### FORMS

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<td>Confidential Complaint</td>
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<td>SCDHHS Behavioral Health Referral and Feedback Form</td>
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**CONFIDENTIAL COMPLAINT**

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

---

**PROGRAM INTEGRITY**

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

**YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.**

---

**SUSPECTED INDIVIDUAL OR INDIVIDUALS:**

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**COMPLAINT:**

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SCDHS Form 126 (revised 06/07)
South Carolina Department of Health and Human Services - Claim Adjustment Form 130

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

Provider Address:

Provider City, State, Zip: Total paid amount on the original claim:

Original CCN:

Provider ID: NPI:

Recipient ID:

Adjustment Type: ☐ Void ☐ Void/Replace  ☐ DHHS  ☐ MCCS  ☐ Provider  ☐ MIVS

Adjustment Type: (Select one)

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

Reason For Adjustment: (Fill One Only)

For Agency Use Only

☐ Hospital/Office Visit included in Surgical Package
☐ Independent lab should be paid for service
☐ Assistant surgeon paid as primary surgeon
☐ Multiple surgery claims submitted for the same DOS
☐ MMIS claims processing error
☐ Rate change

☐ Web Tool error
☐ Reference File error
☐ MCCS processing error
☐ Claim review by Appeals

Comments:

Signature: _____________________________ Date: _____________________________

Phone: ________________________________

DHHS Form 130 Revision date: 03-13-2007
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:

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</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
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) 779-3022

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 SCDDHS Provider web page for instructions on how to complete updates to your EFT information.

Effective January 01, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDDHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching trace number and your ERA can be directed to the Provider Service Center at 1-888-289-0709.

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 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): ________________________________ Medicaid Beneficiary ID: ____________________
Date of Birth: __________________

Section 2: Provider Information
Specify your affiliation: □ Physician □ Hospital □ Other (DME, Lab, Home Health Agency, etc.): ____________________________
NPI: ____________ Medicaid Provider ID: ____________ Facility/Group/Provider Name: ____________________________
Return Mailing Address: ____________________________________________________________
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  □ Licensed Independent Practitioner’s Rehabilitative Services (LIPS)
□ Autism Spectrum Disorder (ASD) Services  □ Local Education Agencies (LEA)
□ Clinic Services  □ Medically Complex Children’s (MCC) Waivers
□ Community Long term Care (CLTC)  □ Nursing Facility Services / Intermediate Care Facility for Individuals
□ Community Mental Health Services with Intellectual Disabilities (ICF/IID)
□ Department of Disabilities and Special Needs (DDSN) Waivers  □ Optional State Supplementation (OSS)
□ Durable Medical Equipment (DME)  □ Pharmacy Services
□ Early Intervention Services  □ Physicians Laboratories, and Other Medical Professionals
□ Enhanced Services  □ Specify:
□ Federally Qualified Health Center (FQHC)  □ Private Rehabilitative Therapy and Audiological Services
□ Home Health Services  □ Psychiatric Hospital Services
□ Hospice Services  □ Rehabilitative/Behavioral Health Services (RBHS)
□ Hospital Services  □ Rural Health Clinic (RHC)
□ Targeted Case Management (TCM)
□ Other: __________________________
Section 5: Desired Outcome

Request submitted by:

Print Name: ____________________________________________

Signature: ____________________________________________ Date: _______


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<tr>
<td>2. PATIENT'S NAME</td>
<td>Doe, John A.</td>
</tr>
<tr>
<td>3. PATIENT'S ADDRESS</td>
<td>123 Windy Lane</td>
</tr>
<tr>
<td>4. INSURED'S NAME</td>
<td>Doe, John A.</td>
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<tr>
<td>5. INSURED'S ADDRESS</td>
<td>123 Windy Lane</td>
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<tr>
<td>6. PATIENT RELATIONSHIP TO INSURED</td>
<td>Self</td>
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<td>Anytown</td>
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**Sample Claim Showing TPL Dental with NPI**
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Sample Remittance Advice (page 1)
This page of the sample Remittance Advice shows a paid claim, suspended claim and rejected claim.
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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<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PROFESSIONAL SERVICES</th>
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ERROR CODES LISTED ON THIS P = PAYMENT MADE ABC HEALTH PROVIDER
FORM REFER TO: "MEDICAID" R = REJECTED |
PROVIDER MANUAL". S = IN PROCESS PO BOX 000000
CERTIFIED AMT MEDICAID TOTAL E = ENCOUNTER FLORENCE SC 00000
IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER |
SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.
CHECK TOTAL CHECK NUMBER
Sample Remittance Advice (page 3)

