### Forms

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<td>Health Insurance Information Referral Form</td>
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<td>Reasonable Effort Documentation</td>
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<td>Electronic Funds Transfer (EFT) Authorization Agreement</td>
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<td>Healthy Mothers, Healthy Futures Maternity Health Education Checklist</td>
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<td>DHHS Pediatric Sub-Specialists Certification Form</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>BOI Universal Screening Tool</td>
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<td>Universal 17-P Authorization Form</td>
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<td></td>
<td>SCDHHS Behavioral Health Referral and Feedback Form</td>
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</table>
**PROGRAM INTEGRITY**

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

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

<table>
<thead>
<tr>
<th>SUSPECTED INDIVIDUAL OR INDIVIDUALS:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NPI or MEDICAID PROVIDER ID:</strong> (if applicable)</td>
</tr>
<tr>
<td><strong>ADDRESS OF SUSPECT:</strong></td>
</tr>
<tr>
<td><strong>DATE OF INCIDENT:</strong></td>
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<table>
<thead>
<tr>
<th>COMPLAINT:</th>
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<tr>
<td><strong>NAME OF PERSON REPORTING:</strong> (Please print)</td>
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<tr>
<td><strong>ADDRESS OF PERSON REPORTING:</strong></td>
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</tbody>
</table>

**SIGNATURE:** (SCDHHS Representative Receiving Report)

SCDHS 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.#</th>
<th>Date(s) of Service</th>
<th>Amount of Medicaid Payment</th>
<th>Amount of Refund</th>
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</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  Mail: Post Office Box 101110
                Columbia, SC  29211-9804

DHHS 931 – Updated February 2018
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 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 an 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 concealment 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 revoking this authorization.

☐ I acknowledge that I have read and understand that payments will be issued only to the bank account of the provider designated to receive payments beginning July 2019 with the transition of Medicaid claims payments to the South Carolina Enterprise Information System (SCEIS). For more information, please visit https://sip.scdhhs.gov/sceis or contact 888.289.6709. Providers’ taxpayer identification numbers (either EIN or SSN) and name must be validated with the Internal Revenue Service’s (IRS) prior to SCEIS claiming 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/emailing it to Medicaid PTSD@scdhhs.com or by fax at 803.254-3513. For questions or assistance, please call the Provider Service Center at 888.289.6709.

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 29222-8809 ● FAX (803) 870-5022

SPECIAL INSTRUCTIONS: For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 888.289.6709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider website for instructions on how to complete steps to your EFT information.

Effective January 01, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reimbursement Trace Number. The trace number will automatically be included in your ECD/ EFT electronic remittance advice. In order for the matching remittance 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 888.289.6709.

EFT Enrollment Form:  Revision Date: July 1, 2015
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 - .70 per page

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

   ________________________________  ______________________________
   Authorizing Signature            Date

SCDHHS (Revised 09/01/17)
CLAIM RECONSIDERATION FORM

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

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

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

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

Section 4: Claim Reconsideration Information
What area is your denial related to? (Please select below)
☐ Ambulance Services
☐ Autism Spectrum Disorder (ASD) Services
☐ Clinic Services
☐ Community Long Term Care (CLTC)
☐ Community Mental Health Services
☐ Department of Disabilities and Special Needs (DDS) 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/IH)
☐ Optional State Supplementation (OSS)
☐ Pharmacy Services
☐ Physicians Laboratories, and Other Medical Professionals
Specify:
☐ 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: ________
This page of the sample Remittance Advice shows a paid claim, suspended claim and rejected claim.

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<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>
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<th>TITLE 19</th>
<th>S</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
<th>M</th>
<th>TLE. 18</th>
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Edits: L00 946 L02 852 08/30/13

TOTALS: 3 | 310.00 | 56.72 | $6.72 |

STATUS CODES: P = PAYMENT MADE | R = REJECTED |

CERTIFIED AMT MEDICAID TOTAL E = ENCOUNTER |

MEDICAID PG TOT | MEDICAID TOTAL | PHONE THE D.H.H.S. NUMBER |

CHECK TOTAL CHECK NUMBER
### Sample Remittance Advice (page 2)

