<table>
<thead>
<tr>
<th>Number</th>
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<tr>
<td>DHHS 126</td>
<td>Confidential Complaint</td>
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<td>DHHS 130</td>
<td>Claim Adjustment Form 130</td>
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<tr>
<td>DHHS 205</td>
<td>Medicaid Refunds</td>
<td>01/2008</td>
</tr>
<tr>
<td>DHHS 931</td>
<td>Health Insurance Information Referral Form</td>
<td>02/2018</td>
</tr>
<tr>
<td></td>
<td>Reasonable Effort Documentation</td>
<td>04/2014</td>
</tr>
<tr>
<td></td>
<td>Electronic Funds Transfer (EFT) Authorization Agreement</td>
<td>08/2017</td>
</tr>
<tr>
<td></td>
<td>Duplicate Remittance Advice Request Form</td>
<td>09/2017</td>
</tr>
<tr>
<td></td>
<td>Claim Reconsideration Form</td>
<td>11/2018</td>
</tr>
<tr>
<td>CMS-1500 (02/12)</td>
<td>Sample Health Insurance Claim Form</td>
<td>02/2012</td>
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<tr>
<td></td>
<td>Sample Remittance Advice (four pages)</td>
<td>04/2014</td>
</tr>
<tr>
<td>DHHS 175</td>
<td>Community Long Term Care Service Provision Form</td>
<td>07/1992</td>
</tr>
<tr>
<td>ID/RD A-3</td>
<td>SCDDSN ID/RD Waiver – Authorization for Services to Be Billed to Medicaid Personal Care</td>
<td>04/2017</td>
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<tr>
<td>ID/RD A-9</td>
<td>SCDDSN ID/RD Waiver – Authorization for Services to Be Billed to Medicaid Psychological Services</td>
<td>04/2017</td>
</tr>
<tr>
<td>ID/RD A-12</td>
<td>SCDDSN ID/RD Waiver – Authorization for Services to Be Billed to Medicaid Nursing Services</td>
<td>04/2017</td>
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<td>SCDDSN ID/RD Waiver – Authorization for Services to Be Billed to Medicaid Private Vehicle Modification</td>
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<tr>
<td>ID/RD A-23</td>
<td>SCDDSN ID/RD Waiver – Authorization for Services to Be Billed to Medicaid Adult Day Health Care Services</td>
<td>04/2017</td>
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<tr>
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<td>SCDDSN ID/RD Waiver – Authorization for Services to Be Billed to DSN Board Respite Services</td>
<td>04/2017</td>
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<tr>
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<td>Revision Date</td>
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<td>SCDDSN ID/RD Waiver – Authorization for Services to Be Billed to Medicaid Audiology Services</td>
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<tr>
<td>ID/RD A-32</td>
<td>SCDDSN ID/RD Waiver – Authorization for ICF/IID (Institutional) Respite Services to Be Billed to DSN Board</td>
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<td>ID/RD 16</td>
<td>SCDDSN ID/RD Waiver Notice of Termination of Service</td>
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<td>ID/RD 16</td>
<td>SCDDSN ID/RD Waiver Process for Appealing Decisions</td>
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<td>HASCI 12-D</td>
<td>SCDDSN HASCI Waiver – Authorization for Medicaid Waiver Nursing Services</td>
<td>02/2004</td>
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<tr>
<td>HASCI 12-E</td>
<td>SCDDSN HASCI Waiver – Authorization for Psychological Services</td>
<td>02/2004</td>
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<td>SCDDSN HASCI Waiver – Authorization for PERS Services</td>
<td>02/2004</td>
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<td>HASCI 12-H</td>
<td>SCDDSN HASCI Waiver – Authorization for Respite Services</td>
<td>02/2004</td>
</tr>
</tbody>
</table>
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)
<table>
<thead>
<tr>
<th>Adjustments</th>
<th>Reason For Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid paid twice - void only</td>
<td>Incorrect provider paid</td>
</tr>
<tr>
<td>Incorrect dates of service paid</td>
<td>Provider filing error</td>
</tr>
<tr>
<td>Medicare adjusted the claim</td>
<td>Other</td>
</tr>
<tr>
<td>Hospital/Office Visit included in Surgical Package</td>
<td>Web Tool error</td>
</tr>
<tr>
<td>Independent lab should be paid for service</td>
<td>Reference File error</td>
</tr>
<tr>
<td>Assistant surgeon paid as primary surgeon</td>
<td>MCCS processing error</td>
</tr>
<tr>
<td>Multiple surgery claims submitted for the same DOS</td>
<td>Claim review by Appeals</td>
</tr>
<tr>
<td>MMIS claims processing error</td>
<td></td>
</tr>
<tr>
<td>Rate change</td>
<td></td>
</tr>
</tbody>
</table>
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)
   □ 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:
   ___________________________________________________________
   ___________________________________________________________
   ___________________________________________________________
   ___________________________________________________________

