

FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	Reasonable Effort Documentation	04/2014
	Authorization Agreement for Electronic Funds Transfer	01/2014
	Duplicate Remittance Advice Request Form	04/2014
	Claim Reconsideration Form	12/2016
CMS-1500 (02/12)	Sample Health Insurance Claim Form	02/2012
	Sample Remittance Advice (four pages)	04/2014
DHHS 175	Community Long Term Care Service Provision Form	07/1992
MR/RD A-3	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to Medicaid Personal Care	03/2004
MR/RD A-9	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to Medicaid Psychological Services	03/2004
MR/RD A-12	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to Medicaid Nursing Services	03/2004
MR/RD A-13	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to Medicaid Private Vehicle Modification	03/2004
MR/RD A-23	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to Medicaid Adult Day Health Care Services	03/2004
MR/RD A-25	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to DSN Board Respite Services	09/2003
MR/RD A-27	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to Medicaid Behavior Support Services	03/2004

FORMS

Number	Name	Revision Date
MR/RD A-28	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to DSN Board Residential Habilitation	08/2001
MR/RD A-31	SCDDSN MR/RD Waiver – Authorization for Services to Be Billed to Medicaid Audiology Services	07/2001
MR/RD A-32	SCDDSN MR/RD Waiver – Authorization for ICF/MR (Institutional) Respite Services to Be Billed to DSN Board	08/2003
MR/RD 16	SCDDSN MR/RD Waiver Notice of Termination of Service	08/2001
MR/RD 16 (reverse)	SCDDSN MR/RD Waiver Process for Appealing Decisions	
HASCI 12-D	SCDDSN HASCI Waiver – Authorization for Medicaid Waiver Nursing Services	02/2004
HASCI 12-E	SCDDSN HASCI Waiver – Authorization for Psychological Services	02/2004
HASCI 12-F	SCDDSN HASCI Waiver – Authorization for PERS Services	02/2004
HASCI 12-H	SCDDSN HASCI Waiver – Authorization for Respite Services	02/2004



SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

NPI or MEDICAID PROVIDER ID: (if applicable)

MEDICAID RECIPIENT ID NUMBER: (if applicable)

ADDRESS OF SUSPECT:

LOCATION OF INCIDENT:

DATE OF INCIDENT:

COMPLAINT:

NAME OF PERSON REPORTING: (Please print)

SIGNATURE OF PERSON REPORTING:

DATE OF REPORT

ADDRESS OF PERSON REPORTING:

TELEPHONE NUMBER OF PERSON REPORTING:

SIGNATURE: (SCDHHS Representative Receiving Report)

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

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

Provider ID:

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

NPI:

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

Recipient ID:

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

Adjustment Type:

- Void Void/Replace

Originator:

- DHHS MCCS Provider MIVS

Reason For Adjustment: (Fill One Only)

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

For Agency Use Only

Analyst ID:

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

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

Comments:

Signature: _____ Date: _____

Phone: _____

**South Carolina Department of Health and Human Services
Form for Medicaid Refunds**

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

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed.

Attach appropriate document(s) as listed in item 8.

1. Provider Name: _____

2. Medicaid Legacy Provider #
(Six Characters)

OR

3. NPI#

& Taxonomy

4. Person to Contact: _____

5. Telephone Number: _____

6. Reason for Refund: [check appropriate box]

- Other Insurance Paid (please complete **a – f** below and attach insurance EOMB)
 - a** Type of Insurance: () Accident/Auto Liability () Health/Hospitalization
 - b** Insurance Company Name _____
 - c** Policy #: _____
 - d** Policyholder: _____
 - e** Group Name/Group: _____
 - f** Amount Insurance Paid: _____

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

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

Other, describe in detail reason for refund:

7. Patient/Service Identification:

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

8. Attachment(s): [Check appropriate box]

- Medicaid Remittance Advice (required)
- Explanation of Benefits (EOMB) from Insurance Company (if applicable)
- Explanation of Benefits (EOMB) from Medicare (if applicable)
- Refund check

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



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM**

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

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

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

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

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

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax:	or	Mail:
803-252-0870		Post Office Box 101110
		Columbia, SC 29211-9804

**III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN
(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)**

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax:	or	Mail:
803-255-8225		Post Office Box 8206, Attention TPL
		Columbia, SC 29202-8206



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION**

PROVIDER _____ **DOS** _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

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

(SIGNATURE AND DATE)

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

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

PROVIDER INFORMATION

Provider Name _____
Doing Business As Name (DBA) _____
Provider Address
Street _____
City _____ State/Province _____
Zip Code/Postal Code _____ Medicaid Provider Number _____
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
I (we) hereby authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to my account indicated above and the financial institution named above, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.
I (we) understand that credit entries to the account of the above named payee are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws.
I (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.
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 SCDHHS 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 SCDHHS 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.

