## Forms

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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

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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:

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<th>NPI or MEDICAID PROVIDER ID: (if applicable)</th>
<th>MEDICAID RECIPIENT ID NUMBER: (if applicable)</th>
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<td>LOCATION OF INCIDENT:</td>
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COMPLAINT:

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<th>SIGNATURE OF PERSON REPORTING:</th>
<th>DATE OF REPORT</th>
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<td>TELEPHONE NUMBER OF PERSON REPORTING:</td>
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<td>SIGNATURE: (SCDHS Representative Receiving Report)</td>
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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 #

   OR

3. NPI# & Taxonomy

4. Person to Contact: ________________________

5. Telephone Number: ________________________

6. Reason for Refund: [check appropriate box]

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

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

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

   - Other, describe in detail reason for refund: ____________________________________________
     ____________________________________________
     ____________________________________________

7. Patient/Service Identification:

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Medicaid I.D.# (10 digits)</th>
<th>Date(s) of Service</th>
<th>Amount of Medicaid Payment</th>
<th>Amount of Refund</th>
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</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) ___________________________
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 excess payment to this bank account, I authorize the Department of Health and Human Services to make an adjusting debit entry to the account up to the amount of the excess payment. Credit entries to the above account are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws. I certify that the information shown is correct and agree to provide 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) 578-3022

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 SC DHHS 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 matching EFT Reassociation Trace Number. This trace number will automatically be included in your SC DHHS electronic remittance advice. In order to verify this matching 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.

EFT Enrollment Form  Revision Date: August 1, 2017
South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form

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

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

1. Provider Name: ____________________________________________________________

2. Medicaid Legacy Provider # ___________ (Six Characters)
   NPI# __________________________ Taxonomy ________________________________

3. Person to Contact: ___________________ Telephone Number: ___________________

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

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

5. Street Address for delivery of request:
   Street: ___________________________
   City: _____________________________
   State: ___________________________
   Zip Code: _______________________

6. Charges for duplicate remittance advice(s) are as follows:
   Request Processing Fee - $20.00
   Page(s) copied - .20 per page

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

__________________________________________  __________________________
Authorizing Signature                          Date

SCDHHS (Revised 05/01/17)
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. Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709.

Section 1: Beneficiary Information

Name (Last, First, MI): ____________________________
Date of Birth: ________________       Beneficiary Medicaid ID: ____________

Section 2: Provider Information

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

Section 3: Claim Information

Communication ID: ____________ CCN: ____________ Date(s) of Service: ____________

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below)
□ Ambulance Services
□ Autism Spectrum Disorder (ASD) Services
□ Clinic Services
□ Community Long Term Care (CLTC)
□ Community Mental Health Services
□ Department of Disabilities and Special Needs (DDSNN) Waivers
□ Durable Medical Equipment (DME)
□ Early Intervention Services
□ Enhanced Services
□ Federally Qualified Health Center (FQHC)
□ Home Health Services
□ Hospice Services
□ Hospital Services

□ Licensed Independent Practitioner’s Rehabilitative Services (LIPS)
□ Local Education Agencies (LEA)
□ Medically Complex Children’s (MCC) Waivers
□ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
□ Optional State Supplementation (OSS)
□ Pharmacy Services
□ Physicians Laboratories, and Other Medical Professionals
□ 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: ________
Sample Remittance Advice (page 1)

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

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|             | | | 36.72 | | | | | | |

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.

STATUS CODES: CHECK TOTAL CHECK NUMBER
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.

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$286.46 |

FOR AN EXPLANATION OF THE CERT. PG TOT | MEDICAID PG TOT |
ERROR CODES LISTED ON THIS | P = PAYMENT MADE | ABC HEALTH PROVIDER |
FORM REFER TO: "MEDICAID | 50.00 | $286.46 | R = REJECTED |
PROVIDER MANUAL". | CERTIFIED AMT | MEDICAID TOTAL | S = IN PROCESS | PO BOX 000000 |
| FLORENCE | SC 00000 |
IF YOU STILL HAVE QUESTIONS |
PHONE THE D.H.H.S. NUMBER | 0.00 |
SPECIFIED FOR INQUIRY OF |
CLAIMS IN THAT MANUAL. | CHECK TOTAL | CHECK NUMBER |
This page of the sample Remittance Advice shows a claim-level Void without a corresponding Replacement claim.
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>
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</table>

<table>
<thead>
<tr>
<th>PROVIDERS</th>
<th>CLAIM</th>
<th>SERVICE</th>
<th>PROC / DRUG</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
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<td>CHECK</td>
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<td>CREDIT</td>
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**PAGE TOTAL:** 4338.95  0.00