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

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This page of the sample Remittance Advice shows a claim-level Void without a corresponding Replacement claim.
Sample Remittance Advice (page 4)

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

☐ OTHER

Date: __________________

Date: __________________

SIGNATURE: ____________________________

ATTENDING PHYSICIAN
# Alcohol and Drug Medical Assessment

<table>
<thead>
<tr>
<th>Patient's Name (Last, First, MI) and I.D. #</th>
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<tbody>
<tr>
<td>Medicaid Client #</td>
</tr>
<tr>
<td>Date of Medical Assessment</td>
</tr>
<tr>
<td>Physician's Name and Address</td>
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</tbody>
</table>

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

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

3. Assessment of patient nutritional status.

ADMA 9/20/90
SCCADA FORM
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/trackings, 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>
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<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>
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</tbody>
</table>

### Mailing Address

(If different from physical location address):

| City: | State: | ZIP+4: |

## Section II: Attestation Statement

Beginning February 1, 2006, the monies appropriated for pediatric physician sub-specialists shall only be available to a physician who:

A) In his/her medical practice, has at least 85% of their patients who are children 18 years or younger and B) practices in one of the following sub-specialties or other pediatric sub-specialty area as may be determined by the Department of Health and Human Services:

### Pediatric Sub-Specialties (Check All That Apply)

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

## 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>Patient Heading</th>
<th>As a Group</th>
<th>As an Individual</th>
<th>TOTAL</th>
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<tbody>
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<tr>
<td>Number of Medicaid patients</td>
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<tr>
<td>Number of patients 18 and under</td>
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<tr>
<td>Number of patients with Medicaid 18 and under</td>
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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 select 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:** P.O.B 8809, Columbia, SC 29202-8809

DHHS Pediatric Sub-Specialists Certification Form

Revised: 06/15 - Replaces: 10/14
ABORTION STATEMENT

This certification meets FFP requirements and must include all of the aforementioned criteria.

Patient's Name: ________________________________

Patient's Medicaid ID#: __________________________

Patient's Address: __________________________________

Physician Certification Statement

I, __________________________ certify that it was necessary to terminate the pregnancy of __________________________ for the following reason:

a. ( ) Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition: __________________________

b. ( ) The patient has certified to me the pregnancy was a result of rape or incest and the police report is attached.

c. ( ) The patient has certified to me the pregnancy was a result of rape or incest and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

_____________________________ _______________________
Physician's Signature Date

The patient's certification statement is only required in cases of rape or incest.

Patient's Certification Statement

I, __________________________ certify that my pregnancy was the result of an act of rape or incest.

(Patient’s Name)

_____________________________ _______________________
Patient’s Signature Date

Both the completed Abortion Statement and appropriate medical records must be submitted with the claim form.
CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

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

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

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

I understand that I will be sterilized by an operation known as a ______________________. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will 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: ______________________. 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:

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:

[ ] Hispanic or Latino [ ] American Indian or Alaska Native
[ ] Not Hispanic or Latino [ ] 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 ______________________

HHS-867 (10/13)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

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

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

To the best of my knowledge and belief the individual to be sterilized is at least 21 years of age 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 ______________________ Date of Sterilization ______________________

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

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

To the best of my knowledge and belief the individual to be sterilized is at least 21 years of age 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 prematurity 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

[ ] 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 comments regarding the burden estimate or any other aspect of this collection of information to the Office of Management and Budget, Paperwork Clearance Division, Room 3514, 700 7th Street NW, Washington, DC 20503. Comments should be addressed to the Office of Management and Budget, Paperwork Clearance Division, Room 3514, 700 7th Street NW, Washington, DC 20503.

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 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.

PATIENT

NAME ________________________________________ MEDICAID # ________________

LAST FIRST MI

BIRTHDATE ________________ GRAVITY ________________ PARITY ________________

MONTH/DAY/YEAR

PROCEDURE CODE: ___________________________ DX CODE: __________________

HOSPITAL ____________________________________________ NAME __________________________

PLANNED ADMISSION DATE __________________ PLANNED SURGERY DATE ________________

TYPE OF HYSTERECTOMY PLANNED ______________________________________________________

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

HCT ____ HGB ____ CHECK ONE: PREMENOPAUSAL _____ POSTMENOPAUSAL _____

CONSERVATIVE TREATMENT/MEDICATION WITH DATES:

___________________________________________________________________________________

___________________________________________________________________________________

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

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

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

ATTENDING PHYSICIAN’S NAME ________________ LAST FIRST MI ________________ NPI

ADDRESS ________________________________________________________________________________

CONTACT PERSON __________________________ TELEPHONE (_____) __________________________

FAX (_____) __________________________

SIGNATURE ___________________________________ DATE __________________________

ATTENDING PHYSICIAN

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

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

PATIENT NAME ______________________________________________________________

LAST   FIRST     MI

BIRTHDATE ____________________   *

MEDICAID# _______________________

MONTH/DAY/YEAR

PROCEDURE ____________________________________ CODE _______________________

DX CODE:_______________________________________

FACILITY _______________________________________    ___________________________

NAME                                 NPI #

PLANNED SURGERY DATE _______________________________________

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

PHYSICIAN’S NAME __________________________________________________________

LAST   FIRST   MI

ADDRESS ____________________________________________________________________

_________________________________ NPI: _____________

CONTACT PERSON _________________________ TELEPHONE (_____) _____________

DATE ____________________   FAX NUMBER (_____) _____________

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

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE

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

Please print:

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

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

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

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

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

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

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

_________________________  __________________________
Physician Signature           Date

Revised 06/2013
South Carolina
Department of Health and Human Services
P O Box 1412
Columbia, South Carolina 29202-1416
www.scdhhs.gov

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

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

The South Carolina Department of Health and Human Services (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:
SCDHHS
Claims, Operations and Provider Relations
ATTN: Out-Of-State Coordinator
P O Box 1412
Columbia, South Carolina 29202-1416


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
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 (SCDHHHS) 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: arezzoissues@Kepro.com

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

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

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

**NAME OF BENEFICIARY:** ____________________________________________ **DATE OF BIRTH:** _______________________________

**SC MEDICAID ID#:** ____________________________________________

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

**REFERRING PHYSICIAN:** _____________________________________________________________________________

**NPI:** ________________________________ **SC MEDICAID #:** __________________________________

**TYPE OF TRANSPLANT:** ________________________________ **Is the patient receiving a _____ living organ or a _____ cadaveric organ?**

**EXPECTED DATE OF SERVICE:** ____________________________ **EXPECTED DATE OF RETURN:** ____________________

**WILL THE BENEFICARY REQUIRE TRANSPORTATION?** YES ☐ NO ☐

**RECOMMENDED MODE OF TRANSPORTATION:** ___________________________________________

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

**RENDERING PHYSICIANS/FACILITY**

**PATIENT REFERRED TO:** _______________________________________________________________

**NAME OF FACILITY AND/OR PHYSICIAN (S)**

**ADDRESS:** _______________________________________________________________________________________________________________

**TELEPHONE:** _______________________________________________________ **FAX:** ________________________________________________

**NAME OF CONTACT PERSON/COORDINATOR:** ______________________________________________________________________________

**REQUIRED DOCUMENTATION**

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

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

☐ Laboratory assessments including serologies

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

**PLEASE ANSWER THE FOLLOWING QUESTIONS**

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

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

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

**SIGNATURE OF REFERRING PHYSICIAN** ____________________________ **DATE** ____________________________

Transplant 08/2012 FRAUD & ABUSE HOTLINE: 1-888-284-3224 Transplant Form
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>
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<tr>
<td></td>
<td>City &amp; State:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DSM-IV TR Diagnosis</th>
<th>Date first seen:</th>
<th>Date of last service:</th>
<th># of additional visits requested:</th>
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</thead>
<tbody>
<tr>
<td>Axis I __ / __ / __</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Axis II __ / __</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Axis III __ / __</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Alcohol/Substance Use</th>
<th>Depression</th>
<th>Relationship Problems</th>
<th>0 1 2 3 4</th>
</tr>
</thead>
<tbody>
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<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Anxiety/Panic</td>
<td>Impulsivity</td>
<td>Sleep Effects</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
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<tr>
<td>Appetite Disturbance</td>
<td>Job/School Problems</td>
<td>Sleep Disturbance</td>
<td>0 1 2 3 4</td>
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<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Attention/Concentration</td>
<td>Mania</td>
<td>Weight Loss</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
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<tr>
<td>Deficit in ADLs</td>
<td>Medical Illness</td>
<td>Other</td>
<td>0 1 2 3 4</td>
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<td>0 1 2 3 4</td>
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<td>0 1 2 3 4</td>
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<td>Delusions</td>
<td>Memory</td>
<td>Current Stressors</td>
<td>0 1 2 3 4</td>
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Services

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Current Medications

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

Compliance

<table>
<thead>
<tr>
<th>Compliance</th>
<th>&gt;90%</th>
<th>50-90%</th>
<th>&lt;50%</th>
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<tbody>
<tr>
<td>1.</td>
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<td></td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<td></td>
<td></td>
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<tr>
<td>4.</td>
<td></td>
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</tr>
</tbody>
</table>

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.

