## FORMS

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<thead>
<tr>
<th>Number</th>
<th>Name</th>
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<tr>
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<td>Confidential Complaint</td>
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<td>Medicaid Refunds</td>
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<td>Health Insurance Information Referral Form</td>
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<td>Electronic Funds Transfer (EFT) Authorization Agreement</td>
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<td>Duplicate Remittance Advice Request Form</td>
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<td>Claim Reconsideration Form</td>
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<td>CMS-1500</td>
<td>Sample Claim Showing TPL Denial with NPI</td>
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<td>Sample Remittance Advice</td>
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<tr>
<td>DHHS 259</td>
<td>Interim Medicaid Targeted Case Management Transition Form w/Instructions (four pages)</td>
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<td>Freedom of Choice</td>
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<td>Freedom of Choice -Spanish</td>
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<td>Parent/Caregiver/Guardian Agreement to Participate in MTCM Services - Spanish</td>
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</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>NPI or MEDICAID PROVIDER ID: (if applicable)</th>
<th>MEDICAID RECIPIENT ID NUMBER: (if applicable)</th>
</tr>
</thead>
</table>

ADDRESS OF SUSPECT:  
LOCATION OF INCIDENT:  
DATE OF INCIDENT:  

COMPLAINT:  

<table>
<thead>
<tr>
<th>NAME OF PERSON REPORTING: (Please print)</th>
<th>SIGNATURE OF PERSON REPORTING:</th>
<th>DATE OF REPORT</th>
</tr>
</thead>
</table>

ADDRESS OF PERSON REPORTING:  
TELEPHONE NUMBER OF PERSON REPORTING:  

SIGNATURE: (SCDHHS Representative Receiving Report)

SCDHHS Form 126 (revised 06/07)
South Carolina Department of Health and Human Services
Form for Medicaid Refunds

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

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. Attach appropriate document(s) as listed in item 8.

1. Provider Name: ________________________

2. Medicaid Legacy Provider # [check appropriate box]
   (Six Characters)

   OR

3. NPI# ________________________

   & Taxonomy ________________________

4. Person to Contact: ________________________

5. Telephone Number: ________________________

6. Reason for Refund: [check appropriate box]
   a Type of Insurance: ( ) Accident/Auto Liability
   b Insurance Company Name __________________________
   c Policy #: __________________________
   d Policyholder: __________________________
   e Group Name/Group: __________________________
   f Amount Insurance Paid: __________________________

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

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

   Other, describe in detail reason for refund:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

7. Patient/Service Identification:

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Medicaid I.D.# (10 digits)</th>
<th>Date(s) of Service</th>
<th>Amount of Medicaid Payment</th>
<th>Amount of Refund</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Attachment(s): [Check appropriate box]
   a Medicaid Remittance Advice (required)
   b Explanation of Benefits (EOMB) from Insurance Company (if applicable)
   c Explanation of Benefits (EOMB) from Medicare (if applicable)
   d Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

DHHS Form 205 (01/08)
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: _________________________ Provider ID or NPI: _________________________
Contact Person: _________________________ Phone #: _________________________ Date: _________________________

I  ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID
MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: _________________________ Date Referral Completed: _________________________
Medicaid ID#: _________________________ Policy Number: _________________________
Insurance Company Name: _________________________ Group Number: _________________________
Insured's Name: _________________________ Insured SSN: _________________________
Employer's Name/Address: _________________________

II  CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

____ a. beneficiary has never been covered by the policy – close insurance.
____ b. beneficiary coverage ended - terminate coverage (date) _________________________
____ c. subscriber coverage lapsed - terminate coverage (date) _________________________
____ d. subscriber changed plans under employer - new carrier is _________________________
                  - new policy number is _________________________
____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.
      (name) _________________________

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).
Fax: 803-252-0870 or Mail: Post Office Box 101110
Columbia, SC 29211-9804

