

## FORMS

Number	Name	Revision Date
DHHS 126	<a href="#">Confidential Complaint</a>	06/2007
DHHS 130	<a href="#">Claim Adjustment Form 130</a>	03/2007
DHHS 205	<a href="#">Medicaid Refunds</a>	01/2008
DHHS 931	<a href="#">Health Insurance Information Referral Form</a>	02/2018
	<a href="#">Reasonable Effort Documentation</a>	04/2014
	<a href="#">Electronic Funds Transfer (EFT) Authorization Agreement</a>	08/2019
	<a href="#">Duplicate Remittance Advice Request Form</a>	09/2017
	<a href="#">Claim Reconsideration Form</a>	11/2018
CMS-1500 (02/12)	<a href="#">Sample Claim Form Showing TPL Denial with NPI</a>	02/2012
	<a href="#">Sample Remittance Advice (four pages)</a>	04/2014
	<a href="#">Fax Cover Sheet for RBHS Exception</a>	08/2021
	<a href="#">Request for Rehabilitative Behavioral Health Services Limit Exception (two pages)</a>	08/2021
	<a href="#">Rehabilitative Behavioral Health Services (RBHS) Referral Form (four pages)</a>	08/2021
	<a href="#">Accreditation Crosswalk for Rehabilitative Behavioral Health Services</a>	03/2021
	<a href="#">Accreditation for Rehabilitative Behavioral Health Services</a>	04/2017
	<a href="#">Program Changes for Rehabilitative Behavioral Health Services</a>	04/2021
	<a href="#">Voluntary Termination Notification for Rehabilitative Behavioral Health Services</a>	04/2017
	<a href="#">Rehabilitative Behavioral Health Services (RBHS) Parent/Caregiver/Guardian Agreement to Participate in Community Support Service (two pages)</a>	04/2017
	<a href="#">Rehabilitative Behavioral Health Services (RBHS) Parent/Caregiver/Guardian Agreement to Participate in Community Support Service - Spanish (two pages)</a>	04/2017
	<a href="#">Community Integration Services Provider Credentialing Request (three pages)</a>	08/2021
	<a href="#">Therapeutic Childcare Center Credentialing Request (three pages)</a>	08/2021
	<a href="#">Multisystemic Therapy (MST) Request for Approval of Continued Services</a>	01/2024



**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)

# 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

Originator:

☐ DHHS ☐ MCCS ☐ Provider ☐ MIVS

Reason For Adjustment: (Fill One Only )

- |                                                                         |                                                       |
|-------------------------------------------------------------------------|-------------------------------------------------------|
| <input type="radio"/> Insurance payment different than original claim   | <input type="radio"/> Medicaid paid twice - void only |
| <input type="radio"/> Keying errors                                     | <input type="radio"/> Incorrect provider paid         |
| <input type="radio"/> Incorrect recipient billed                        | <input type="radio"/> Incorrect dates of service paid |
| <input type="radio"/> Voluntary provider refund due to health insurance | <input type="radio"/> Provider filing error           |
| <input type="radio"/> Voluntary provider refund due to casualty         | <input type="radio"/> Medicare adjusted the claim     |
| <input type="radio"/> Voluntary provider refund due to Medicare         | <input type="radio"/> Other                           |

For Agency Use Only

Analyst ID:

--	--	--	--	--	--

- |                                                                          |                                               |
|--------------------------------------------------------------------------|-----------------------------------------------|
| <input type="radio"/> Hospital/Office Visit included in Surgical Package | <input type="radio"/> Web Tool error          |
| <input type="radio"/> Independent lab should be paid for service         | <input type="radio"/> Reference File error    |
| <input type="radio"/> Assistant surgeon paid as primary surgeon          | <input type="radio"/> MCCS processing error   |
| <input type="radio"/> Multiple surgery claims submitted for the same DOS | <input type="radio"/> Claim review by Appeals |
| <input type="radio"/> MMIS claims processing error                       |                                               |
| <input type="radio"/> Rate change                                        |                                               |

Comments:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_

**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

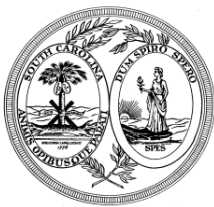
Make all checks payable to: South Carolina Department of Health and Human Services

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:**  
803-252-0870

**or**

**Mail:**  
Post Office Box 101110  
Columbia, SC 29211-9804



**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.**

REASON FOR SUBMISSION											
<input type="checkbox"/> <b>Change to Current EFT (i.e. account or bank changes)</b> <input type="radio"/> <b>Individual</b> <input type="radio"/> <b>Organization</b>											
INDIVIDUAL PROVIDER/ORGANIZATION INFORMATION											
Individual Provider/Organization Legal Business Name											
Doing Business as Name (DBA)											
Street											
City				State		Zip Code/Postal Code					
Medicaid Provider Number				National Provider Identifier (NPI)							
Designate Tax Identification Number (TIN)				<input type="radio"/> <b>SSN (individual)</b> <input type="radio"/> <b>EIN (organization)</b>							
SSN				EIN							
ORGANIZATION/INDIVIDUAL PROVIDER EFT CONTACT INFORMATION											
Provider Contact Name											
Telephone Number										Extension	
Email Address											
FINANCIAL INSTITUTION INFORMATION											
Financial Institution Name											
Financial Institution Address											
City				State		Zip Code/Postal Code					
PROVIDER'S ACCOUNT NUMBER WITH FINANCIAL INSTITUTION											
Financial Institution Routing Number (Nine digits)											
Provider's Account Number with Financial Institution (Up to 17 digits)											
Type of Account at Financial Institution (TRANSIT CODE)				<input type="radio"/> <b>22 – Checking Account</b> or <input type="radio"/> <b>32 – Savings Account</b>							

By signing this form, I authorize the SCDHHS to initiate credit entries, if necessary, debit entries for any credits in error to the checking or savings account at the financial institution identified above. Credit entries will pertain only to the SCDHHS payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the SCDHHS 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 30 days written notice to the address shown below prior to revoking or revising 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://vip.scdhhs.gov/sceis> or contact 888-289-0709.

**ALL EFT REQUESTS ARE SUBJECT TO A 10-DAY PRENOTE PERIOD IN WHICH ALL ACCOUNTS ARE VERIFIED BY THE QUALIFYING FINANCIAL INSTITUTION BEFORE ANY MEDICAID DIRECT DEPOSITS ARE MADE.**

Signature of Person Submitting Form (print to sign)

Printed Name of Person Submitting Form

Submission Date

**SPECIAL INSTRUCTIONS:** For questions regarding the status of your EFT update, please contact the Provider Service Center at 888-289-0709. Please refer to the EFT section of the provider enrollment manual found at <https://www.scdhhs.gov/provider> for instructions on how to complete updates to your EFT information.

