CURRENT DEBIT BALANCE -----+   0.00   +-----+	ADJUSTMENTS -----+   \$193.71-   +-----+	CHECK TOTAL -----+   \$50.00   +-----+	PROVIDER NAME AND ADDRESS -----+   ABC HEALTH PROVIDER PO BOX 000000 FLORENCE SC 00000   +-----+

# Sample Remittance Advice (page 4)

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

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

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

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

**South Carolina Department of Health and Human Services**  
**PRTF Alternative CHANCE Waiver**  
**Freedom of Choice Form**

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Medicaid #** \_\_\_\_\_ **DOB** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**Phone** \_\_\_\_\_

If you meet the level of care for a Psychiatric Residential Treatment Facility (PRTF), you have the right to choose between care provided in the home and community or care provided through placement in a Psychiatric Residential Treatment Facility.

By choosing to receive services through the PRTF Alternative CHANCE waiver, I understand:

- Services will be provided to me in my home, or the least restrictive setting by the qualified waiver provider of my choice
- My family and I will be an active part of my treatment team and will have the ability to make decisions about services and treatment
- I am required to receive and participate in the delivery of all appropriate services identified by me and my service plan development team
- I will continue to access Medicaid benefits (e.g., Doctor visits, etc.)
- I am required to discontinue my Medicaid HMO

By choosing to receive services in a PRTF placement, I understand the following:

- Services will be provided to me in an institutional setting
- Decisions regarding services and treatment will be made by the treatment team at the facility

I have chosen:    \_\_\_\_\_ **PRTF Alternative CHANCE Waiver services**  
                          \_\_\_\_\_ **Psychiatric Residential Treatment Facility placement**

I understand that I can change my mind at any time.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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*This section is to be completed by the individual who informed the youth/family of the Freedom of Choice regarding the choice between PRTF Alternative CHANCE Waiver Services and PRTF placement.*

This is to certify that I \_\_\_\_\_ informed the above named individual of the alternatives to Psychiatric Residential Treatment Facility placement under the PRTF Alternative CHANCE waiver. I informed the youth/family of the choices regarding available services for those who meet Level of Care for PRTF placement. The individual named above, by his/her written acknowledgement, or by the written acknowledgement of his/her parent/guardian, has chosen the option indicated.

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

Date: \_\_\_\_\_ Agency Phone: \_\_\_\_\_

Agency Address: \_\_\_\_\_

South Carolina Department of Health and Human Services  
 PRTF Alternative CHANCE Waiver  
 Grievances and Appeals Notice

<b>Name</b>		<b>Date</b>	
<b>Medicaid #</b>		<b>DOB</b>	

The Grievances and Appeals Notice is discussed and signed at the time of enrollment into the waiver and/or when there are changes to the grievance and appeals process. This notice is to inform you of the grievance and appeals process available under the PRTF Alternative CHANCE Waiver.

**Right to file a grievance:**

*A grievance is the process that a youth/parent/guardian can take to address a complaint or concern.*

**Waiver participants have the right to file a grievance when they are dissatisfied with a situation or condition relating to their waiver services.**

*Some examples of issues that can be addressed as grievances are: dissatisfaction with how qualified providers of PRTF Alternative CHANCE Waiver services have treated you or your family, dissatisfaction with service delivery, dissatisfaction with service provider or staff or person's job performance, dissatisfaction with the course of treatment or dissatisfaction with the operating/administrative entity.*

*A grievance can be filed when a waiver participant and/or their family feel that some action or inaction has violated the participant's waiver rights and the violation could not be adequately addressed through the service plan development process. (See rights and responsibilities agreement for list of rights)*

If you have a concern or complaint that meets the above definition of a grievance, you can file a grievance to have your concern addressed. To file a grievance, the youth or family can contact the Federation of Families (The waiver's family advocacy organization) to report their complaint. The family must submit a written statement describing the complaint. Once the written statement is submitted, the concern will be addressed through a local mediation process. *Mediation is a meeting between the effected parties to resolve the issues and concerns with the help of a mediator.* The federation of Families staff is the mediator in this process. If the grievance is resolved, it shall be acknowledged in writing and documented in the participant's record at SCDHHS.