3. NPI# [check appropriate box] & Taxonomy (Six Characters)
   □ 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

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

PROVIDER INFORMATION

Provider Name

Doing Business As Name (DBA)

Provider Address
Street
City
State/Province
Zip Code/Postal Code

Provider Federal Identification Number (TIN) or
Employer Identification Number (EIN)

National Provider Identifier (NPI)

Provider EFT Contact Information
Provider Contact Name
Telephone Number
Telephone Number Extension
Email Address

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution Address
Street
City
State/Province
Zip Code/Postal Code

Financial Institution Routing Number

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

Provider’s Account Number with Financial Institution

Account Number Linkage to Provider Identifier (select one)
☐ Provider Tax Identification Number (TIN)
☐ National Provider Identifier (NPI)

REASON FOR SUBMISSION:
☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

By signing this form, I authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to the checking or savings account indicated above at the financial institution identified above. Credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the Department of Health and Human Services to make an adjusting debit entry to the account up to the amount of the excess payment. Credit entries to the above account are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws. I certify that the information shown is correct and agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

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

Written Signature of Person Submitting Enrollment

Printed Name of Person Submitting Enrollment

Submission Date

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

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

SPECIAL INSTRUCTIONS: For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SDHHS Provider web page for instructions on how to complete updates to your EFT information.

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

EFT Enrollment Form Revision Date: August 1, 2017
South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form

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

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

1. Provider Name: ____________________________________________________________

2. Medicaid Legacy Provider # _____________ (Six Characters)
   NPI# __________________________ Taxonomy ________________________________

3. Person to Contact: ____________________ Telephone Number: ________________

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

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

5. Street Address for delivery of request:
   Street: ________________________________
   City: _________________________________
   State: ________________________________
   Zip Code: ____________________________

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

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

__________________________________________________________________________
Authorizing Signature ____________________________ Date ______________________

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

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

Section 1: Beneficiary Information
Name (Last, First, MI): ________________________________
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: ________________________________
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>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB00080000</td>
<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
<td>02/14/2014</td>
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<tr>
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<th>CLAIM</th>
<th>SERVICE RENDERED</th>
<th>AMOUNT</th>
<th>TITLE 19</th>
<th>RECIPENT</th>
<th>RECIPENT NAME</th>
<th>M</th>
<th>TLE. 18</th>
<th>COPAY</th>
<th>TITLE</th>
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</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>O</td>
<td>ALLOWED</td>
<td>AMT</td>
<td>PAYMENT</td>
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<tr>
<td>NUMBER</td>
<td>NUMBER</td>
<td>PY IND</td>
<td>MMDDYY</td>
<td>PROC.</td>
<td>PAYMENT</td>
<td>MEDICAID</td>
<td>S</td>
<td>I I LAST NAME</td>
<td>I I LAST NAME</td>
<td>D</td>
</tr>
</tbody>
</table>