DHHS 931 – Updated February 2018
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER ____________________________________________  DOS _______________________
NPI or MEDICAID PROVIDER ID __________________________________
MEDICAID BENEFICIARY NAME ____________________________________________
MEDICAID BENEFICIARY ID# ____________________________________________
INSURANCE COMPANY NAME ____________________________________________
POLICYHOLDER ___________________________________________________________________
POLICY NUMBER __________________________________________________________________
ORIGINAL DATE FILED TO INSURANCE COMPANY ________________________________
DATE OF FOLLOW UP ACTIVITY _________________________________________________
RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _________________________________________________
RESULT:

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

__________________________________________
(SIGNATURE AND DATE)

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

Revised 04/2014
Electronic Funds Transfer (EFT) Authorization Agreement

REASON FOR SUBMISSION
☐ Change to Current EFT (i.e. account or bank changes) ☐ Individual ☐ Organization

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) ☐ SSN (Individual) ☐ EIN (organization)
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: ____________
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) ☐ 22 – Checking Account ☐ 32 – savings Account

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 revoking this authorization.

☐ I acknowledge that I have read and understand that payments will be issued only to the bank account of the provider designated to receive payments beginning July 2013 with the transition of Medicaid claims payments to the South Carolina Enterprise Information System (SCEIS). For more information, please visit https://dip.scdhhs.gov/sceis or contact 888-289-0709.

ALL EFT REQUESTS ARE SUBJECT TO A 30-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 last name): ____________________________
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

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

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

Section 1: Beneficiary Information

Name (Last, First, MI): ____________________________
Date of Birth: __________________ Medicaid Beneficiary ID: ____________________________

Section 2: Provider Information

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

Section 3: Claim Information (Only one CCN allowed per request)

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

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below)
□ Ambulance Services
□ Autism Spectrum Disorder (ASD) Services
□ Clinic Services
□ Community Long Term Care (CLTC)
□ Community Mental Health Services
□ Department of Disabilities and Special Needs (DDSN) Waivers
□ Durable Medical Equipment (DME)
□ Early Intervention Services
□ Enhanced Services
□ Federally Qualified Health Center (FQHC)
□ Home Health Services
□ Hospice Services
□ Hospital Services

□ Licensed Independent Practitioner’s Rehabilitative Services (LIPS)
□ Local Education Agencies (LEA)
□ Medically Complex Children’s (MCC) Waivers
□ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
□ Optional State Supplementation (OSS)
□ Pharmacy Services
□ Physicians Laboratories, and Other Medical Professionals Specify:

□ Private Rehabilitative Therapy and Audiological Services
□ Psychiatric Hospital Services
□ Rehabilitative Behavioral Health Services (RBHS)
□ Rural Health Clinic (RHC)
□ Targeted Case Management (TCM)
□ Other: ____________________________

SCDHHS CR Form (11/18)
Section 5: Desired Outcome

Request submitted by:

Print Name: ________________________________

Signature: ________________________________ Date: ________
## Sample Remittance Advice (page 1)

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

<table>
<thead>
<tr>
<th>PROVIDER ID</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB00080000</td>
<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
<td>REMITTANCE ADVICE</td>
<td>02/14/2014</td>
<td>1</td>
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</tbody>
</table>

### Claims Details

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<thead>
<tr>
<th>PROVIDER</th>
<th>REF.</th>
<th>SERVICE</th>
<th>DATE</th>
<th>AMOUNT</th>
<th>TITLE</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
<th>M</th>
<th>TLE.</th>
<th>COPAY</th>
<th>TITLE</th>
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<tr>
<td>ABB1AA</td>
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<td>101713</td>
<td>6.72</td>
<td>P</td>
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<td>M</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>ABB2AA</td>
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<td>101713</td>
<td>6.72</td>
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<td>M</td>
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<tr>
<td>ABB3AA</td>
<td>01</td>
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<td>071913</td>
<td>12.00</td>
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<td>M CLARK</td>
<td>A5120</td>
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<td>M CLARK</td>
<td>A4927</td>
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<td>0.00</td>
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**TOTALS**: 310.00

