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<th>Number</th>
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<th>Revision Date</th>
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<td>Claim Reconsideration Form</td>
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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:  

<table>
<thead>
<tr>
<th>NPI or MEDICAID PROVIDER ID: (if applicable)</th>
<th>MEDICAID RECIPIENT ID NUMBER: (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS OF SUSPECT:</td>
<td>LOCATION OF INCIDENT:</td>
</tr>
<tr>
<td></td>
<td>DATE OF INCIDENT:</td>
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</tbody>
</table>

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)  

SCD HHS Form 126 (revised 06/07)
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>
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<tbody>
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</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)
I  ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: ___________________________ Date Referral Completed: ___________________________

Medicaid ID#: ___________________________ Policy Number: ___________________________

Insurance Company Name: ___________________________ Group Number: ___________________________

Insured’s Name: ___________________________ Insured SSN: ___________________________

Employer’s Name/Address: ___________________________

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

_____ a. beneficiary has never been covered by the policy – close insurance.

_____ b. beneficiary coverage ended - terminate coverage (date) ___________________________

_____ c. subscriber coverage lapsed - terminate coverage (date) ___________________________

_____ d. subscriber changed plans under employer - new carrier is ___________________________
   - new policy number is ___________________________

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.
   (name) ___________________________

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

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

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

DHHS 931 – Updated February 2018
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
- **Individual Provider/Organization Legal Business Name**
- **Doing Business as Name (DBA)**
- **Street**
- **City**
- **State**
- **Zip Code/Postal Code**
- **Medicaid Provider Number**
- **National Provider Identifier (NPI)**
- **Designate Tax Identification Number (TIN)**
  - [ ] SSN (individual)
  - [ ] EIN (organization)
- **SSN**
- **EIN**

### ORGANIZATION/INDIVIDUAL PROVIDER EFT CONTACT INFORMATION
- **Provider Contact Name**
- **Telephone Number**
- **Email Address**
- **Extension**

### FINANCIAL INSTITUTION INFORMATION
- **Financial Institution Name**
- **Financial Institution Address**
- **City**
- **State**
- **Zip Code/Postal Code**
- **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, 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://sip.scdhhs.gov/ScEIS](https://sip.scdhhs.gov/ScEIS) or contact 888-289-0709.

**ALL EFT REQUESTS ARE SUBJECT TO A 10-DAY PROMOTE 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 to 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/providers](https://www.scdhhs.gov/providers) 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 a 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

---

**EFT Authorization Agreement**

**Revision Date:** August 1, 2019
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, M): ____________________________________________
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 ☐ Licensed Independent Practitioner’s Rehabilitative Services (LIPS)
☐ Autism Spectrum Disorder (ASD) Services ☐ Local Education Agencies (LEA)
☐ Clinic Services ☐ Medically Complex Children’s (MCC) Waivers
☐ Community Long Term Care (CLTC) ☐ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
☐ Community Mental Health Services ☐ Optional State Supplementation (OSS)
☐ Department of Disabilities and Special Needs (DDS) Waivers ☐ Pharmacy Services
☐ Durable Medical Equipment (DME) ☐ Physicians Laboratories, and Other Medical Professionals Specify:
☐ Early Intervention Services ☐ Private Rehabilitative Therapy and Audiological Services
☐ Enhanced Services ☐ Psychiatric Hospital Services
☐ Federally Qualified Health Center (FQHC) ☐ Rehabilitative Behavioral Health Services (RBHS)
☐ Home Health Services ☐ Rural Health Clinic (RHC)
☐ Hospice Services ☐ Targeted Case Management (TCM)
☐ Hospital Services ☐ Other: ________________________________
Section 5: Desired Outcome

Request submitted by:

Print Name: ______________________________________

Signature: ______________________________________ Date: _________