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>DEBIT BALANCE</th>
<th>MEDICAID TOTAL</th>
<th>CERTIFIED AMT</th>
<th>TO BE REFUNDED IN THE FUTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>INCENTIVE</td>
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<td>0.00</td>
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<tr>
<td></td>
<td>ADJUSTMENTS</td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**YOUR CURRENT DEBIT BALANCE:** -4338.95

**CHECK TOTAL:** 0.00

**CHECK NUMBER:** | ABC HEALTH PROVIDER | PO BOX 00000 | 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.

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>COMPLETED</th>
<th>DATE(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OFFICE SERVICES AND ROUTINES:</strong> Information about hours, appointments, lab tests, and other general procedures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GENERAL INSTRUCTION ABOUT PREGNANCY:</strong> such as hygiene, exercise, sexuality, medication, and importance of prenatal care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FETAL GROWTH AND DEVELOPMENT:</strong> 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><strong>NUTRITION:</strong> including routine prenatal diet instruction. (Be sure to make referral to WIC PROGRAM)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EXPLANATION OF EDC:</strong> Understanding the due date.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DANGER SIGNS OF PREGNANCY:</strong> 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><strong>RISKY BEHAVIORS:</strong> smoking, alcohol, substance use and abuse the risks, consequences to baby and methods for avoiding risks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NOTE:</strong> Possible referral for smoking cessation or substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PROCESS OF LABOR AND DELIVERY:</strong> discussion of physical process of labor and delivery; including psychological changes experienced.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>METHODS OF ANESTHESIA:</strong> Information on types of anesthesia with discussion of benefits, risks and alternatives; also pain medication.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CESAREAN SECTION:</strong> discussion of what it is and what are the usual indications including risks and benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RELAXATION AND BREATHING EXERCISES:</strong> preparation for labor including demonstration and practice of exercises and breathing techniques</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BREASTFEEDING:</strong> factors to consider in decision making and preparation of the breasts. <strong>Note:</strong> Possible referral to La Leche or Breastfeeding Support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 inter-conceptional 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: __________

[ ] HRCP (if applicable)

[ ] High Risk Channeling Project Date: __________

[ ] OTHER Date: __________

SIGNATURE: ________________________________

ATTENDING PHYSICIAN
# Alcohol and Drug Medical Assessment

**Patient’s Name (Last, First, MI) and I.D. #**

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

**Physician’s Name and Address**

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

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

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

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

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

7. It is ordered that ____________________________ receive alcohol/drug rehabilitative services.

Physician's Signature and Date
# PEDIATRIC SUB-SPECIALISTS CERTIFICATION FORM

## SECTION 1: 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>ZIP+4:</td>
<td></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:

### PEDIATRIC SUB-SPECIALTIES (CHECK ALL THAT APPLY)

- [ ] Adolescent Medicine
- [ ] Emergency Medicine
- [ ] Nephrology
- [ ] Pulmonology
- [ ] Allergy
- [ ] Endocrinology
- [ ] Neurology
- [ ] Radiology
- [ ] Cardiology
- [ ] Gastroenterology/Nutrition
- [ ] Neurological Surgery
- [ ] Rheumatology
- [ ] Cardiothoracic Surgery
- [ ] Genetics
- [ ] Ophthalmology
- [ ] Surgery
- [ ] Child Abuse Pediatrics
- [ ] Hematology/Oncology
- [ ] Orthopedic Surgery
- [ ] Urology
- [ ] Critical Care
- [ ] Infectious Disease
- [ ] Otolaryngology
- [ ] Psychiatry
- [ ] Developmental-Behavioral Pediatrics
- [ ] Neonatology
- [ ] Psychology

## 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.

### Patient Heading  

<table>
<thead>
<tr>
<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>
</tr>
<tr>
<td>Number of Medicaid patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of patients 18 and under</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of patients with Medicaid 18 and under</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.

<table>
<thead>
<tr>
<th>Physician Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

## CONTACT PERSON INFORMATION

<table>
<thead>
<tr>
<th>Contact Person Name (please print):</th>
<th>Contact Email Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Telephone Number:</td>
<td>Contact Fax Number:</td>
</tr>
</tbody>
</table>

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 _______________________________

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 those alternatives and chosen to be sterilized.

Understand that I will be sterilized by an operation known as a _________________. The discomforts, risks 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 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _______________________________  Date _______________________________

I hereby consent of my own free will to be sterilized by _______________________________  Doctor or Clinic _______________________________

by a method called _______________________________  Specify Type of Operation _______________________________

My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to:

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

I have received a copy of this form.

