

**FORMS**

<b>Number</b>	<b>Name</b>	<b>Revision Date</b>
DHHS 126	<a href="#">Confidential Complaint</a>	06/2007
DHHS 130	<a href="#">Claim Adjustment Form 130</a>	03/2007
DHHS 205	<a href="#">Medicaid Refunds</a>	01/2008
DHHS 931	<a href="#">Health Insurance Information Referral Form</a>	01/2008
	<a href="#">Reasonable Effort Documentation</a>	04/2014
	<a href="#">Authorization Agreement for Electronic Funds Transfer</a>	01/2014
	<a href="#">Duplicate Remittance Advice Request Form</a>	04/2014
	<a href="#">Claim Reconsideration Form</a>	12/2016
CMS-1500 (02/12)	<a href="#">Sample Claim Showing TPL Denial with NPI</a>	02/2012
CMS-1500 (02/12)	<a href="#">Sample Claim Showing TPL Denial with NPI and Medicaid Provider ID</a>	02/2012
	<a href="#">Sample Remittance Advice</a>	04/2014



**STATE OF SOUTH CAROLINA  
DEPARTMENT OF HEALTH  
AND HUMAN SERVICES**

# CONFIDENTIAL COMPLAINT

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

## PROGRAM INTEGRITY

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

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

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:

Grid for Original CCN (15 boxes)

Provider ID:

Grid for Provider ID (6 boxes)

NPI:

Grid for NPI (10 boxes)

Recipient ID:

Grid for Recipient ID (8 boxes)

Adjustment Type:

- Void, Void/Replace

Originator:

- 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

Analyst ID:

Grid for Analyst ID (6 boxes)

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

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).

<b>Fax:</b>	<b>or</b>	<b>Mail:</b>
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).

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

Nikki R. Haley GOVERNOR  
Christian L. Soura DIRECTOR  
P.O. Box 8206 > Columbia, SC 29202  
[www.scdhhs.gov](http://www.scdhhs.gov)

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**Section 5: Desired Outcome**

**Request submitted by:**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Community Mental Health Services  
Sample Claim Showing TPL Denial  
with NPI

**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#) MEDICAID <input checked="" type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input checked="" type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890																								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John A.										3. PATIENT'S BIRTH DATE MM DD YY 01 01 1947 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street) 123 Windy Lane CITY: Anytown STATE: SC ZIP CODE: 29999 TELEPHONE (Include Area Code): ( )										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: ZIP CODE: TELEPHONE (Include Area Code): ( )																			
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State): c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)					11. INSURED'S POLICY GROUP OR FECA NUMBER 22222222222B a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) 0 00 c. INSURANCE PLAN NAME OR PROGRAM NAME 401 d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, complete items 9, 9a, and 9d.																			
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. SIGNED: Signature on File DATE:										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:																								
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL:										15. OTHER DATE QUAL: MM DD YY					18. 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.					17b. NPI																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					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.: A. 295.32 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER																								
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS ON UNITS H. SPOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																																		
1										01 07 14 01 07 14 53 90801 102 00 1 ZZ 1212121212 1234567890																								
2																																		
3																																		
4																																		
5																																		
6																																		
25. FEDERAL TAX I.D. NUMBER 55555555 SGN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. DOE1234					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 102 00					29. AMOUNT PAID \$ 0 00					30. Paid for NUCC Use 102 00				
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 a. NPI b.										33. BILLING PROVIDER INFO & PH # (555) 5555555 Local CMH Center 11 Main Street Anytown, SC 22222-2222 a. 1234567890 b. ZZ1212121212														

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION



# HEALTH INSURANCE CLAIM FORM

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

Community Mental Health Services  
Sample Claim Showing TPL Denial  
with NPI and Medicaid Provider ID

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> PIGA <span style="float: right;"><input type="checkbox"/> PIGA</span>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#DoD#) (Member ID#) (ID#) (ID#)</small>						1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John A.						3. PATIENT'S BIRTH DATE MM DD YY 01 01 1947			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
5. PATIENT'S ADDRESS (No., Street) 123 Windy Lane						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 Anytown STATE SC				8. RESERVED FOR NUCC USE				CITY		STATE	
ZIP CODE 29999 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 222222222222B	
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				b. 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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLAGE (State)				c. OTHER CLAIM ID (Designated by NUCC) 0 00		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.	
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				d. INSURANCE PLAN NAME OR PROGRAM NAME 401		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, complete items 9, 9a, and 9d.	
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC) 1				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	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL						15. OTHER DATE MM DD YY QUAL			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. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES			22. RESUBMISSION CODE ORIGINAL REF. NO.		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Incl.											
A. 295 32 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	
01 07 14 01 07 14			53		90801			102 00		1 1D ABC 123 NPI 1234567890	
2			3		4			5		6	
25. FEDERAL TAX I.D. NUMBER 555555555			26. PATIENT'S ACCOUNT NO. DOE1234		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 102 00		29. AMOUNT PAID \$ 0 00		30. Paid for NUCC Use 102 00
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 a. NPI b.			33. BILLING PROVIDER INFO & PH # (555) 5555555 Local CMH Center 11 Main Street Anytown, SC 2222-2222 a. 1234567890 b. 1DABC123					
SIGNED DATE			SIGNED DATE			APPROVED OMB-0938-1197 FORM 1500 (02-12)					