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

<table>
<thead>
<tr>
<th>PROVIDER ID</th>
<th>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
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<thead>
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<th>CLAIM</th>
<th>SERVICE RENDERED</th>
<th>AMOUNT</th>
<th>TITLE 19</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
<th>M</th>
<th>TLE. 18</th>
<th>COPAY</th>
<th>TITLE</th>
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<tbody>
<tr>
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<td>REFERENCE</td>
<td>DATE(S)</td>
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<td>PAYMENT</td>
<td>ID.</td>
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<td>AMT</td>
<td>PAYMENT</td>
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</tr>
<tr>
<td>NUMBER</td>
<td>NUMBER</td>
<td>PY IND</td>
<td>MMDDYY</td>
<td>PROC.</td>
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<td>I I LAST NAME</td>
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| ABB22222 | 1405200415812200A | 02/18/2014 | 1192.00 | 243.71 | M CLARK | 000 | 0.00 |
| ABB22222 | 1405200415812200A | 02/18/2014 | 392.00 | 126.00 | M CLARK | 000 | 0.00 |
| VOID OF ORIGINAL CCN 132830224813300A PAID 20131018 | 01 | 100213 | S0315 | 1112.00 | 143.71 | M CLARK | 000 | 0.00 |
| REPLACEMENT OF ORIGINAL CCN 130471253670430A PAID 20131018 | 01 | 100213 | S0315 | 142.50 | 42.75 | M CLARK | 000 | 0.00 |

**Total:** $286.46

---

**STATUS CODES:**

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<th>MEDICAID PG TOT</th>
<th>ERROR CODES LISTED ON THIS FORM REFER TO: &quot;MEDICAID PROVIDER MANUAL&quot;.</th>
</tr>
</thead>
</table>

**IF YOU STILL HAVE QUESTIONS:**

PHONE THE D.H.H.S. NUMBER | SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

**Certified AMT:**

| MEDICAID TOTAL | E = ENCOUNTER | P = PAYMENT MADE | R = REJECTED | S = IN PROCESS | D = ALLOWED | AMT | PAYMENT | CHECK TOTAL |

| PO BOX 000000 | FLORENCE SC 00000 | CHECK NUMBER |
This page of the sample Remittance Advice shows a claim-level Void without a corresponding Replacement claim.

### Sample Remittance Advice (page 3)

<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>CLAIM</th>
<th>ADJUSTMENTS</th>
<th>PAYMENT DATE</th>
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<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
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</tr>
</tbody>
</table>

**Debit Balance**: $50.00
**Check Number**: 4197304

**Provider Name and Address**: ABC HEALTH PROVIDER
**Address**: PO BOX 000000
**City**: FLORENCE
**State**: SC 00000

**Incentive Credit Amount**: $243.71
**Prior to This Debit Balance**: $243.71
**Adjustments**: $0.00
**Accounting**: $0.00
**Remittance Your Current**: $193.71

This page is a sample only.
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>PROVIDERS</th>
<th>CLAIM NUMBER</th>
<th>SERVICE REFERENCE</th>
<th>DATE(S)</th>
<th>CODE</th>
<th>PROC / DRUG</th>
<th>RECIPIENT ID.</th>
<th>RECIPIENT NAME</th>
<th>ORIG. CHECK</th>
<th>PAYMENT ACTION</th>
<th>CREDIT AMOUNT</th>
<th>DEBIT / EXCESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPL 2</td>
<td>1404900004000100U</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
<td>DEBIT</td>
<td>-2389.05</td>
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</tr>
<tr>
<td>TPL 4</td>
<td>14055000076000400U</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>DEBIT</td>
<td>-1949.90</td>
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</tr>
<tr>
<td>TPL 5</td>
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<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>DEBIT</td>
<td>-477.25</td>
<td></td>
</tr>
<tr>
<td>TPL 6</td>
<td>14055000076000400U</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>CREDIT</td>
<td>477.25</td>
<td></td>
</tr>
</tbody>
</table>