_____________________________  Signature _______________________________  Date _______________________________

Medicaid

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

Names of my Race (mark one or more):
[ ] American Indian or Alaska Native
[ ] Asian
[ ] Black or African American
[ ] Native Hawaiian or Other Pacific Islander
[ ] White

**INTERPRETER’S STATEMENT**

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

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

_____________________________  Interpreter's Signature _______________________________  Date _______________________________

**STATEMENT OF PERSON OBTAINING CONSENT**

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

I explained 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 Federally funded funds.

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

_____________________________  Signature of Person Obtaining Consent _______________________________  Date _______________________________  Facility _______________________________  Address _______________________________

**PHYSICIAN’S STATEMENT**

Shortly before I performed a sterilization operation upon _______________________________  Name of Individual _______________________________
on _______________________________  Date of Sterilization _______________________________.

I explained to him/her the nature of the sterilization operation _______________________________  Specify Type of Operation _______________________________. I explained to him/her 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 Federally funded 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 off the paragraph which is not used.

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

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

   [ ] Premature delivery
   Individual’s expected date of delivery _______________________________.
   [ ] Emergency abdominal surgery (describe circumstances): _______________________________.

_____________________________  Physician’s Signature _______________________________  Date _______________________________
PAPERWORK REDUCTION ACT STATEMENT

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHB 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. 9, 1978, as amended at 58 FR 33343, June 17, 1993; 68 FR 12308, 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.

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>MEDICAID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAST</td>
<td>FIRST</td>
</tr>
<tr>
<td>BIRTHDATE</td>
<td>GRAVITY</td>
</tr>
<tr>
<td>MONTH/DAY/YEAR</td>
<td></td>
</tr>
</tbody>
</table>

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 _______________________________    __________________

ADDRESS ________________________________________________

CONTACT PERSON _______________________________ TELEPHONE (_____) ___________________

FAX (_____) ___________________

SIGNATURE ___________________________________ DATE ___________________________

ATTENDING PHYSICIAN

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

Revised: 06/01/12
PATIENT NAME ______________________________________________________________

LAST   FIRST     MI

BIRTHDATE ____________________   *

MEDICAID# _______________________

PROCEDURE ____________________________________ CODE _______________________

DX CODE:_______________________________________

FACILITY _______________________________________    ___________________________

NAME                                 NPI #

PLANNED SURGERY DATE _______________________________________

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

PHYSICIAN’S NAME __________________________________________________________

LAST   FIRST   MI

ADDRESS ____________________________________________________________________

_________________________________ NPI: _____________

CONTACT PERSON _________________________ TELEPHONE (_____) _______________

DATE ____________________   FAX NUMBER (_____) ______________

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

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE

Revised: 06/01/12
Section I: Demographic Information
Please Print:

<table>
<thead>
<tr>
<th>Supervising Clinician Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Telephone:</td>
</tr>
<tr>
<td>National Provider Identifier Number (NPI)</td>
</tr>
<tr>
<td>Fax:</td>
</tr>
<tr>
<td>Email:</td>
</tr>
</tbody>
</table>

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>
</tr>
</thead>
<tbody>
<tr>
<td>License Number &amp; Expiration Date:</td>
</tr>
<tr>
<td>LMSW Name (as it appears on their license):</td>
</tr>
<tr>
<td>License Number &amp; Expiration Date:</td>
</tr>
<tr>
<td>LMSW Name (as it appears on their license):</td>
</tr>
<tr>
<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 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 corrected as of the date of this certificate.

Physician Signature ___________________________ Date ____________

Revised 06/2013
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 (SCDHHHS) 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 SCDHHHS protocol in referring the beneficiary to an out-of-state provider. All available resources must have been considered and indicated in the request to SCDHHHS for the out-of-state referral. The following guidelines outline the requirements for an out-of-state referral.

Prior to contacting SCDHHHS, 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 SCDHHHS 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:

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.
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 SCDHSS, 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 (SCDHHSS) 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

SCDHHSS 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?**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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><strong>Yes</strong></th>
<th><strong>No</strong></th>
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</table>

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** ____________________________

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**  
Axis I __________ / __________ / __________  
Axis II __________ / __________  
Axis III __________ / __________  

