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<td>DHHS 126</td>
<td>Confidential Complaint</td>
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<td>Health Insurance Information Referral Form</td>
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<td>Reasonable Effort Documentation</td>
<td>04/2014</td>
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<td>Electronic Funds Transfer (EFT) Authorization Agreement</td>
<td>08/2019</td>
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<tr>
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<td>Duplicate Remittance Advice Request Form</td>
<td>09/2017</td>
</tr>
<tr>
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<td>Claim Reconsideration Form</td>
<td>11/2018</td>
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<td>CMS-1500</td>
<td>Sample Health Insurance Claim Form</td>
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<td>Sample Remittance Advice (four pages)</td>
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## FORMS

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<td>ID/RD 16</td>
<td>SCDDSN ID/RD Waiver Process for Appealing Decisions</td>
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<td>02/2004</td>
</tr>
<tr>
<td>HASCI 12-H</td>
<td>SCDDSN HASCI Waiver – Authorization for Respite Services</td>
<td>02/2004</td>
</tr>
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</table>
**CONFIDENTIAL COMPLAINT**

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

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

<table>
<thead>
<tr>
<th>SUSPECTED INDIVIDUAL OR INDIVIDUALS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI or MEDICAID PROVIDER ID: (if applicable)</td>
</tr>
<tr>
<td>ADDRESS OF SUSPECT:</td>
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<tr>
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<td>COMPLAINT:</td>
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<tr>
<th>NAME OF PERSON REPORTING: (Please print)</th>
<th>SIGNATURE OF PERSON REPORTING:</th>
<th>DATE OF REPORT</th>
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<td>TELEPHONE NUMBER OF PERSON REPORTING:</td>
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<td>SIGNATURE: (SCDHHS Representative Receiving Report)</td>
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</table>

SCDHHS Form 126 (revised 06/07)
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  Orignator:  ☐ DHHS  ☐ MCCS  ☐ Provider  ☐ MIVS

Reason For Adjustment (Fill One Only):
☐ Insurance payment different than original claim  ☐ Medicaid paid twice - void only
☐ Keying errors  ☐ Incorrect provider paid
☐ Incorrect recipient billed  ☐ Incorrect dates of service paid
☐ Voluntary provider refund due to health insurance  ☐ Provider filing error
☐ Voluntary provider refund due to casualty  ☐ Medicare adjusted the claim
☐ Voluntary provider refund due to Medicare  ☐ Other

For Agency Use Only

☐ Hospital/Office Visit included in Surgical Package  ☐ Web Tool error
☐ Independent lab should be paid for service  ☐ Reference File error
☐ Assistant surgeon paid as primary surgeon  ☐ MCCS processing error
☐ Multiple surgery claims submitted for the same DOS  ☐ Claim review by Appeals
☐ MMIS claims processing error  

☐ Rate change

Comments:

Signature: __________________________________________________________ Date: ________________________________

Phone: __________________________________________________________

DHHS Form 130 Revision date: 03-13-2007
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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</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 – 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  Mail:  Post Office Box 101110
                       Columbia, SC  29211-9804

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

PROVIDER ____________________________________________  DOS _______________________
NPI or MEDICAID PROVIDER ID ___________________________
MEDICAID BENEFICIARY NAME _____________________________
MEDICAID BENEFICIARY ID# ________________________________
INSURANCE COMPANY NAME ______________________________
POLICYHOLDER __________________________________________
POLICY NUMBER __________________________________________
ORIGINAL DATE FILED TO INSURANCE COMPANY _________________
DATE OF FOLLOW UP ACTIVITY ________________________________

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _________________________________

RESULT:

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

________________________________________________________
(SIGNATURE AND DATE)

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

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

## REASON FOR SUBMISSION
- [ ] Change to Current EFT (i.e. account or bank changes)
- [ ] Individual
- [ ] Organization

## INDIVIDUAL PROVIDER/ORGANIZATION INFORMATION

<table>
<thead>
<tr>
<th>Individual Provider/Organization Legal Business Name</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Doing Business as Name (DBA)</td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Medicaid Provider Number</td>
<td>National Provider Identifier (NPI)</td>
</tr>
<tr>
<td>Designate Tax Identification Number (TIN)</td>
<td>[ ] SSN (individual)</td>
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</table>