**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: _____ 4. Telephone Number: _____
5. Requesting:
 Remittance Advice Pages Edit Correction Form (ECF)
Pages Only*

(*) ECFs are available only for Remittance Advice dates prior to January 17, 2014. Please note that SCDHHS no longer accepts ECFs for processing as of April 1, 2014.

6. 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.

7. Street Address for delivery of request:
Street: _____
City: _____
State: _____
Zip Code: _____

8. 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



Nikki R. Haley GOVERNOR
 Christian L. Soura DIRECTOR
 P.O. Box 8206 > Columbia, SC 29202
 www.scdhhs.gov

Submit your Claim Reconsideration request to:
Fax: 1-855-563-7086
or
Mail: South Carolina Healthy Connections Medicaid
 ATTN: Claim Reconsiderations
 Post Office Box 8809
 Columbia, SC 29202-8809

CLAIM RECONSIDERATION FORM

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. 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: _____ 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)

- | | |
|---|---|
| <input type="checkbox"/> Ambulance Services
<input type="checkbox"/> Clinic Services
<input type="checkbox"/> Community Long Term Care (CLTC)
<input type="checkbox"/> Community Mental Health Services
<input type="checkbox"/> Durable Medical Equipment (DME)
<input type="checkbox"/> Early Intervention Services
<input type="checkbox"/> Federally Qualified Health Center (FQHC)
<input type="checkbox"/> Enhanced Services
<input type="checkbox"/> Home Health Services
<input type="checkbox"/> Hospice Services
<input type="checkbox"/> Hospital Services
<input type="checkbox"/> Licensed Independent Practitioner's Rehabilitative Services (LIPS)
<input type="checkbox"/> Local Education Agencies (LEA) | <input type="checkbox"/> Nursing Facility Services
<input type="checkbox"/> Optional State Supplementation (OSS)
<input type="checkbox"/> Pharmacy Services
<input type="checkbox"/> Physicians Laboratories, and Other Medical Professionals
Specify: _____
<input type="checkbox"/> Private Rehabilitative Therapy and Audiological Services
<input type="checkbox"/> PRTF CHANCE Waiver
<input type="checkbox"/> Psychiatric Hospital Services
<input type="checkbox"/> Rehabilitative Behavioral Health Services (RBHS)
<input type="checkbox"/> Rural Health Clinic (RHC)
<input type="checkbox"/> Targeted Case Management (TCM)
<input type="checkbox"/> Other: _____ |
|---|---|

Nikki R. Haley GOVERNOR
Christian L. Soura DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature: _____

Date: _____



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA												<input type="checkbox"/> PICA																																																																																															
1. MEDICARE <input type="checkbox"/> (Medicare#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																																																															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>												4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																			
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>												7. INSURED'S ADDRESS (No., Street)																																																																																			
CITY						STATE						CITY						STATE																																																																																									
ZIP CODE						TELEPHONE (Include Area Code)						ZIP CODE						TELEPHONE (Include Area Code)																																																																																									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:												11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO												a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																																			
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO												b. OTHER CLAIM ID (Designated by NUCC)																																																																																			
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO												c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																			
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. CLAIM CODES (Designated by NUCC)												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, complete items 9, 9a, and 9d.																																																																																			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																																																											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																																																															
SIGNED												DATE												SIGNED																																																																																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL:												15. OTHER DATE MM DD YY												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												17a.												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												17b. NPI												20. OUTSIDE LAB? # CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)												ICD Ind.												22. RESUBMISSION CODE ORIGINAL REF. NO.																																																																																			
A. _____												B. _____												C. _____												D. _____																																																																							
E. _____												F. _____												G. _____												H. _____																																																																							
I. _____												J. _____												K. _____												L. _____																																																																							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY												B. PLACE OF SERVICE EMG												C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER												E. DIAGNOSIS POINTER												F. # CHARGES												G. DAYS OR UNITS												H. EPICRT Family Plan												I. ID. QUAL												J. RENDERING PROVIDER ID. #											
1																																																																																																											
2																																																																																																											
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4																																																																																																											
5																																																																																																											
6																																																																																																											
25. FEDERAL TAX I.D. NUMBER												89N EIN												26. PATIENT'S ACCOUNT NO.												27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO												28. TOTAL CHARGE \$												29. AMOUNT PAID \$												30. Raved for NUCC Use																																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												32. SERVICE FACILITY LOCATION INFORMATION												33. BILLING PROVIDER INFO & PH # ()																																																																																			
SIGNED												DATE												a. NPI												b.												a. NPI												b.																																															