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

# Sample Remittance Advice (page 1)

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

PROVIDER ID.	PROFESSIONAL SERVICES						PAYMENT DATE	PAGE		
AB00080000	DEPT OF HEALTH AND HUMAN SERVICES SOUTH CAROLINA MEDICAID PROGRAM						02/14/2014	1		
PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED DATE(S) PY IND MMDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M TLE. 18 O ALLOWED D CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB1AA	1403004803012700A 01	101713	71010	27.00 27.00	6.72 P 6.72 P	1112233333	M CLARK	026	0.00	0.00
ABB2AA	1403004804012700A 01	101713	74176	259.00 259.00	0.00 S 0.00 S	1112233333	M CLARK	026	0.00	0.00
ABB3AA	1403004805012700A 01 02	071913 071913	A5120 A4927	24.00 12.00 12.00	0.00 R 0.00 R 0.00 R	1112233333	M CLARK	000 000	0.00	0.00 0.00
TOTALS		3		310.00			Edits: L00 946 L02 852 08/30/13		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 \$0.00 CERTIFIED AMT	MEDICAID PG TOT \$286.46 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
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Please note that the procedure codes and payment amounts used in these samples are examples only. They are not the actual charge amounts for the services listed.

# 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.	PROFESSIONAL SERVICES						PAYMENT DATE	PAGE																		
AB00080000	DEPT OF HEALTH AND HUMAN SERVICES						02/28/2014	1																		
	SOUTH CAROLINA MEDICAID PROGRAM																									
REMITTANCE ADVICE																										
PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT														
ABB222222	1405200415812200A		021814	S0315	1192.00	243.71 P	1112233333	CLARK			0.00															
	01		021814	S0315	800.00	117.71 P						0.00														
	02		021814	S9445	392.00	126.00 P						0.00														
VOID OF ORIGINAL CCN 13283002244813300A PAID 20131018																										
ABB222222	1405200077700000U		100213	S0315	1412.00-	273.71- P	1112233333	CLARK																		
	01		100213	S0315	1112.00-	143.71- P																				
	02		100213	S9445	300.00-	130.00- P																				
REPLACEMENT OF ORIGINAL CCN 1304711253670430A PAID 20131018																										
ABB222222	1405200414812200A		100213	S0315	1001.50	42.75 P	1112233333	CLARK			0.00															
	01		100213	S0315	142.50	42.75 P						0.00														
	02		100313	S9445	859.00	0.00 R						0.00														
											\$286.46															
<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; vertical-align: top;">                 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.             </td> <td style="width: 20%; vertical-align: top; border: none;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;">CERT. PG TOT</td> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black; text-align: right;">\$0.00</td> </tr> <tr> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;">MEDICAID PG TOT</td> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black; text-align: right;">\$286.46</td> </tr> <tr> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;">CERTIFIED AMT</td> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;"></td> </tr> <tr> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;">MEDICAID TOTAL</td> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black; text-align: right;">0.00</td> </tr> <tr> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;">CHECK TOTAL</td> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;"></td> </tr> </table> </td> <td style="width: 20%; vertical-align: top; border: none;">                 STATUS CODES:                  P = PAYMENT MADE                  R = REJECTED                  S = IN PROCESS                  E = ENCOUNTER             </td> <td style="width: 30%; vertical-align: top; border: none;">                 PROVIDER NAME AND ADDRESS                  ABC HEALTH PROVIDER                  PO BOX 000000                  FLORENCE SC 00000             </td> </tr> </table>													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.	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;">CERT. PG TOT</td> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black; text-align: right;">\$0.00</td> </tr> <tr> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;">MEDICAID PG TOT</td> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black; text-align: right;">\$286.46</td> </tr> <tr> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;">CERTIFIED AMT</td> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;"></td> </tr> <tr> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;">MEDICAID TOTAL</td> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black; text-align: right;">0.00</td> </tr> <tr> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;">CHECK TOTAL</td> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;"></td> </tr> </table>	CERT. PG TOT	\$0.00	MEDICAID PG TOT	\$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
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.	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;">CERT. PG TOT</td> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black; text-align: right;">\$0.00</td> </tr> <tr> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;">MEDICAID PG TOT</td> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black; text-align: right;">\$286.46</td> </tr> <tr> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;">CERTIFIED AMT</td> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;"></td> </tr> <tr> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;">MEDICAID TOTAL</td> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black; text-align: right;">0.00</td> </tr> <tr> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;">CHECK TOTAL</td> <td style="border-top: 1px dashed black; border-bottom: 1px dashed black;"></td> </tr> </table>	CERT. PG TOT	\$0.00	MEDICAID PG TOT	\$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													
CERT. PG TOT	\$0.00																									
MEDICAID PG TOT	\$286.46																									
CERTIFIED AMT																										
MEDICAID TOTAL	0.00																									
CHECK TOTAL																										

Please note that the procedure codes and payment amounts used in these samples are examples only. They are not the actual charge amounts for the services listed.

# Sample Remittance Advice (page 3)

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

PROVIDER ID.			CLAIM ADJUSTMENTS	PAYMENT DATE	PAGE
AB11110000	DEPT OF HEALTH AND HUMAN SERVICES			02/28/2014	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	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	M F I	ORG CHECK DATE	ORIGINAL CCN
ABB222222	1405200077700000U				513.00-	197.71-	P1112233333	CLARK	M	131018	1328300224813300A
	01		100213	S0315	453.00	160.71-	P			000	
	02		100213	S9445	60.00	33.00-	P			000	
	TOTALS		1		513.00-	193.71-					

  

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

Please note that the procedure codes and payment amounts used in these samples are examples only. They are not the actual charge amounts for the services listed.

# 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
AB11110000	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

Please note that the procedure codes and payment amounts used in these samples are examples only. They are not the actual charge amounts for the services listed.