**CERT. AMT**: 6.72

**STATUS CODES**: P = PAYMENT MADE

**MEDICAID TOTAL**: 283.46

**SUSPENDED**: 0.00

**REJECTED**: 0.00

**NOT Processed**: 0.00

**ERROR CODES LISTED ON THIS FORM REFER TO**: "MEDICAID PROVER Manual"

**IF YOU STILL HAVE QUESTIONS**: PHONE THE D.H.S.S. NUMBER

**SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL**: CHECK TOTAL 0.00 CHECK NUMBER
This page of the sample Remittance Advice shows a paid claim, as well as a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle.

<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB00080000</td>
<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
<td>REMITTANCE ADVICE</td>
<td>02/28/2014</td>
<td>1</td>
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<table>
<thead>
<tr>
<th>PROVIDERS REF.</th>
<th>CLAIM</th>
<th>SERVICE RENDERED</th>
<th>AMOUNT</th>
<th>TITLE 19</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
<th>M</th>
<th>TLE. 18</th>
<th>COPAY</th>
<th>TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>OWN REF.</td>
<td>REFERENCE</td>
<td>DATE(S)</td>
<td>BILLED</td>
<td>PAYMENT</td>
<td>ID.</td>
<td>F M</td>
<td>ALLOWED</td>
<td>AMT</td>
<td>PAYMENT</td>
<td></td>
</tr>
<tr>
<td>NUMBER</td>
<td>NUMBER</td>
<td>PY IND</td>
<td>MMDDYY</td>
<td>PROC.</td>
<td>MEDICAID</td>
<td>S</td>
<td>NUMBER</td>
<td>LAST NAME</td>
<td>I I LAST NAME</td>
<td>D</td>
</tr>
</tbody>
</table>

| | | | | | | | | | | | |
| ABB222222 | 1405200415812200A | 1192.00 | 243.71 | P | 1112233333 | M | CLARK | 0.00 | 0.00 | |
| | | | | | | | | | | | |
| VOID OF ORIGINAL CCN 13283002244813300A PAID 20131018 | |
| ABB222222 | 1405200077700000U | 1412.00 | 273.71 | P | 1112233333 | M | CLARK | 0.00 | 0.00 | |
| | | | | | | | | | | | |
| REPLACEMENT OF ORIGINAL CCN 1304711253670430A PAID 20131018 | |
| ABB222222 | 1405200414812200A | 1001.50 | 42.75 | P | 1112233333 | M | CLARK | 0.00 | 0.00 | |
| | | | | | | | | | | | |

$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.

CERTIFIED AMT | MEDICAID TOTAL | E | ENCOUNTER | FLORENCE |
|--------------|----------------|---|-----------|----------|
### Sample Remittance Advice (page 3)

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

<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>CLAIM</th>
<th>ADJUSTMENTS</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB11110000</td>
<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
<td></td>
<td></td>
<td>02/28/2014</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROVIDERS</th>
<th>CLAIM</th>
<th>SERVICE RENDERED</th>
<th>AMOUNT</th>
<th>TITLE 19</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
<th>ORG</th>
<th>CHECK</th>
<th>ORIGINAL CCN</th>
</tr>
</thead>
<tbody>
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<td>ABB222222</td>
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<td>453.00</td>
<td>160.71</td>
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<td>100213</td>
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<td>000</td>
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| TOTALS | 1 | 513.00- | 193.71- |

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>DEBIT BALANCE</th>
<th>MEDICAID TOTAL</th>
<th>CERTIFIED AMT</th>
<th>TO BE REFUNDED</th>
<th>IN THE FUTURE</th>
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<tbody>
<tr>
<td>INCENTIVE</td>
<td>$243.71</td>
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<td>$193.71</td>
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<tr>
<td>CREDIT AMOUNT</td>
<td>0.00</td>
<td>ADJUSTMENTS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>REMITTANCE</td>
<td>0.00</td>
<td>CHECK TOTAL</td>
<td>CHECK NUMBER</td>
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</tr>
<tr>
<td>DEBIT BALANCE</td>
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<td>FLORENCE SC 00000</td>
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<table>
<thead>
<tr>
<th>PROVIDER NAME AND ADDRESS</th>
<th>ABC HEALTH PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PO BOX 00000</td>
</tr>
</tbody>
</table>