|          |          |      |         |      |        |        | |          |                   |   |       |       |       |
| ABB1AA   | 1403004803012700A |      | 27.00  | 6.72 | P | 1112233333 | M | CLARK |   |       |   0.00 |   0.00 |
|          | 01 | 101713 | 71010 | 27.00 | 6.72 | P | | | | | | |
| | | | | | | | | | | | |
| ABB2AA   | 1403004804012700A |      | 259.00 | 0.00 | S | 1112233333 | M | CLARK | | |   0.00 |   0.00 |
|          | 01 | 101713 | 74176 | 259.00 | 0.00 | S | | | | | | |
| | | | | | | | | | | | | |
| ABB3AA   | 1403004805012700A |      | 24.00  | 0.00 | R | 1112233333 | M | CLARK | | |   0.00 |   0.00 |
|          | 01 | 071913 | A5120 | 12.00 | 0.00 | R | | | | | | |
|          | 02 | 071913 | A4927 | 12.00 | 0.00 | R | | | | | | |

| ABB1AA   |                |      |        |      |        |        | |          |                   |   |       |       |       |
| ABB2AA   |                |      |        |      |        |        | |          |                   |   |       |       |       |
| ABB3AA   |                |      |        |      |        |        | |          |                   |   |       |       |       |
|          |                |      |        |      |        |        | |          |                   |   |       |       |       |

| TOTALS | 3 | 310.00 | 6.72 |

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

CERTIFIED AMT: $6.72

STATUS CODES: P = PAYMENT MADE | R = REJECTED | S = IN PROCESS | E = ENCOUNTER | Q = QUESTION | D = Diagnosis | C = Code | I = ICD-10-PCS | S = Supervisor

CERTIFIED MEDICAID TOTAL: $6.72

FOR AN EXPLANATION OF THE CERT. PG TOT MEDICAIDs: | ABC HEALTH PROVIDER | PO BOX 000000 | FLORENCE | SC 00000 |

IF YOU STILL HAVE QUESTIONS SPECIFIED: 0.00 | | | |

PHONE THE D.H.H.S. NUMBER: | | | | | | 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.

<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>[ABB222222]</td>
<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
<td>REMITTANCE ADVICE</td>
<td>02/28/2014</td>
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<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>
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<td>PAYMENT</td>
<td>ID.</td>
<td>F M</td>
<td>O</td>
<td>ALLOWED</td>
<td>AMT</td>
<td>PAYMENT</td>
</tr>
<tr>
<td>NUMBER</td>
<td>NUMBER</td>
<td>PY IND</td>
<td>MMDDYY</td>
<td>PROC.</td>
<td>MEDICAID</td>
<td>NUMBER</td>
<td>I I LAST NAME</td>
<td>D</td>
<td>CHARGES</td>
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</tr>
</tbody>
</table>

| [ABB222222]| 1405200415812200A | | | | | | | | | |
| 01 | 021814 | S0315 | 800.00 | 117.71 | P | [1112233333] | M | CLARK | 000 | 0.00 | |
| 02 | 021814 | S9445 | 392.00 | 126.00 | P | [1112233333] | M | CLARK | 000 | 0.00 | |
| VOID OF ORIGINAL CCN 13283002244813300A PAID 20131018 | | | | | | | | | |
| [ABB222222]| 1405200415812200A | | | | | | | | | |
| 01 | 100213 | S0315 | 1112.00 | 143.71 | P | [1112233333] | M | CLARK | 000 | 0.00 | |
| 02 | 100213 | S9445 | 300.00 | 130.00 | P | [1112233333] | M | CLARK | 000 | 0.00 | |
| REPLACEMENT OF ORIGINAL CCN 1304711253670430A PAID 20131018 | | | | | | | | | |
| [ABB222222]| 1405200415812200A | | | | | | | | | |
| 01 | 100213 | S0315 | 142.50 | 42.75 | P | [1112233333] | M | CLARK | 000 | 0.00 | |
| 02 | 100313 | S9445 | 859.00 | 0.00 | R | [000000] | | | 0.00 | 0.00 |

<table>
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<tbody>
<tr>
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</table>

