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<td>01/2008</td>
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<td>Health Insurance Information Referral Form</td>
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<td>Electronic Funds Transfer (EFT) Authorization Agreement</td>
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<td>Claim Reconsideration Form</td>
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<td>Sample Claim Showing TPL Payment with NPI</td>
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<td>(02/12)</td>
<td>Sample Remittance Advice (four pages)</td>
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<td>Healthy Mothers, Healthy Futures Maternity Health Education Checklist</td>
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<td>Alcohol and Drug Medical Assessment</td>
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<td>Abortion Statement</td>
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<td>Consent For Sterilization (two pages)</td>
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<td>Surgical Justification Review for Hysterectomy</td>
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<td>Request for Prior Approval Review</td>
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<td>Allied Profession Supervision Form</td>
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<td>Referral Request Form for Out-of-State Services (three pages)</td>
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<td>Transplant Prior Authorization Request Form &amp; Instructions (two pages)</td>
<td>08/2012</td>
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<td>Mental Health Form</td>
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<td>Universal 17-P Authorization Form</td>
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<td>SCDHHS Behavioral Health Referral and Feedback Form</td>
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<td>Hereditary Breast and Ovarian Cancer (HBOC)</td>
<td>08/2019</td>
</tr>
</tbody>
</table>
**CONFIDENTIAL COMPLAINT**

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

**PROGRAM INTEGRITY**

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

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

**SUSPECTED INDIVIDUAL OR INDIVIDUALS:**

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

**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)

SCDHHS Form 126 (revised 06/07)
South Carolina Department of Health and Human Services
Form for Medicaid Refunds

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

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. Attach appropriate document(s) as listed in item 8.

1. Provider Name: ________________________

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

   OR

3. NPI# □□□□□□□□□□□□□□□□ & Taxonomy □□□□□□□□□□□□□□□□

4. Person to Contact: ________________________

5. Telephone Number: ________________________

6. Reason for Refund: [check appropriate box]

   □ Other Insurance Paid (please complete a – f below and attach insurance EOMB)
   a Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
   b Insurance Company Name _______________________________________________________
   c Policy #:__________________________________________________________
   d Policyholder: _______________________________________________________
   e Group Name/Group: ________________________________________________
   f Amount Insurance Paid:______________________________________________

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

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

   □ Other, describe in detail reason for refund:
   _______________________________________________________
   _______________________________________________________
   _______________________________________________________
   _______________________________________________________

7. Patient/Service Identification:

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

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

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

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

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

Provider or Department Name: ___________________________ Provider ID or NPI: ___________________________
Contact Person: _______________________ Phone #: ___________________________ Date: _______________________

I  ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS
Beneficiary Name: ___________________________ Date Referral Completed: ___________________________
Medicaid ID#: ___________________________ Policy Number: ___________________________
Insurance Company Name: ___________________________ Group Number: ___________________________
Insured's Name: ___________________________ Insured SSN: ___________________________
Employer's Name/Address: ___________________________

II  CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS
   _____ a. beneficiary has never been covered by the policy – close insurance.
   _____ b. beneficiary coverage ended - terminate coverage (date) ___________________________
   _____ c. subscriber coverage lapsed - terminate coverage (date) ___________________________
   _____ d. subscriber changed plans under employer - new carrier is ___________________________
                   - new policy number is ___________________________
   _____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.
                   (name) ___________________________

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.
Submit this information to Medicaid Insurance Verification Services (MIVS).
Fax: 803-252-0870 or Mail: Post Office Box 101110
     Columbia, SC 29211-9804

DHHS 931 – Updated February 2018
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER ____________________________________________ DOS _______________________
NPI or MEDICAID PROVIDER ID ____________________________
MEDICAID BENEFICIARY NAME _______________________________
MEDICAID BENEFICIARY ID# __________________________________
INSURANCE COMPANY NAME __________________________________
POLICYHOLDER _____________________________________________
POLICY NUMBER _____________________________________________

ORIGINAL DATE FILED TO INSURANCE COMPANY
________________________________________

DATE OF FOLLOW UP ACTIVITY ________________________________________________
RESULT: ____________________________________________________________

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _________________________________________________
RESULT: ____________________________________________________________

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

__________________________________________________________
(SIGNATURE AND DATE)

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

Revised 04/2014
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)

Name on file with the IRS for the above TIN/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

By signing this form, I 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 the checking or savings account indicated above at the financial institution identified above. Credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider. In the event of a debit entry to the account up to the amount of the excess payment, credit entries to the account are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of material facts, may be prosecuted under applicable federal or state laws. I certify that the information shown is correct and agree to provide thirty (30) days written notice to the address shown below prior to revoking or reviving this authorization.