SAMPLE ONLY
Sample Remittance Advice (page 4)
This page of the sample Remittance Advice shows four gross-level adjustments. Gross-level adjustments always appear on the final page of the Remittance Advice.
This interim form must be maintained in the beneficiary’s MTCM record and completed no later than March 31, 2013 for dates of service beginning January 1, 2013.

DHHS Form 259 (Revised - 01/01/14)
Interim Medicaid Targeted Case Management Transition Form

Medical Necessity Criteria:

- Beneficiary would benefit from a referral to services that are necessary to diagnose, treat, cure, or prevent an illness
- Beneficiary would benefit from a referral for services that would reduce, correct or ameliorate the physical, mental, developmental, or behavioral effects of an illness, injury or disability
- Assist the beneficiary to achieve or maintain sufficient functional capacity to perform age-appropriate or developmentally appropriate daily activities;
- The beneficiary, parent or caregiver is unable to provide adequate coordination of services.
- There is a lack of food, clothing, shelter, or other concrete resources that impact the health and well-being of the beneficiary.

Current or Past Service Providers:

List physicians, psychologist, and staff from providers such as DSS, DJJ, Continuum of Care, DDSN, Mental Health, School for Deaf and Blind, therapist, special education, Head Start, First Steps, and Drug and Alcohol treatment. Obtain signed releases and include dates of service if known.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

I recommend that the above named Medicaid beneficiary receive MTCM service[s]. The beneficiary is aware that MTCM services are not required to receive Medicaid services to address identified needs.

By my signature, I attest that the beneficiary was provided an opportunity to choose from a list of enrolled Medicaid TCM providers. (Attach a copy of the signed and dated Freedom of Choice Form.)

________________________________________________________________________

Printed Name

Case Manager’s Signature

________________________________________________________________________

Title

Date

This interim form must be maintained in the beneficiary’s MTCM record and completed no later than March 31, 2013 for dates of service beginning January 1, 2013.

DHHS Form 259 (Revised - 04/01/17)
INTERIM MEDICAID TARGETED CASE MANAGEMENT (MTCM) TRANSITION FORM 259
INSTRUCTIONS

Purpose

The purpose of this form is to provide a process for transitioning existing clients to the new MTCM system on or after January 1, 2013 and to also accommodate any new referrals until April 1, 2013 when the prior authorization (PA) process will be in place. The form must indicate the target group and provide the appropriate documentation to support medical necessity during the transition period from January 1, 2013 through March 31, 2013. In addition to documenting the specific target group(s) and providing the required medical necessity component, the form also moves the program toward Phase II implementation which will include (PA) based on documented medical necessity reviewed by SCDHHS or a quality improvement entity. The implementation for Phase II is projected to be April 1, 2013 and will include PA and the other reforms to the MTCM program.

Completion of transition Form 259

The form must be completed by the case manager during the three month transition period, but no later than March 31, 2013, and placed in the beneficiary’s case file. The Office of Program Integrity at SCDHHS will not audit MTCM records during this transitional period for compliance on completion of Form 259 on dates of service after January 1, 2013.

Beneficiary Identification – self explanatory

Current Targeted Case Management Agency

This contact information will be used for the (PA) Process once Phase II is implemented in order to notify the agency of the PA status.

Interim Validation/Revalidation of Existing Beneficiary

This section should indicate if the beneficiary is a new referral or an existing beneficiary until Phase II is operational. The form should indicate the target group and provide the appropriate documentation to support medical necessity. Examples of supporting documents are provided on the form.

Target Groups

Circle the arrow in the left margin to indicate the appropriate target group(s).