**STATUS CODES:**
- P = PAYMENT MADE
- R = REJECTED
- S = IN PROCESS
- E = ENCOUNTER
- D = CHARGES
- M = MEDICAID
- C = CERTIFIED

**CERTIFIED AMT:**
- [ABC HEALTH PROVIDER]

**MEDICAID TOTAL:**
- [FLORENCE SC 00000]

**ENCOUNTER:**
- [PO BOX 00000]

**ERROR CODES LISTED ON THIS FORM REFER TO:**
- "MEDICAID PROVIDER MANUAL".
- FORM REFER TO: "MEDICAID PROVIDER MANUAL".
- 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.

- CHECK TOTAL | CHECK NUMBER
Sample Remittance Advice (page 3)

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

Provider ID. | Dept of Health and Human Services | Claim | Payment Date | Page
-------------+---------------------------------+-------+-------------+---+
| AB11110000 | South Carolina Medicaid Program |     |            | 2 |

| Providers | Claim | Service Rendered | Amount | Title 19 | Recipient | Recipient Name | M | Org |
|-----------+-------+------------------|--------|----------|----------|--------------|---|-----|
| Own Ref.  | Reference |_py | Date(s) | Billed | Payment | ID. | F.M.O | Check | Original CCN |
| Number | Number | Ind | MMDDYY | Proc. | Medicaid | Number | Last Name | First Name | D | Date |

| ABB222222 | 1405200077700000U | 01 | 100213 | S0315 | 453.00 | 160.71 | P | 000 | 131018 | 1328300224813300A |
| 01 | 100213 | S0315 | 453.00 | 160.71 | P | 000 |
| 02 | 100213 | S9445 | 60.00 | 33.00 | P | 000 |

| Totals | 1 | 513.00 | 193.71 |

<table>
<thead>
<tr>
<th>Provider</th>
<th>Debit Balance</th>
<th>Medicaid Total</th>
<th>Certified AMT</th>
<th>To Be Refunded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incenive</td>
<td>Prior To This</td>
<td>$243.71</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
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<td>Remittance</td>
<td>$243.71</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>Adjustments</td>
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<td>0.00</td>
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Your Current | Debit Balance | Check Total | Check Number |
|-------------|--------------|-------------|--------------|

| 0.00 | 0.00 | 550.00 | 4197304 | Florence SC 00000 |

---
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.

<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
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<tbody>
<tr>
<td>ABC1110000</td>
<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
<td>02/28/2014</td>
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<p>| | | | |</p>
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<td>PROC / DRUG</td>
</tr>
<tr>
<td>NUMBER</td>
<td>REFERENCE</td>
<td>DATE(S)</td>
<td>CODE</td>
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<td>1404900004000100U</td>
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<tr>
<td>TPL 4</td>
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<td>TPL 5</td>
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<td>TPL 6</td>
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<table>
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<tr>
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<th>MEDICAID TOTAL</th>
<th>CERTIFIED AMT</th>
<th>TO BE REFUNDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>INCENTIVE PRIOR TO THIS REMITTANCE</td>
<td>-4388.95</td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

YOUR CURRENT DEBIT BALANCE CHECK TOTAL CHECK NUMBER | ABC HEALTH PROVIDER |
PO BOX 000000 | FLORENCE SC 00000 |
### Service Provision Form

**Community Long Term Care**

**Type of Authorization:**
- New

**From:**

**Authorization is hereby given to provide the following service(s) under your contract with the state department of health and human services for the provision thereof.**

<table>
<thead>
<tr>
<th>Service(s) Authorized</th>
<th>CLTC Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorized Start Date</th>
<th>Authorized End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(if applicable)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Units Authorized</th>
<th>Sun</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thur</th>
<th>Fri</th>
<th>Sat</th>
<th>Unit Cost: $</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### Client Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Birthdate</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Address               |           |     |
|                       |           |     |