☐ I acknowledge that I have read and understand that payments will be issued only to the bank account of the provider designated to receive payments beginning July 1, 2019 with the transition of Medicaid claims payments to the South Carolina Enterprise Information System (SCeIS). For more information, please visit https://sc.epscdhhsc.gov/scor or contact 803-294-0701. Providers’ taxpayer identification numbers (either TIN or SSN) and name must be validated with the Internal Revenue Service’s (IRS) prior to SCeIS using Medicaid claims payment. If providers’ information fails IRS validation, providers are responsible for obtaining a confirmation letter from the IRS and providing this information to Provider Enrollment to correct the mismatch. Providers can request a confirmation letter by calling the IRS business & specialty tax line at 800-829-4933, 7 a.m. -10 p.m., Monday - Friday. Please submit the IRS confirmation letter to Provider Enrollment with a subject line of “IRS Confirmation Letter” by scanning/mailing it to Medicaid.Pets@Hcbssc.com or by fax at 803-254-5913. For questions or assistance, please call the Provider Service Center at 888-289-0709.

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, South Carolina 29282-8809  FAX (803) 870-5022

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 SCdHSS Provider website for instructions on how to complete the EFT information. Effective January 01, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (EDR) via a matching EFT Transaction Trace Number. The trace number will be installed in your SCdHSS electronic remittance advice. In order for the matching trace number to appear in your EFT notification, you must contact your financial institution and request the inclusion of this information. Any questions regarding the matching trace number and your EIR 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](http://www.scdhhs.gov/contact-us) for instructions on submission of your request.

1. Provider Name: _______________________________________________________

2. Medicaid Legacy Provider #: _______________ (Six Characters)
   NPI# ____________________________ Taxonomy __________________________

3. Person to Contact: ______________________ Telephone Number: ___________

4. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

   Note: Remittance advices are available electronically through the Web Tool. Please check
   the Web Tool for the availability of the remittance advice date before submitting your
   request.

5. Street Address for delivery of request:
   Street: __________________________
   City: ____________________________
   State: __________________________
   Zip Code: _______________________

6. Charges for duplicate remittance advice(s) are as follows:
   Request Processing Fee - $20.00
   Page(s) copied - $0.20 per page

I understand and acknowledge that a charge is associated with this request and will be deducted from my provider’s payment by debit adjustment on a future remittance advice.

_________________________________________  _______________________
Authorizing Signature                  Date

SCDHHS (Revised 06/01/17)
CLAIM RECONSIDERATION FORM

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. A separate SCDHHS CR form is required for each claim control number (CCN). Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709. Note: Timely filing guidelines apply.

Section 1: Beneficiary Information
Name (Last, First, MI): ____________________________  Medicaid Beneficiary ID: ____________________
Date of Birth: ____________________

Section 2: Provider Information
Specify your affiliation: □ Physician □ Hospital □ Other (DME, Lab, Home Health Agency, etc.): ____________________
NPI: __________  Medicaid Provider ID: __________  Facility/Group/Provider Name: ____________________
Return Mailing Address: ____________________________
Street or Post Office Box: __________________________
State: __________  Zip: __________
Contact: ____________________  Email: ____________________  Telephone #: ____________________  Fax #: ____________________

Section 3: Claim Information (Only one CCN allowed per request.)
Communication ID: __________  CCN: __________  Date(s) of Service: ____________________

Section 4: Claim Reconsideration Information
What area is your denial related to? (Please select below)
□ Ambulance Services
□ Autism Spectrum Disorder (ASD) Services
□ Clinic Services
□ Community Long Term Care (CLTC)
□ Community Mental Health Services
□ Department of Disabilities and Special Needs (DDSN) Waivers
□ Durable Medical Equipment (DME)
□ Early Intervention Services
□ Enhanced Services
□ Federally Qualified Health Center (FQHC)
□ Home Health Services
□ Hospice Services
□ Hospital Services
□ Licensed Independent Practitioner’s Rehabilitative Services (LIPS)
□ Local Education Agencies (LEA)
□ Medically Complex Children’s (MCC) Waivers
□ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
□ Optional State Supplementation (OSS)
□ Pharmacy Services
□ Physician Laboratories, and Other Medical Professionals
□ Private Rehabilitative Therapy and Audiological Services
□ Psychiatric Hospital Services
□ Rehabilitative/Behavioral Health Services (RBHS)
□ Rural Health Clinic (RHC)
□ Targeted Case Management (TCM)
□ Other: ____________________________
Section 5: Desired Outcome

Request submitted by:

Print Name: ____________________________________________

Signature: ____________________________________________ Date: __________
**HEALTH INSURANCE CLAIM FORM**

**Sample Claim Showing TPL Dental with NPI**

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<thead>
<tr>
<th>Item</th>
<th>Information</th>
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<tbody>
<tr>
<td>1.</td>
<td>Medicare, Medicaid, TriCare, CHAMPVA, Other</td>
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<tr>
<td>2.</td>
<td>Patient's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>3.</td>
<td>Patient's Birth Date</td>
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<tr>
<td>4.</td>
<td>Insured's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>5.</td>
<td>Insured's Address (No., Street)</td>
</tr>
<tr>
<td>6.</td>
<td>Insured's Relationship to Insured</td>
</tr>
<tr>
<td>7.</td>
<td>Insurer's Address (No., Street)</td>
</tr>
<tr>
<td>8.</td>
<td>Insurer's ZIP Code</td>
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<tr>
<td>9.</td>
<td>Insurer's Telephone (Include Area Code)</td>
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<tr>
<td>38.</td>
<td>Insurer's Other Number 29</td>
</tr>
<tr>
<td>39.</td>
<td>Insurer's Other Number 30</td>
</tr>
</tbody>
</table>