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Sample Remittance Advice (page 1)

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

PROVIDER ID.	DEPT OF HEALTH AND HUMAN SERVICES	PROFESSIONAL SERVICES	PAYMENT DATE	PAGE
AB00080000	SOUTH CAROLINA MEDICAID PROGRAM	REMITTANCE ADVICE	02/14/2014	1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT	
ABB1AA	1403004803012700A01		101713	71010	27.00	6.72 P	1112233333	M CLARK			0.00	0.00	
					27.00	6.72 P							026
ABB2AA	1403004804012700A01		101713	74176	259.00	0.00 S	1112233333	M CLARK			0.00	0.00	
					259.00	0.00 S							026
ABB3AA	1403004805012700A01		071913	A5120	24.00	0.00 R	1112233333	M CLARK			0.00	0.00	
			071913	A4927	12.00	0.00 R							000
					12.00	0.00 R							000
TOTALS			3		310.00						0.00	0.00	

\$6.72

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

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

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

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS
ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 2)

This page of the sample Remittance Advice shows a paid claim, as well as a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle.

PROVIDER ID.	DEPT OF HEALTH AND HUMAN SERVICES	PROFESSIONAL SERVICES	PAYMENT DATE	PAGE
AB00080000	REMITTANCE ADVICE		02/28/2014	1
	SOUTH CAROLINA MEDICAID PROGRAM			

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	1405200415812200A			1192.00	243.71	P	1112233333	M CLARK			0.00	
	01		021814 S0315	800.00	117.71	P				000		0.00
	02		021814 S9445	392.00	126.00	P				000		0.00
VOID OF ORIGINAL CCN 13283002244813300A PAID 20131018												
ABB222222	1405200077700000U			1412.00-	273.71-	P	1112233333	M CLARK				
	01		100213 S0315	1112.00-	143.71-	P				000		
	02		100213 S9445	300.00-	130.00-	P				000		
REPLACEMENT OF ORIGINAL CCN 1304711253670430A PAID 20131018												
ABB222222	1405200414812200A			1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		100213 S0315	142.50	42.75	P				000		0.00
	02		100313 S9445	859.00	0.00	R				000		0.00
											0.00	0.00

\$286.46

FOR AN EXPLANATION OF THE 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.

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

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

CHECK NUMBER

PROVIDER NAME AND ADDRESS
ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 3)

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

PROVIDER ID. +-----+ AB11110000 +-----+	DEPT OF HEALTH AND HUMAN SERVICES +-----+ CLAIM ADJUSTMENTS +-----+	PAYMENT DATE +-----+ 02/28/2014 +-----+	PAGE +-----+ 2 +-----+
SOUTH CAROLINA MEDICAID PROGRAM			

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME I	M F I	M O D	ORG CHECK DATE	ORIGINAL CCN	
ABB222222	1405200077700000U		100213	S0315	513.00-	197.71-	P	1112233333	CLARK	M		131018	1328300224813300A
			01		453.00	160.71-	P				000		
			02	S9445	60.00	33.00-	P				000		
	TOTALS		1		513.00-	193.71-							

PROVIDER INCENTIVE CREDIT AMOUNT	DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	TO BE REFUNDED IN THE FUTURE
0.00	0.00	\$243.71	0.00	0.00
		ADJUSTMENTS		
		\$193.71-		
	YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PROVIDER NAME AND ADDRESS
	0.00	\$50.00	4197304	ABC HEALTH PROVIDER
				PO BOX 000000 FLORENCE SC 00000

Sample Remittance Advice (page 4)

This page of the sample Remittance Advice shows four gross-level adjustments.
Gross-level adjustments always appear on the final page of the Remittance Advice.