<table>
<thead>
<tr>
<th>CLTC Client No.</th>
<th>Social Sec No</th>
<th>Medicaid No.</th>
<th>Eligibility Type</th>
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<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Primary Phone</th>
<th>Secondary Phone</th>
<th>Third Phone</th>
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<tbody>
<tr>
<td></td>
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<td></td>
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</table>

### Responsible Party

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
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<td></td>
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<table>
<thead>
<tr>
<th>Relationship</th>
<th>Home Telephone</th>
<th>Work Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Physician:**

**Directions to client’s home:**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Case Manager’s Signature:**

**Sent:** __________  **Date:** __________  **Initials:** __________  

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>BILLING CLERK</th>
<th>FILE</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

SCDHHS FORM 175 JUL 92
TO: ____________________________________________________________

______________________________________________________________

RE: ____________________________________________________________

Recipient’s Name / Date of Birth

Address

Medicaid # / / / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / / / / / /

Personal Care Services (T1020) – Attach ID/RD Form 10

☐ Personal Care I (PC I) S5130
☐ Personal Care II (PC II) T1019

Number of Units Per Week to be Provided: _________ (one unit = 15 minutes)

Start Date: ___________

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Signature of Person Authorizing Services ___________________________ Date ___________________________

ID/RD Form A-3 (04/17)
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO MEDICAID

TO: ____________________________________________________________

RE: ____________________________________________________________

Recipient's Name / Date of Birth

Address

Medicaid # / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / /

PSYCHOLOGICAL SERVICES (H0046):

Assessment: Number of Units ____________ (one unit = 30 minutes)

Counseling/Therapy: Start Date: _____________________________

Number of Units (one unit = 30 minutes) _____________________________

Frequency: _____________________________________________________

** NO MORE THAN 8 HOURS/16 UNITS PER DAY MAY BE AUTHORIZED **

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

______________________________________________                 _____________________________

______________________________________________                 _____________________________

______________________________________________                 _____________________________

______________________________________________                 _____________________________

Signature of Person Authorizing Services ___________________________ Date ___________________

ID/RD Form A-9 (04/17)
TO: ________________________________

__________________________________________

RE: _______________________________________

Recipient's Name                /                  Date of Birth

Address

Medicaid # / / / / / / / / / / / / / / / / / / / / / / / /

NOTE: The provider is responsible for pursuing all other resources prior to accessing Medicaid. State Plan Medicaid resources must be exhausted before accessing ID/RD Waiver. Our information indicates this person has:

☐ Medicaid Only  ☐ 3rd Party liability  ☐ Medicare

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / / / / / / / / / / / / / / / / /

Nursing Services:

Total Number of Units Per Week to be Provided: __________ (one unit = 60 minutes)

☐ LPN Hours/Week (S9124) ______

☐ RN Hours/Week (S9123) ______

Start Date: __________

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

______________________________________________

______________________________________________

______________________________________________

Signature of Person Authorizing Services _____________________________ Date _____________________________
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE *BILLED TO MEDICAID*

TO: 

__________________________________________________________

__________________________________________________________

RE: 

__________________________________________________________

Recipient's Name / Date of Birth

Address

Medicaid # / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / /

Private Vehicle Modification (X9322):

General Description: __________________________________________

____________________________________________________________________

____________________________________________________________________

Cost: __________________________________
(Attach a copy of the bid)

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

__________________________________________________________

__________________________________________________________

__________________________________________________________

Signature of Person Authorizing Services ___________________________ Date ____________________

ID/RD Form A-13 (04/17)
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS  
ID/RD WAIVER  

AUTHORIZATION FOR SERVICES  
TO BE BILLED TO MEDICAID

TO: ____________________________________________

RE: ____________________________________________

Recipient’s Name / Date of Birth

Address

Medicaid #: / / / / / / / / / / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization #: / / / / / / / / / / / / / / / / / / / /

Adult Day Health Care Services (X6987)

Number of Units Per Week: _________ one unit = 1 (5 hour) day

Start Date: _____________________________

OR

The above named recipient cannot tolerate 5 hour day. Therefore you are authorized to provide:

Number of Units Per Week:___________ (one unit = _____ hours per day)

Start Date: _____________________________

Service coordinator: Name / Address / Phone # (Please Print):

______________________________________________                 _____________________________

Signature of Person Authorizing Services ___________________________ Date _____________________________

ID/RD Form A-23 (04/17)
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO DSN BOARD

TO: ____________________________________________________________

______________________________________________________________

RE: ____________________________________________________________

Recipient's Name / Date of Birth

Address

Medicaid #: / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Respite Services

Hourly Respite
Number of Units Per Week: __________ (one unit = 1 hour of service)

Daily Respite:
Number of Units Per __________: __________
(one unit = 1 respite period of more than 8 consecutive hours)

REMIT BILL TO (Please print):

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Signature of Person Authorizing Services __________________________ Date __________________________

ID/RD Form A-25 (04/17)
TO: ________________________________________________________________

______________________________________________________________

RE: ________________________________________________________________

Recipient’s Name / Date of Birth

Address

Medicaid # / / / / / / / / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # / / / / / / / / / /

BEHAVIOR SUPPORT SERVICES (H0045)

Assessment: Number of Units ___________ (one unit = 30 minutes)

Number of Units (one unit = 30 minutes) ___________

Frequency: ______________________________

Start Date: ______________________________

** NO MORE THAN 8 HOURS/16 UNITS PER DAY MAY BE AUTHORIZED**

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

______________________________________________________________

______________________________________________________________

______________________________________________________________

Signature of Person Authorizing Services  Date

ID/RD Form A-27 (04/17)
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO DSN BOARD

TO: ____________________________________________

_________________________________________________

RE: ______________________________________________
Recipient’s Name / Date of Birth

Address

Medicaid # / / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Residential Habilitation

Hourly:
Number of Units Per Week: ______________
(one unit = 1 hour of service provided to someone in an SLP I setting)

Daily:
Number of Units Per Year: ______________
(one unit = 1 night (present at midnight) in a CTH I, CTH II, CRCF or SLP II)

REMIT BILL TO (Please print):

____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________

Signature of Person Authorizing Services __________________________ Date ________________

ID/RD Form A-28 (04/17)
S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO MEDICAID

TO: __________________________

____________________________________

RE: __________________________

____________________________________

Recipient’s Name / Date of Birth

____________________________________

Address

____________________________________

Medicaid # ______/______/______/______/______/______/______/______/______/______/______

You are hereby authorized to provide the following service(s) to the person named above. Only the
number of units rendered may be billed. Please note: This nullifies any previous authorization to this
provider for this service(s).

Prior Authorization # ______/______/______/______/______/______/______/______/______

Audiology Services:

____ Hearing Aid Evaluation: $49.00
____ Hearing Aid Orientation: $24.00
____ Hearing Aid Analysis: $10.50
____ Hearing Aid Re-Check: $16.00
____ Conduction Test: $8.50
____ Impedance Test: $10.25
____ Hearing Consultation: $13.00

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

____________________________________

____________________________________

____________________________________

Signature of Person Authorizing Services __________________________ Date __________________________

MR/RD Form A-31 (7/01)
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR ICF/IID (INSTITUTIONAL) RESPITE SERVICES
TO BE BILLED TO DSN BOARD

☐ Center-Based Respite  ☐ Community ICF/MR

☐ Coastal Center
☐ Midlands Center  Name of facility
☐ Pee Dee Center
☐ Saleeby Center
☐ Whitten Center

TO:
For Center Based: Claims and Collections (See Attached)
For Community ICF/IID: Board/Provider Finance Director

Address

RE:
Recipient’s Name   /   Date of Birth

Medicaid # / / / / / / / / / /
Social Security # / / / / / / / / / /

You are hereby authorized to provide institutional respite to the consumer named above. The consumer cannot be admitted to the ICF/IID (DHHS 181 completed) without first notifying the Service Coordinator (noted below) and verifying that the consumer has been disenrolled from the ID/RD Waiver. Please note: This nullifies any previous authorization to this provider for this service.