**PAGE TOTAL:** 4338.95 0.00

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

**ADJUSTMENTS**

**PROVIDER NAME AND ADDRESS**

ABC HEALTH PROVIDER
PO BOX 00000
FLORENCE SC 00000

**YOUR CURRENT DEBIT BALANCE CHECK TOTAL CHECK NUMBER**

0.00 0.00
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>OFFICE SERVICES AND ROUTINES: Information about hours,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>appointments, lab tests, and other general procedures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GENERAL INSTRUCTION ABOUT PREGNANCY: such as hygiene,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>exercise, sexuality, medication, and importance of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>prenatal care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FETAL GROWTH AND DEVELOPMENT: how the baby develops</td>
<td></td>
<td></td>
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<tr>
<td>month by month and physical and psychological changes</td>
<td></td>
<td></td>
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<tr>
<td>experienced by the mother; including comfort measures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NUTRITION: including routine prenatal diet instruction.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and significance and risk of each; including specific</td>
<td></td>
<td></td>
</tr>
<tr>
<td>instructions on what to do, who to contact and where to</td>
<td></td>
<td></td>
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<tr>
<td>go in an emergency.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RISKY BEHAVIORS: smoking, alcohol, substance use and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>abuse the risks, consequences to baby and methods for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>avoiding risks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
<td></td>
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<tr>
<td>process of labor and delivery, including psychological</td>
<td></td>
<td></td>
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<tr>
<td>changes experienced.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>METHODS OF ANESTHESIA: Information on types of anesthesia</td>
<td></td>
<td></td>
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<tr>
<td>with discussion of benefits, risks and alternatives;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>also pain medication.</td>
<td></td>
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</tr>
<tr>
<td>CESAREAN SECTION: discussion of what it is and what are</td>
<td></td>
<td></td>
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<tr>
<td>the usual indications including risks and benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RELAXATION AND BREATHING EXERCISES: preparation for</td>
<td></td>
<td></td>
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<tr>
<td>labor including demonstration and practice of exercises</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and breathing techniques</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BREASTFEEDING: factors to consider in decision making</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and preparation of the breasts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Possible referral to La Leche or Breastfeeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td></td>
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</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:

☐ WIC PROGRAM: Date: 

☐ HRCP (if applicable) Date: 

☐ 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 I: PHYSICIAN DEMOGRAPHIC INFORMATION**

*(PLEASE PRINT)*

<table>
<thead>
<tr>
<th>Name (First, Middle, Last):</th>
<th>NPI#:</th>
</tr>
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<tbody>
<tr>
<td>Physical Location Address:</td>
<td></td>
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<tr>
<td>City:</td>
<td>State:</td>
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<tr>
<td></td>
<td>ZIP+4:</td>
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<tr>
<td>E-mail Address:</td>
<td></td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>Fax Number:</td>
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<tr>
<td>Mailing Address</td>
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<td>City:</td>
<td>State:</td>
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<td>ZIP+4:</td>
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**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
- [ ] Developmental-Behavioral Pediatrics
- [ ] Neonatology
- [ ] Psychiatry

---

**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>
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<tbody>
<tr>
<td>Number of patients seen</td>
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<td></td>
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<tr>
<td>Number of Medicaid patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of patients 18 and under</td>
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<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>

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**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: 08/15 - 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

Doctor or Clinic

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

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

consent expires 180 days from the date of my signature below.

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

Representatives of the Department of Health and Human Services,

or Employees of programs or projects funded by the Department

but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature

Date

Medicaid ID

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

□ 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 of Sterilization

I explained to him/her the nature of the sterilization operation

Specify Type of Operation

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

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

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

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

Signature of Person Obtaining Consent

Date

Facility

Address

Physician’s Signature

Date

■ PHYSICIAN’S STATEMENT ■

I explained to him/her the nature of the sterilization operation

Specify Type of Operation

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

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

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

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

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

(1) At least 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

□ Emergency abdominal surgery (describe circumstances):

Individual’s expected date of delivery:

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, ASETF/Budget Room 503 HH-H 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 12908, Mar. 14, 2003]
SOUTHERN 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 ________________________________

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

Revised: 06/01/12
PATIENT NAME ______________________________________________________________
LAST   FIRST     MI

BIRTHDATE ____________________   *
MONTH/DAY/YEAR

MEDICAID# _______________________

PROCEDURE ___________________________ CODE _______________________

DX CODE:_______________________________________

FACILITY _______________________________________
NAME ___________________________ NPI #

PLANNED SURGERY DATE _______________________________________

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

PHYSICIAN’S NAME __________________________________________________________
LAST   FIRST   MI

ADDRESS ____________________________________________________________________

_________________________________ NPI: _____________

CONTACT PERSON _________________________ TELEPHONE (_____) _______________

DATE ____________________   FAX NUMBER (_____) ______________

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

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE

Revised: 06/01/12
**Section I: Demographic Information**

<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>
<th>License Number &amp; Expiration Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<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></td>
<td></td>
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</thead>
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<td></td>
<td></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 correct 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 SCDHHS, is mandatory in order to make the necessary travel arrangements. Call the Provider Service Center at 888-289-0709 for additional questions.