## ORGANIZATION/INDIVIDUAL PROVIDER EFT CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Provider Contact Name</th>
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</thead>
<tbody>
<tr>
<td>Telephone Number</td>
<td>Extension</td>
</tr>
<tr>
<td>Email Address</td>
<td></td>
</tr>
</tbody>
</table>

## FINANCIAL INSTITUTION INFORMATION

| Financial Institution Name | |
| Financial Institution Address | |
| City | State | Zip Code/Postal Code |

## PROVIDER’S ACCOUNT NUMBER WITH FINANCIAL INSTITUTION

| Financial Institution Routing Number (Nine digits) | |
| Provider’s Account Number with Financial Institution (Up to 17 digits) | |
| Type of Account at Financial Institution (TRANSIT CODE) | [ ] 22 – Checking Account | [ ] 32 – Savings Account |

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

[ ] I acknowledge that I have read and understand that payments will be issued only to the bank account of the provider designated to receive payments beginning July 2019 with the transition of Medicaid claims payments to the South Carolina Enterprise Information System (SCEIS). For more information, please visit [https://vip.scdhhs.gov/sceis](https://vip.scdhhs.gov/sceis) or contact 888-289-0709.

ALL EFT REQUESTS ARE SUBJECT TO A 10-DAY PROMT PERIOD IN WHICH ALL ACCOUNTS ARE VERIFIED BY THE QUALIFYING FINANCIAL INSTITUTION BEFORE ANY MEDICAID DIRECT DEPOSITS ARE MADE.

Signature of Person Submitting Form (print or sign)

Printed Name of Person Submitting Form

Submission Date

### SPECIAL INSTRUCTIONS:
For questions regarding the status of your EFT update, please contact the Provider Service Center at 888-289-0709. Please refer to the EFT section of the provider enrollment manual found at [https://www.scdhhs.gov/provider](https://www.scdhhs.gov/provider) for instructions on how to complete updates to your EFT information.

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

To process EFT updates, please return this completed form along with verification of your electronic deposit information on your financial institution’s letterhead to:

SCDHHS, Medicaid Provider Enrollment • PO BOX 8809 • Columbia, South Carolina 29202-8809 • FAX 803-870-9022
South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form

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

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

1. Provider Name: ________________________________________________________________

2. Medicaid Legacy Provider # ____________ (Six Characters)
   NPI# _________________________ Taxonomy ________________________________

3. Person to Contact: ___________________ Telephone Number: ____________________

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

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

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

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

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

________________________________________         ___________________________
Authorizing Signature                      Date

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

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

Section 1: Beneficiary Information
Name (Last, First, MI): 
Date of Birth: ________ Medicaid Beneficiary ID: ________

Section 2: Provider Information
Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other (DME, Lab, Home Health Agency, etc.): __________________________
NPI: ________ Medicaid Provider ID: ________ Facility/Group/Provider Name: __________________________
Return Mailing Address: __________________________
Street or Post Office Box __________________________ State ZIP __________________________
Contact: __________________________ Email: __________________________ Telephone #: __________________________ Fax #: __________________________

Section 3: Claim Information (Only one CCN allowed per request.)
Communication ID: __________________________ CCN: __________________________ Date(s) of Service: __________________________

Section 4: Claim Reconsideration Information
What area is your denial related to? (Please select below)
☐ Ambulance Services
☐ Autism Spectrum Disorder (ASD) Services
☐ Clinic Services
☐ Community Long Term Care (CLTC)
☐ Community Mental Health Services
☐ Department of Disabilities and Special Needs (DDS/N) 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 Center (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>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PROFESSIONAL SERVICES</th>
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<th>PAGE</th>
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<tbody>
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<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
<td>REMITTANCE ADVICE</td>
<td>02/14/2014</td>
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<th>CLAIM</th>
<th>SERVICE RENDERED</th>
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<th>TITLE 19</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
<th>M</th>
<th>TLE. 18</th>
<th>COPAY</th>
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<tbody>
<tr>
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<td>REFERENCE</td>
<td>DATE(S)</td>
<td>BILLED</td>
<td>PAYMENT</td>
<td>ID.</td>
<td>F M</td>
<td>O</td>
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<td>AMT</td>
<td>PAYMENT</td>
</tr>
<tr>
<td>PY IND</td>
<td>MMDDYY</td>
<td>PROC.</td>
<td>MEDICAID</td>
<td>NUMBER</td>
<td></td>
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| ABB1AA | 1403004803012700A | 01 | 101713 | 71010 | 27.00 | 6.72 | P | 1112233333 | M | CLARK | 026 | 0.00 | 0.00 |
| ABB2AA | 1403004804012700A | 01 | 101713 | 74176 | 259.00 | 0.00 | S | 1112233333 | M | CLARK | 026 | 0.00 | 0.00 |
| ABB3AA | 1403004805012700A | 01 | 071913 | A5120 | 12.00 | 0.00 | R | 1112233333 | M | CLARK | 000 | 0.00 | 0.00 |
|          | 02 | 071913 | A4927 | 12.00 | 0.00 | R | 000 | 0.00 | 0.00 |
| TOTALS  |            | 3  |        |       | 310.00 | $6.72 | |