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: _____________________________
LAST           FIRST           Mi
MEDICAID #: _____________________________

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: _____________________________
LAST           FIRST           Mi
MEDICAID PROVIDER ID #:

ADDRESS: ____________________________________________

CONTACT PERSON: _____________________________
PHONE #: _____________________________

*KePRO 1-855-300-0082
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>Provider Option</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOI</td>
<td>877-285-3226</td>
</tr>
<tr>
<td>BlueChoice HealthPlan</td>
<td>855-580-2810</td>
</tr>
<tr>
<td>Molina</td>
<td>866-423-3889</td>
</tr>
<tr>
<td>Wellcare</td>
<td>866-455-6062</td>
</tr>
<tr>
<td>Advocate</td>
<td>888-781-4316</td>
</tr>
<tr>
<td>First Choice by Select Health</td>
<td>866-533-5493</td>
</tr>
<tr>
<td>SCDHHS (Rec-For-Service)</td>
<td>803-235-6247</td>
</tr>
<tr>
<td>&amp; BlueChoice HealthPlan</td>
<td>803-870-9864</td>
</tr>
</tbody>
</table>

### PATIENT INFORMATION

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

### PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>Practice name:</th>
<th>Group NPI:</th>
<th>Individual NPI:</th>
<th>Screening provider's name:</th>
<th>Phone no:</th>
</tr>
</thead>
</table>

### PATIENT SCREENING INFORMATION

**Parents**

Did any of your parents have a problem with alcohol or drug use? YES NO

**Peers**

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

**Partner**

Does your partner have a problem with alcohol or other drug use? YES NO

**Violence**

Are you feeling at all unsafe in any way in your relationship with your current partner? YES NO

**Emotional Health**

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

**Past**

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

**Present**

In the past month, have you drunk any alcohol or used other drugs? 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

<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><strong>At Risk Drinking</strong></td>
<td></td>
</tr>
<tr>
<td>Did you Advise to abstain or reduce use?</td>
<td>Non-Pregnant</td>
<td></td>
</tr>
<tr>
<td>Did you check patient's reaction?</td>
<td>Pregnant/Manning Pregnancy</td>
<td></td>
</tr>
<tr>
<td>Did you refer for future assessment?</td>
<td>7+ drinks/week</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8+ drinks/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any Use Is Risky Drinking</td>
<td></td>
</tr>
</tbody>
</table>

### CONFIDENTIAL SBIRT REFERRAL INFORMATION

<table>
<thead>
<tr>
<th>Patient referred to: (Check all that apply)</th>
<th>Date of referral appointment (00AM/YY):</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMH</td>
<td>Patient refused referral</td>
</tr>
<tr>
<td>DAODAS</td>
<td>Referral not warranted</td>
</tr>
<tr>
<td>DHEC Quitline</td>
<td>Patient requested assistance</td>
</tr>
<tr>
<td>Private provider (Name &amp; NPI)</td>
<td>863-256-2900</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>803-870-9864</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.

☐ Absolute Total Care  ☐ BlueChoice HealthPlan  ☐ First Choice by Select Health  ☐ WellCare Health Plan, Inc.
P: 803-933-3850  ☐ P: 888-902-1668  P: 888-559-1010 x55251  ☐ P: 888-585-8842

☐ Advicare  ☐ Molina Healthcare, Inc.
P: 888-781-4371  ☐ P: 855-237-6176
F: 888-781-4316  ☐ 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  Experiencing Preterm Labor  ☐ Yes  ☐ No
(Home care 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: ____________________________  Makesen or 17-P Compound

☐ Provider Information

Ordering Provider Name ____________________________

Ordering Provider NPI ____________________________  Tax ID ____________________________
Address ____________________________  City/State/Zip ____________________________
Phone ____________________________  Fax ____________________________

Provider Type: ☐ OB/GYN  ☐ Family Medicine  ☐ MFM/Perinatology  ☐ Other
Practice Name: ____________________________  Practice NPI: ____________________________  Phone: ____________________________
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

<table>
<thead>
<tr>
<th>Date:</th>
<th>Initial</th>
<th>Follow-up</th>
</tr>
</thead>
</table>

**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:**

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**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**

---

**Contact Person**

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