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

To process **EFT updates**, please return this completed form along with verification of your electronic deposit information on your financial institution's letterhead to:

**SCDHHS, Medicaid Provider Enrollment • PO BOX 8809 • Columbia, South Carolina 29202-8809 • FAX 803-870-9022**

**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**



**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. 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)

- |                                                                                      |                                                                                                                                          |
|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Ambulance Services                                          | <input type="checkbox"/> Licensed Independent Practitioner's Rehabilitative Services (LIPS)                                              |
| <input type="checkbox"/> Autism Spectrum Disorder (ASD) Services                     | <input type="checkbox"/> Local Education Agencies (LEA)                                                                                  |
| <input type="checkbox"/> Clinic Services                                             | <input type="checkbox"/> Medically Complex Children's (MCC) Waivers                                                                      |
| <input type="checkbox"/> Community Long Term Care (CLTC)                             | <input type="checkbox"/> Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) |
| <input type="checkbox"/> Community Mental Health Services                            | <input type="checkbox"/> Optional State Supplementation (OSS)                                                                            |
| <input type="checkbox"/> Department of Disabilities and Special Needs (DDSN) Waivers | <input type="checkbox"/> Pharmacy Services                                                                                               |
| <input type="checkbox"/> Durable Medical Equipment (DME)                             | <input type="checkbox"/> Physicians Laboratories, and Other Medical Professionals Specify: _____                                         |
| <input type="checkbox"/> Early Intervention Services                                 | <input type="checkbox"/> Private Rehabilitative Therapy and Audiological Services                                                        |
| <input type="checkbox"/> Enhanced Services                                           | <input type="checkbox"/> Psychiatric Hospital Services                                                                                   |
| <input type="checkbox"/> Federally Qualified Health Center (FQHC)                    | <input type="checkbox"/> Rehabilitative Behavioral Health Services (RBHS)                                                                |
| <input type="checkbox"/> Home Health Services                                        | <input type="checkbox"/> Rural Health Clinic (RHC)                                                                                       |
| <input type="checkbox"/> Hospice Services                                            | <input type="checkbox"/> Targeted Case Management (TCM)                                                                                  |
| <input type="checkbox"/> Hospital Services                                           | <input type="checkbox"/> Other: _____                                                                                                    |



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**Section 5: Desired Outcome**

**Request submitted by:**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Alcohol & Drug Rehabilitation Services  
Sample Claim Form Showing TPL Denial  
with NPI

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input checked="" type="checkbox"/> FECA BLK (LUNG) (ID#) <input type="checkbox"/> OTHER <input type="checkbox"/>												PICA <input type="checkbox"/>											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John A.												3. PATIENT'S BIRTH DATE MM DD YY 01 01 1947		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street) 123 Windy Lane												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)		8. RESERVED FOR NUCC USE							
CITY Anytown				STATE SC				CITY				STATE											
ZIP CODE 29999				TELEPHONE (Include Area Code) ( )				ZIP CODE				TELEPHONE (Include Area Code) ( )											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER A1111111									
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY 0 00		SEX M <input type="checkbox"/> F <input type="checkbox"/>							
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b. OTHER CLAIM ID (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME							
c. RESERVED FOR NUCC USE 22												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		401		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, complete items 9, 9a, and 9d.							
d. INSURANCE PLAN NAME OR PROGRAM NAME 401												10d. CLAIM CODES (Designated by NUCC) 1		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL												15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI												18. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		19. CHARGES		20. RESUBMISSION CODE ORIGINAL REF. NO.							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												21. PRIOR AUTHORIZATION NUMBER											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. 295.32 B. C. D. E. F. G. H. I. J. K. L.												22. F. CHARGES		G. DAYS OR UNITS		H. FROST Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #			
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. CHARGES G. DAYS OR UNITS H. FROST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #												1		01 07 14 01 07 14 11 H0001		102.00		1		ZZ 1212121212		NPI 1234567890	
2																							
3																							
4																							
5																							
6																							
25. FEDERAL TAX I.D. NUMBER SSN EIN 555555555 <input type="checkbox"/> <input checked="" type="checkbox"/>												26. PATIENT'S ACCOUNT NO. DOE1234		27. ACCEPT ASSIGNMENT? For gov. claims, see back <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 102.00		29. AMOUNT PAID \$ 0.00		30. Paid for NUCC Use 102.00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # (555) 5555555									
SIGNED DATE												a. NPI		b. 1234567890		c. ZZ1212121212							

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

# 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
DEPT OF HEALTH AND HUMAN SERVICES														
AB00080000		REMITTANCE ADVICE										02/14/2014		1
SOUTH CAROLINA MEDICAID PROGRAM														
PROVIDERS	CLAIM	SERVICE RENDERED	AMOUNT	TITLE 19	S	RECIPIENT	RECIPIENT NAME	M	TLE. 18	COPAY	TITLE			
OWN REF.	REFERENCE	DATE(S)	BILLED	PAYMENT	T	ID.	F M	O	ALLOWED	AMT	18			
NUMBER	NUMBER	PY IND	MMDDYY	PROC.	MEDICAID	S	NUMBER	I	I LAST NAME	D	CHARGES	PAYMENT		
ABB1AA	1403004803012700A				27.00	6.72	P	1112233333	M	CLARK				
	01		101713	71010	27.00	6.72	P				0.00	0.00		
ABB2AA	1403004804012700A				259.00	0.00	S	1112233333	M	CLARK				
	01		101713	74176	259.00	0.00	S				0.00	0.00		
ABB3AA	1403004805012700A				24.00	0.00	R	1112233333	M	CLARK				
	01		071913	A5120	12.00	0.00	R					0.00		
	02		071913	A4927	12.00	0.00	R					0.00		
									Edits: L00 946 L02 852 08/30/13					
	TOTALS		3		310.00						0.00	0.00		
					\$6.72			STATUS CODES:		PROVIDER NAME AND ADDRESS				
FOR AN EXPLANATION OF THE		CERT. PG TOT		MEDICAID PG TOT				P = PAYMENT MADE		ABC HEALTH PROVIDER				
ERROR CODES LISTED ON THIS								R = REJECTED						
FORM REFER TO: "MEDICAID		\$0.00		\$286.46				S = IN PROCESS		PO BOX 000000				
PROVIDER MANUAL".								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 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
DEPT OF HEALTH AND HUMAN SERVICES				REMITTANCE ADVICE				02/28/2014				1
SOUTH CAROLINA MEDICAID PROGRAM												
PROVIDERS	CLAIM	SERVICE RENDERED		AMOUNT	TITLE 19	S	RECIPIENT	RECIPIENT NAME	M	TLE. 18	COPAY	TITLE
OWN REF.	REFERENCE	DATE (S)		BILLED	PAYMENT	T	ID.	F M	O	ALLOWED	AMT	18
NUMBER	NUMBER	PY IND	MMDDYY	PROC.	MEDICAID	S	NUMBER	I I LAST NAME	D	CHARGES		PAYMENT
ABB222222	1405200415812200A				1192.00		243.71	P	1112233333	M	CLARK	
	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	
	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								
FOR AN EXPLANATION OF THE				CERT. PG TOT	MEDICAID PG TOT			STATUS CODES:		PROVIDER NAME AND ADDRESS		
ERROR CODES LISTED ON THIS				\$0.00	\$286.46			P = PAYMENT MADE		ABC HEALTH PROVIDER		
FORM REFER TO: "MEDICAID								R = REJECTED				
PROVIDER MANUAL".				CERTIFIED AMT	MEDICAID TOTAL			S = IN PROCESS		PO BOX 000000		
IF YOU STILL HAVE QUESTIONS								E = ENCOUNTER		FLORENCE SC 00000		
PHONE THE D.H.H.S. NUMBER					0.00							
SPECIFIED FOR INQUIRY OF												
CLAIMS IN THAT MANUAL.				CHECK TOTAL				CHECK NUMBER				