If the family is not satisfied with the outcome of the mediation, they may appeal in writing to the DHHS Waiver Director. The Federation of Families can assist the family with this process. SCDHHS Waiver staff will investigate the grievance, and the issues addressed in the mediation session. SCDHHS must issue a written decision within ten (10) working days from the date the grievance was received in writing. If the grievance is resolved, it will be acknowledged in writing and documented in the participant's record at SCDHHS.

South Carolina Department of Health and Human Services  
 PRTF Alternative CHANCE Waiver  
 Grievances and Appeals Notice

<b>Name</b>		<b>Date</b>	
<b>Medicaid #</b>		<b>DOB</b>	

If the family is not satisfied, and the grievance is one which affords the complainant fair hearing rights, then the family may appeal the decision and utilize the fair hearing process. Grievances, which do not afford fair hearing rights, are completed with the decision of the SCDHHS Waiver Director.

**Right to a fair hearing:**

*A fair hearing is the process by which a family may have a decision reconsidered (an appeal) regarding a waiver participant's eligibility for services*

**Waiver participants have the right to request an appeal of any decision that adversely affects his/her eligibility status and/or receipt of services and/or assistance.**

*Some examples of decisions that afford fair hearing rights are decisions made by a provider or the operating/administrating entity that the family and/or youth feel unduly resulted in: loss of eligibility, loss of access to services or prevention of youth or family to get needed assistance.*

*The formal process of review and adjudication of actions/determinations is done under the authority of Section 1-23-310 et. seq., Code of Laws, State of South Carolina, 1976, as amended, and the Department of Health and Human Services regulations Section 126-150, et.seq.*

A formal request for reconsideration must be made in writing to the Division Director of Behavioral Health Services at SCDHHS, P. O. Box 8206, Columbia, SC 29202-8206 within thirty (30) calendar days of notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the individual, representative, or person assisting the individual in filing the request. If necessary, the family advocate will assist the individual in filing a written reconsideration.

In order for waiver benefits/services to continue during the reconsideration/appeal process, the individual/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision.

The Division Director or his/her designee will issue a written decision within ten (10) working days of receipt of the written reconsideration request and will communicate this decision to the youth/representative. If the Division Director/designee upholds the original adverse action/decision, the reason(s) will be specifically identified in the written decision.

If the youth/representative fully completes the above reconsideration process and is dissatisfied with the results, the youth/representative has the right to request an appeal. The purpose of an administrative appeal is to prove error in fact or law. The youth/representative must submit a written

South Carolina Department of Health and Human Services  
PRTF Alternative CHANCE Waiver  
Grievances and Appeals Notice

<b>Name</b>		<b>Date</b>	
<b>Medicaid #</b>		<b>DOB</b>	

request to the following address no later than thirty (30) calendar days from the receipt of the Division Director’s written reconsideration decision.

Division of Appeals and Hearings  
SC Department of Health and Human Services  
PO Box 8206  
Columbia, SC 29202-8206

The youth/representative must attach a copy of the written reconsideration notifications received from the SCDHHS regarding the specific matter on appeal. In the appeal request the youth/representative must clearly state with specificity, which issue(s) the youth/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDHHS Division Director’s written reconsideration decision, the decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30th) calendar day following receipt of the Division Director’s written reconsideration decision. The youth/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

**My signature indicates that I have been notified of the Grievance and Appeals Process available under the PRTF Alternative CHANCE Waiver.**

Signature of Youth

Date

Signature of Parent/Guardian

Date

Signature of Family Advocate

Date

South Carolina Department of Health and Human Services  
 PRTF Alternative CHANCE Waiver  
**Rights and Responsibilities Agreement**

Name		Date	
Medicaid #		Date of Birth	
Case Manager		CM Agency	

The purpose of this document is to explain your rights and responsibilities for receiving services under the PRTF Alternative CHANCE Waiver. This document must be reviewed and signed by you and your family at the time of enrollment in the PRTF Alternative CHANCE waiver, or when there is a change in the Case Manager, as evidence that you understand the rights and responsibilities associated with participation in this program.