**CLAIM INFORMATION**

- **Claim Date:** mm/dd/yyyy
- **Provider:** Doe, John A.
- **Insured:** Doe, John A., 123 Windy Lane, Anytown, SC 29909
- **Insured's Relationship:** Self

**DIAGNOSIS INFORMATION**

- **Diagnosis Code:** E99213
- **Procedure Code:** 35.00

**PAYMENT INFORMATION**

- **Claim ID:** ZZ12121212
- **TPA ID:** 1234567890
- **Insurer:** TPL Dental
- **Policy Number:** Doe1234
- **Provider Identification:** 55555555

**RECEIPT OF FILING INFORMATION**

- **Date:** mm/dd/yyyy
- **Provider:** Doe, John A.
- **Insured:** Doe, John A., 123 Windy Lane, Anytown, SC 29909
- **Insurer:** TPL Dental

**NUCC Instruction Manual available at:** www.nucc.org

**PLEASE PRINT OR TYPE**

**APPROVED OMB 0990-1197 FORM 1600 (02-12)**
This page of the sample Remittance Advice shows a paid claim, suspended claim and rejected claim.

<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
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<td>02/14/2014</td>
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<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
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</table>

<table>
<thead>
<tr>
<th>CLAIM</th>
<th>SERVICE RENDERED</th>
<th>AMOUNT</th>
<th>TITLE 19</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
<th>M</th>
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<td>000</td>
<td>0.00</td>
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<td></td>
</tr>
</tbody>
</table>

**TOTALS**: $310.00 | $0.00 | 0.00 | 0.00 | 0.00

**CERTIFIED AMT**: $310.00 | **MEDICAID TOTAL**: $0.00 | **E**: ENCRYPTED | **P**: PAYMENT MADE | **R**: REJECTED | **S**: IN PROCESS | **C**: CHARGES | **T**: PAYMENT

**EDIT**: L00 946 L02 852 08/30/13

---

**SAMPLE ONLY**
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.

<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB00080000</td>
<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
<td>REMITTANCE ADVICE</td>
<td>02/28/2014</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROVIDERS</th>
<th>CLAIM</th>
<th>SERVICE RENDERED</th>
<th>AMOUNT</th>
<th>TITLE 19</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
<th>M TLE. 18</th>
<th>COPAY</th>
<th>TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>OWN REF.</td>
<td>REFERENCE</td>
<td>DATE(S)</td>
<td>BILLED</td>
<td>PAYMENT</td>
<td>ID.</td>
<td>F M</td>
<td>ALLOWED</td>
<td>AMT</td>
<td>PAYMENT</td>
</tr>
<tr>
<td>NUMBER</td>
<td>NUMBER</td>
<td>PY IND</td>
<td>MMDDYY</td>
<td>PROC.</td>
<td>MEDICAID</td>
<td>NUMBER</td>
<td>I I LAST NAME</td>
<td></td>
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</tr>
<tr>
<td>ABB222222</td>
<td>1405200415812200A</td>
<td>01</td>
<td>021814</td>
<td>IS0315</td>
<td>192.00</td>
<td>M CLARK</td>
<td>0112233333</td>
<td></td>
<td>0.00</td>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>FOR AN EXPLANATION OF THE</th>
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</thead>
<tbody>
<tr>
<td>ERROR CODES LISTED ON THIS</td>
</tr>
<tr>
<td>FORM REFER TO: &quot;MEDICAID&quot;</td>
</tr>
<tr>
<td>PROVIDER MANUAL&quot;.</td>
</tr>
<tr>
<td>CERTIFIED AMT</td>
</tr>
<tr>
<td>IF YOU STILL HAVE QUESTIONS</td>
</tr>
<tr>
<td>PHONE THE D.H.H.S. NUMBER</td>
</tr>
<tr>
<td>SPECIFIED FOR INQUIRY OF</td>
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<tr>
<td>CLAIMS IN THAT MANUAL.</td>
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</table>

$286.46 |

<table>
<thead>
<tr>
<th>STATUS CODES:</th>
<th>PROVIDER NAME AND ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>ABC HEALTH PROVIDER</td>
</tr>
<tr>
<td>R</td>
<td>REJECTED</td>
</tr>
<tr>
<td>S</td>
<td>IN PROCESS</td>
</tr>
<tr>
<td>E</td>
<td>FLORENCE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHECK TOTAL</th>
<th>CHECK NUMBER</th>
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</thead>
</table>
### Sample Remittance Advice (page 3)

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

<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>CLAIM</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB11110000</td>
<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
<td></td>
<td>02/28/2014</td>
<td>2</td>
</tr>
</tbody>
</table>

