

FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	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 Claim Showing TPL Payment with NPI	02/2012
	Sample Remittance Advice (four pages)	04/2014
	Healthy Mothers, Healthy Futures Maternity Health Education Checklist (two pages)	
	Alcohol and Drug Medical Assessment (two pages)	09/1990
	DHHS Pediatric Sub-Specialists Certification Form	06/2015
	Abortion Statement	
DHHS 1723	Consent For Sterilization	06/2010
	Surgical Justification Review for Hysterectomy	06/2012
	Request for Prior Approval Review	09/2010
	Allied Profession Supervision Form	08/2013
	OOS Referral Package (four pages)	05/2014
	Transplant Prior Authorization Request Form & Instructions (two pages)	08/2012
	Mental Health Form	09/2013
	Psychiatric Prior Authorization Form – Inpatient	06/2012
	Circumcision Prior Authorization Form	02/2011
	BOI Universal Screening Tool	11/2012
	Universal 17-P Authorization Form	12/2013
	SCDHHS Behavioral Health Referral and Feedback Form	12/2013



STATE OF SOUTH
CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

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

PROGRAM INTEGRITY

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

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

NPI or MEDICAID PROVIDER ID: (if applicable)

MEDICAID RECIPIENT ID NUMBER: (if applicable)

ADDRESS OF SUSPECT:

LOCATION OF INCIDENT:

DATE OF INCIDENT:

COMPLAINT:

NAME OF PERSON REPORTING: (Please print)

SIGNATURE OF PERSON
REPORTING:

DATE OF REPORT

ADDRESS OF PERSON REPORTING:

TELEPHONE NUMBER OF PERSON REPORTING:

SIGNATURE: (SCDHHS Representative Receiving Report)

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

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

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Grid for Original CCN (15 boxes)

Provider ID:

Grid for Provider ID (6 boxes)

NPI:

Grid for NPI (10 boxes)

Recipient ID:

Grid for Recipient ID (10 boxes)

Adjustment Type:

- Void, Void/Replace

Originator:

- DHHS, MCCS, Provider, MIVS

Reason For Adjustment: (Fill One Only)

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

For Agency Use Only

Analyst ID:

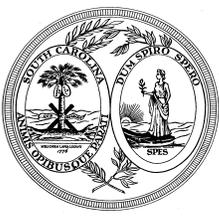
Grid for Analyst ID (6 boxes)

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

Comments:

Signature: _____ Date: _____

Phone: _____



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
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

**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).

Fax: 803-255-8225 **or** **Mail:** 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. Soura 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: _____ 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) | |

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

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature: _____

Date: _____



HEALTH INSURANCE CLAIM FORM

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

Physicians
Sample Claim Showing TPL Denial
with NPI

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA																													
1. MEDICARE <input type="checkbox"/> (Medicare#) <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> TRICARE <input type="checkbox"/> (ID#DoD#) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input checked="" type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (ID#) <input type="checkbox"/> FECA BLX (LUNG) <input type="checkbox"/> (ID#) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John A.										3. PATIENT'S BIRTH DATE MM DD YY 01 01 1947																													
5. PATIENT'S ADDRESS (No., Street) 123 Windy Lane										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																													
CITY Anytown					STATE SC					7. INSURED'S ADDRESS (No., Street)					CITY					STATE																			
ZIP CODE 29999					TELEPHONE (Include Area Code) ()					ZIP CODE					TELEPHONE (Include Area Code) ()																								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER A123450A										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																			
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLAGE (State)										b. OTHER CLAIM ID (Designated by NUCC)																			
c. RESERVED FOR NUCC USE 22										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME 401										10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, complete Items 9, 9a, and 9d.																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										15. OTHER DATE QUAL MM DD YY										18. 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. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Incl. A. 250.00 B. C. D. E. F. G. H. I. J. K. L.																				22. RESUBMISSION CODE ORIGINAL REF. NO.																			
23. PRIOR AUTHORIZATION NUMBER																				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. EPIC Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																			
1 01 07 14 01 07 14 11 99213 35 00 1 ZZ 1212121212 NPI 1234567890																				2																			
3																				4																			
5																				6																			
25. FEDERAL TAX I.D. NUMBER 55555555										SBN EIN <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. DOE1234					27. ACCEPT ASSIGNMENT? (For gov't claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 35 00					29. AMOUNT PAID \$ 22 00					30. Paid for NUCC Use 13 00				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # (555) 5555555 Jane Smith, MD 111 Main Street Anytown, SC 22222-2222																			
SIGNED										DATE										a. NPI 1234567890					b. ZZ1212121212														