WILL THE BENEFICIARY REQUIRE LODGING, MEAL REIMBURSEMENT and TRANSPORTATION? YES_______NO______

RECOMMENDED MODE OF TRANSPORTATION: ____________________________

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

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

SIGNATURE OF REFERRING PHYSICIAN ___________________ DATE ________________
South Carolina

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

Referral Request Form for
Out-of-State Services

OUT-OF-STATE PROVIDER

NAME: ____________________________________________________________

NAME OF PHYSICIAN (S) AND/OR FACILITY

ADDRESS: _________________________________________________________

_________________________________________________________________

TELEPHONE#: ________________________ FAX#: ________________________

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

_________________________________________________________________

SIGNATURE OF OUT-OF-STATE PHYSICIAN ____________________________

DATE ____________________________
TRANSPLANT PRIOR AUTHORIZATION REQUEST FORM

INSTRUCTIONS

In determining whether to provide Prior Authorization, the South Carolina Department of Health and Human Services (SCDHHS) may use guidelines that include clinical standards, protocols, or criteria regarding the treatment of specific conditions.

When submitting a completed Transplant Prior Authorization Request Form:

1. The referring South Carolina (SC) Medicaid provider must complete the form.
2. All fields on the form must be completed.
3. Include supporting clinical documentation (e.g., clinical notes, diagnostic studies, lab results)
4. This is not an authorization for payment. Payments are made subject to the beneficiary’s eligibility and benefits on the day of service.
5. Providers seeking reimbursement for services must be credentialed with SC Medicaid.
6. You must provide sufficient information to allow us to make a decision regarding your request.
7. If the transplant service is available in state and this case is being referred outside of the South Carolina Medical Service Area (SCMSA), you must indicate why.
8. Requests for prior authorizations from KePRO may be submitted using one of the following methods.

   KePRO Customer Service: 1-855-326-5219  
   KePRO Fax # 1-855-300-0082
   For Provider Issues email: atrezzoissues@Kepro.com

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

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

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

NAME OF BENEFICIARY: ____________________________ DATE OF BIRTH: ____________________________

SC MEDICAID ID#: ____________________________

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

REFERRING PHYSICIAN: ____________________________

NPI: ____________________________ SC MEDICAID #: ____________________________

TYPE OF TRANSPLANT: ____________________________ Is the patient receiving a living organ or a cadaveric organ?

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

WILL THE BENEFICIARY REQUIRE TRANSPORTATION? YES ______ NO ______

RECOMMENDED MODE OF TRANSPORTATION: ____________________________

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

RENDERING PHYSICIANS/FACILITY

PATIENT REFERRED TO: ____________________________ NAME OF FACILITY AND/OR PHYSICIAN (S)

ADDRESS: __________________________________________________________________________________________

TELEPHONE: ____________________________ FAX: ____________________________

NAME OF CONTACT PERSON/COORDINATOR: ____________________________

REQUIRED DOCUMENTATION

☐ Letter of Medical Necessity for the transplant, including the following: summary of course of illness, current medications, smoking, alcohol, and drug abuse history

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

☐ Laboratory assessments including serologies

☐ Letter to support the need to have the transplant performed outside of the South Carolina Medical Service Area (SCMSA) – If applicable.

PLEASE ANSWER THE FOLLOWING QUESTIONS

Yes No

<table>
<thead>
<tr>
<th>Question</th>
<th></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>
</tr>
<tr>
<td>Has the patient had active alcohol, tobacco, or substance abuse within the past 6 months?</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>
</tr>
<tr>
<td>Does the patient have any uncontrolled/untreatable infections or diseases?</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, the service is not available and cannot be provided within the SCMSA.

