

FORMS

Form Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	Reasonable Effort Documentation	04/2014
	Authorization Agreement for Electronic Funds Transfer	01/2014
	Duplicate Remittance Advice Request Form	04/2014
	Claim Reconsideration Form	12/2016
CMS-1500 (02/12)	Sample Health Insurance Claim Form	02/2012
	Sample Remittance Advice (four pages)	04/2014



**STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES**

CONFIDENTIAL COMPLAINT

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

PROGRAM INTEGRITY

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

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

NPI or MEDICAID PROVIDER ID: (if applicable)

MEDICAID RECIPIENT ID NUMBER: (if applicable)

ADDRESS OF SUSPECT:

LOCATION OF INCIDENT:

DATE OF INCIDENT:

COMPLAINT:

NAME OF PERSON REPORTING: (Please print)

SIGNATURE OF PERSON REPORTING:

DATE OF REPORT

ADDRESS OF PERSON REPORTING:

TELEPHONE NUMBER OF PERSON REPORTING:

SIGNATURE: (SCDHHS Representative Receiving Report)

SCDHHS Form 126 (revised 06/07)

**South Carolina Department of Health and Human Services
Form for Medicaid Refunds**

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

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed.

Attach appropriate document(s) as listed in item 8.

1. Provider Name: _____

2. Medicaid Legacy Provider #
(Six Characters)

OR

3. NPI#

& Taxonomy

4. Person to Contact: _____

5. Telephone Number: _____

6. Reason for Refund: [check appropriate box]

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

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

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

Other, describe in detail reason for refund:

7. Patient/Service Identification:

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

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:	or	Mail:
803-252-0870		Post Office Box 101110
		Columbia, SC 29211-9804

III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN (SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax:	or	Mail:
803-255-8225		Post Office Box 8206, Attention TPL
		Columbia, SC 29202-8206



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION**

PROVIDER _____ **DOS** _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

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

(SIGNATURE AND DATE)

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

**South Carolina Department of Health and Human Services
Electronic Funds Transfer (EFT) Authorization Agreement**

PROVIDER INFORMATION

Provider Name _____
Doing Business As Name (DBA) _____
Provider Address _____
Street _____
City _____ State/Province _____
Zip Code/Postal Code _____ Medicaid Provider Number _____
Provider Federal Identification Number (TIN) or
Employer Identification Number (EIN) _____
National Provider Identifier (NPI) _____
Provider EFT Contact Information
Provider Contact Name _____
Telephone Number _____ Telephone Number Extension _____
Email Address _____

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name _____
Financial Institution Address _____
Street _____
City _____ State/Province _____
Zip Code/Postal Code _____
Financial Institution Routing Number _____

Type of Account at Financial Institution (select one) Checking Savings

Provider's Account Number with Financial Institution _____

Account Number Linkage to Provider Identifier (select one)

Provider Tax Identification Number (TIN)

National Provider Identifier (NPI)

REASON FOR SUBMISSION: New Enrollment Change Enrollment Cancel Enrollment

I (we) hereby authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to my account indicated above and the financial institution named above, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.

I (we) understand that credit entries to the account of the above named payee are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws.

I (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.

Written Signature of Person Submitting Enrollment _____

Printed Name of Person Submitting Enrollment _____

Submission Date _____

TO PROCESS YOUR EFT ENROLLMENT OR CHANGE EXISTING INFORMATION, PLEASE RETURN THIS COMPLETED FORM ALONG WITH VERIFICATION OF YOUR ELECTRONIC DEPOSIT INFORMATION ON YOUR FINANCIAL INSTITUTION'S LETTERHEAD TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 870-9022

SPECIAL INSTRUCTIONS: For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider web page for instructions on how to complete updates to your EFT information.
Effective January 01, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDHHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching trace number and your ERA can be directed to the Provider Service Center at 1-888-289-0709.

**South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form**

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

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

1. Provider Name: _____
2. Medicaid Legacy Provider # _____ (Six Characters)
NPI# _____ & Taxonomy _____
3. Person to Contact: _____ 4. Telephone Number: _____
5. Requesting:
 Remittance Advice Pages Edit Correction Form (ECF)
Pages Only*

(*) ECFs are available only for Remittance Advice dates prior to January 17, 2014. Please note that SCDHHS no longer accepts ECFs for processing as of April 1, 2014.

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

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

7. Street Address for delivery of request:
Street: _____
City: _____
State: _____
Zip Code: _____

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

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

Authorizing Signature

Date



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

Submit your Claim Reconsideration request to:

Fax: 1-855-563-7086

or

Mail: South Carolina Healthy Connections Medicaid
 ATTN: Claim Reconsiderations
 Post Office Box 8809
 Columbia, SC 29202-8809

CLAIM RECONSIDERATION FORM

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

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____ Medicaid ID: _____

Section 2: Provider Information

Specify your affiliation: Physician Hospital Other (DME, Lab, Home Health Agency, etc.): _____

NPI: _____ Medicaid Provider ID: _____ Facility/Group/Provider Name: _____

Return Mailing Address: _____
Street or Post Office Box State ZIP

Contact: _____ Email: _____ Telephone #: _____ Fax #: _____

Section 3: Claim Information

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

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below)