Institutional Respite

☐ Number of Units _________ (one unit = number of nights spent in the ICF/IID)
Start Date: ______________________

Service Coordinator: __________________________________________

Board/Provider: __________________________________________

Address: __________________________________________

Phone Number (with extension when appropriate): ____________________________

Signature of Person Authorizing Services _____________________ Date __________

ID/RD Form A-32 (04/17)
DATE FORM IS COMPLETED: _________________________________

PROVIDER: ________________________________________________

RE:

__________________________________

Recipient’s Name Date of Birth

Medicaid #

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF ______/_______/______ MAY BE BILLED.

For SC/EI: the effective date is 10 calendar days from the date the form is completed with the exception of death, loss of Medicaid, or admission to an ICF/IID or NF. This allows the consumer 10 days notice prior to termination of service.

☐ Respite Care
☐ Adult Day Health Care
☐ Assistive Technology:_______________________
☐ Environmental Modifications
☐ Personal Care Services
☐ Medicaid Waiver Nursing Services
☐ CheckBox14
☐ CheckBox15
☐ CheckBox22
☐ Habilitation (specify)
☐ Residential habilitation
☐ Day Habilitation
☐ Prevocational services
☐ Supportive Employment services
☐ CheckBox17
☐ CheckBox18
☐ CheckBox19
☐ Prescribed Drugs
☐ CheckBox20
☐ Adult Dental Services
☐ Private Vechicle Modifications
☐ Environmental Modifications

Reason:
☐ Change in need no longer justifies original request
☐ Change in ICF/IID Level of Care
☐ Change in provider availability
☐ CheckBox28
☐ CheckBox30
☐ Death (do not send a copy to the family)
☐ Medical Condition has improvised
☐ No longer meets ICF/IID Level of Care
☐ Medicaid ineligible
☐ Consumer moved out of state
☐ Hospital/Nursing home stay exceeded more than 30 consecutive calendar days

Comments (required for all reasons:_____________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

Service Coordinator/Early Interventionist: ____________________________

DSN Board/Provider: ____________________________ Phone: ____________________________

Address: ________________________________________________________________

Signature: __________________________________________ Date: _____________/________________/____________

Original: Provider Copy: Consumer/Legal Guardian and File

ID/RD Form 16 (04/17)
The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Intellectual Disabled/Related Disabilities (ID/RD) Waiver and the Head and Spinal Cord Injury (HASCI) Waiver. A request for reconsideration of an adverse decision must be sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process must be completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the consumer, representative, or person assisting the consumer in filing the request. If necessary, staff will assist the consumer in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the consumer/representative’s request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the consumer/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the consumer/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the consumer/representative fully completes the above reconsideration process and is dissatisfied with the results, the consumer/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The consumer/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision:

Division of Appeals and Hearings  
SC Department of Health and Human Services  
PO Box 8206  
Columbia, SC 29202-8206

The consumer/representative must attach a copy of the written reconsideration decision received from the SCDDSN regarding the specific matter on appeal. In the appeal request the consumer/representative must clearly state with specificity, which issue(s) the consumer/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30th) calendar day following receipt of the SCDDSN written reconsideration decision. The consumer/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.
South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for Medicaid Waiver Nursing Services

Medicaid #: ____________________________

Referred To: ____________________________

____________________________

Indivudual Name: ____________________________

Address: ____________________________

Date of Birth: ____________________________

City/State/Zip: ____________________________

Prior Authorization Number: ____________________________

Billing should be submitted to: DHHS DSN Board

You are hereby authorized to provide:

Medicaid Waiver Nursing Services: LPN (S9124) RN (S9123)

Start Date: ____________________________

Authorized Total: ____________________________ Units per ____________________________

Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for Medicaid Waiver Nursing Services.