Medical Necessity Criteria

This section is used to assist the person completing the validation portion of the form on what type of information helps define the Medical Necessity Criteria and does not require annotation.

Current or Past Service Providers

If additional information is required to meet medical necessity, this section provides information to the PA reviewer on previous and current services being rendered. Past services would include those provided within the last 6 months to a year.
Freedom of Choice

As of January 1, 2013 the following providers of MTCM include:

Department of Social Services  Department of Mental Health
Department of Disabilities and Special Needs  Department of Juvenile Justice
Department of Alcohol and Other Substance Abuse  Continuum of Care
School for the Deaf and Blind  First Steps
James R. Clark Sickle Cell Foundation

Once other providers enroll, a list of qualified Medicaid providers geographically will be maintained on the agency web site. A Freedom of Choice form is attached.
South Carolina Department of Health and Human Services

FREEDOM OF CHOICE

This form should be completed after MTCM eligibility determinations have been made.

I have been informed of the Medicaid Targeted Case Management (MTCM) services available to me or my child. I understand I have a right to choose the provider of Medicaid Targeted Case Management services, and I have been given the opportunity to choose between enrolled Medicaid providers in my community setting.

As long as I remain eligible for MTCM services, I will continue to have the opportunity to choose between qualified MTCM providers.

I understand that I have the right to refuse MTCM services. Refusal of MTCM services does not prevent me from receiving other Medicaid services for which I may qualify.

☐ I agree to receive Medicaid Targeted Case Management services for

Beneficiary Name ______________________________ Medicaid Number ______________________________

I select ______________________________ as my provider for MTCM Services.

Name of Provider ______________________________

☐ I decline Medicaid Targeted Case Management Services

Beneficiary Name ______________________________ Medicaid Number ______________________________

Signature of recipient ______________________________ Date signed (month, day, year) ______________________________

Signature of: (check one) __Family __ Guardian __ Witness

Date signed (month, day, year) ______________________________

Signature of Case Manager ______________________________ Date signed (month, day, year) ______________________________

DISTRIBUTION: Original – Provider Case File

Beneficiary Copy

12/2012
LIBERTAD DE ELECCIÓN

Este formulario debe completarse después de que se hayan realizado las determinaciones acerca de la elegibilidad para MTCM.

He sido informado/a acerca de los servicios de la Administración de casos específicos de Medicaid (Medicaid Targeted Case Management, MTCM) que se encuentran disponibles para mí o mi hijo/a. Entiendo que tengo derecho a elegir el proveedor de servicios de la Administración de casos específicos de Medicaid y que se me ha dado la oportunidad de elegir entre proveedores inscritos de Medicaid en mi comunidad.

Mientras siga siendo elegible para los servicios de MTCM, continuaré teniendo la oportunidad de elegir entre proveedores de MTCM calificados.

Entiendo que tengo derecho a rechazar los servicios de MTCM. Si rechazo los servicios de MTCM eso no me impedirá recibir otros servicios de Medicaid para los cuales pueda calificar.

☐ Acepto recibir los servicios de la Administración de casos específicos de Medicaid para

<table>
<thead>
<tr>
<th>Nombre del beneficiario</th>
<th>Número de Medicaid</th>
</tr>
</thead>
</table>

Selecciono a ___________________________ como mi proveedor de servicios de MTCM. Nombre del proveedor

☐ Rechazo los servicios de la Administración de casos específicos de Medicaid.