SIGNATURE OF REFERRING PHYSICIAN ____________________________ DATE ____________________________
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>
</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>Category</th>
<th>Score</th>
<th>Category</th>
<th>Score</th>
<th>Category</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggression</td>
<td>0 1 2 3 4</td>
<td>Depressions</td>
<td>0 1 2 3 4</td>
<td>Relationship Problems</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>Alcohol/Substance Use</td>
<td>0 1 2 3 4</td>
<td>Hallucinations</td>
<td>0 1 2 3 4</td>
<td>Side Effects</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>Anxiety/Panic</td>
<td>0 1 2 3 4</td>
<td>Impulsivity</td>
<td>0 1 2 3 4</td>
<td>Sleep Effects</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>Appetite Disturbance</td>
<td>0 1 2 3 4</td>
<td>Job/School Problems</td>
<td>0 1 2 3 4</td>
<td>Sleep Disturbance</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>Attention/Concentration</td>
<td>0 1 2 3 4</td>
<td>Mania</td>
<td>0 1 2 3 4</td>
<td>Weight Loss</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>Deficit in ADLs</td>
<td>0 1 2 3 4</td>
<td>Medical Illness</td>
<td>0 1 2 3 4</td>
<td>Other</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>Delusions</td>
<td>0 1 2 3 4</td>
<td>Memory</td>
<td>0 1 2 3 4</td>
<td>Current Stressors</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>

**Services**

- ☐ 90833
- ☐ 90836
- ☐ 90838
- ☐ 90846
- ☐ 90847
- ☐ 96101
- ☐ 90853
- ☐ 90832
- ☐ 90837
- ☐ 96102

**Current Medications**

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

**MONTH/DAY/YEAR**

**INPATIENT**  **OUTPATIENT**

**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: _______________________________ MEDICAID PROVIDER ID #: __________________**

**LAST**  **FIRST**  **MI**

**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

**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
SBIRT INTEGRATED SCREENING TOOL

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

<table>
<thead>
<tr>
<th>□ Absolute Total Care</th>
<th>□ BlueChoice Health Plan Medicaid</th>
<th>□ Molina Healthcare</th>
<th>□ Wellcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax: 877-285-1226</td>
<td>Fax: 855-280-2810</td>
<td>Fax: 866-423-3889</td>
<td>Fax: 866-455-6562</td>
</tr>
<tr>
<td>□ Advantage</td>
<td>□ First Choice by Select Health</td>
<td>□ SC DHHS (Pre-Pay)</td>
<td>□ BlueCross BlueShield of South Carolina &amp; BlueChoice Healthcare</td>
</tr>
<tr>
<td>Fax: 888-781-4316</td>
<td>Fax: 866-533-5103</td>
<td>Fax: 803-255-6247</td>
<td>Fax: 803-870-9884</td>
</tr>
</tbody>
</table>

**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
- Do any of your friends have a problem with alcohol or other drug use? [ ] YES [ ] NO

**Peer**
- Does your partner have a problem with alcohol or drug use? [ ] YES [ ] NO

**Violence**
- Are you feeling at all unsafe in any way in your relationship with your current partner? [ ] YES [ ] NO

**Emotional Health**
- Over the last few weeks, has worry, anxiety, depression or sadness made it difficult for you to do your work, get along with people or take care of things at home? [ ] YES [ ] NO

**Past**
- In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications? [ ] YES [ ] NO

**Present**
- In the past month, have you drank 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 have 4 or more drinks per day in the last month? ______
  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**

Y = Yes
N = No
N/A = Not Applicable

<table>
<thead>
<tr>
<th>At Risk Drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Pregnant</td>
</tr>
<tr>
<td>Pregnant/Pregnancy</td>
</tr>
</tbody>
</table>

7+ drinks/week
8+ drinks/day

Any Use is Risky Drinking

**CONFIDENTIAL SBIRT REFERRAL INFORMATION**

- **Patient referred to:**
  □ DMH
  □ DAODAS
  □ DHEC Quitline (800-483-3114)
  □ Private provider (Name & NPI)
  □ Domestic violence (803-256-2900)

- **Date of referral appointment (DD/MM/YY):**
- **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 present 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.

☐ Absolute Total Care  ☐ BlueChoice HealthPlan  ☐ First Choice by Select Health  ☐ WellCare Health Plan, Inc.
P: 803-933-3850  P: 888-902-1689  P: 866-559-1010 x55251  P: 888-585-8842

☐ Advocare  ☐ Molina Healthcare, Inc.
P: 866-781-4371  P: 866-781-4316
F: 866-781-4316  F: 866-571-3011

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 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. 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: ____________________________ Makeena 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: ____________________________ Phone: ____________________________ Practice NPI: ____________________________ Fax: ____________________________

Contact Person: ____________________________ Phone: ____________________________

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