1. **I have the right to make informed decisions.** My Case Manager and service plan development team will help my family and I understand and make informed choices. My personal choices will be respected and supported by my Case Manager and my service plan development team. *\*A person has made an informed choice when he/she has made a decision based on good understanding of the options available and good understanding of how choice may affect his/her life.*
2. **Freedom of Choice:**
  - A. **I have the freedom to choose who I want to provide Case Management to me.** I also have the right to make an informed decision to change Case Managers if I feel I can be better served by another Case Manager. I must choose a qualified Waiver provider to provide this service.
  - B. **I have the freedom to choose who I want to provide other waiver services.** I also have the right to make an informed decision to change Waiver service staff/providers if I feel I can be better served by another staff/provider. I must choose a qualified Waiver provider to provide services to me.  
*\*Freedom of choice means that a person can choose to receive Home and Community based services rather than receiving services in a Psychiatric Residential Treatment Facility and a person can choose to make informed decisions to change staff or providers when they are no longer satisfied with the supports and services they are receiving. Service providers cannot deny services for discriminatory purposes such as: sex, race, religion or disability.*
3. **My family and I will participate in the development of an Individual Plan of Care to ensure that my plan is person centered and family driven.** My Case Manager and Service Plan Development team will work with my family and I to ensure that the supports and services provided to me address my needs. I will actively participate in the development of my plan to ensure that it is meeting my needs to allow me to stay in the least restrictive environment. *\*The Individual Plan of Care should be based on the needs of the youth and family. The service plan development team including the youth and family will meet every 90 days to review and update the Individual Plan of Care. All Waiver service providers, youth and caregivers are expected to participate in the 90 day reviews to ensure coordinated quality care is being provided.*
4. **I have the right to understand what I am signing before I sign my name in agreement.** My case manager will review the Individual Plan of Care with me and my family to ensure that it accurately addresses the needed supports as discussed in the service plan development team meeting. I have the right to request corrections or revisions if I feel that the final plan is inaccurate. I have the right to have all forms explained to me and my family so I understand them before I sign them. I will be given a copy of my Individual Plan of Care and any forms that I am asked to sign. *\*The Case Manager must assess the youth/families ability to read/comprehend the Individual Plan of Care/forms and determine how best to communicate the contents of the Individual Plan of Care/forms. The Case Manager must ensure that the youth/family knows what in in their plan and what they are signing off on.*
5. **I have the right to access services and natural supports that I need and desire to achieve my goals and remain in the least restrictive environment.** My Case Manager will provide advocacy, linkage and referral to needed services regardless of funding source and service provider. Services will be explored based on recommendations from my service plan development team (or any member of the team) and acted on based on informed decisions made by myself and my family.. *\*Services and supports should be based on the needs of the youth and their family. Youth and family should be given information about all available supports and services (Waiver, state plan,*

South Carolina Department of Health and Human Services  
PRTF Alternative CHANCE Waiver  
**Rights and Responsibilities Agreement**

*church funded, school funded etc.) even if those services are provided by a competitive providing agency or provided/funded by an entity that the Case Manager would not pick for themselves.*

6. **I have the right to confidentiality.** While I understand that my information will need to be shared for treatment and billing purposes, my information will be kept private and confidential. *\*Information can only be shared for the purposes of treatment, billing or health care operations. Any other communication regarding personal health information (PHI) would require a signed consent to indicate who that information can be shared with and for what purpose. Inappropriate disclosure of PHI would be a violation of HIPAA and privacy laws.*
7. **I have the right to be treated with dignity and respect.**
8. **I have the right to file a grievance.** I can contact the Federation of Families (family advocacy organization) to file a formal grievance if I have a complaint that cannot be resolved by my Case Manager and service plan development team. *\*Written grievances will be addressed as per the grievance process in the Waiver manual. Questions regarding the process can be directed to Federation of Families or SC DHHS staff.*
9. **If I am denied or refused services I have the right to file an appeal.** I can contact the Federation of Families (family advocacy organization) to file a formal appeal if I feel that I have been denied or refused services. *\*Written appeals will be addressed as per the fair hearing process in the CHANCE Waiver manual. Questions regarding the process can be directed to Federation of Families or SC DHHS staff.*
10. **I have the right to discontinue my participation in Waiver services at any time.** I understand that I must receive at least one waiver service within 30 days in order to remain eligible for PRTF Alternative Waiver services. Failure to participate may result in a Level of Care assessment being completed to determine if I am still eligible to receive waiver services. Family support and youth participation will be considered when the clinician does this evaluation. I understand that participation in the PRTF Alternative CHANCE Waiver is voluntary and I can make an informed decision to discontinue my services at any time. *\*Termination of waiver services must be the result of the one of the acceptable reasons for termination as per the CHANCE Waiver manual.*

**My responsibilities:**

1. I will be considerate and courteous to my service providers.
2. I will provide accurate and complete information about:
  - My medical history and present medical conditions
  - My family and others who can provide supports
  - My financial information and changes in my income or assets
  - All services and benefits being provided to me
  - Changes in my condition, situation, treatment or care such as hospitalization
  - Changes in my address, phone number and other contact information
3. I will follow my Individual Plan of Care, including emergency, afterhours and crisis intervention plan.
4. I will be present and participate on the dates and times that services are scheduled to be delivered. If I am unable to attend at the scheduled time and date, I will contact the providing agency within 24 hours of the scheduled visit.