<table>
<thead>
<tr>
<th>Nombre del beneficiario</th>
<th>Número de Medicaid</th>
</tr>
</thead>
</table>

Firma del destinatario Fecha de firma (mes, día, año)

Firma de: (seleccione una opción)  
| Familiar | Tutor | Testigo |

Fecha de firma (mes, día, año)

Firma del Administrador de casos Fecha de firma (mes, día, año)

DISTRIBUTION: Original - Provider Case File Beneficiary Copy
12/2012
FAX COVER SHEET

CONFIDENTIAL INFORMATION ENCLOSED

DATE: ____________

TO: SCDHHS – Division of Behavioral Health
Attn: MTCM Prior Authorization
Fax #: 803-255-8209

FROM: ____________________________________________________________
Telephone #: __________________
Email Address: __________________________________________________
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.
# MTCM Prior Authorization Request

## Beneficiary Information

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Medicaid ID #:</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Start date MTCM services:</td>
</tr>
</tbody>
</table>

## Provider Information

<table>
<thead>
<tr>
<th>Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider NPI:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>City / State / Zip Code:</td>
</tr>
<tr>
<td>Phone Number:</td>
</tr>
<tr>
<td>Fax Number:</td>
</tr>
</tbody>
</table>

Diagnosis - Code / Description: /
Target Population: 

## Procedure Code

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Service Name</th>
<th># of Units Requested</th>
</tr>
</thead>
</table>

## Rationale for Request

What service component(s) of TCM is the PA for?

- [ ] Assessment
- [ ] Case Management Plan
- [ ] Referral and Linkage
- [ ] Monitoring and Follow-up
<table>
<thead>
<tr>
<th>Rationale for Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>What specific need(s) will be addressed?</td>
</tr>
<tr>
<td>Are these new or ongoing needs? If the latter, please explain what prior MTMC services were provided to address and their outcome.</td>
</tr>
<tr>
<td>Please describe specific activities that are planned to address the need(s) and estimated time frame for each specific activity</td>
</tr>
<tr>
<td>Has there been a recent change in the beneficiary’s circumstances? (if yes, please explain)</td>
</tr>
<tr>
<td>Has there been a recent change in case manager? (if yes, please explain)</td>
</tr>
</tbody>
</table>

**Disclaimer:** An authorization is not a guarantee of payment. Beneficiary must be eligible at the time services are rendered, with medical necessity being met and service must be a MTMC service. Payment of service rendered is determined by the provider’s timely claim submission.
<table>
<thead>
<tr>
<th>Rationale for Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate the intensity of need:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case Manager Signature, Date and Credentials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Manager Signature: _____________________ Date: ____________</td>
</tr>
<tr>
<td>Title:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attachments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Most recent Case Management Assessment (no more than 180 days old)</td>
</tr>
<tr>
<td>2. Referrals made on behalf of beneficiary and reports and updates from service providers</td>
</tr>
<tr>
<td>3. Most recent Case Management Plan</td>
</tr>
<tr>
<td>4. Most recent review of the Case Management Plan</td>
</tr>
<tr>
<td>5. All CSNs for all MTCM services rendered to beneficiary during the previous 30 days</td>
</tr>
<tr>
<td>6. Parent/Caregiver/Guardian Agreement to Participate</td>
</tr>
<tr>
<td>7. Fax Cover Sheet for MTCM Prior Authorization</td>
</tr>
<tr>
<td>8. MTCM Prior Authorization Form</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MTCM DHHS Staff Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid services are hereby:</td>
</tr>
</tbody>
</table>

**JUSTIFICATION:**

| MTCM Staff Signature: ______________________ Date: ____________ |

---

**Disclaimer:** An authorization is not a guarantee of payment. Beneficiary must be eligible at the time services are rendered, with medical necessity being met and service must be a MTCM service. Payment of service rendered is determined by the provider’s timely claim submission.
Medicaid Targeted Case Management (MTCM)
Parent/Caregiver/Guardian Agreement to Participate in
MTCM Services

Name of Beneficiary: __________________________ Date of Birth: __________
Medicaid Number: __________________________

What are Medicaid Targeted Case Management (MTCM) Services?
Medicaid Targeted Case Management (MTCM) is a means for achieving beneficiary wellness through communication, education and services identification and referral. MTCM is a time-limited process that provides an organized and structured process for moving beneficiaries toward the goal of self-sufficiency.