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

[illegible]

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	CLAIM	SERVICE	PROC / DRUG	RECIPIENT	RECIPIENT NAME	ORIG.	ORIGINAL		DEBIT /		EXCESS						
OWN REF.	REFERENCE	DATE (S)		ID.	F M	CHECK	PAYMENT		CREDIT								
NUMBER	NUMBER	MMDDYY	CODE	NUMBER	LAST NAME I I	DATE			AMOUNT		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		DEBIT BALANCE		MEDICAID TOTAL		CERTIFIED AMT		TO BE REFUNDED									
INCENTIVE		PRIOR TO THIS		0.00		0.00		IN THE FUTURE									
CREDIT AMOUNT		REMITTANCE															
0.00		0.00		ADJUSTMENTS													
				-4338.95		0.00		PROVIDER NAME AND ADDRESS									
		YOUR CURRENT		CHECK TOTAL		CHECK NUMBER		ABC HEALTH PROVIDER									
		DEBIT BALANCE		0.00				PO BOX 000000									
								FLORENCE		SC 00000							

# Healthy Connections

## MEDICAID



Henry McMaster  
Governor

Robert M. Kerr  
Director

## FAX COVER SHEET

CONFIDENTIAL INFORMATION ENCLOSED

**DATE:** \_\_\_\_\_

**TO:** SCDHHS — Division of Behavioral Health

Attn: RBHS Exceptions

Fax 803-255-8204

**FROM:** \_\_\_\_\_

Telephone #: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Total Number of Pages Transmitted: \_\_\_\_\_ (Including Cover Sheet)

**COMMENTS:**

### Confidentiality Note

This message is intended for the use of the person or entity to which it is addressed and may contain information, including health information, that is privileged, confidential, and the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this in error, please notify us immediately and destroy the related message. Thank you.

Long Term Care and Behavioral Health Services  
P. O. Box 8206 Columbia South Carolina 29202-8206  
(803) 898-2565 Fax (803) 255-8204



## Request for Rehabilitative Behavioral Health Services Limit Exception

Beneficiary Information	
Name:	
Address:	
Medicaid ID #:	
Date of Birth:	

Provider Information	
Provider Name:	
Provider NPI:	
Address:	
City / State / Zip Code	
Phone Number	
Fax Number	

Diagnosis - Code / Description:	/
Diagnosis - Code / Description:	/
Diagnosis - Code / Description:	/

Clinical Rationale for Request

Community Support Services (PRS, B-Mod, FS, TCC and CIS only)			
Procedure Code	Service Name	# of Daily Units Currently Authorized	# of Daily Units Requested

All Other Rehabilitative Behavioral Health Services			
Procedure Code	Service Name	# of Units Requested	# of Encounters Requested

LPHA Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Henry McMaster GOVERNOR

Robert M. Kerr DIRECTOR

P.O. Box 8206 &gt; Columbia, SC 29202

www.scdhhs.gov

### Rehabilitative Behavioral Health Services (RBHS) Referral Form

This form shall be completed only by state agencies and submitted to private RBHS providers in accordance with HIPAA regulations as it contains Protected Health Information (PHI) of Medicaid beneficiaries.

<b>Referring State Agency</b>	<input type="checkbox"/> Department of Social Services	<input type="checkbox"/> Department of Disabilities and Special Needs
	Region:	Region:
	<input type="checkbox"/> Department of Mental Health	<input type="checkbox"/> Department of Juvenile Justice
	CMHC:	Region:
	<input type="checkbox"/> Continuum of Care	<input type="checkbox"/> Department of Education
	Region:	District:
	<input type="checkbox"/> Department of Alcohol and Other Drug Abuse Services	
	Commission:	

<b>Provider (Referred to)</b>				<b>NPI</b>	
<b>Address</b>					
<b>City</b>		<b>State</b>		<b>Zip</b>	
<b>Phone Number</b>		<b>Fax Number</b>			

<b>Beneficiary Name</b>					
<b>Legally Responsible Person(s)</b>					
<b>Address</b>					
<b>City</b>		<b>State</b>		<b>Zip</b>	
<b>Date of Birth</b>		<b>Gender</b>	<input type="checkbox"/> Female	<input type="checkbox"/> Male	
<b>Social Security Number (last 4 digits)</b>		<b>Medicaid Number</b>			

Medical Necessity	
<b>Diagnosis – Code / Description</b>	/
<b>Diagnosis – Code / Description</b>	/
<b>Diagnosis – Code / Description</b>	/

#### Clinical Rationale for Rehabilitative Behavioral Health Services Recommendations

I recommend that the above-named Medicaid beneficiary receive Rehabilitative Behavioral Health Services. This beneficiary meets the Medical Necessity criteria for services as evidenced by a mental health and/or substance use disorder from the current edition of the DSM or the ICD.

