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<th>Revision Date</th>
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<td>DHHS 126</td>
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<td>Claim Adjustment Form 130</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>Claim Reconsideration Form</td>
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<td>Community Long Term Care Service Provision Form</td>
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<td>Name</td>
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<td>SCDDSN ID/RD Waiver Notice of Termination of Service</td>
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<td>SCDDSN ID/RD Waiver Process for Appealing Decisions</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>
**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>
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</thead>
</table>

<table>
<thead>
<tr>
<th>ADDRESS OF SUSPECT:</th>
<th>LOCATION OF INCIDENT:</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>DATE OF INCIDENT:</th>
</tr>
</thead>
<tbody>
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<td></td>
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</table>

**COMPLAINT:**

NAME OF PERSON REPORTING: (Please print)  
SIGNATURE OF PERSON REPORTING:  
DATE OF REPORT

<table>
<thead>
<tr>
<th>ADDRESS OF PERSON REPORTING:</th>
<th>TELEPHONE NUMBER OF PERSON REPORTING:</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>SIGNATURE: (SCDHHS Representative Receiving Report)</th>
</tr>
</thead>
</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 # □□□□□□□□ (Six Characters)

OR

3. NPI# □□□□□□□□□□□□□□□□□□□□ & Taxonomy □□□□□□□□□□□□□□□□□□□□

4. Person to Contact: ______________________ 5. Telephone Number: ______________________

6. Reason for Refund: [check appropriate box]
   □ Other Insurance Paid (please complete a – f below and attach insurance EOMB)
     a Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
     b Insurance Company Name __________________________________________________
     c Policy #: _____________________________________________________________
     d Policyholder: _________________________________________________________
     e Group Name/Group: ________________________________________________
     f Amount Insurance Paid: _____________________________________________
   □ Medicare
     ( ) Full payment made by Medicare
     ( ) Deductible not due
     ( ) Adjustment made by Medicare
   □ Requested by DHHS (please attach a copy of the request)
   □ Other, describe in detail reason for refund:
     _________________________________________________________________
     _________________________________________________________________
     _________________________________________________________________

7. Patient/Service Identification:

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

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

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

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 – MI VS 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 (MI VS).
Fax: 803-252-0870  or  Mail: Post Office Box 101110
Columbia, SC 29211-9804

DHHS 931 – Updated February 2018
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

State/Province

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 1-888-286-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCHHIS 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 SCHHIS 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 1-888-286-0709.

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. Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709.

Section 1: Beneficiary Information

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

Section 2: Provider Information

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

Section 3: Claim Information

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

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below)
☐ Ambulance Services
☐ Autism Spectrum Disorder (ASD) Services
☐ Clinic Services
☐ Community Long Term Care (CLTC)
☐ Community Mental Health Services
☐ Department of Disabilities and Special Needs (DDS) 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>
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<th>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
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<td>02/14/2014</td>
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<tr>
<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
<td>REMITTANCE ADVICE</td>
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<tr>
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<th>AMOUNT</th>
<th>TITLE 19</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
<th>M</th>
<th>TLE. 18</th>
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<td>ID.</td>
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<tr>
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<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>
<td>PAYMENT</td>
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| ABB1AA | 1403004803012700A | | | | | | | | | | |
| 01 | 101713 | 71010 | 27.00 | 6.72 | P | 1112233333 | M | CLARK | | | |

| ABB2AA | 1403004804012700A | | | | | | | | | | |
| 01 | 101713 | 74176 | 259.00 | 0.00 | S | 1112233333 | M | CLARK | | | |

| ABB3AA | 1403004805012700A | | | | | | | | | | |
| 01 | 071913 | A5120 | 12.00 | 0.00 | R | 1112233333 | M | CLARK | | | |
| 02 | 071913 | A4927 | 12.00 | 0.00 | R | 1112233333 | M | CLARK | | | |

| TOTALS | | 3 | 310.00 | | | | | | | |

| $6.72 | | | | | | | | | | |

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

CERTIFIED AMT | MEDICAID TOTAL | E = ENCOUNTER | FLORENCE | SC 00000 |

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

SPECIFIED FOR INQUIRY OF
CLAIMS IN THAT MANUAL.