FOR AN EXPLANATION OF THE STATUS CODES:

CERT. PG TOT  MEDICAID PG TOT  P = PAYMENT MADE  |ABC HEALTH PROVIDER |
ERROR CODES LISTED ON THIS FORM REFER TO:  "MEDICAID"  R = REJECTED  |ABC HEALTH PROVIDER |
FORM REFER TO:  "MEDICAID"  S = IN PROCESS  |PO BOX 000000 |
PROVIDER MANUAL".  |FLORENCE 00000  SC 00000 |

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER  | | 0.00 |
SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.  |CHECK TOTAL CHECK NUMBER |
This page of the sample Remittance Advice shows a paid claim, as well as a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle.

<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
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<td>AB00080000</td>
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<th>SERVICE RENDERED</th>
<th>AMOUNT</th>
<th>TITLE 19</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
<th>M</th>
<th>TITLE 18</th>
<th>COPAY</th>
<th>TITLE</th>
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<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>
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<td>NUMBER</td>
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STATUS CODES: P = PAYMENT MADE R = REJECTED S = IN PROCESS E = ENCOUNTER F = MEDICAID TOTAL D = CHARGES
This page of the sample Remittance Advice shows a claim-level Void without a corresponding Replacement claim.
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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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: $ __________

CLTC PROCEDURE CODE:

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)
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE *BILLING 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)
S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/ RD WAIVER

AUTHORIZED FOR SERVICES
TO BE BILLED TO MEDICAID

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

ID/RD Form A-12 (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 # / / / / / / / / / / /

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)
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  
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 # / / / / / / / / /

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 __________
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)
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 # ________________________________ ________________________________ __________/________/_____

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: ________________________________
☐ Personal Care Services
☐ Medicaid Waiver Nursing Services
☐ Habilitation (specify)
 ☐ Residential habilitation
 ☐ Day Habilitation
 ☐ Prevocational services
 ☐ Supportive Employment services
☐ Prescribed Drugs
☐ Adult Dental Services
☐ Environmental Modifications
☐ CheckBox14
☐ CheckBox15
☐ CheckBox22
☐ Physical Therapy Services
☐ CheckBox17
☐ CheckBox18
☐ CheckBox19
☐ CheckBox20
☐ Private Vehicle Modifications
☐ CheckBox28
☐ CheckBox30
☐ Death (do not send a copy to the family)

Reason:
☐ Change in need no longer justifies original request
☐ Change in ICF/IID Level of Care
☐ Change in provider availability
☐ 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)
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 Intellectual Disabled/Related Disabilities (ID/RD) Waiver and the Head and Spinal Cord Injury (HASCII) 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 02/94)
South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for Psychological Services

Medicaid #: ________________________________

Referral To:
________________________________________
________________________________________

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

Referred To: __________________________

______________________________

______________________________

Individu1l 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: __________________________

HASC1 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 #: 1 2 3 4 5 6 7 8 9 10

Referred To: ____________________________

__________________________

Individuals Name ____________________________ Address ____________________________

Date of Birth ____________________________ City/State/Zip ____________________________

Prior Authorization Number: ____________________________ Billing should be submitted to: ☐ DHHS ☐ DSN Board

1 2 3 4 5 6 7

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: ____________________________

HASCI Form 12-H (Revised 02/04)