Name of LPHA: \_\_\_\_\_

Credentials: \_\_\_\_\_

Signature of LPHA: \_\_\_\_\_

Date: \_\_\_\_\_



Recommendations for Rehabilitative Behavioral Health Services							
	Service Description	Procedure Code	Unit	Total Units Authorized	Start Date	End Date	Specific Frequency (# of units per day, # of days per week)
<b>SCREENING AND ASSESSMENT SERVICES</b>							
<input type="checkbox"/>	Behavioral Health Screening	H0002	15 minutes				
<input type="checkbox"/>	Psychiatric Diagnostic Assessment without Medical Services - Initial	90791	Encounter				
<input type="checkbox"/>	Psychiatric Diagnostic Assessment with Medical Services – Initial	90792	Encounter				
<input type="checkbox"/>	Mental Health Comprehensive Diagnostic Assessment – Follow-up	H0031	Encounter				
<input type="checkbox"/>	Psychological Testing / Evaluation	96101	60 minutes				
<input type="checkbox"/>	Comprehensive Evaluation – Initial	H2000	Encounter (average of 3 hours)				
<input type="checkbox"/>	Comprehensive Evaluation – Follow up	H0031	Encounter				
<b>SERVICE PLAN DEVELOPMENT</b>							
<input type="checkbox"/>	Mental Health Service Plan Development (Non-physician)	H0032	15 minutes				
<input type="checkbox"/>	Service Plan Development (Team Conference w/ Client/Family)	99366	Encounter (minimum 30 minutes)				
<input type="checkbox"/>	Service Plan Development (Team Conference w/o Client/Family)	99367	Encounter (minimum 30 minutes)				
<b>CORE TREATMENT – PSYCHOTHERAPY AND COUNSELING SERVICES</b>							
<input type="checkbox"/>	Individual Psychotherapy	90832	30 minutes				
<input type="checkbox"/>	Individual Psychotherapy	90834	45 minutes				

Recommendations for Rehabilitative Behavioral Health Services							
	Service Description	Procedure Code	Unit	Total Units Authorized	Start Date	End Date	Specific Frequency (# of units per day, # of days per week)
<input type="checkbox"/>	Individual Psychotherapy	90837	60+ minutes				
<input type="checkbox"/>	Group Psychotherapy	90853	60+ minutes				
<input type="checkbox"/>	Family Psychotherapy w/o Client	90846	60+ minutes				
<input type="checkbox"/>	Family Psychotherapy w/ Client	90847	60+ minutes				
<input type="checkbox"/>	Multiple Family Group Psychotherapy	90849	60+ minutes				
<input type="checkbox"/>	Crisis Management	H2011	15 minutes				
<input type="checkbox"/>	Medication Management	H0034	15 minutes				
<b>COMMUNITY SUPPORT SERVICES</b>							
<input type="checkbox"/>	Psychosocial Rehabilitation Service (PRS)	H2017	15 minutes				
<input type="checkbox"/>	Behavior Modification (B-Mod)	H2014	15 minutes				
<input type="checkbox"/>	Family Support (FS)	S9482	15 minutes				
<input type="checkbox"/>	Therapeutic Child Care	H2037	15 minutes				
<input type="checkbox"/>	Community Integration Services	H2030	15 minutes				
<input type="checkbox"/>	Therapeutic Foster Care	S5145	Per diem				

**State Agency Representative Authorization (optional, per internal state agency processes)**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Accreditation Crosswalk for Rehabilitative Behavioral Health Services

### Commission on Accreditation of Rehabilitation Facilities (CARF)

**General Program Standards:** For an organization to achieve quality services, the persons served are active participants in the planning, prioritization, implementation, and ongoing evaluation of the services offered. The service planning process is individualized, establishing goals and objectives that incorporate the unique strengths, needs, abilities, and preferences of the persons served. General program standards typically require the following (but should be verified and reviewed within Section 2 of the CARF Child and Youth Services [CYS] & Behavioral Health [BH] Standards Manuals):

- Comprehensive Program Structure
- Screening and Access to Services
- Person-centered Plans
- Transition/Discharge Planning
- Medication Use
- Non-Violent Practices
- Records of Persons Served
- Quality Records Management

**Behavioral Health Field Categories:** For each behavioral healthcare program selected for accreditation from Section 3, an organization must identify which behavioral health field category the core program operates. Field categories are used to characterize the purpose, intent, and overall focus of a core program. A field category is not required for any program under the CYS Manual.

**Providers must choose one of the following field categories:**

- Substance Use Disorders (SUD)
- Mental Health
- Psychosocial Rehabilitation
- Family Services
- Integrated SUD/Mental Health
- Integrated DD/Mental Health

**Specific Population Designation: Child and adolescent providers must demonstrate evidence of designation**

- Children and Adolescents (CA) (up to age 18)

**Accepted Levels of Accreditation Decisions:**

- Three-Year Accreditation
- Provisional Accreditation
- One-Year Accreditation

#### CARF Manuals

- Behavioral Health (BH) Standards Manual
- Child and Youth Services (CYS) Standards Manual
- Employment and Community Services (ECS) Standards Manual

CARF's standards can be accessed at: <http://www.carf.org/home/>

CARF Standards	Covered Rehabilitative Services
Assessment and Referral (BH Manual or CYS Manual)	Behavioral Health Screening (BHS), Diagnostic Assessment (DA), Psychological Testing and Evaluation (PTE), Service Plan Development (SPD)
Behavioral Consultation (CYS Manual)	BHS, Behavior Modification (B-Mod), DA, PTE
Case Management/Services Coordination (BH Manual or CYS Manual)	BHS, DA, PTE, SPD
Community Employment Services (ECS Manual)	SPD, MM (Medication Management), Individual Psychotherapy (IP), Group Psychotherapy (GP)
Community Integration (BH Manual)	BHS, Community Integration Services (CIS), DA, PRS, PTE, SPD
Counseling/Outpatient (CYS Manual)	BHS, DA, Family Psychotherapy (FP), Family Support (FS), GP, IP, Multiple Family Group Psychotherapy (MFGP), Psychosocial Rehabilitation Services (PRS), PTE, SPD, Therapeutic Childcare Center (TCC)
Crisis Intervention (BH Manual or CYS Manual)	BHS, Crisis Management (CM), DA, PTE, SPD
Day Treatment (BH Manual or CYS Manual)	BHS, DA, FP, GP, MFGP, IP, PTE, SPD
Early Childhood Development (CYS Manual)	BHS, B-Mod, DA, PRS, PTE, SPD, TCC
Foster Family and Kinship Care (CYS Manual)	BHS, B-Mod, DA, FP, FS, GP, IP, MFGP, PRS, PTE, SPD
Intensive Family Based Services (BH Manual or CYS Manual)	BHS, B-Mod, CM, DA, FP, FS, GP, IP, MFGP, MM, PRS, PTE, SPD, TCC
Intensive Outpatient Treatment (BH Manual or CYS Manual)	BHS, DA, FP, FS, GP, MFGP, IP, PTE, SPD, TCC
Outpatient Treatment (BH Manual)	BHS, DA, FP, FS, GP, IP, MFGP, PRS, PTE, SPD, TCC
Residential Treatment (BH Manual or CYS Manual)	BHS, B-Mod, CM, DA, FP, FS, GP, IP, MFGP, PRS, PTE, SPD
Specialized or Treatment Foster Care (BH Manual or CYS Manual)	BHS, B-Mod, DA, FP, FS, GP, IP, MFGP, MM, PTE, SPD
Supported Living (BH Manual)	BHS, DA, FS, MM, PRS, PTE, SPD

#### Council on Accreditation (COA)

##### Administration and Management Standards and Service Delivery Administration Standards

**All organizations are required to implement COA's Administration and Management Standards and Service Delivery Administration Standards which include:**