CHECK TOTAL | CHECK NUMBER

STATUS CODES: | | | | | | | | | | |
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>
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<td>REMITTANCE ADVICE</td>
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<td>CLAIM</td>
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<td>AMOUNT</td>
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| 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 1328300224481330A PAID 20131018 |
| ABB222222 | 1405200077700000U | | | | | | | | |
| 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 | 1405200414812200A | | | | | | | | |
| 01 | 100213 | S0315 | 142.50 | 42.75 | P | 1112233333 | M | CLARK | 000 | 0.00 |
| 02 | 100313 | S9445 | 859.00 | 0.00 | R | 1112233333 | M | CLARK | 000 | 0.00 |
| $286.46 | | | | | |

| ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL" |
| CERT. PG TOT | MEDICAID PG TOT |
| P = PAYMENT MADE | R = REJECTED |
| S = IN PROCESS | |
| E = ENCOUNTER | |
| CHECK TOTAL | CHECK NUMBER |

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

IF YOU STILL HAVE QUESTIONS SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

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

IF YOU STILL HAVE QUESTIONS SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.
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>PAYMENT DATE</th>
<th>PAGE</th>
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| PROVIDER NAME AND ADDRESS | | |
| ABC HEALTH PROVIDER | | |

| CHECK NUMBER | | |
| PO BOX 000000 | | |
| FLORENCE SC 0000 | | |
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.

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**Page Total:** 4338.95 0.00

**MEDICAID TOTAL CERTIFIED AMT TO BE REFUNDED**

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**Your Current Debit Balance: 4338.95 0.00**

**Page Total:** 4338.95 0.00

**Medicaid Total Certified Amnt To Be Refunded:**

**Provider Name and Address:**

ABC HEALTH PROVIDER

PO BOX 000000

FLORENCE SC 00000
Community Long Term Care
Service Provision Form

PROVIDER: VERIFY
MEDICAID ELIGIBILITY MONTHLY

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.

Service(s) Authorized:

Authorized Start Date: Authorized End Date: (if applicable)

Comments:

Total Units Authorized: Sun Mon Tue Wed Thur Fri Sat Unit Cost: $

CLIENT INFORMATION

NAME

BIRTHDATE

SEX

ADDRESS

CLTC CLIENT NO.

SOCIAL SEC NO

MEDICAID NO.

ELIGIBILITY TYPE

PRIMARY PHONE

SECONDARY PHONE

THIRD PHONE

RESPONSIBLE PARTY

NAME

ADDRESS

RELATIONSHIP

HOME TELEPHONE

WORK TELEPHONE

Physician:

Directions to client's home:

________________________________________________________________________

________________________________________________________________________

Case Manager's Signature: Date:

Sent: Date: Initials: □ PROVIDER □ BILLING CLERK □ FILE

SCDHHS FORM 175 JUL 92
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 # / / / / / / / / / / / / /

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)
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
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)
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)
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
☐ Pee Dee Center
☐ Saleeby Center
☐ Whitten Center

Name of facility

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

RE:

Address

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)
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER-NOTICE OF TERMINATION OF SERVICE

DATE FORM IS COMPLETED: _________________________________

PROVIDER: ________________________________________________

RE:
__________________________________  /  /  
Recipient’s Name  Date of Birth

Medicaid #  1  2  3  4  5  6  7  8  9  10

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  ☐ Environmental Modifications
☐ Assistive Technology: __________________________
☐ Personal Care Services  ☐ CheckBox14
☐ Medicaid Waiver Nursing Services  ☐ CheckBox15
☐ Habilitation (specify)  ☐ CheckBox22
☐ Residential habilitation  ☐ Physical Therapy Services
☐ Day Habilititation  ☐ CheckBox17
☐ Prevocational services  ☐ CheckBox18
☐ Supportive Employment services  ☐ CheckBox19
☐ Prescribed Drugs  ☐ CheckBox20
☐ Adult Dental Services  ☐ Private Vehicle Modifications

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

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: __________________________

__________________________

__________________________

__________________________

Individuals 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 02/04)
South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for Psychological Services

Medicaid #: ____________________

Referred To: ___________________________________________

Indivduals 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: __________________________

______________________________

______________________________

______________________________

Individuals Name

Date of Birth

Address

City/State/Zip

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: (____) - ext.

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: _________________________________________

_____________________________________________________

_____________________________________________________

Individuals 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:

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 (X7027)

☐ 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: ____________________________

HASCI Form 12-H (Revised 02/04)