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	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB1AA	1403004803012700A 01		101713	71010	27.00 27.00	6.72 6.72	P P	1112233333	M CLARK		026	0.00	0.00
ABB2AA	1403004804012700A 01		101713	74176	259.00 259.00	0.00 0.00	S S	1112233333	M CLARK		026	0.00	0.00
ABB3AA	1403004805012700A 01 02		071913 071913	A5120 A4927	24.00 12.00 12.00	0.00 0.00 0.00	R R R	1112233333	M CLARK		000 000	0.00 0.00	0.00 0.00
TOTALS				3	310.00				Edits: L00 946 L02 852 08/30/13			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	CHECK NUMBER

STATUS CODES:

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

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 2)

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

PROVIDER ID.			PROFESSIONAL SERVICES			PAYMENT DATE	PAGE				
+-----+	DEPT OF HEALTH AND HUMAN SERVICES		REMITTANCE ADVICE		02/28/2014		+-----+				
AB00080000	SOUTH CAROLINA MEDICAID PROGRAM						1				
+-----+	+-----+		+-----+		+-----+		+-----+				
PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S RECIPIENT ID. NUMBER	M RECIPIENT NAME F M I I LAST NAME	M TLE. 18 O ALLOWED D CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	1405200415812200A		021814	S0315	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		100213	S0315	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		100213	S0315	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".					CERT. PG TOT	MEDICAID PG TOT	STATUS CODES:		PROVIDER NAME AND ADDRESS		
IF YOU STILL HAVE QUESTIONS+ PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF + CLAIMS IN THAT MANUAL.					\$0.00	\$286.46	P = PAYMENT MADE R = REJECTED S = IN PROCESS E = ENCOUNTER		ABC HEALTH PROVIDER PO BOX 000000 FLORENCE SC 00000		
+-----+					CERTIFIED AMT	MEDICAID TOTAL	+-----+		+-----+		
+-----+					0.00	0.00	+-----+		+-----+		
+-----+					CHECK TOTAL	+-----+					
+-----+					CHECK NUMBER	+-----+					

Sample Remittance Advice (page 3)

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

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

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY 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 I I	ORG CHECK DATE	ORIGINAL CCN
ABB222222	1405200077700000U				513.00-	197.71-	P	1112233333	CLARK	M	131018	1328300224813300A
	01		100213	S0315	453.00	160.71-	P				000	
	02		100213	S9445	60.00	33.00-	P				000	
	TOTALS		1		513.00-	193.71-						

SAMPLE ONLY

PROVDER INCENTIVE CREDIT AMOUNT	DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	TO BE REFUNDED IN THE FUTURE
0.00	0.00	\$243.71	0.00	0.00
		ADJUSTMENTS		
		\$193.71-		
	YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PROVIDER NAME AND ADDRESS
	0.00	\$50.00	4197304	ABC HEALTH PROVIDER PO BOX 000000 FLORENCE SC 00000

Sample Remittance Advice (page 4)

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

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

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

SAMPLE ONLY

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

HEALTHY MOTHERS, HEALTHY FUTURES

Maternity Health Education Checklist

PATIENT'S NAME: _____

INSTRUCTIONS: This format provides for written documentation of providing health education to Medicaid maternity patients and suggests the range of topics that generally would be provided.