- Ethical Practice (ETH) \*\*\*
- Financial Management (FIN)
- For-Profit Administration and Financial Management (AFM)\*
- Governance (GOV)
- Human Resources Management (HR)



- Network Administration (NET)\*\*
- Performance and Quality Improvement (PQI)
- Risk Prevention and Management (RPM)
- Administrative and Service Environment (ASE)
- Behavior Support and Management (BSM)
- Client Rights (CR)
- Program Administration (PRG)\*\*\*\*
- Training and Supervision (TS)

*\*This standard is only applicable to for-profit entities*

*\*\*This standard is only applicable to network management entities*

*\*\*\* This standard will not apply to organizations accredited after 2020*

*\*\*\*\* This standard only applies to organizations accredited after 2020*

### **Service Standards**

As a result of COA's comprehensive structure of its Service Standards, Core Rehabilitative Services, Core Treatment, and Community Support Services can be contained within many different COA Service Standards as they are components of a larger program. The chart below details the varying applicable COA Service Standard sections.

Organizations currently accredited for Supported Community Living (SCL) will maintain this designated accreditation until they transition to Housing Stabilization and Community Living Services (HSCL).

### **Accepted Levels of Accreditation Decisions:**

Accreditation or Reaccreditation Approval (effective for a period of four years)

COA's standards can be accessed at: [www.coanet.org](http://www.coanet.org)

COA Standards	Covered Rehabilitative Services
Adult Day Services (AD)	Service Plan Development (SPD), Behavioral Health Screening (BHS), Diagnostic Assessment (DA), Community Integration Services (CIS)
Child and Family Development and Support Services (CFD)	SPD, BHS, DA, Psychosocial Rehabilitation Services (PRS), Behavior Modification (B-Mod), Family Support (FS), Therapeutic Childcare Center (TCC)
Counseling/Coaching Support, and Education Services (CSE)	BHS, PRS, B-Mod, FS, CIS
Crisis Response and Information Services (CRI)	BHS, DA, Crisis Management (CM)
Day Treatment Services (DTX)	BHS, DA, SPD, PRS, B-Mod, FS, Individual Psychotherapy (IT), Group Psychotherapy (GT), Multiple Family Group Psychotherapy (MFT), Family Psychotherapy (FT), CM, CIS, TCC
Family Foster Care and Kinship Care (FKC)	Psychological Testing and Evaluation (PTE), DA, BHS, SPD, IT, FT, CM, PRS, B-Mod, FS
Family Preservation and Stabilization Services (FPS)	BHS, DA, SPD, IT, FT, CM, PRS, B-Mod, FS, TCC
Group Living Services (GLS)	PTE, BHS, DA, SPD, IT, GT, MFT, FT, PRS, B-Mod, FS

Housing Stabilization and Community Living Services (HSCL)	SPD, BHS, DA, PRS, CIS
Medication Control and Administration	Medication Management (MM)
Psychiatric Rehabilitation Services (PRS)	BHS, DA, SPD, PRS, CIS
Residential Treatment Services (RTX)	PTE, DA, BHS, SPD, IT, GT, MFT, FT, PRS, B-Mod, FS, CM
Services for Mental Health and/or Substance Use Disorders (MHSU)	PTE, BHS, DA, SPD, IT, GT, MFT, FT, CM, PRS, B-Mod, FS, CIS, TCC
Shelter Services (SH)	BHS, DA, SPD, PRS, B-Mod, FS
Supervised Visitation and Exchange (SVE)	SPD, BHS, DA, IT, FT
Supported Community Living Services (SCL)	SPD, BHS, DA, PRS, CIS
Vocational Rehabilitation Services (VOC)	SPD, BHS, DA, CIS
Youth Independent Living Services (YIL)	BHS, DA, SPD, PRS

### The Joint Commission (TJC)

**Comprehensive Accreditation Manual for Behavioral Health Care:** Providers are required to demonstrate compliance with all applicable standards contained in the Behavioral Health Care Manual.

**The standards-based performance areas for all behavioral health care organizations are:**

- Care, Treatment and Services (CTS)
- Environment of Care (EC)
- Emergency Management (EM)
- Human Resources Management (HRM)
- Infection Prevention and Control (IC)
- Information Management (IM)
- Leadership (LD)
- Life Safety (LS) (in 24-hour settings)
- Medication Management (MM)
- National Patient Safety Goals (NPSG)
- Performance Improvement (PI)
- Record of Care, Treatment and Services (RC)
- Rights and Responsibilities of the Individual (RI)
- Waived Testing (WT) (when applicable)

**Accepted Levels of Accreditation Decisions:**

- Accreditation

TJC's standards can be accessed at: <http://www.jointcommission.org/>

Core Rehabilitative Service Standards	TJC Standards
Service Plan Development (SPD)	Care, Treatment, and Services
Behavioral Health Screening (BHS)	Care, Treatment, and Services
Diagnostic Assessment (DA)	Care, Treatment, and Services
Psychological Testing and Evaluation (PTE)	Care, Treatment, and Services
Core Treatment	TJC Service

Individual Psychotherapy (IT)	Outpatient Mental Health/Substance Use Services
Group Psychotherapy (GT)	Outpatient Mental Health/Substance Use Services
Multiple Family Group Psychotherapy (MFT)	Outpatient Mental Health/Substance Use Services
Family Psychotherapy (FT)	Outpatient Mental Health/Substance Use Services
Crisis Management (CM)	Outpatient Mental Health/Substance Use Services
Medication Management (MM)	Outpatient Mental Health/Substance Use Services
<b>Community Support Services</b>	<b>TJC Service/Setting</b>
Psychosocial Rehabilitation Services (PRS)	Service: Mental Health/Substance Use Services  Setting: Outpatient, Day Treatment, Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP)
Behavior Modification (B-Mod)	Service: Mental Health/Substance Use Services  Setting: Outpatient
Family Support (FS)	Service: Mental Health/Substance Use Services, Family Support Services, Community Integration  Setting: Outpatient
Therapeutic Childcare Services (TCC)	Service: Mental Health, Child/Youth Category  Setting: Day Treatment
Community Integration Services (CIS)	Service: Mental Health, Adult and Community Integration  Setting: Day Treatment, Outpatient

### Accreditation for Rehabilitative Behavioral Health Services

This form shall be completed and submitted to the Division of Behavioral Health for each office location via the following options:

Email: [behavioralhealth002@scdhhs.gov](mailto:behavioralhealth002@scdhhs.gov) or Fax: (803) 255-8204.

The applicable accreditation letter, certificate, and most recent survey report must be submitted as evidence with this form.