\_\_\_\_\_  
Signature of PRTF Alternative CHANCE Waiver Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of PRTF Alternative Case Manager

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Family Advocate

\_\_\_\_\_  
Date

South Carolina Department of Health and Human Services  
PRTF Alternative CHANCE Waiver  
**Rights and Responsibilities Agreement**

**CONTACT INFORMATION:**

Case Manager Agency	
Case Manager	
Phone	
Email Address	
Address	

Case Manager Agency	
Case Manager Supervisor	
Phone	
Email Address	
Address	

Family Advocate	Federation of Families
Contact person	Belinda Pearson Barber
Phone	803-772-5210
Email address	<a href="mailto:belinda.pearson@fedfamsc.org">belinda.pearson@fedfamsc.org</a>
Address	810 Dutch Square Blvd., Suite 205 Columbia, SC 29210

SC DHHS	Waiver Project Director
Contact person	Jennifer Gilmore
Phone	803-898-1535
Email address	<a href="mailto:jennifer.gilmore@scdhhs.gov">jennifer.gilmore@scdhhs.gov</a>
Address	PO Box 8206 Columbia, SC 29202-8206

SC DHHS	Division Director of Behavioral Health Services
Contact person	Pete Liggett
Phone	803-898-2505
Email address	<a href="mailto:liggettp@scdhhs.gov">liggettp@scdhhs.gov</a>
Address	PO Box 8206 Columbia, SC 29202-8206

**CHANCE – PRTF Waiver**  
**90 Day Client Service PRTF Waiver Plan of Care**  
**Service Authorization Form**

*PRIOR to starting services, the Case Manager must fill out and sign this Authorization Form and fax it, along with a copy of the PRTF Waiver Individual Plan of Care or Addendum and Budget, to South Carolina Department of Health and Human Services Waiver staff at 803-255-8204. An Authorization Form must be submitted for EACH PROVIDER providing a service to the waiver client listed.*

*In order to claim Medicaid reimbursement, the provider will need to enter the  
**Prior Authorization #** on the CMS 1500 Claim Form.*

Today's Date: \_\_\_/\_\_\_/\_\_\_      Client Name: \_\_\_\_\_  
 Child's Medicaid # \_\_\_\_\_      Child's DOB: \_\_\_/\_\_\_/\_\_\_  
 Provider Name: \_\_\_\_\_      NPI # \_\_\_\_\_  
 Contact Person: \_\_\_\_\_      Title: \_\_\_\_\_  
 Phone: (    )      Fax: (    )      Email: \_\_\_\_\_

Primary Diagnosis Code: \_\_\_\_\_      Service Start Date : \_\_\_/\_\_\_/\_\_\_      Service End Date: \_\_\_/\_\_\_/\_\_\_

**SERVICES REQUESTED:**

Service Name	Minutes Per Unit	# Units Requested	Unit Rate \$	Hours/Day	Hours/Week	Days/Week	Days/Month	Total Units Requested: 90 Day Plan of Care

I attest that the above information is COMPLETE and ACCURATE :

PRTF Waiver Case Manager: \_\_\_\_\_  
*Signature* *Print Name*

**WAIVER ELIGIBILITY DATE:** \_\_\_/\_\_\_/\_\_\_  
**PRIOR AUTHORIZATION #** \_\_\_\_\_  
**DHHS WAIVER STAFF AUTHORIZATION:** \_\_\_\_\_  
*Signature*  
**DATE APPROVED:** \_\_\_/\_\_\_/\_\_\_

This financial authorization includes client-identifying information that is protected from disclosure by applicable law. This information may be viewed, used and/or disclosed only by persons authorized by the SCDHHS PRTF Waiver staff and is otherwise subject to SCDHHS Privacy Practices.