TOPIC	COMPLETED	DATE(S)
OFFICE SERVICES AND ROUTINES: Information about hours, appointments, lab tests, and other general procedures.	<input type="checkbox"/>	_____
GENERAL INSTRUCTION ABOUT PREGNANCY: such as hygiene, exercise, sexuality, medication, and importance of prenatal care.	<input type="checkbox"/>	_____
FETAL GROWTH AND DEVELOPMENT: how the baby develops month by month and physical and psychological changes experienced by the mother; including comfort measures.	<input type="checkbox"/>	_____
NUTRITION: including routine prenatal diet instruction. (Be sure to make referral to WIC PROGRAM)	<input type="checkbox"/>	_____
EXPLANATION OF EDC: Understanding the due date.	<input type="checkbox"/>	_____
DANGER SIGNS OF PREGNANCY: recognizing the warning signs and significance and risk of each; including specific instructions on what to do, who to contact and where to go in an emergency.	<input type="checkbox"/>	_____
RISKY BEHAVIORS: smoking, alcohol, substance use and abuse the risks, consequences to baby and methods for avoiding risks. NOTE: Possible referral for smoking cessation or substance abuse	<input type="checkbox"/>	_____
PROCESS OF LABOR AND DELIVERY: discussion of physical process of labor and delivery, including psychological changes experienced.	<input type="checkbox"/>	_____
METHODS OF ANESTHESIA: Information on types of anesthesia with discussion of benefits, risks and alternatives; also pain medication.	<input type="checkbox"/>	_____
CESAREAN SECTION: discussion of what it is and what are the usual indications including risks and benefits	<input type="checkbox"/>	_____
RELAXATION AND BREATHING EXERCISES: preparation for labor including demonstration and practice of exercises and breathing techniques	<input type="checkbox"/>	_____
BREASTFEEDING: factors to consider in decision making and preparation of the breasts Note: Possible referral to La Leche or Breastfeeding Support	<input type="checkbox"/>	_____

(Continued on Reverse)

MATERNITY EDUCATION CHECKLIST (Continued)

PREPARATION OF OTHER FAMILY MEMBERS: sibling preparation and needs of other family members before and after birth of child; father support and involvement.

DATE(S)

DELIVERY ARRANGEMENTS: Hospital tours, expectations and procedures during delivery and hospital stay.

POSTPARTUM CARE: Immediate postpartum needs and six weeks check-up and physical care at home, including psychological needs and adjustments.

FAMILY PLANNING: Importance of family planning; risks of short inter-conceptual period and discussion of all methods.

INFANT CARE AND PARENT EDUCATION: Routine infant care needs including preventive care, safety, expectations for infant development and provision for infant health care provider. Note: possible EPSDT referral.

OTHER: Note special areas covered

REFERRAL:

WIC PROGRAM:

Date: _____

HRCF (if applicable)
High Risk Channeling Project

Date: _____

OTHER

Date: _____

Date: _____

SIGNATURE:

ATTENDING PHYSICIAN

Alcohol and Drug Medical Assessment

Patient's Name (Last, First, MI) and I.D. #	
Medicaid Client #	Date of Medical Assessment
Physician's Name and Address	
1. Brief medical history to include hospital admissions, surgeries, allergies, present medications, information (where appropriate) about shared needles, sexual activity/orientation and history of hepatitis and liver disease.	
2. History of patient /family involvement with alcohol/drugs.	
3. Assessment of patient nutritional status.	

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

PEDIATRIC SUB-SPECIALISTS CERTIFICATION FORM

SECTION 1: PHYSICIAN DEMOGRAPHIC INFORMATION (PLEASE PRINT)

Name (First, Middle, Last):		NPI#:
Physical Location Address:		Suite/Unit #:
City:	State:	ZIP+4:
E-mail Address:		
Telephone Number:		Fax Number:
Mailing Address (if different from physical location address):		
City:	State:	ZIP+4:

SECTION II: ATTESTATION STATEMENT

Beginning February 1, 2006, the monies appropriated for pediatric physician sub-specialists shall only be available to a physician who: **A)** in his/her medical practice, has at least 85% of their patients who are children 18 years or younger and **B)** practices in one of the following sub-specialties or other pediatric sub-specialty area as may be determined by the Department of Health and Human Services:

PEDIATRIC SUB-SPECIALTIES (CHECK ALL THAT APPLY)			
<input type="checkbox"/> Adolescent Medicine	<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Nephrology	<input type="checkbox"/> Pulmonology
<input type="checkbox"/> Allergy	<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Neurology	<input type="checkbox"/> Radiology
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Gastroenterology/Nutrition	<input type="checkbox"/> Neurological Surgery	<input type="checkbox"/> Rheumatology
<input type="checkbox"/> Cardiothoracic Surgery	<input type="checkbox"/> Genetics	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Surgery
<input type="checkbox"/> Child Abuse Pediatrics	<input type="checkbox"/> Hematology/Oncology	<input type="checkbox"/> Orthopedic Surgery	<input type="checkbox"/> Urology
<input type="checkbox"/> Critical Care	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Otolaryngology	
<input type="checkbox"/> Developmental-Behavioral Pediatrics	<input type="checkbox"/> Neonatology	<input type="checkbox"/> Psychiatry	

CERTIFICATION

I hereby certify that:

- I am a physician member in good standing on the medical staff of a hospital.
- I am qualified in and practice in the pediatric specialty noted in Section II above.
- At least 85% of my total practice, including after-hours patients, is dedicated to children age 18 years and under.

Patient Heading	As a Group	As an Individual	TOTAL
Number of patients seen			
Number of MediCAID patients			
Number of patients 18 and under			
Number of patients with MediCAID 18 and under			

ATTESTATION/ASSURANCES AND SIGNATURE

I am providing this attestation certificate to the South Carolina Department of Health and Human Services with the request that I be included on the list of pediatric specialists eligible for enhanced reimbursement for selected services provided to children enrolled in the South Carolina Medicaid program. I hereby certify, under penalty of perjury, that the information provided on this certificate is correct as of the date of this certificate.

Physician Signature:	Date:
----------------------	-------

CONTACT PERSON INFORMATION

Contact Person Name (please print):	Contact Email Address:
Contact Telephone Number:	Contact Fax Number:

Please **FAX** or **MAIL** completed/signed form to:
Medicaid Provider Enrollment
FAX: 803-870-9022
MAIL: POB 8809, Columbia, SC 29202-8809

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.



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.

■ CONSENT TO STERILIZATION ■

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

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

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

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

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

I am at least 21 years of age and was born on: _____
Date
I, _____, hereby consent of my own free will to be sterilized by _____
Doctor or Clinic
by a method called _____
Specify Type of Operation
My consent expires 180 days from the date of my signature below.

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

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

I have received a copy of this form.

Signature _____
Date

Medicaid ID

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

- Ethnicity: Hispanic or Latino Not Hispanic or Latino
Race (mark one or more):
 American Indian or Alaska Native
 Asian
 Black or African American
 Native Hawaiian or Other Pacific Islander
 White

■ INTERPRETER'S STATEMENT ■

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

Interpreter's Signature _____
Date

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the consent form, I explained to him/her the nature of sterilization operation _____
Name of Individual
_____, the fact that it is _____
Specify Type of Operation

intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

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

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

Signature of Person Obtaining Consent _____
Date

Facility

Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

_____ on _____
Name of Individual _____
Date of Sterilization
I explained to him/her the nature of the sterilization operation _____
Specify Type of Operation
_____, the fact that it is _____

intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

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

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

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

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

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

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

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

Physician's Signature _____
Date

**SOUTH CAROLINA MEDICAID PROGRAM
SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY**

THIS COMPLETED FORM AND A SIGNED "ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION" FORM MUST BE RECEIVED 30 DAYS PRIOR TO SCHEDULED SURGERY.