PROVIDER INFORMATION			
Legal Name of Organization: <input style="width: 90%;" type="text"/>			
Address: <input style="width: 80%;" type="text"/>			Suite: <input style="width: 20%;" type="text"/>
City: <input style="width: 40%;" type="text"/>		State: <input style="width: 15%;" type="text"/>	Zip Code: <input style="width: 25%;" type="text"/>
Phone: <input style="width: 30%;" type="text"/>		Fax: <input style="width: 30%;" type="text"/>	
NPI#: <input style="width: 20%;" type="text"/>		Medicaid ID#: <input style="width: 30%;" type="text"/>	
Primary Contact Name: <input style="width: 40%;" type="text"/>		Primary Contact Title: <input style="width: 40%;" type="text"/>	
Primary Contact Phone: <input style="width: 30%;" type="text"/>		Primary Contact Fax: <input style="width: 30%;" type="text"/>	
Primary Contact Email Address: <input style="width: 90%;" type="text"/>			

Column A: List each service the provider requests to render to Medicaid beneficiaries (limit of one service per row)	Column B: List the accreditation organization / List the corresponding accreditation standard per the accreditation crosswalk for each service listed in Column A
<i>Example: Psychosocial Rehabilitation Services</i>	<i>Example: CARF / Community Integration</i>
<input style="width: 95%;" type="text"/>	<input style="width: 50%;" type="text"/> / <input style="width: 45%;" type="text"/>
<input style="width: 95%;" type="text"/>	<input style="width: 50%;" type="text"/> / <input style="width: 45%;" type="text"/>
<input style="width: 95%;" type="text"/>	<input style="width: 50%;" type="text"/> / <input style="width: 45%;" type="text"/>
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<input style="width: 95%;" type="text"/>	<input style="width: 50%;" type="text"/> / <input style="width: 45%;" type="text"/>
<input style="width: 95%;" type="text"/>	<input style="width: 50%;" type="text"/> / <input style="width: 45%;" type="text"/>
<input style="width: 95%;" type="text"/>	<input style="width: 50%;" type="text"/> / <input style="width: 45%;" type="text"/>

Signature of Provider Representative: <div style="border-bottom: 1px solid black; height: 20px; width: 80%; margin-top: 10px;"></div>	Date: <div style="border-bottom: 1px solid black; height: 20px; width: 60%; margin-top: 10px;"></div>
------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------

SCDHHS Use Only	
Date received: <input style="width: 80%;" type="text"/>	Received by: <input style="width: 80%;" type="text"/>
Actions taken: <input style="width: 95%;" type="text"/>	

### Program Changes for Rehabilitative Behavioral Health Services

This form shall be completed and submitted to the Division of Behavioral Health for each office location via the following options:

Email: [behavioralhealth002@scdhhs.gov](mailto:behavioralhealth002@scdhhs.gov) or Fax: (803) 255-8324

PROVIDER INFORMATION			
Legal Name of Organization:			
Address:			Suite:
City:		State:	Zip Code:
Phone:		Fax:	
NP #I:		Medicaid ID #:	
Primary Contact Name:		Primary Contact Title:	
Primary Contact Phone:		Primary Contact Fax:	
Primary Contact Email Address:			

PROGRAM CHANGES	
<ul style="list-style-type: none"> <li>Provide pertinent details for each applicable change, including but not limited to: name(s) of new staff, effective date of each change, conditions of status changes, expiration dates, etc.</li> <li>Evidence for each applicable change must be submitted with this form</li> <li>Refer to the Reporting Program Changes section of the RBHS manual for further information</li> </ul>	
Change in Administrator (CEO/Director):	
Change in Clinical Director:	
Change in the number of RBHS staff resulting in less than two professional or paraprofessional staff available to provide services at any time :	
Adverse event(s) concerning staff licensure:	

Any change in accreditation status:	
Any change in facility license:	
Other:	
Other:	

Signature of Provider Representative:	Date:
---------------------------------------	-------

SCDHHS Use Only	
Date received:	Received by:
Actions taken:	

### Voluntary Termination Notification for Rehabilitative Behavioral Health Services

This form shall be completed and submitted to the Division of Behavioral Health via the following options:

Encrypted Email: [behavioralhealth002@scdhhs.gov](mailto:behavioralhealth002@scdhhs.gov) or Fax: (803) 255-8204.

PROVIDER INFORMATION			
Legal Name of Organization: <input style="width: 90%;" type="text"/>			
Address: <input style="width: 80%;" type="text"/>		Suite: <input style="width: 20%;" type="text"/>	
City: <input style="width: 40%;" type="text"/>		State: <input style="width: 10%;" type="text"/>	Zip Code: <input style="width: 40%;" type="text"/>
Phone: <input style="width: 40%;" type="text"/>		Fax: <input style="width: 60%;" type="text"/>	
NPI#: <input style="width: 20%;" type="text"/>		Medicaid ID#: <input style="width: 80%;" type="text"/>	
Primary Contact Name: <input style="width: 80%;" type="text"/>		Primary Contact Title: <input style="width: 20%;" type="text"/>	
Primary Contact Phone: <input style="width: 40%;" type="text"/>		Primary Contact Fax: <input style="width: 60%;" type="text"/>	
Primary Contact Email Address: <input style="width: 90%;" type="text"/>			

Level of Change (select only one):

☐ **Voluntary Termination**

Intent to completely terminate enrollment as an RBHS provider. This change requires adequate notice to beneficiaries. Evidence of such notification shall be retained by the provider.

☐ **Voluntary Reduction in Array of Services**

Intent is to reduce the array of services offered/rendered to beneficiaries as an RBHS provider; is not a full termination of enrollment as a provider. This change requires adequate notice to beneficiaries. Evidence of such notification shall be retained by the provider.

Please answer each item below for either level:

1. Effective date of termination/reduction:
2. Rationale for voluntary termination/reduction:
3. Service(s) to be voluntarily terminated/reduced (identify each service to be terminated and population(s) of each service to be terminated):
4. Number of beneficiaries affected:
5. Plans for either (1) discharge or (2) assistance with referral and linkage to follow-up services for continuity of care for affected beneficiaries (attach supporting documentation as evidence):
6. Impact on Staff:
7. Records management and security plan:
8. Other entities notified of voluntary termination/reduction:

This letters serves to notify the Division of Behavioral Health that

has elected to voluntarily terminate participation in the South Carolina Medicaid Program. I understand that the organization must reapply for enrollment and be approved before rendering services again to beneficiaries in the future.

Signature of Provider Representative:	Date:
<div></div>	<div></div>

SCDHHS Use Only	
Date received: <div></div>	Received by: <div></div>
Actions taken: <div></div>	



**Rehabilitative Behavioral Health Services (RBHS)  
 Parent/Caregiver/Guardian Agreement to Participate in Community Support Services**

Name of Beneficiary:  
 Medicaid Number:

Date of Birth:

**What are Rehabilitative Behavioral Health Services (RBHS) Community Support Services?**  
 RBHS Community Support Services help the child and you develop skills to live successfully in the home and community. Services include Psychosocial Rehabilitation Services (PRS), Behavior Modification (B-Mod), Family Support (FS), and Therapeutic Child Care (TCC). These services are for youth with mental health and/or substance use disorders. Services are not for summer camps, after-school programs, recreation or mentoring services.