**Credit Amount**              **Remittance Prior To This**       **Adjustments**       **To Be Refunded**

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>INCENTIVE</th>
<th>DEBIT BALANCE</th>
<th>MEDICAID TOTAL</th>
<th>CERTIFIED AMT</th>
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<tbody>
<tr>
<td></td>
<td>$193.71</td>
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<td></td>
</tr>
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</table>

**Provider Name and Address**

<table>
<thead>
<tr>
<th>PROVIDER NAME AND ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC HEALTH PROVIDER</td>
</tr>
<tr>
<td>PO BOX 000000</td>
</tr>
<tr>
<td>FLORENCES SC 00000</td>
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</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB11110000</td>
<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
<td>02/28/2014</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROVDER</th>
<th>CLAIM NUMBER</th>
<th>SERVICE CODE</th>
<th>PROC / DRUG CODE</th>
<th>RECIPIENT ID.</th>
<th>RECIPIENT NAME</th>
<th>ORIG. PAYMENT</th>
<th>ACTION</th>
<th>CREDIT AMOUNT</th>
<th>REMITTANCE</th>
<th>MEDICAID TOTAL</th>
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</thead>
<tbody>
<tr>
<td>TPL 2</td>
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<td>TPL 4</td>
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<td>TPL 5</td>
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<td>477.25</td>
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<td></td>
</tr>
</tbody>
</table>

PAGE TOTAL: 4383.95
### HEALy mothers, heALTl hyfutures
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.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Completed</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Services and Routines: Information about hours, appointments, lab tests, and other general procedures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Instruction About Pregnancy: such as hygiene, exercise, sexuality, medication, and importance of prenatal care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fetal Growth and Development: how the baby develops month by month and physical and psychological changes experienced by the mother; including comfort measures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition: including routine prenatal diet instruction. (Be sure to make referral to WIC Program)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explanation of EDC: Understanding the due date.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process of Labor and Delivery: discussion of physical process of labor and delivery, including psychological changes experienced.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methods of Anesthesia: Information on types of anesthesia with discussion of benefits, risks and alternatives; also pain medication.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cesarean Section: discussion of what it is and what are the usual indications including risks and benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relaxation and Breathing Exercises: preparation for labor including demonstration and practice of exercises and breathing techniques</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfeeding: factors to consider in decision making and preparation of the breasts. Note: Possible referral to La Leche or Breastfeeding Support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(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.

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 interconceptional 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:

<table>
<thead>
<tr>
<th>Option</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>WIC PROGRAM:</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>HRCP (if applicable)</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>High Risk Channeling Project</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
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</table>

SIGNATURE: ____________________________

ATTENDING PHYSICIAN
### Alcohol and Drug Medical Assessment

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

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

<table>
<thead>
<tr>
<th>Physician's Name and Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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 I: PHYSICIAN DEMOGRAPHIC INFORMATION

(Please print)

<table>
<thead>
<tr>
<th>Name (First, Middle, Last):</th>
<th>NPI#:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Location Address:</td>
<td>Suite/Unit #:</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>E-mail Address:</td>
<td>ZIP+4:</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>Fax Number:</td>
</tr>
<tr>
<td>Mailing Address</td>
<td>City:</td>
</tr>
<tr>
<td>(If different from physical location address):</td>
<td>State:</td>
</tr>
<tr>
<td></td>
<td>ZIP+4:</td>
</tr>
</tbody>
</table>

#### 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:

<table>
<thead>
<tr>
<th>PEDIATRIC SUB-SPECIALTIES (CHECK ALL THAT APPLY)</th>
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</thead>
<tbody>
<tr>
<td>☐ Adolescent Medicine</td>
</tr>
<tr>
<td>☐ Allergy</td>
</tr>
<tr>
<td>☐ Cardiology</td>
</tr>
<tr>
<td>☐ Cardiothoracic Surgery</td>
</tr>
<tr>
<td>☐ Child Abuse Pediatrics</td>
</tr>
<tr>
<td>☐ Critical Care</td>
</tr>
<tr>
<td>☐ Developmental-Behavioral Pediatrics</td>
</tr>
<tr>
<td>☐ Emergency Medicine</td>
</tr>
<tr>
<td>☐ Endocrinology</td>
</tr>
<tr>
<td>☐ Gastroenterology/Nutrition</td>
</tr>
<tr>
<td>☐ Genetics</td>
</tr>
<tr>
<td>☐ Hematology/Oncology</td>
</tr>
<tr>
<td>☐ Infectious Disease</td>
</tr>
<tr>
<td>☐ Inpatient Medicine</td>
</tr>
<tr>
<td>☐ Infectious Medicine</td>
</tr>
<tr>
<td>☐ Inpatient Medicine</td>
</tr>
<tr>
<td>☐ Internal Medicine</td>
</tr>
<tr>
<td>☐ Nephrology</td>
</tr>
<tr>
<td>☐ Neonatology</td>
</tr>
<tr>
<td>☐ Neurology</td>
</tr>
<tr>
<td>☐ Neurological Surgery</td>
</tr>
<tr>
<td>☐ Ophthalmology</td>
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<tr>
<td>☐ Ophthalmology</td>
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<tr>
<td>☐ Otolaryngology</td>
</tr>
<tr>
<td>☐ Orthopedic Surgery</td>
</tr>
<tr>
<td>☐ Psychiatry</td>
</tr>
</tbody>
</table>