PATIENT

NAME _____ MEDICAID # _____
 LAST FIRST MI
BIRTHDATE _____ GRAVITY _____ PARITY _____
 MONTH/DAY/YEAR

PROCEDURE CODE: _____ **DX CODE:** _____
HOSPITAL _____
 NAME NPI (IF AVAILABLE)
PLANNED ADMISSION DATE _____ PLANNED SURGERY DATE _____
TYPE OF HYSTERECTOMY PLANNED _____

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:

HCT ____ HGB ____ CHECK ONE: PREMENOPAUSAL ____ POSTMENOPAUSAL ____

CONSERVATIVE TREATMENT/MEDICATION WITH DATES:

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

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

ATTENDING PHYSICIAN'S NAME _____
 LAST FIRST MI NPI
ADDRESS _____
CONTACT PERSON _____ TELEPHONE (____) _____
 FAX (____) _____
SIGNATURE _____ DATE _____
 ATTENDING PHYSICIAN

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.



State of South Carolina
 Department of Health and Human Services

Please return signed original certificate to:

Mailing Address:

SC Dept. of Health and Human Services
 Behavioral Health Services
 Post Office Box 8206
 Columbia, South Carolina 29202-8206
 Fax: (803) 255-8204

Section I: Demographic Information

Please Print:

Supervising Clinician Name:	
Address:	
Telephone:	
National Provider Identifier Number (NPI)	
Fax:	
Email:	

Section II: Allied Professional Update Form

The Licensed Master Social Workers (LMSW) listed below are under my supervision and services rendered and billed to South Carolina Medicaid will be in compliance with the guidelines as provided in the South Carolina Medicaid Physicians and other Medical Professions Manual

LMSW Name (as it appears on their license):	
License Number & Expiration Date:	
LMSW Name (as it appears on their license):	
License Number & Expiration Date:	
LMSW Name (as it appears on their license):	
License Number & Expiration Date:	

Should there be changes to this list, the professional's qualifications, and/or licensure, I will notify South Carolina Medicaid utilizing this form within thirty days (30). Failure to comply may result in the recoupment for services rendered. All allied professionals must be listed each time this form is submitted and a maximum of three allied professionals are permitted.

I hereby certify, that the information provided in the certificate is correct as of the date of this certificate.

 Physician Signature

 Date

South Carolina
Department of Health and Human Services
P O Box 1412
Columbia, South Carolina 29202-1416
www.scdhhs.gov

Policy for medical treatment outside of the
South Carolina Medical Service Area

This serves to clarify our policy for reimbursement of services rendered to a South Carolina Medicaid beneficiary outside the South Carolina Medical Service Area (SCMSA). The service area includes all of South Carolina and regions of North Carolina and Georgia that are within 25 miles of the South Carolina border. All services performed outside of the SCMSA require prior approval. Prior approval guidelines are listed below.

The South Carolina Department of Health and Human Services (SCDHHS) provides compensation to medical providers outside the SCMSA for services rendered to beneficiaries only in the following situations:

- ❖ When emergency medical services, pregnancy related services and/or delivery are necessary to protect the health of the beneficiary traveling outside the SCMSA.
- ❖ When a SCMSA physician certifies that needed services are not available within the SCMSA and follows SCDHHS protocol in referring the beneficiary to an out-of-state provider. All available resources must have been considered and indicated in the request to SCDHHS for the out-of-state referral. The following guidelines outline the requirements for an out-of-state referral.

Prior to contacting SCDHHS, the referring physician must contact the out of state provider rendering service to the beneficiary and inform them of the beneficiary's Medicaid status. The out-of-state provider must confirm, in writing, that they will enroll in the South Carolina Medicaid program and will accept the Medicaid reimbursement as payment in full. The written confirmation must be submitted to SCDHHS along with a completed Referral Request Form (attached) for out-of-state services.