The service is authorized for the individual named above. Only medical services may be billed to the Waiver under Medicaid Waiver Nursing Services and documentation must be provided for any services rendered. The services must be specifically for the Waiver participant and must be medically necessary, as indicated by the individual’s physician.

The following services are requested:

____________________________

____________________________

Comments: ____________________________

____________________________

PLEASE PRINT

DSN Board Name: ____________________________ Svc. Coord.: ____________________________

Address: ____________________________

Phone: ( ) - ext. ____________________________

Signature: ____________________________ Date: ____________________________

HASC1 Form 12-D (Revised 02/94)
South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for Psychological Services

Medicaid #: ____________________________

Referred To: ____________________________

____________________________

____________________________

Individually Name ____________________________ Address ____________________________

Date of Birth ____________________________ City/State/Zip ____________________________

Prior Authorization Number: ____________________________

Billing should be submitted to: ☐ DHHS ☐ DSN Board

You are hereby authorized to provide:

Psychological Services
☐ Psychological Assessment (H0023) ☐ Family/Individual Therapy - LISW (H0023)
☐ Cognitive Rehabilitation Therapy (H0023) ☐ Family/Individual Therapy - BA/MH Practitioner (H0023)
☐ Drug and Alcohol Abuse Counseling (T1007) ☐ Psychiatric Services (H0023)
☐ Family/Individual Therapy - Psychologist (H0023) ☐ Neuropsychological Assessment (G0114)

Start Date: ____________________________

Authorized Total: ____________________________ Units per ____________________________

Only the number of units rendered may be billed.
Please note: This nullifies any previous authorization to this provider for psychological services.

Comments: ________________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

PLEASE PRINT

DSN Board Name: ____________________________ Svc. Coord.: ____________________________

Address: ________________________________________________________________

Phone: ____________________________ ext. ____________________________

Signature: ____________________________ Date: ____________________________

HASCI Form 12-E (Revised 02/04)
South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for PERS Services

Medicaid #: 

Referred To: 

<table>
<thead>
<tr>
<th>Individuals Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>City/State/Zip</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prior Authorization Number: 

1 2 3 4 5 6 7

Billing should be submitted to:  
☐ DHHS  ☐ DSN Board

You are hereby authorized to provide:

☐ PERS Services

☐ PERS Installation (S5160)  
Start Date: 

☐ PERS Monitoring (S5161)  
Start Date: 

Only the number of units rendered may be billed.  
Please note: This nullifies any previous authorization to this provider for PERS Services.

**PLEASE PRINT**

DSN Board Name:  
Svc. Coord.: 

Address:  

Phone:  

Signature:  
Date:  

HASIC Form 12-F (Revised 02/04)
South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for Respite Services

Medicaid #: ____________

Referred To: ____________________________________________

______________________________________________________

<table>
<thead>
<tr>
<th>Individuals Name</th>
<th>Address</th>
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Date of Birth: ______________________

City/State/Zip: ______________________

Prior Authorization Number: ____________

Billing should be submitted to: □ DHHS  □ DSN Board

You are hereby authorized to provide:

**Respite Services:**

Services will be provided in the following location:

- [ ] Individual's Home  [ ] Hourly (X7028)  [ ] Daily (X7027)
- [ ] Caregiver's Home (must be licensed by DDSN)  [ ] Hourly (X7028)  [ ] Daily (X7027)
- [ ] Licensed Respite Care Facility (X70027)
- [ ] ICF/MR (H0045)
- [ ] Nursing Facility (H0045)
- [ ] Hospital (H0045)
- [ ] CRCF (T1020)

Start Date: ______________________

Authorized Total: ______________________ Units per ______________________

*Only the number of units rendered may be billed.*

*Please note: This nullifies any previous authorization to this provider for respite services.*

Comments: __________________________________________________________

________________________________________________________

PLEASE PRINT

DSN Board Name: ______________________ Svc. Coord.: ______________________

Address: ______________________

Phone: (___) ______ ext. ______________________

Signature: ______________________ Date: ______________________

HASC1 Form 12-H (Revised 02/04)