**The child has been diagnosed with the following mental health and/or substance use disorder(s).  
 Please list both code and description (your provider is required to explain the diagnoses to you):**

Diagnosis - Code / Description	/
Diagnosis - Code / Description	/
Diagnosis - Code / Description	/
Diagnosis - Code / Description	/
Diagnosis - Code / Description	/

**The provider has recommended the following services (check all that apply):**

- ☐ Psychosocial Rehabilitation Services (PRS): PRS helps the child build skills to successfully live in the home and community, succeed in school and/or work and build healthy relationships with family, friends and others.
- ☐ Behavior Modification (B-Mod): B-Mod helps the child to reduce undesirable behaviors. You and the child will receive training in managing these behaviors. This training will help the child replace undesired behaviors with suitable ones, during and after treatment.
- ☐ Family Support (FS): FS helps you to serve as an active member of the child's treatment team and improve your ability to care for the child's behavioral health needs. FS can connect you to groups that support youth with mental health needs. FS may also encourage you to participate in other types of groups which may be helpful to you.
- ☐ Therapeutic Child Care (TCC): TCC helps children with severe emotional and/or behavioral problems. You and your child will work on your relationship in order to reduce the impact of traumatic experiences. TCC helps children to gain social and emotional skills needed to interact well with parents, adults, and playmates.

**What will be asked of you?**

You will be asked to:

- Participate in treatment planning meetings
- Participate in training sessions where you will be taught skills to help the child like modeling, redirecting, coaching, and reinforcing
- Monitor the child's behaviors and report to the treatment team
- Based on the child's needs, you may be asked to participate in other activities the treatment team recommends

**What can you expect of \_\_\_\_\_ staff?**  
 (Provider Name)

- Explain all treatments in language you will understand
- Explain all known benefits and risks of the treatment in a way you will understand

Name of Beneficiary:  
Medicaid Number:

Date of Birth:

- Treat you and all your family members with respect
- Treat you as an essential member of the treatment team
- Work with you to schedule visits, and notify you in advance if the provider must cancel or reschedule
- Discuss the child's progress with you during every visit
- Answer any questions you have regarding the child's treatment
- Respond to your concerns in a timely and respectful manner
- Provide information about community resources

Because your participation is a key to success, you will be asked to confirm your willingness to participate in these services every ninety (90) days.

By signing this form:

- I, \_\_\_\_\_, agree to participate in the following recommended RBHS  
(Name of Parent/Caregiver/Guardian)

Community Support Services:

- ☐ Psychosocial Rehabilitation Services (PRS)
- ☐ Behavior Modification (B-Mod)
- ☐ Family Support (FS)
- ☐ Therapeutic Child Care (TCC)

- I give permission for \_\_\_\_\_, to participate in the following  
(Name of Beneficiary)

recommended RBHS Community Support Services:

- ☐ Psychosocial Rehabilitation Services (PRS)
- ☐ Behavior Modification (B-Mod)
- ☐ Family Support (FS)
- ☐ Therapeutic Child Care (TCC)

- I agree the provider has explained the mental health and/or substance use disorder diagnoses to me.

I understand that at any time I can let staff know, either verbally in or writing, that I (a) no longer wish to participate in these services and/or (b) no longer wish for the child to receive these services. I also understand that I can end these services at any time, unless participation is court-ordered.

\_\_\_\_\_  
Printed Name of Parent/Caregiver/Guardian

\_\_\_\_\_  
Relationship to Beneficiary

\_\_\_\_\_  
Signature of Parent/Caregiver/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Staff

\_\_\_\_\_  
Name of Provider

\_\_\_\_\_  
Signature and Credentials of Staff

\_\_\_\_\_  
Date

**Servicios de Rehabilitación de la Salud Conductual (RBHS por sus siglas en inglés)**  
**Acuerdo del padre, cuidador o tutor para participar en los servicios de apoyo comunitario**

Nombre del beneficiario:  
Número de Medicaid:

Fecha de nacimiento:

**¿Qué son los Servicios de Rehabilitación de Salud Conductual (RBHS) Servicios de Apoyo Comunitario?**

Los Servicios de Apoyo Comunitario de los RBHS ayudan al niño y a usted a desarrollar habilidades para vivir exitosamente en el hogar y la comunidad. Los servicios incluyen Servicios de Rehabilitación Psicosocial (PRS por sus siglas en inglés), Modificación de la Conducta (B-Mod por sus siglas en inglés), Apoyo Familiar (FS por sus siglas en inglés) y Cuidado Infantil Terapéutico (TCC por sus siglas en inglés). Estos servicios son para los jóvenes que padecen de trastornos de salud mental y / o consumo de sustancias. Los servicios no son para campamentos de verano, programas extracurriculares, recreación o servicios de tutoría.

**El niño ha sido diagnosticado con los siguientes trastornos de salud mental y / o uso de sustancias.**

**Por favor, indique el código y la descripción (su proveedor debe explicar los diagnósticos):**

Diagnóstico - Código / Descripción	/
Diagnóstico - Código / Descripción	/
Diagnóstico - Código / Descripción	/
Diagnóstico - Código / Descripción	/
Diagnóstico - Código / Descripción	/

**El proveedor ha recomendado los siguientes servicios (compruebe todos los que aplican):**

☐ **Servicios de Rehabilitación Psicosocial (PRS):** PRS ayuda al niño a desarrollar habilidades para vivir exitosamente en el hogar y la comunidad, tener éxito en la escuela y / o en el trabajo y construir relaciones saludables con la familia, los amigos y demás personas.

☐ **Modificación del Comportamiento (B-Mod):** B-Mod ayuda al niño a reducir los comportamientos indeseables. Usted y el niño recibirán capacitación en el manejo de estos comportamientos. Este entrenamiento ayudará al niño a reemplazar los comportamientos no deseados por otros adecuados, durante y después del tratamiento.

☐ **Apoyo Familiar (FS por sus siglas en inglés):** FS le ayuda a funcionar como miembro activo del equipo de tratamiento del niño y mejorar su capacidad para atender las necesidades de salud conductual del niño. FS puede conectarlo con grupos que apoyan a los jóvenes que tienen necesidades de salud mental. FS también puede animarlo a participar en otros tipos de grupos que pueden ser útiles para usted.

☐ **Cuidado Terapéutico del Niño (TCC por sus siglas en inglés):** TCC ayuda a los niños que tienen problemas emocionales y / o del comportamiento graves. Usted y su hijo trabajarán en su relación con el fin de reducir el impacto de las experiencias traumáticas. TCC ayuda a los niños a adquirir las habilidades sociales y emocionales necesarias para interactuar bien con sus padres, los adultos y sus compañeros de juego.