**CERTIFICATION**

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

<table>
<thead>
<tr>
<th>Patient Heading</th>
<th>As a Group</th>
<th>As an Individual</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients seen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Medicaid patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of patients 18 and under</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of patients with Medicaid 18 and under</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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

DHHS Pediatric Sub-Specialists Certification Form

Revised: 06/15 - Replaces: 10/14
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 ____________________________ 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 ____________________________ The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

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

I am at least 21 years of age and was born on ____________________________ .

I, ____________________________, hereby consent of my own free will to be sterilized by ____________________________ .

Doctor or Clinic ____________________________

Specify Type of Operation ____________________________

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 ____________________________ Representative 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 ____________________________ Date ____________________________

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

□ Hispanic or Latino □ American Indian or Alaska Native

□ Not Hispanic or Latino □ Asian

□ Black or African American □ Native Hawaiian or Other Pacific Islander

□ White ____________________________

■ PHYSICIAN’S STATEMENT ■

Shortly before I performed a sterilization operation upon ____________________________ .

Name of Individual ____________________________ Date ____________________________

I explained to him/her the nature of the sterilization operation ____________________________ , the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

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

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or 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 ____________________________

Signature of Physician ____________________________ Date ____________________________

Physician’s Signature ____________________________ Date ____________________________

■ 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 ____________________________

HHS-887 (04/22)
PAPERWORK REDUCTION ACT STATEMENT

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

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

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual’s consent, pursuant to any applicable confidentiality regulations. [43 FR 52165, Nov. 8, 1978, as amended at 58 FR 33343, June 17, 1993; 68 FR 12300, Mar. 14, 2003]
SOUTH CAROLINA MEDICAID PROGRAM
SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY

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

PATIENT
NAME _________________________________________________ MEDICAID # __________________
LAST                   FIRST            MI

BIRTHDATE _______________________ GRAVITY _______________ PARITY ________________
MONTH/DAY/YEAR

PROCEDURE CODE: ______________________________     DX CODE:__________________

HOSPITAL ______________________________________________    ___________________________
NAME         NPI (IF AVAILABLE)

PLANNED ADMISSION DATE _______________ PLANNED SURGERY DATE ________________

TYPE OF HYSTERECTOMY PLANNED__________________________________________________

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

HCT ____   HGB ____   CHECK ONE: PREMENOPAUSAL _____  POSTMENOPAUSAL _____

CONSERVATIVE TREATMENT/MEDICATION WITH DATES:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

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

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

ATTENDING PHYSICIAN’S NAME _______________________________________        _______________
LAST FIRST  MI                        NPI
ADDRESS ________________________________________________________________________________

CONTACT PERSON _______________________________ TELEPHONE (_____) ___________________
FAX (_____) ___________________

SIGNATURE _____________________________________  DATE __________________________________

ATTENDING PHYSICIAN

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

Revised: 06/01/12
SOUTH CAROLINA MEDICAID PROGRAM
REQUEST FOR PRIOR APPROVAL REVIEW BY KEPRO

PATIENT NAME ______________________________________________________________
LAST   FIRST     MI
BIRTHDATE ____________________   *MEDICAID# ____________________________
MONTH/DAY/YEAR
PROCEDURE ______________________________________ CODE _______________________
DX CODE:_______________________________________
FACILITY _______________________________________    ___________________________
NAME                                 NPI #
PLANNED SURGERY DATE ____________________________________________

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

PHYSICIAN’S NAME __________________________________________________________
LAST   FIRST   MI
ADDRESS ____________________________________________________________________
_________________________________ NPI: _____________
CONTACT PERSON _________________________ TELEPHONE (_____) _______________
DATE ____________________   FAX NUMBER (_____) ______________

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

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE

Revised: 06/01/12
State of South Carolina
Department of Health and Human Services

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.

<table>
<thead>
<tr>
<th>LMSW Name (as it appears on their license):</th>
<th>License Number &amp; Expiration Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>LMSW Name (as it appears on their license):</td>
<td>License Number &amp; Expiration Date:</td>
</tr>
<tr>
<td>LMSW Name (as it appears on their license):</td>
<td>License Number &amp; Expiration Date:</td>
</tr>
</tbody>
</table>

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 (30) days. 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 ___________________________

Revised 08/2013
Referral Request Form for Out of State Services
To be completed by the referring physician

Send to:
SCDHHS Claims and Provider Services
ATTN: Out of State Coordinator
FAX: (803) 255-8255

<table>
<thead>
<tr>
<th>From</th>
<th># of pages (including this cover page)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Point of Contact Information