The written request for out-of-state referrals must include the following information:

- ✓ Beneficiary's name and South Carolina Medicaid identification number
- ✓ Date of Service (state as "tentative" if unscheduled at the time of request)
- ✓ Name, address, telephone number and fax number of the out-of-state provider(s) who will render the medical services (i.e. hospital and physician(s) involved in the beneficiary's medical treatment)
- ✓ An explanation why these services must be rendered out-of-state versus within the SCMSA
- ✓ Identification of any services that are considered experimental and/or investigational, sponsored under a research program, or performed in few medical centers across the United States
- ✓ A copy of the beneficiary's medical records for the past year relating to the treatment of the condition

Services outside of SCMSA *will not* be approved if:

- ✓ All information on the referral form is not provided
- ✓ The provider rendering the service(s) will not enroll in the South Carolina Medicaid program and adhere to the enrollment criteria
- ✓ The provider rendering the service(s) will not accept the South Carolina Medicaid reimbursement as payment in full

For out-of-state referrals, the referring physician may fax the attached Referral Request Form with supporting documentation to (803) 255-8255 or mail the information to the following address:

SCDHHS
Claims, Operations and Provider Relations
ATTN: Out-Of-State Coordinator
P O Box 1412
Columbia, South Carolina 29202-1416

For information concerning enrollment and claims submission for out-of-state **hospital** providers see section 2, “Out-of-State Hospitals” in the Hospitals 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 current policy, please refer to the Physicians, Laboratories and Other Medical Professionals Provider Manual. The most current version of the provider manual is maintained on the SCDHHS web site at www.scdhhs.gov. Section two (2), Policies and Procedures outline the Out-of-State policy and further detail. If you have any additional questions, please contact the Provider Service Center at 1-888-289-0709, submit an online inquiry at <http://www.scdhhs.gov/contact-us>, or your Managed Care program representative at (803) 898-4614.

South Carolina
Department of Health and Human Services
P O Box 1416
Columbia, South Carolina 29202-1416
www.scdhhs.gov

**Referral Request Form for
Out-of-State Services**

BENEFICIARY INFORMATION

NAME: _____

SC MEDICAID ID#: _____ DATE OF BIRTH: _____

NAME OF GUARDIAN: _____

CONTACT NUMBER: _____

REFERRING PHYSICIAN

NAME: _____

NPI#: _____ SC MEDICAID #: _____

PATIENT IS BEING REFERRED TO: _____
NAME OF FACILITY AND/OR PHYSICIAN (S)

CONDITION REQUIRING TREATMENT: _____

DIAGNOSIS CODE (S): _____

PROCEDURE CODE (S): _____

DATE OF SERVICE: _____ DATE OF RETURN: _____

Medicaid patients, as well as their escort, being referred out-of-state may be provided transportation when necessary. Adequate advance notice, as well as prior approval from SCDHHS, is mandatory in order to make the necessary travel arrangements. Call the Provider Service Center at 888-289-0709 for additional questions.

WILL THE BENEFICIARY REQUIRE LODGING, MEAL REIMBURSEMENT and
TRANSPORTATION? YES _____ NO _____

RECOMMENDED MODE OF TRANSPORTATION: _____

Please include as an attachment, an explanation why these services must be rendered out-of-state instead of within the SCMSA. You must identify any services that are considered experimental and/or investigational, sponsored under a research program, or performed in few medical centers across the United States. Also, a copy of the beneficiary's medical records, relating to treatment of the condition, for the past year must be included.

I certify that contact has been made with the out-of-state provider. I certify that these services are not available and cannot be provided within the South Carolina service area, which includes North Carolina and Georgia (within 25 miles of the South Carolina border).

SIGNATURE OF REFERRING PHYSICIAN

DATE

South Carolina

Department of Health and Human Services

P O Box 1416

Columbia, South Carolina 29202-1416

www.scdhhs.gov

**Referral Request Form for
Out-of-State Services**

OUT-OF-STATE PROVIDER

NAME: _____
NAME OF PHYSICIAN (S) AND/OR FACILITY

ADDRESS: _____

TELEPHONE#: _____ FAX#: _____

I certify that I have agreed to enroll in the South Carolina Medicaid program and I am willing to accept South Carolina Medicaid reimbursement as payment in full.