PROVIDER ID.	DEPT OF HEALTH AND HUMAN SERVICES	ADJUSTMENTS	PAYMENT DATE	PAGE
ABC1110000	SOUTH CAROLINA MEDICAID PROGRAM		02/28/2014	3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME F M LAST NAME I I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	1404900004000100U	-						DEBIT	-2389.05	
TPL 4	1405500076000400U	-						DEBIT	-1949.90	
TPL 5	1404900004000100U	-						DEBIT	-477.25	
TPL 6	1405500076000400U	-						CREDIT	477.25	
PAGE TOTAL:									4338.95	0.00

PROVDER INCENTIVE CREDIT AMOUNT	DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	TO BE REFUNDED IN THE FUTURE
0.00	0.00	0.00	0.00	0.00
		ADJUSTMENTS		
		-4338.95	0.00	
	YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PROVIDER NAME AND ADDRESS
	0.00	0.00		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: _____ CLTC PROCEDURE CODE: _____
 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

**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 # / / / / / / / / /

Personal Care Services (T1020) – Attach MR/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

**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 # / / / / / / / / / /

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

**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 # / / / / / / / / / /

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

**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 # / / / / / / / / / /

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

**S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/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

**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 # / / / / / / / / / /

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

**S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER**

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

- | | |
|---|---|
| <input type="checkbox"/> Center-Based Respite | <input type="checkbox"/> Community ICF/MR |
| <input type="checkbox"/> Coastal Center | |
| <input type="checkbox"/> Midlands Center | _____ |
| <input type="checkbox"/> Pee Dee Center | Name of facility |
| <input type="checkbox"/> Saleeby Center | |
| <input type="checkbox"/> Whitten Center | |

TO: _____
For Center Based: Claims and Collections (See Attached)
For Community ICF/MR: 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/MR (DHHS 181 completed) without first notifying the Service Coordinator (noted below) and verifying that the consumer has been disenrolled from the MR/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/MR)
Start Date: _____

Service Coordinator: _____

Board/Provider: _____

Address: _____

Phone Number (with extension when appropriate): _____

Signature of Person Authorizing Services _____
Date

**S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/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/MR or NF. This allows the consumer 10 days notice prior to termination of service.

- | | |
|---|--|
| <input type="checkbox"/> Respite Care | |
| <input type="checkbox"/> Adult Day Health Care | <input type="checkbox"/> Environmental Modifications |
| <input type="checkbox"/> Assistive Technology: _____ | |
| <input type="checkbox"/> Personal Care Services | <input type="checkbox"/> CheckBox14 |
| <input type="checkbox"/> Medicaid Waiver Nursing Services | <input type="checkbox"/> CheckBox15 |
| <input type="checkbox"/> Habilitation (specify) | <input type="checkbox"/> CheckBox22 |
| <input type="checkbox"/> Residential habilitation | <input type="checkbox"/> Physical Therapy Services |
| <input type="checkbox"/> Day Habilitation | <input type="checkbox"/> CheckBox17 |
| <input type="checkbox"/> Prevocational services | <input type="checkbox"/> CheckBox18 |
| <input type="checkbox"/> Supportive Employment services | <input type="checkbox"/> CheckBox19 |
| <input type="checkbox"/> Prescribed Drugs | <input type="checkbox"/> CheckBox20 |
| <input type="checkbox"/> Adult Dental Services | <input type="checkbox"/> Private Vehicle Modifications |

Reason:

- | | |
|--|---|
| <input type="checkbox"/> Change in need no longer justifies original request | <input type="checkbox"/> Medical Condition has improved |
| <input type="checkbox"/> Change in ICF/MR Level of Care | <input type="checkbox"/> No longer meets ICF/MR Level of Care |
| <input type="checkbox"/> Change in provider availability | <input type="checkbox"/> Medicaid ineligible |
| <input type="checkbox"/> CheckBox28 | <input type="checkbox"/> Consumer moved out of state |
| <input type="checkbox"/> CheckBox30 | <input type="checkbox"/> Hospital/Nursing home stay exceeded more than 30 consecutive calendar days |
| <input type="checkbox"/> 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

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Mental Retardation/Related Disabilities (MR/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 PERS Services**

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

Referred To: _____

Individuals Name	Address
Date of Birth	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: _____