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td></td>
</tr>
</tbody>
</table>

Please complete the following checklist prior to submission:

☐ Out-Of-State Provider has been contacted and has confirmed in writing that they are enrolled or have begun to enroll in the South Carolina Medicaid program and will accept the Medicaid reimbursement as payment in full (see Form B)

☐ Completed and signed Form A: Beneficiary and Referring Physician Information

☐ Completed and signed Form B: Out-of-State Provider Information (submit one per out-of-state Provider from whom the beneficiary is to receive services)

☐ One year of medical records/clinical notes supporting the decision to refer out of state are attached

☐ If Medicaid is not the primary insurance, Prior Authorization from Primary insurance is attached (if applicable)

☐ Valid points of contact are provided for referring and out-of-state physicians

☐ Brief explanation of services to be rendered is provided below

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

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

To be completed by the referring Provider.

Please complete all fields.

Beneficiary Information

Name: ______________________________________________________

SC Medicaid Number: __________________________ Date of Birth: ______________________

Name of Guardian: ________________________________________

Contact Number: ________________________________________

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

☐ Yes  ☐ No

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

Referring Provider (In State Provider)

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

Name: ______________________________________________________

Contact Number: __________________________________________

NPI Number: __________________________ SC Medicaid Number: ______________________

Patient Is Being Referred To: __________________________________________

Name of Facility and Physician

Condition Requiring Treatment: ______________________________________

Diagnosis Code(s):

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

Date(s) of Service: __________________________ Date of Return: ______________________

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

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

_________________________ ______________________
Signature of Referring Provider Date
Form B: Out-of-State Physician Information

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

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

Please complete all fields.

Out of State Provider

☐ Physician  ☐ Facility

Name: ________________________________

Name of Facility or Physician

NPI Number: __________________________ SC Medicaid Number: __________________

Telephone Number: _____________________ Fax Number: _________________________

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

- Enrolled or have begun to enroll in South Carolina Medicaid (if enrolling, please provide a communication ID or a screen shot of the in-process application)
- Accepting South Carolina Medicaid Reimbursement as Payment in Full

____________________________________  __________________________
Authorized Signature of Out of State Provider  Date

____________________________________
Printed Name of Authorized Representative

Please Note

If the Out of State Provider does not sign or indicates a reason for refusal, referrals will not be processed or reviewed.

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

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

For a complete copy of the Out-of-State (OOS) Services policy, please refer to the Physicians Services Provider Manual. The most current version of the provider manual is maintained on the SCDHSS web site at www.scdhhs.gov. If you have additional questions, please contact the Provider Service Center at 1-888-789-0709, submit an only inquiry at http://www.scdhhs.gov/contact-us, or contact your MCO representative at (803) 898-4614.
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@Kepro.com

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

All transplant prior authorization requests require at least 10 days advance notice.
Transplant Prior Authorization Request Form

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

NAME OF BENEFICIARY: ____________________________________________ DATE OF BIRTH: ___________________________________

SC MEDICAID ID#: ________________________________________________

NAME OF GUARDIAN (if applicable): _____________________________________________ CONTACT NUMBER: ____________________________

REFERING 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

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

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

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

SIGNATURE OF REFERRING PHYSICIAN ________________________________ DATE ____________________________

Transplant 08/2012 FRAUD & ABUSE HOTLINE: 1-888-284-3224
South Carolina
Department of Health and Human Services
Mental Health Form

FILL OUT COMPLETELY TO AVOID DELAYS

<table>
<thead>
<tr>
<th>Beneficiary Information</th>
<th>Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary’s Name:</td>
<td>Individual NPI:</td>
</tr>
<tr>
<td>Medicaid ID #:</td>
<td>Organization NPI:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Service Location Address:</td>
</tr>
<tr>
<td></td>
<td>City &amp; State:</td>
</tr>
</tbody>
</table>

DSM-IV TR Diagnosis

<table>
<thead>
<tr>
<th>Axis I</th>
<th>Axis II</th>
<th>Axis III</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date first seen: __________ Date of last service: __________ 

# of additional visits requested: __________

Current Clinical Information: (Circle each. Scale 0=None, 1=Mild, 2=Moderate, 3=Severe, 4=Extreme)

<table>
<thead>
<tr>
<th>Alcohol/Substance Use</th>
<th>Depression</th>
<th>Relationship Problems</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anxiety/Panic</th>
<th>Impulsivity</th>
<th>Sleep Effects</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appetite Disturbance</th>
<th>Job/School Problems</th>
<th>Sleep Disturbance</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attention/Concentration</th>
<th>Mania</th>
<th>Weight Loss</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deficit in ADLs</th>
<th>Medical Illness</th>
<th>Other</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Delusions</th>
<th>Memory</th>
<th>Current Stressors</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>

Current Medications

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ New 1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ New 2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ New 3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ New 4.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Compliance ☐ >90% ☐ 50-90% ☐ <50%

Reasons for Noncompliance:

__________________________ ( ) ____________________________ ( ) ____________________________

Physician Name Phone: Fax

Physician Signature Date

Clinical documentation must be submitted with this request and submitted to the QIO using one of the following methods:

Disclaimer: Authorization indicates that SCDHHS determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary’s eligibility and benefit limitations at the time services are rendered. The Physician Assistant is not authorized to sign this form.