SIGNATURE OF OUT-OF-STATE PHYSICIAN

DATE

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:

1-855-326-5219

KePRO Fax #

1-855-300-0082

For Provider Issues email:

atrezzoissues@Keapro.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 BENEFICARY 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 SCDHHS 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

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

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



INSTITUTE FOR HEALTH AND RECOVERY - INTEGRATED SCREENING TOOL

***Fax the COMPLETED form to the patient's plan with the requested information**

- Absolute Total Care Fax: 877-285-3226
- BlueChoice HealthPlan Fax: 877-798-1028
- Carolina Medical Homes Fax: 803-509-5366
- First Choice by Select Health Fax: 866-533-5493
- Palmetto Physician Connections Fax: 888-781-4316
- SC Solutions Fax: 866-907-4842
- UnitedHealthcare Community Plan Fax: 866-456-6722
- SCDHHS (Fee-for-Service) Fax: 803-255-8232

Women's health can be affected by emotional problems, alcohol, tobacco, other drug use, and domestic violence. Women's health is also affected when those same problems are present in people close to us. By "alcohol," we mean beer, wine, wine coolers, or liquor.

Parents Did any of your parents have a problem with alcohol or other drug use?	YES				NO
Peers Do any of your friends have a problem with alcohol or other drug use?	YES				NO
Partner Does your partner have a problem with alcohol or other drug use?			YES		NO
Violence Are you feeling at all unsafe in any way in your relationship with your current partner?		YES			NO
Emotional Health Over the last few weeks, has worry, anxiety, depression, or sadness made it difficult for you to do your work, get along with people, or take care of things at home?				YES	NO
Past In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?			YES		NO
Present In the past month, have you drunk any alcohol or used other drugs? 1. How many days per month do you drink? <input type="text"/> 2. How many drinks on any given day ? <input type="text"/> 3. How often did you have 4 or more drinks per day in the last month? <input type="text"/>			YES		NO
Smoking Have you smoked any cigarettes in the past three months? <input type="text"/>			YES		NO

Review Risk Review Domestic Violence Resources Review Substance Use, Set Healthy Goals Consider Mental Evaluation

Advice for Brief Intervention

	Y	N	N/A						
Did you State your medical concern?				At-Risk Drinking <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Non-Pregnant</td> <td style="width: 50%;">Pregnant/Planning Pregnancy</td> </tr> <tr> <td>> 7 drinks/week > 3 drinks/day</td> <td>Any Use is Risky Drinking</td> </tr> </table>		Non-Pregnant	Pregnant/Planning Pregnancy	> 7 drinks/week > 3 drinks/day	Any Use is Risky Drinking
Non-Pregnant	Pregnant/Planning Pregnancy								
> 7 drinks/week > 3 drinks/day	Any Use is Risky Drinking								
Did you Advise to abstain or reduce use?									
Did you Check patient's reaction?									
Did you Refer for further assessment?									

Patient Referred to: DHEC Quit Line DMH DAODAS Private Provider (Name & NPI)

Check applicable box(es)

Date Screened: Patient Refused Referral: Referral Not Warranted:

Medicaid Recipient #: Patient's Health Plan:

Practice Name: Practice NPI:

Screening Provider's Name:

For the best health of mothers and babies, we strongly recommend that pregnant women, or those planning to become pregnant, do not use alcohol, illegal drugs or tobacco. Safe levels of usage have not been determined.

Language:

Race:

Ethnicity:

Universal 17-P Authorization Form

*Fax the COMPLETED form OR call the plan with the requested information.

Absolute Total Care BlueChoice HealthPlan First Choice by Select Health WellCare Health Plan, Inc.

P: 803-933-3689

P: 866-902-1689

P: 888-559-1010 x55251

P: 888-588-9842

F: 866-918-4451

F: 800-823-5520

F: 866-533-5493

F: 866-458-9245

Advicare

Molina Healthcare, Inc.