- The MTCM process is a shared partnership between the beneficiary’s parent/caregiver/guardian and the case manager.
- Parents/Caregivers/Guardians are actively involved in all phases of the process – assessment, planning, problem solving and identification of resources.
- MTCM ensures available resources are efficiently accessed and being used in a timely and cost effective manner.

South Carolina Medicaid allows provision of MTCM services to the following target population(s):
- Individuals with Intellectual and Related Disabilities
- At Risk Children
- Adults with Serious and Persistent Mental Illness
- At Risk Pregnant Women and Infants
- Individuals with Psychoactive Substance Disorder
- Individuals at Risk for Genetic Disorders
- Individuals with Head and Spinal Cord Injuries and Related Disabilities
- Individuals with Sensory Impairments
- Adults with Functional Impairments

The provider has provided adequate explanation to me that my child meets criteria for the following MTCM target population group(s):
(Circle one)
1) Yes  2) No, I need further explanation

What does South Carolina Medicaid expect of you?
A. You will be asked to:
   - Whenever possible, access your child’s treatment needs on your own; MTCM is only for when you are unable to do this on your own or with the support of family and friends.
   - Participate in case management planning meetings.
   - Monitor your child’s case management needs and report these to your child’s MTCM case manager
B. You will be provided with links to community resources that may support you and your family and you will be expected to reach out to those organizations.
C. Based on your child’s needs, you may be asked to engage in other specific interventions by your child’s MTCM service provider

What can you expect of your MTCM provider?
You can expect your provider to:
- Explain the purpose of all interventions in language that you understand
- Explain all known benefits and risks of the interventions in language that you understand
- Treat you and all your family members with respect
- Treat you as an essential member of the treatment team
• Coordinate times and frequency of visits with you and to let you know in advance if he/she has to cancel or reschedule a visit
• Discuss the child’s progress with you during every visit
• Answer any questions you have regarding the child’s treatment
• Respond to all concerns you express to them 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 that I as parent/caregiver guardian need MTCM on behalf of my child in the following areas:
• Give permission for , the beneficiary, to participate in the following recommended MTCM Services:
• Acknowledge that the provider has explained the target population(s) in which my child meets criteria and how he or she meets that criteria.

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 further understand that services can be immediately terminated upon my request unless these services are court ordered.

______________________________  ________________________________
Printed Name of Parent/Caregiver/Guardian  Relationship to Beneficiary

______________________________  ________________________________
Signature of Parent/Caregiver/Guardian  Date

I hereby attest that I have provided adequate explanation of: the criteria for the identified MTCM target population to the Parent/Caregiver/Guardian; how the child meets this criteria; and (as applicable) that the child will be receiving behavioral health services.

______________________________
Printed Name of Staff

______________________________  ________________________________
Signature and Credentials of Staff  Date

______________________________
Name of Provider
Nombre del beneficiario:  
Número de Medicaid:
Fecha de nacimiento:

¿Para qué sirven los servicios de Administración de casos específicos de Medicaid (MTCM)?

Los servicios de Administración de casos específicos de Medicaid (Medicaid Targeted Case Management, MTCM) constituyen un medio para alcanzar el bienestar del beneficiario mediante la comunicación, la educación, y la identificación y la derivación de servicios. MTCM es un proceso de tiempo limitado que proporciona un proceso organizado y estructurado para ayudar a los beneficiarios a alcanzar el objetivo de la autosuficiencia.

- El proceso de MTCM constituye una asociación compartida entre el padre/la madre/el cuidador/el tutor del beneficiario y el administrador de casos.
- El padre/la madre/los cuidadores/tutores participan activamente en todas las fases del proceso (la evaluación, planificación, resolución de problemas e identificación de los recursos).
- MTCM garantiza el acceso eficiente a los recursos disponibles y que se los utilice de forma oportuna y rentable.