Behavioral Health Services
Post Office Box 8206
Columbia, South Carolina 29022-8206

DHHS Mental Health Form (Revised 09/2013)
SOUTH CAROLINA MEDICAID PROGRAM
PSYCHIATRIC PRIOR AUTHORIZATION

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

DATE: ______________________

PATIENT NAME: ____________________________ MEDICAID #: ____________________________
LAST       FIRST       MI

BIRTH DATE: ____________________________ INPATIENT _________ OUTPATIENT _________
MONTH/DAY/YEAR

PRIMARY DX: (CIRCLE ONE→)
OPPOSITIONAL DEFiance DISORDER OR CONDUCT DISORDER

DX CODE(s): ____________________________

PLANNED ADMISSION DATE: ____________________________

HOSPITAL: ____________________________
NAME ____________________________ MEDICAID ID #

INFORMATION NEEDED (PLEASE CIRCLE ALL INCLUDED):

HISTORY & PHYSICAL:

OFFICE NOTES - PCP AND/OR SPECIALIST

PREVIOUS TREATMENTS:

MEDICATION

**CURRENT CLINICAL NOTES DOCUMENTING THE REASON FOR ADMISSION INCLUDING ABOVE INFORMATION MUST BE ATTACHED**

PHYSICIAN’S NAME: ____________________________
LAST       FIRST       MI MEDICAID PROVIDER ID #:

ADDRESS: ______________________________________

CONTACT PERSON: ____________________________ PHONE #: ____________________________

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

Fax To: KePRO 1-855-300-0082

DHHS Psychiatric Prior Authorization Form – Inpatient–06/2012
SOUTH CAROLINA MEDICAID PROGRAM
CIRCUMCISION
REQUEST FOR PRIOR APPROVAL REVIEW

SEND COMPLETED REQUEST FORM WITH MEDICAL RECORDS TO:
SCDHHS
CIRCUMCISION PRIOR APPROVAL REVIEW
FAX: (803) 255-8255

PATIENT NAME ______________________________________________________________
LAST      FIRST    MI

BIRTHDATE ____________________ *MEDICAID# _______________________
MONTH/DAY/YEAR

PROCEDURE ____________________________________ CODE _______________________

DX CODE: ______________________________________

FACILITY _______________________________________ ___________________________
NAME       NPI #

PLANNED SURGERY DATE __________________________________________

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

PHYSICIAN’S NAME __________________________________________________________
LAST     FIRST     MI

ADDRESS ____________________________________________________________________

_________________________________ NPI: _____________

CONTACT PERSON _________________________ TELEPHONE (_____) _______________

DATE ____________________ FAX NUMBER (____) ______________

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

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE

Revised: 02/01/11
**SBIRT INTEGRATED SCREENING TOOL**

Fax the COMPLETED form to the patient’s plan and referral site and keep a copy in patient file.

**PATIENT INFORMATION**

- Patient’s last name:
- First:
- Middle:
- Language:
- Race:
- Ethnicity:
- Expected due date:
- Phone no.:
- Street address:
- Member ID no.:

**PROVIDER INFORMATION**

- Practice name:
- Group NPI:
- Individual NPI:
- Screening provider’s name:
- Phone no.:

**PATIENT SCREENING INFORMATION**

- **Parents**
  - Did any of your parents have a problem with alcohol or 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
  - Over the last few weeks, has your 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? YES/NO
    - 1. How many days per month do you drink?
    - 2. How many drinks on any given day?
    - 3. How often did you drink 4 or more drinks per day in the last month? YES/NO
    - 4. In the past month have you taken any prescription drugs? YES/NO
- **Smoking**
  - Have you smoked any cigarettes in the past three months? YES/NO

Please provide additional details for any “yes” responses:

**ADVICE FOR BRIEF INTERVENTION**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you state your medical concern?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you advise to abstain or reduce use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you check patient’s reaction?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you refer for future assessment?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**At Risk Drinking**

<table>
<thead>
<tr>
<th>Non-Pregnant</th>
<th>Pregnant/Maternity Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>7+ drinks/week</td>
<td>Any Use is Risky Drinking</td>
</tr>
<tr>
<td>8+ drinks/day</td>
<td></td>
</tr>
</tbody>
</table>

**CONFIDENTIAL SBIRT REFERRAL INFORMATION**

- Patient referred to:
  - DMH
  - DAODAS
  - DHEC Quitline
  - Private provider (Name & NPI)
  - Domestic violence

- Date of referral appointment (DD/MM/YYYY):
  - Date screened:
    - Patient refused referral
    - Referral not warranted
    - Patient requested assistance

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

Physician’s Signature:

*Adapted from Institute for Health & Recovery, (2015)*
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: 803-333-3580  P: 888-502-1688  P: 888-559-1016 x55251  P: 888-585-6842

☐ Advocare  ☐ 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
Address (Street, Apt. #)  First  Middle  Last  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 (mm/dd/yyyy)  EOD  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 PPROM even if it resulted in C-section ☐ Yes ☐ No

Delivery was not due to medical indication, e.g. pre eclampsia, abruptio, etc. ☐ Yes ☐ No

Medication 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: ____________________________

☐ 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: ____________________________  Contact Person: ____________________________

Practice NPI: ____________________________  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: __________________________

Follow-up Arranged or Provided by Consultant:
☐ Further diagnostic testing __________________________
☐ Individual psychotherapy __________________________
☐ Family psychotherapy __________________________
☐ Medication management __________________________
☐ Group psychotherapy __________________________
☐ Lab tests __________________________
☐ Return visit __________________________

Other Care Needed:
☐ Medication management by PCP __________________________
☐ Referrals recommended __________________________
☐ Follow-up recommended __________________________
☐ Other __________________________

Name (type or print) Signature: __________________________

FAX to: __________________________  Contact Person: __________________________
Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Form: Beneficiary Informed Consent for Hereditary Cancer Genetic Testing

Instructions: Prior authorization request for BRCA 1 and BRCA 2 genes and BRCA Analysis Rearrangement testing for breast and ovarian cancer must be submitted to KEPRO. The Hereditary Breast and Ovarian Cancer Genetic Testing Prior Authorization Form must be completed and signed as outlined in the instructions below. The completed form with the original dated signature must be retained by the requesting physician in the beneficiary’s medical record. The form is subject to retrospective review.

The following forms, documents, and information must be submitted with the prior authorization request to KEPRO:

- The completed and signed Hereditary Breast and Ovarian Cancer Genetic Testing Prior Authorization Form
- Medical necessity documentation, including documentation of the efforts made to obtain the test results of previous comprehensive sequencing when appropriate
- Attestation for comprehensive testing. The attestation must indicate that familial BRCA testing results could not be obtained (as necessary).

Providers can refer to the South Carolina Department of Health and Human Services Physician Services Guide on the website at www.scdhhs.gov for specific information about coverage guidelines, prior authorization requirements and billing guidance.
Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Form:
Beneficiary Informed Consent for Hereditary Cancer Genetic Testing

Section A: Beneficiary Information
Name:
Medicaid ID#:
Date of birth:

Section B: Requested procedure or service information
Check one:
☐ This request is for initial BRCA 1 and BRCA 2 testing.
☐ This request is for repeat BRCA 1 and BRCA 2 comprehensive sequencing testing because initial results are negative, or are not available, and large rearrangement testing is necessary. Note: The physician must make every reasonable effort to obtain from the previous physician any available BRCA 1 and BRCA 2 test results for the beneficiary and must submit documentation of the efforts made to obtain the test results of previous comprehensive sequencing to KEPRO with the prior authorization request.

Expected dates of service:
From:
To:
Procedure code requested:
Procedure code description:

Comments:

Section C: Medical necessity information – Submit clinical notes to support genetic testing request.
Diagnosis code(s):
Medical necessity:

Information about close blood relatives from the same side of the family who have been diagnosed with ovarian, breast, prostate (Gleason score of 7 or greater), or pancreatic cancer, or who have had a positive BRCA1 or BRCA2 test results with no diagnosis of cancer:

<table>
<thead>
<tr>
<th>Relative #1</th>
<th>a. Age</th>
<th>b. Gender</th>
<th>c. Cancer</th>
<th>d. Relationship to Beneficiary</th>
<th>e. Positive BRCA1 or BRCA2 Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative #2:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative #3:</td>
<td></td>
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</tr>
<tr>
<td>Relative #4:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For full sequence or gene variants: Positive familial BRCA testing results could not be obtained
☐ Yes
☐ No

Ethnic decent of beneficiary if associated with deleterious mutations (including, but not limited to: Ashkenazi Jewish, Icelandic Swedish, or Hungarian):

Physician’s name:
Telephone number:
Fax number:
Physician’s NPI:
Facility/Office NPI:
Physician’s signature:
Date signed:
Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Form:
Beneficiary Informed Consent for Hereditary Cancer Genetic Testing

**Section D: Requirements for genetic counseling and beneficiary consent** – The beneficiary must receive pre-testing genetic counseling and provide consent for genetic testing before the prior authorization is submitted and the blood specimen is obtained. Documentation of the genetic counseling must be maintained in the beneficiary’s medical record.

| Date the beneficiary received pre-testing genetic counseling: |
| Name of person who provided pre-testing genetic counseling: |
| Qualifications of person providing pre-testing genetic counseling: |
| Counselor telephone number: | Counselor fax number: |
| Date beneficiary’s consent was obtained for the genetic testing: |

**Section E: Laboratory provider information**

| Provider name: |
| Address/City/Zip |
| Contact person: |
| Telephone number: | Fax number: |
| NPI: | Tax ID: |