

FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 140	Medicaid Provider Inquiry	06/2007
DHHS 142	Request for Medicaid Forms and Publications	06/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	Reasonable Effort Documentation	06/2007
	Authorization Agreement for Electronic Funds Transfer	01/2009
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	Standing Order (Sample)	



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: _____



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

MEDICAID PROVIDER INQUIRY

MAIL TO: ATTENTION _____ UNIT S.C. DEPT. OF HEALTH AND HUMAN SERVICES POST OFFICE BOX 8206 COLUMBIA, SOUTH CAROLINA 29202-8206	TODAY'S DATE:
	NPI or MEDICAID PROVIDER ID:
	TELEPHONE:
PROVIDER NAME AND ADDRESS:	TYPE OF PROVIDER (i.e., Dentist, Group, etc.)
	DATE CLAIM FILED:

-----FOLD HERE-----

PATIENT'S NAME (First, Initial, Last)	MEDICAID NUMBER (10 Digits)	DATE OF SERVICE
HAS THE CLAIM APPEARED ON THE PROVIDER'S REMITTANCE ADVICE? (CHECK ONE)		IS MEDICARE COVERAGE INVOLVED?
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
CLAIMS STATUS ON REMITTANCE ADVICE	PAYMENT DATE	17-DIGIT CLAIM REFERENCE NUMBER
STATEMENT OF PROBLEM OR QUESTION		
SIGNATURE OF PROVIDER		
RESPONSE		
AGENCY REPRESENTATIVE		DATE



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

**REQUEST FOR MEDICAID
FORMS AND PUBLICATIONS**

WHEN COMPLETED PLEASE FORWARD TO:

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUPPLY
POST OFFICE BOX 8206
COLUMBIA, SOUTH CAROLINA 29202-8206

-OR- FAX TO: (803) 898-4528

NPI or MEDICAID PROVIDER ID:

TYPE OF PROVIDER:

TELEPHONE: - -

CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY (PLEASE PRINT OR TYPE)

ITEMS REQUESTED

FORM/PUBLICATION NO.	TITLE OF FORM OR PUBLICATION	QUANTITY

**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

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: 803-255-8225 **or** **Mail:** 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 FORM TO THE APPROPRIATE CLAIM OR ECF 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 _____
Medicaid Provider Number _____
Provider NPI Number _____
Provider Address _____
City _____ State _____ Zip _____

BANKING INFORMATION (Please include a copy of the electronic deposit information on bank letterhead. This is required and the information will be used to verify your bank account information).

Financial Institution Name _____
Financial Institution Address _____
City _____ State _____ Zip _____
Routing Number (nine digit) _____
Account Number _____

Type of Account (check one) Checking Savings

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 below and the financial institution named below, 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.

Contact Name: _____ Phone Number: _____

Signed _____ (Signature)
_____ (Print)

Title _____ Date _____

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.

RETURN COMPLETED FORM TO:

**Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 699-8637**

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

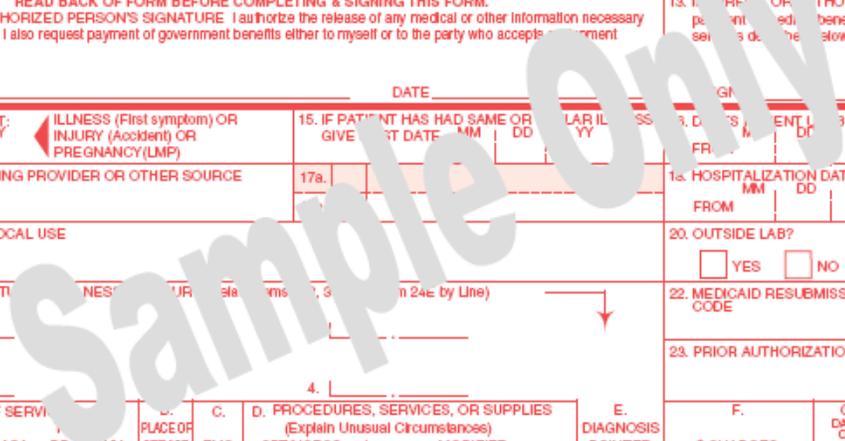
PICA PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BKLUNG OTHER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE SEX
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED
7. INSURED'S ADDRESS (No., Street)
8. PATIENT STATUS
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
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
13. INSURED'S DATE OF BIRTH SEX
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY PREVIOUSLY, GIVE DATE
16. DOES PATIENT ABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURAL CAUSE OF ILLNESS (List in 24c by Line)
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER
24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. PROCEDURES, SERVICES, OR SUPPLIES D. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9-CM CODE I. ID. QUAL. J. RENDERING PROVIDER ID. #
25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT?
28. TOTAL CHARGE
29. AMOUNT PAID
30. BALANCE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
32. SERVICE FACILITY LOCATION INFORMATION
33. BILLING PROVIDER INFO & PH #

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



RUN DATE 05/01/2007 000001204
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM

CLAIM CONTROL #9999999999999999A
PAGE 1136 ECF 1136 PAGE 1 OF 1

ANALYST ID
SIGNON ID

HIC - 10 PRAC SPEC - 28

DOC IND N

ORIGINAL CCN:

TAXONOMY:

SFL ZIP:

PRV ZIP:

ADJ CCN:

1 2 3 4 5 6 7 8 9
PROV/XWALK RECIPIENT P AUTH TPL INJURY EMERG PC COORD ---- DIAGNOSIS ----
ID ID NUMBER CODE PRIMARY SECONDARY
ABC123 1111111111 298.9 .
NPI: 1234567890

EDITS
INSURANCE EDITS

CLAIM EDITS

LINE EDITS

01) 510

02)

03)

** AGENCY USE ONLY **

** APPROVED EDITS **

** REJECTED LINE EDITS **

** **

10 RECIPIENT NAME - DOE, JANE 11 DATE OF BIRTH 01/25/1992 12 SEX F

13 14 15 16 17 18 19 20 21 22
RES ALLOWED LN DATE OF PLACE PROC MOD INDIVIDUAL CHARGE PAY UNITS
NO SERVICE CODE PROVIDER IND

23
NDC

.00 1 12/22/04 53 90801 000 123456 40.00 1.000
NPI: 1234567890 TAXONOMY:
2 / /
NPI: 1234567890 TAXONOMY:53 90862 000 123456 32.00 1.000

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !

!
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

24 25 26
INS CARR POLICY INS CARR
NUMBER NUMBER PAID
01 27 TOTAL CHARGE 72.00
02 28 AMT REC'D INS .00
03 29 BALANCE DUE 72.00
30 OWN REF # 012345

RESOLUTION DECISION _R_

ADDITIONAL DIAG CODES:

RETURN TO: INSURANCE POLICY INFORMATION
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412
PROVIDER:
ABC PROVIDER
PO BOX 00000
ANYTOWN, SC 00000-0000

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

Sample Remittance Advice (page 1)

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
+-----+	+-----+	+-----+	+-----+
AB11110000	DEPT OF HEALTH AND HUMAN SERVICES	03/26/2007	1
+-----+	REMITTANCE ADVICE	+-----+	+-----+
	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	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	0406001089000400A				1192.00	243.71 P	1112233333	M CLARK			0.00	
	01		021507	H0032	800.00	117.71 P			000			0.00
	02		021507	H2015	392.00	126.00 P			000			0.00
VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0406001089000400U				1412.00-	273.71-	1112233333	M CLARK				
	01		012107	H0032	1112.00-	143.71-			000			
	02		012107	H2015	300.00-	130.00-			000			
REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0407701389002500A				1001.50	42.75 P	1112233333	M CLARK			0.00	
	01		012107	H0032	142.50	42.75 P			000			0.00
	02		012107	H2015	859.00	0.00 R			000			0.00
TOTALS				2	2193.50	286.46					0.00	0.00

\$286.46	\$286.46
----------	----------

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

FEDERAL RELIEF

CERT. PG TOT	MEDICAID PG TOT
\$0.00	\$286.46
CERTIFIED AMT	MEDICAID TOTAL
\$0.00	0.00
MAXIMUS AMT	CHECK TOTAL

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

ABC PROVIDER
PO BOX 000000
ANYTOWN SC 00000-0000

CHECK NUMBER

Sample Remittance Advice (page 2)

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

PROVIDER ID. +-----+ AB11110000 +-----+	DEPT OF HEALTH AND HUMAN SERVICES SOUTH CAROLINA MEDICAID PROGRAM	+-----+ CLAIM ADJUSTMENTS +-----+	PAYMENT DATE +-----+ 03/26/2007 +-----+	PAGE +-----+ 2 +-----+
--	--	--	--	-------------------------------------

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME I I	M F M O I I D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	0406001089000400U				513.00-	197.71-	1112233333	CLARK	M		0404711253670430A
	01		012107	H0032	453.00	160.71-	P			000	
	02		012107	H2015	60.00	33.00-	P			000	
	TOTALS		1		513.00-	193.71-					

SAMPLE ONLY

DEBIT BALANCE PRIOR TO THIS REMITTANCE	+-----+ \$243.71 +-----+	+-----+ 0.00 +-----+	+-----+ 0.00 +-----+	TO BE REFUNDED IN THE FUTURE
	+-----+ 0.00 +-----+	+-----+ 0.00 +-----+	+-----+ 0.00 +-----+	+-----+ 0.00 +-----+
YOUR CURRENT DEBIT BALANCE	+-----+ 0.00 +-----+	+-----+ 0.00 +-----+	+-----+ 0.00 +-----+	
	+-----+ 0.00 +-----+	+-----+ 0.00 +-----+	+-----+ 0.00 +-----+	

MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
+-----+ \$243.71 +-----+	+-----+ 0.00 +-----+	+-----+ 0.00 +-----+	+-----+ 0.00 +-----+
ADJUSTMENTS	MAXIMUS AMT	PROVIDER NAME AND ADDRESS	
+-----+ \$193.71 +-----+	+-----+ +-----+	ABC PROVIDER PO BOX 000000 ANYTOWN SC 00000-0000	
CHECK TOTAL	CHECK NUMBER		
+-----+ \$50.00 +-----+	+-----+ 4197304 +-----+		

Sample Remittance Advice (page 3)

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		03/26/2007	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	0408600003700000U	-						DEBIT	-2389.05	
TPL 4	0408600004700000U	-						DEBIT	-1949.90	
TPL 5	0408600005700000U	-						DEBIT	-477.25	
TPL 6	0408600006700000U	-						DEBIT	-477.25	
PAGE TOTAL:									5293.45	0.00

SAMPLE ONLY

DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
0.00	0.00	0.00	0.00	0.00
YOUR CURRENT DEBIT BALANCE	ADJUSTMENTS	MAXIMUS AMT	PROVIDER NAME AND ADDRESS	
5293.45	0.00	0.00	ABC PROVIDER	
	CHECK TOTAL	CHECK NUMBER	PO BOX 000000	
	0.00		ANYTOWN SC 00000-0000	

**S.C. Medicaid Dental Program
Referral Form for Broken Appointments**

This form is used to refer Medicaid beneficiaries who are non-compliant. The referral will be followed up by appropriate Department of Health and Environmental Control (DHEC) staff and efforts will be made to encourage beneficiary compliance. Please provide as much information as you can to assist in contacting the beneficiary or the beneficiary's parent/guardian.

Dentist _____

Phone Number _____

Dental Office Contact Person _____

Beneficiary's Name	Medicaid ID Number	Date of Birth
Beneficiary's Phone Number	Beneficiary's Address	
Parent/Caregiver's Name		
<i>CHECK ONE BLOCK BELOW</i>		
Missed Sedation/Complex/Emergency Appointment (URGENT)		
Missed Restorative Appointment (Moderate)		
Missed Preventive Appointment (Minor)		
Reason Given for Missed Appointment:		
Other Concerns/Comments:		

Beneficiary's Name	Medicaid ID Number	Date of Birth
Beneficiary's Phone Number	Beneficiary's Address	
Parent/Caregiver's Name		
<i>CHECK ONE BLOCK BELOW</i>		
Missed Sedation/Complex/Emergency Appointment (URGENT)		
Missed Restorative Appointment (Moderate)		
Missed Preventive Appointment (Minor)		
Reason Given for Missed Appointment:		
Other Concerns/Comments:		

STANDING ORDER (SAMPLE)

In order for individuals to maintain an optimal state of health, it is imperative that they be linked with a Primary Care Physician (PCP) who provides medical preventive and acute care, that they use care appropriately, and that they practice healthy behaviors. (*Insert Name of Facility*) staff may perform the following PSPCE and RSPCE:

- Assessment provided by Licensed Practitioner of the Healing Arts (LPHA) to determine client strengths, resources, perceptions of need relative to appropriate use of primary medical care, and practice of healthy behaviors;
- Evaluation of information and developing a plan of care in conjunction with the patient and PCP (must be verbal or written) which addresses health-related, medical, and developmental risks/needs appropriate for P/RSPCE;
- Determination of the patient's risks and his or her readiness for intervention;
- Determination of interventions indicated, and whether interventions should be PSPCE or RSPCE;
- Implementation, coordination, and monitoring of the plan of care to determine patient progress toward goal achievement;
- Ongoing reassessment to determine necessary changes in the plan of care and/or interventions;
- Communication (must be verbal or written) will be maintained and documented in the clinical record during all phases of the patient's care; and
- Identification of PCP (medical home):
 1. It is the responsibility of the PSPCE or RSCPE provider to assist the patient in locating a PCP within six months; to obtain permission to share PSPCE or RSPCE information with the PCP; and to communicate (must be verbal or written) the activities to the PCP during all phases of the patient's care.
 2. This Standing Order may be used to authorize provision of PSPCE or RSPCE as long as efforts are being made to locate a PCP for the patient, but no longer than six months.

PSPCE may be provided by a LPHA as determined in the assessment in order to:

- prevent disease, disability, and other health conditions or their progression;
- prolong life; and
- promote physical and mental health efficiency.

PSPCE promotes full and appropriate use of medical care, promote positive health outcomes, prevents deterioration of chronic conditions, and enhances the practice of healthy behaviors.

RSPCE may be recommended by LPHA as determined in the assessment in order to reduce physical or mental disability and restore an individual to his or her best possible functioning level. This service also promotes changes in behavior, improves health status, and develops healthier practices to restore and maintain the patient at the highest possible functioning level.

P/RSPCE Dental Services

Signed by

Date

Documentation Note: If this Standing Order is being used to authorize PSPCE or RSPCE, a copy must be placed in the patient's chart