P: 888- 781-4371

P: 855- 237-6178

F: 888- 781-4316

F: 855- 571-3011

Date of Request for Authorization _____

Patient/Member Name _____ DOB _____

First Middle Last

Address (Street, Apt.#) _____ City/State/Zip _____

Phone _____ Medicaid Number _____ MCO ID Number _____

Pregnancy Information and History

G ___ T ___ P ___ A ___ L ___ (Note: A= abortion (spontaneous and medically induced) EDC _____

Last menstrual period _____ EDD _____ Current Gestational age _____ weeks

Bed Rest Yes No Experiencing Preterm Labor Yes No

(Home administration available if on bed rest)

Singleton Pregnancy Multiple Pregnancy

At least 16 weeks gestation Yes No** Major Fetal or Uterine Anomaly Yes No

Patient has a history of prior spontaneous singleton preterm birth between 20-36.6 weeks Yes No

Delivery was due to preterm labor or PPRM even if it resulted in C-section Yes No

Delivery was not due to medical indication, e.g. preeclampsia, abruption, etc. Yes No

Medication Allergies _____ No known drug allergies

Other Pertinent Clinical Information: _____

Pharmacy Information

Ship to patient's home address End Date of Service _____

Ship to provider's address End Date of Service _____

Shipping Preference: Regular Mail Ground Overnight

Ordering Physician's Signature: _____ Makena or 17-P Compound _____

Provider Information

Ordering Provider Name _____

(Please Print)

Ordering Provider NPI _____ Tax ID _____

Address _____ City/State/Zip _____

Phone _____ Fax _____

Provider Type: OB/GYN Family Medicine MFM/Perinatology Other

Practice Name: _____ Practice NPI: _____

Contact Person: _____ Phone: _____ Fax: _____

FOR MCO USE ONLY:

Approved Denied Authorization # _____ Number of Injections _____

Date of Notification to Provider: _____ Reviewer(s) name & title: _____

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.

** Prescription may be written prior to 16 weeks, but the vial shipment may be withheld by the pharmacy until the 15th week

**SCDHHS Behavioral Health Referral & Feedback Form
Physician Referral for Licensed Independent Practitioner Services**

Date: _____ () Initial () Follow-up

Referring Physician Name: _____

Address: _____
(Street/PO Box) City State Zip

Fax: () _____ Phone: () _____

Patient's Name: _____ DOB: _____

Parent's Name (if minor): _____ Address: _____ Phone: _____

Date(s) Patient Seen: _____

Reason(s) for Referral: _____

Any Specific Questions or Requests: _____

_____ **Referring Physician's Printed Name/Signature**

Thank you for evaluating this patient. To facilitate communication and treatment, please make copies of the following form to retain in the patient's record; complete a form after initial assessment; complete additional forms periodically during treatment (as indicated) and when treatment is terminated; and mail or fax completed form(s) to the physician listed above. This is not a request for copies of psychotherapy notes, which require a signed consent to release. Thank you for your collaboration.

Licensed Independent Practitioner's Report

Date(s) Patient Seen: _____

Patient did not make appointment.
 Patient made an appointment but did not keep appointment.
 Patient not seen within 60 days.

Initial Diagnoses:
 1. _____
 2. _____
 3. _____

Recommendations: _____

Medications Prescribed: _____

<p>Follow-up Arranged or Provided by Consultant:</p> <input type="checkbox"/> Further diagnostic testing _____ <input type="checkbox"/> Individual psychotherapy <input type="checkbox"/> Family psychotherapy <input type="checkbox"/> Medication management <input type="checkbox"/> Group psychotherapy <input type="checkbox"/> Lab tests <input type="checkbox"/> Return visit _____	<p>Other Care Needed:</p> <input type="checkbox"/> Medication management by PCP <input type="checkbox"/> Referrals recommended _____ <input type="checkbox"/> Follow-up recommended _____ <input type="checkbox"/> Other: _____
--	---

Name (type or print) Signature

FAX to _____ # _____ *Contact Person*