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>
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<th>0 1 2 3 4</th>
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<th>0 1 2 3 4</th>
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<tbody>
<tr>
<td>Aggression</td>
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<tr>
<td>Alcohol/Substance Use</td>
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<tr>
<td>Anxiety/Panic</td>
<td>1 2 3 4</td>
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<tr>
<td>Appetite Disturbance</td>
<td>1 2 3 4</td>
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<tr>
<td>Attention/Concentration</td>
<td>1 2 3 4</td>
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<tr>
<td>Deficit in ADLs</td>
<td>1 2 3 4</td>
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<tr>
<td>Delusions</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Hallucinations</td>
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<tr>
<td>Impulsivity</td>
<td>0 1 2 3 4</td>
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<tr>
<td>Job/School Problems</td>
<td>0 1 2 3 4</td>
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<tr>
<td>Mania</td>
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<tr>
<td>Medical Illness</td>
<td>0 1 2 3 4</td>
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<tr>
<td>Memory</td>
<td>0 1 2 3 4</td>
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</tbody>
</table>

**Services**  

| 90833          | 90846          | 90853          | 90837          |
| 90836          | 90847          | 90832          | 96102          |
| 90838          | 96101          | 90834          |

**Current Medications**  

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.</td>
<td></td>
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<tr>
<td></td>
<td>2.</td>
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<td>3.</td>
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<tr>
<td></td>
<td>4.</td>
<td></td>
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<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.
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 DEFIAENCE 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 #: ____________________________

Fax To: KePRO 1-855-300-0082
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
<p>SBIRT INTEGRATED SCREENING TOOL</p>

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

- Absolute Total Care: Fax: 877-285-3226
- BlueCross HealthPlan Medicaid: Fax: 855-580-2810
- Molina: Fax: 866-423-3889
- Wellcare: Fax: 866-455-6562
- Advisor: Fax: 888-781-4316
- First Choice by Select Health: Fax: 866-533-5493
- SCDHHS (Pre-Preg Service): Fax: 803-255-6247
- BlueCross BlueShield of South Carolina & BlueChoice HealthPlan: Fax: 803-870-9864

### PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s last name</td>
<td>First: Middle: Language: Race: Ethnicity: Expected due date:</td>
</tr>
<tr>
<td>Phone no.</td>
<td>Street address:</td>
</tr>
<tr>
<td>( )</td>
<td>Member ID no.:</td>
</tr>
</tbody>
</table>

### PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice name:</td>
<td>Group NPI: Individual NPI: Screening provider’s name: Phone no.:</td>
</tr>
</tbody>
</table>

### PATIENT SCREENING INFORMATION

<table>
<thead>
<tr>
<th>Question</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents</td>
<td>Did any of your parents have a problem with alcohol or drug use?</td>
<td>YES</td>
</tr>
<tr>
<td>Peers</td>
<td>Do any of your friends have a problem with alcohol or other drug use?</td>
<td>YES</td>
</tr>
<tr>
<td>Partner</td>
<td>Does your partner have a problem with alcohol or other drug use?</td>
<td>YES</td>
</tr>
<tr>
<td>Violence</td>
<td>Are you feeling at all unsafe in any way in your relationship with your current partner?</td>
<td>YES</td>
</tr>
<tr>
<td>Emotional Health</td>
<td>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?</td>
<td>YES</td>
</tr>
<tr>
<td>Past</td>
<td>In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?</td>
<td>YES</td>
</tr>
<tr>
<td>Present</td>
<td>In the past month, have you drunk any alcohol or used other drugs?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>1. How many days per month do you drink?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. How many drinks on any given day?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. How often did you have 4 or more drinks per day in the last month?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. In the past month have you taken any prescription drugs?</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>Have you smoked any cigarettes in the past three months?</td>
<td>YES</td>
</tr>
</tbody>
</table>

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 patients 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

- Non-Pregnant
- Pregnant/Manning Pregnancy

- 7+ drinks/week
- 8+ drinks/day

### CONFIDENTIAL SBIRT REFERRAL INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient referred to: (Check all that apply)</td>
<td>DMH</td>
</tr>
<tr>
<td></td>
<td>803-256-2900</td>
</tr>
<tr>
<td>Date of referral appointment (DD/MM/YY):</td>
<td>Date screened:</td>
</tr>
</tbody>
</table>

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, (2013)*
**Universal 17-P Authorization Form**

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

<table>
<thead>
<tr>
<th>Absolute Total Care</th>
<th>BlueChoice HealthPlan</th>
<th>First Choice by Select Health</th>
<th>WellCare Health Plan, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>P: 803-933-3585</td>
<td>P: 888-902-1886</td>
<td>P: 888-559-1010 x55251</td>
<td>P: 888-585-8842</td>
</tr>
</tbody>
</table>

Adicare
P: 866-781-4371
F: 866-781-4316

Molina Healthcare, Inc.
P: 855-237-6178
F: 855-571-3011

Date of Request for Authorization

Patient/Member Name

DOB

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 _EDD_ Current Gestational age _weeks_

Bed Rest ☐ Yes ☐ No

Experience 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. 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 90 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