Medicaid de Carolina del Sur (South Carolina Medicaid) permite el suministro de los servicios de MTCM a la siguiente población específica:

- Personas con discapacidades intelectuales o relacionadas.
- Niños en riesgo.
- Adultos con enfermedades mentales graves o persistentes.
- Embarazadas y bebés en riesgo.
- Personas con trastorno por el consumo de sustancias psicoactivas.
- Personas en riesgo de sufrir trastornos genéticos.
- Personas con lesiones en la cabeza o en la médula ósea y discapacidades relacionadas.
- Personas con discapacidades sensoriales.
- Adultos con discapacidades funcionales.

El proveedor me ha explicado de manera adecuada que mi hijo/a cumple con los requisitos para el siguiente grupo de población específica para MTCM:

(Encierre en un círculo una sola opción)
1) Sí  
2) No, necesita más explicaciones

¿Qué espera Medicaid de Carolina del Sur de usted?

A. Se le pedirá que:

- Cuando sea posible, acceda por sí mismo a las necesidades de tratamiento de su hijo/a; MTCM solamente debe utilizarse para cuando usted no pueda hacerlo por sí mismo o con el apoyo de familiares o amigos.
- Participe en las reuniones de planificación de la administración de casos.
- Supervise las necesidades de administración de casos de su hijo/a e infórmelas al administrador de casos de MTCM de su hijo/a.

B. Se le proporcionará información sobre enlaces para obtener recursos de la comunidad que le puedan ayudar a usted y a su familia, y usted deberá comunicarse con esas organizaciones.

C. Con relación a las necesidades de su hijo/a, el proveedor de servicios de MTCM de su hijo/a podría pedirle que participe en otras intervenciones específicas.

¿Qué puede esperar usted de su proveedor de MTCM?

Usted puede esperar que su proveedor:

- Explique el propósito de todas las intervenciones utilizando un lenguaje que usted pueda entender.
- Explique todos los beneficios y riesgos conocidos de las intervenciones utilizando un lenguaje que usted pueda entender.
- Lo trate con respeto a usted y a todos los miembros de su familia.
- Lo trate como miembro imprescindible del equipo de tratamiento.
• Coordene con usted el momento y la frecuencia de las visitas, y que le informe con anticipación si debe cancelar o reprogramar una visita.
• Analice el progreso de su hijo/a con usted en cada visita.
• Responda cualquier pregunta que usted tenga en relación con el tratamiento de su hijo/a.
• Responda a todas las inquietudes que usted exprese de manera oportuna y respetuosa.
• Le brinde información acerca de los recursos de la comunidad.

Debido a que su participación es clave para conseguir un resultado satisfactorio, cada noventa (90) días se le pedirá que confirme su voluntad para participar en estos servicios.

Al firmar este formulario, yo:
• Acepto que como padre/madre/cuidador/tutor, y en nombre de mi hijo/a, necesito los servicios de MTCM en las siguientes áreas:
• Brindo mi autorización para que
  Servicios de MTCM recomendados:
• Reconozco que el proveedor me ha explicado la población específica para la cual mi hijo/a cumple los requisitos y la manera en que él o ella cumple dichos requisitos.

Entiendone que en cualquier momento puedo informar al personal, ya sea de forma escrita o verbal, que yo (a) ya no deseo participar en estos servicios; o (b) ya no deseo que mi hijo/a reciba estos servicios. También entiendo que el suministro de los servicios puede interrumpirse de forma inmediata cuando yo lo solicite, a menos que un tribunal ordene que se brinden estos servicios.

Nombre en letra de molde del padre/madre/persoona a cargo del cuidado/tutor
Firma del padre/madre/persoona a cargo del cuidado/tutor

Relación con el beneficiario
Fecha

Por el presente certifico que he explicado de manera adecuada lo siguiente: los criterios de identificación para la población específica de MTCM al padre/madre/cuidador/tutor; la manera en que el niño/la niña cumple los requisitos; y (según corresponda) que el niño/la niña recibirá servicios de salud conductual.

Nombre en letra de molde del personal
Firma y credenciales del personal

Fecha

Nombre del proveedor

Parent/Caregiver/Gardentian Agreement to Participate in MTCM Services 01/2016