- | | |
|---|---|
| <input type="checkbox"/> Ambulance Services | <input type="checkbox"/> Nursing Facility Services |
| <input type="checkbox"/> Clinic Services | <input type="checkbox"/> Optional State Supplementation (OSS) |
| <input type="checkbox"/> Community Long Term Care (CLTC) | <input type="checkbox"/> Pharmacy Services |
| <input type="checkbox"/> Community Mental Health Services | <input type="checkbox"/> Physicians Laboratories, and Other Medical Professionals |
| <input type="checkbox"/> Durable Medical Equipment (DME) | Specify: _____ |
| <input type="checkbox"/> Early Intervention Services | <input type="checkbox"/> Private Rehabilitative Therapy and Audiological Services |
| <input type="checkbox"/> Federally Qualified Health Center (FQHC) | <input type="checkbox"/> PRTF CHANCE Waiver |
| <input type="checkbox"/> Enhanced Services | <input type="checkbox"/> Psychiatric Hospital Services |
| <input type="checkbox"/> Home Health Services | <input type="checkbox"/> Rehabilitative Behavioral Health Services (RBHS) |
| <input type="checkbox"/> Hospice Services | <input type="checkbox"/> Rural Health Clinic (RHC) |
| <input type="checkbox"/> Hospital Services | <input type="checkbox"/> Targeted Case Management (TCM) |
| <input type="checkbox"/> Licensed Independent Practitioner's Rehabilitative Services (LIPS) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Local Education Agencies (LEA) | |

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

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature: _____

Date: _____

Sample Remittance Advice (page 1)

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

PROVIDER ID.					PROFESSIONAL SERVICES					PAYMENT DATE	PAGE		
+-----+ AB00080000	DEPT OF HEALTH AND HUMAN SERVICES				REMITTANCE ADVICE				+-----+ 02/14/2014				+-----+ 1
+-----+													
+-----+													
PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT T MEDICAID S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT	
+-----+	+-----+	+-----+	+-----+	+-----+	+-----+	+-----+	+-----+	+-----+	+-----+	+-----+	+-----+	+-----+	
ABB1AA	1403004803012700A 01		101713	71010	27.00 27.00	6.72 P 6.72 P	1112233333	M CLARK		026	0.00	0.00	
ABB2AA	1403004804012700A 01		101713	74176	259.00 259.00	0.00 S 0.00 S	1112233333	M CLARK		026	0.00	0.00	
ABB3AA	1403004805012700A 01 02		071913 071913	A5120 A4927	24.00 12.00 12.00	0.00 R 0.00 R 0.00 R	1112233333	M CLARK		000 000	0.00	0.00 0.00	
+-----+													
+-----+													
TOTALS					3	310.00					0.00	0.00	
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Sample Remittance Advice (page 2)

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

PROVIDER ID.			PROFESSIONAL SERVICES			PAYMENT DATE	PAGE					
+-----+ AB00080000 +-----+	DEPT OF HEALTH AND HUMAN SERVICES		REMITTANCE ADVICE		+-----+ 02/28/2014 +-----+		+-----+ 1 +-----+					
SOUTH CAROLINA MEDICAID PROGRAM												
PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY PROC.	AMOUNT BILLED	TITLE 19 PAYMENT T MEDICAID S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT	
ABB222222	1405200415812200A			1192.00	243.71 P	1112233333	M CLARK			0.00		
	01		021814 S0315	800.00	117.71 P			000			0.00	
	02		021814 S9445	392.00	126.00 P			000			0.00	
VOID OF ORIGINAL CCN 13283002244813300A PAID 20131018												
ABB222222	1405200077700000U			1412.00	273.71 P	1112233333	M CLARK					
	01		100213 S0315	1112.00	143.71 P			000				
	02		100213 S9445	300.00	130.00 P			000				
REPLACEMENT OF ORIGINAL CCN 1304711253670430A PAID 20131018												
ABB222222	1405200414812200A			1001.50	42.75 P	1112233333	M CLARK			0.00		
	01		100213 S0315	142.50	42.75 P			000			0.00	
	02		100313 S9445	859.00	0.00 R			000			0.00	
										0.00	0.00	
				\$286.46								
				CERT. PG TOT	MEDICAID PG TOT	STATUS CODES:		PROVIDER NAME AND ADDRESS				
FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".				\$0.00	\$286.46	P = PAYMENT MADE		ABC HEALTH PROVIDER				
				CERTIFIED AMT	MEDICAID TOTAL	R = REJECTED		PO BOX 000000				
				0.00	0.00	S = IN PROCESS		FLORENCE SC 00000				
IF YOU STILL HAVE QUESTIONS+-----+ +-----+ +-----+						E = ENCOUNTER						
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.

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

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME I I	M F M O D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	1405200077700000U				513.00-	197.71-	P	1112233333	CLARK	M	131018	1328300224813300A
	01		100213	S0315	453.00	160.71-	P				000	
	02		100213	S9445	60.00	33.00-	P				000	
	TOTALS		1		513.00-	193.71-						

SAMPLE ONLY

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

Sample Remittance Advice (page 4)

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

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

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

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