**¿Qué se le pedirá?**

Se le pedirá que:

- Participe en las reuniones de planificación del tratamiento
- Participará en sesiones de entrenamiento donde se le enseñarán habilidades para ayudar al niño como modelar, redirigir, entrenar y reforzar
- Monitoreará los comportamientos del niño e informar al equipo del tratamiento
- Según las necesidades del niño, es posible que se le pida que participe en otras actividades que les recomiende el equipo de tratamiento

**¿Qué puede esperar del \_\_\_\_\_ personal?**

(Nombre del proveedor)

- Explique todos los tratamientos en un lenguaje que pueda entender
- Explique todos los beneficios conocidos y los riesgos del tratamiento de una manera que usted comprenderá

Nombre del beneficiario:

Fecha de nacimiento:

Acuerdo de padres, cuidadores y tutores para participar en los servicios de apoyo a la comunidad de abril de 2017

Número de Medicaid:

- Los trata a usted y a todos los miembros de su familia con respeto
- Le trata como un miembro esencial del equipo de tratamiento
- Trabaja con usted para programar las visitas y notificarle con antelación si el proveedor debe cancelar o reprogramar
- Habla con usted sobre el progreso del niño durante cada visita
- Responde a cualquier pregunta que tenga sobre el tratamiento del niño
- Responde a sus preocupaciones de manera oportuna y respetuosa
- Proporciona información sobre los recursos comunitarios

Debido a que su participación es clave para el éxito, se le pedirá que confirme su voluntad de participar de estos servicios cada noventa (90) días.

Al firmar este formulario:

- Yo, \_\_\_\_\_ acuerdo participar en la siguiente recomendación de la RBHS  
(Nombre del padre, madre, cuidador o tutor)

Servicios de apoyo a la comunidad:

- ☐ Servicios de Rehabilitación Psicosocial (PRS)
- ☐ Modificación del Comportamiento (B-Mod)
- ☐ Apoyo Familiar (FS)
- ☐ Cuidado Infantil Terapéutico (TCC)

- Doy el permiso para \_\_\_\_\_ para participar en lo siguiente  
(Nombre del beneficiario)

recomendó los Servicios de Apoyo Comunitario de RBHS:

- ☐ Servicios de Rehabilitación Psicosocial (PRS)
- ☐ Modificación del Comportamiento (B-Mod)
- ☐ Apoyo Familiar (FS)
- ☐ Cuidado Infantil Terapéutico (TCC)

- Estoy de acuerdo con que el proveedor que me ha explicado los diagnósticos de salud mental y / o trastorno por uso de sustancias.

Entiendo que en cualquier momento puedo hacerle saber al personal, ya sea verbalmente o por escrito, que (a) ya no deseo participar de estos servicios y / o (b) ya no deseo que el niño reciba estos servicios. También entiendo que puedo terminar estos servicios en cualquier momento, a menos que la participación sea ordenada por un tribunal.

Nombre, en letra de molde, del padre/la madre/  
el cuidador/el tutor legal

Relación con el beneficiario

Firma del padre/la madre/el cuidador/el tutor legal

Fecha

Nombre del miembro del personal en letra de molde

Nombre del proveedor

Firma y credenciales del miembro del personal

Fecha

## Community Integration Services Provider Credentialing Request

Provider Information	
Provider Name	
Provider NPI	
Provider Medicaid ID #	
Address	
City / State / Zip Code	
Phone Number	
Fax Number	
Email Address	

Accreditation Information			
Accreditation Body	Accreditation Program/Standard	Date Accredited	Expiration Date

Program Information	
Days of Operation	Hours of Operation (list open and closing times OR "closed")
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Evidenced Based/Best Practice Treatment Model (s)	Staff credentialed





Staff Information		
Staff Name	Staff Credentials	Supervisory Responsibilities (Y/N)

I attest that the aforementioned information is accurate.

Owner name (printed) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please attach the following supporting documentation:

1. Copies of all accreditation documentation (i.e. certificate, letter and survey)
2. Copies of credentialing documentation for all staff who will be providing the service of CIS

## Therapeutic Childcare Center Credentialing Request

Provider Information	
Provider Name:	
Provider NPI:	
Provider Medicaid ID #	
Address:	
City / State / Zip Code	
Phone Number	
Fax Number	
Email Address	

Licensing and Accreditation Information			
Accreditation Body	Accreditation Program/Standard	Date Accredited	Expiration Date
SCDSS License or Approval Number		Date Licensed	Expiration Date

Program Information	
Days of Operation	Hours of Operation (list open and closing times OR "closed")
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Evidenced Based/Best Practice Treatment Model (s)	Staff credentialed





Description of Population Served (Ages, diagnoses, length of time in treatment)		
Age Range	Primary Diagnoses	Average length of time in treatment

Description of Program	

[illegible]

I attest that the aforementioned information is accurate.

Owner name \_\_\_\_\_

Signature \_\_\_\_\_

Date: \_\_\_\_\_

Please attach the following supporting documentation:

1. Copies of all accreditation documentation (i.e. certificate, letter and survey)
2. Copies of current DSS daycare license or approval and most recent site visit survey
3. Copies of credentialing documentation for all staff who will be providing the service of TCC

## MULTISYSTEMIC THERAPY (MST) Request for Approval of Continued Services

Member Name: \_\_\_\_\_

Member Medicaid ID#: \_\_\_\_\_

Provider Name: \_\_\_\_\_ MST Start Date: \_\_\_\_\_

Provider Contact Information (Phone Number and Email Address): \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Secondary Diagnosis(es): \_\_\_\_\_

Does the youth continue to meet MST medical necessity criteria? YES \_\_\_\_\_ NO \_\_\_\_\_

Brief Description of Continued Stay Request and Medical Necessity (attach additional information as necessary): \_\_\_\_\_

Continued services are requested from \_\_\_\_\_ (date) to \_\_\_\_\_ (date), for a total of \_\_\_\_\_ additional units of service (number of per diems requested).

*\*Completed form must be submitted as an attachment to 49<sup>th</sup> service claim via the Medicaid webtool if services not completed in initial 48 encounters.*

Questions or other inquiries may be submitted to [behavioralhealth004@scdhhs.gov](mailto:behavioralhealth004@scdhhs.gov).

MST Supervisor Printed Name: \_\_\_\_\_

MST Supervisor Signature \_\_\_\_\_ Date: \_\_\_\_\_

MST Consultant Printed Name: \_\_\_\_\_

MST Consultant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SCDHHS Office of Behavioral Health Approval: YES \_\_\_\_\_ NO \_\_\_\_\_

Approver Name: \_\_\_\_\_ Date: \_\_\_\_\_

