

FORMS

Number	Name	Revision Date
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	Authorization Agreement for Electronic Funds Transfer	01/2009
DHEC 0762	Children's Rehabilitative Services Orthodontic Referral Form	11/2005
DHHS 219-DG	Medicaid Enrollment Data Group Dentist and Attachments (two pages)	07/2006
DHHS 219-DI	Medicaid Enrollment Data Individual Dentist and Attachments (three pages)	07/2006
DHHS 214	Prior Authorization Form	06/2008
IRS W-9	Request for Taxpayer Identification Number and Certification (W-9 Form) (three pages)	12/1996
	S.C. Medicaid Dental Program Referral Form for Broken Appointments	
ADA J400	Example Dental Claim Form	2006
ADA J400	Example Dental Claim Form Reporting Third-Party or Medicare Information	2006
CMS-1500	Example Dental Claim Form Oral and Maxillofacial Surgeons Only	08/2005
CMS-1500	Example Dental Claim Form Reporting Third-Party and/or Medicare Payments or Denials Oral and Maxillofacial Surgeons Only	08/2005
	Sample Remittance Advices	
	Sample ECF for American Dental Association 2006 Claim Form	10/2008
	Sample ECF for the CMS-1500 Claim Form	10/2008

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 (10 boxes)

Adjustment Type:

- Void, Void/Replace

Originator:

- DHHS, MCCS, Provider, MIVS

Reason For Adjustment: (Fill One Only)

- Insurance payment different than original claim, Keying errors, Incorrect recipient billed, Voluntary provider refund due to health insurance, Voluntary provider refund due to casualty, Voluntary provider refund due to Medicare, Medicaid paid twice - void only, Incorrect provider paid, Incorrect dates of service paid, Provider filing error, Medicare adjusted the claim, 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).

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

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

Medicaid Beneficiary ID: _____ SSN: _____

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

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

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

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

PROVIDER INFORMATION

Provider Name _____
Medicaid Provider Number _____
Provider NPI Number _____
Provider Address _____
City _____ State _____ Zip _____

BANKING INFORMATION (Please include a copy of the electronic deposit information on bank letterhead. This is required and the information will be used to verify your bank account information).

Financial Institution Name _____
Financial Institution Address _____
City _____ State _____ Zip _____
Routing Number (nine digit) _____
Account Number _____

Type of Account (check one) Checking Savings

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 below and the financial institution named below, 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.

Contact Name: _____ Phone Number: _____

Signed _____ (Signature)
_____ (Print)

Title _____ Date _____

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.

RETURN COMPLETED FORM TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 699-8637



Children's Rehabilitative Services Orthodontic Referral Form

Patient's Name _____ Date of Birth _____ Name of Parent/Guardian _____

Address _____ City/State/Zip _____ Phone # _____

Have the child position their teeth in the centric position. Record all measurements in the order given and round off to the nearest millimeter (mm).

Score all conditions listed.

1. Overjet in millimeters.....(class II's only / positive numbers only)..... _____
 2. Overbite in millimeters...(positive numbers only)..... _____
 3. Reverse or Negative Overjet in millimeters(Class III's ONLY)..... Number _____ mm x 5 = _____
 4. Anterior open bite in millimeters..... Number _____ mm x 4 = _____
 5. Number of Radiographically Documented Impacted Teeth Number of teeth _____ x 5 = _____
Crowded or blocked out teeth do not count
 - 6a. Moderate crowding (<6 millimeters) 2 points per arch..... Number of Arches _____ x 2 = _____
 - 6b. Severe crowding (>6 millimeters) 4 points per archNumber of Arches _____ x 4 = _____
 - 7a. Total Number of teeth (upper & lower) in anterior crossbite Number of teeth _____ x 2 = _____
 - 7b. Total Number of teeth (upper & lower) in posterior crossbite..... Number of teeth _____ x 2 = _____
 8. Habits affecting arch development (*specify*) 2 points _____
- TOTAL** _____

Other Comments

The South Carolina CRS Program sets 35 points as the minimum necessary to be considered for orthodontic treatment by the program. *include high quality facial and intra-oral photographs with all referrals. If impacted teeth are reported, then also include radiographic documentation.* Some unusual situations may exist when children do not meet the 35-point minimum yet their condition represents a very serious problem. In such cases, the referring orthodontist or dentist should document the unique circumstances (especially any disproportionate skeletal growth pattern) and include justification in the "Other Comments" section above, along with photographs and radiographic documentation. *Children referred to the CRS Program should take the completed form and supporting documentation to the nearest health department to complete a CRS Program application.* The CRS program will determine eligibility.

Signature of Referring Dentist or Orthodontist _____ Date _____

Print name _____ Phone Number _____

Address _____

AS A CONDITION OF PARTICIPATION AND PAYMENT, I UNDERSTAND AND AGREE:

- That this agreement shall not be assigned or transferred.
- That upon acceptance of this agreement, the South Carolina Department of Health and Human Services (SCDHHS) will issue a Medicaid provider number, which must be used in filing all claims.
- That services shall be provided to Medicaid recipients in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, as amended, and the Age Discrimination Act of 1975 and any regulations promulgated pursuant to any of these Acts.
- In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 *et seq.*) and regulations pursuant thereto, (45 CFR Part 80, 1996, as amended). In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 *et seq.*) and its implementing regulation at 45 CFR Part 80, the provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement.
- That adequate and correct fiscal and medical records shall be kept to disclose the extent of services rendered and to assure that claims for funds are in accordance with all applicable laws, regulations, and policies.
- That all fiscal and medical records shall be retained for a period of three (3) years after last payment was made for services rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the three (3) years, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the three (3) year period, whichever is later.
- That, for the purposes of reviewing, copying, and reproducing documents, access shall be allowed to all records concerning services and payment under this agreement to the SCDHHS, the State Auditor's Office, the South Carolina Attorney General's Office, the Department of Health and Human Services and/or their designee during normal business hours.
- That upon request, information must be furnished regarding any claim for payment to the SCDHHS.
- That requests for reimbursement for services shall reflect any third party payment received and that any payment received subsequent to claims filing shall be reported.
- That Medicaid will reimburse the co-insurance and/or deductible portions (cost sharing) of Medicare claims for recipients with both coverages only if the provider accepts Medicare assignment. Cost sharing is limited by the Medicaid allowed amount for the service.
- That Medicaid reimbursement is always made to the provider of services and that the recipient shall not be billed pending receipt of such payment.
- That Medicaid reimbursement is payment in full and that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient or any other person, family member, relative, organization or entity for care or services to a recipient/patient except as may otherwise be allowed under Federal regulations or in accordance with SCDHHS policy.
- That this statement applies only to those recipients for whom Medicaid claims are filed and that it in no way requires that the provider render services to any Medicaid recipient.
- Either party may terminate this agreement upon providing the other party with thirty (30) days written notice termination. Such termination shall be sent by Certified Mail, Return Receipt Requested, and be effective thirty (30) days after the date of receipt.
- That the provider shall disclose full and complete information as to ownership, business transactions, and criminal activity in accordance with 42 CFR 455.104 through 455.106 (1999). Furthermore, the provider shall disclose any felony convictions under Federal or State law in accordance with 42 CFR 1001.101 Subpart B through 1001.1701 Subpart C (1999).
- That, for any dispute arising under this agreement, the provider shall have as his sole and exclusive remedy the right to request a hearing from SCDHHS within thirty (30) calendar days of the Commission action which he believes himself aggrieved. Such proceedings shall be in accordance with SCDHHS appeals procedures and S.C. Code Ann. 1-23-310 *et seq.* (1976, as amended). Judicial review of any final agency administrative decision shall be in accordance with S.C. Code Ann. 1-23-380 (1976, as amended).
- That the provider shall safeguard the use and disclosure of information concerning applicants for or recipients of Title XIX (Medicaid) services in accordance with 42 CFR Part 431 Subpart F (1991), SHHSFC's regulation R.126-170, *et seq.*, Code of Laws of South Carolina (1976) Volume 27 as amended, and all applicable State laws and regulations.
- That none of the funds provided under this agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for political office, or otherwise in violation of the "Hatch Act".
- That all services rendered and claims submitted shall be in compliance with all applicable federal and state laws and regulations and in accordance with SCDHHS policies, procedures, and Medicaid Provider Manuals.
- That all information provided on the Medicaid enrollment form is incorporated as a part of this agreement.
- That the provider shall be held personally liable for all claims submitted by him or on his behalf as evidenced by his endorsement of his Medicaid reimbursement check.
- That Medicaid reimbursement (payment of claims) is from state and federal funds and that any falsification (false claims, statement or documents) or concealment of material fact may be prosecuted under applicable state and federal laws.
- That the provider must comply with all requirements of the Americans with Disabilities Act of 1990 (ADA), as applicable.
- That the provider shall comply with all terms and conditions of the Drug Free Workplace Act, S.C. Code Ann. Section 44-107-10 *et seq.* (1976, as amended) if this agreement is for a stated or estimated value of Fifty Thousand Dollars or more.
- That in accordance with 31 U.S.C. 1352, funds received through this agreement may not be expended to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or

employee of Congress, or an employee of a Member of Congress in connection with any of the following covered Federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. This restriction is applicable to all contractors and subcontractors.

- The Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification: Standard Unique Health Identifier for Health Care Providers regulations (42 CFR 165 Subparts A & D), states that all covered entities: health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a standard transaction must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES) no later than May 23, 2007.
- Pursuant to the Standard Unique Health Identifier regulations (42 CFR 165 Subparts A & D), and if the provider is a covered health care provider as defined in 42 CFR §162.402, the provider agrees to disclose its NPI to SCDHHS once obtained from the NPPES. Provider also agrees to use the NPI it obtained from the NPPES to identify itself on all standard transactions that it conducts with SCDHHS.

COUNTY CODES (ITEM 15)

01	Abbeville	24	Greenwood
02	Aiken	25	Hampton
03	Allendale	26	Horry
04	Anderson	27	Jasper
05	Bamberg	28	Kershaw
06	Barnwell	29	Lancaster
07	Beaufort	30	Laurens
08	Berkeley	31	Lee
09	Calhoun	32	Lexington
10	Charleston	33	McCormick
11	Cherokee	34	Marion
12	Chester	35	Marlboro
13	Chesterfield	36	Newberry
14	Clarendon	37	Oconee
15	Colleton	37	Orangeburg
16	Darlington	39	Pickens
17	Dillon	40	Richland
18	Dorchester	41	Saluda
19	Edgefield	42	Spartanburg
20	Fairfield	43	Sumter
21	Florence	44	Union
22	Georgetown	45	Williamsburg
23	Greenville	46	York

- 60 Georgia within SC Svc. Area
- 61 Georgia outside SC Svc. Area
- 62 North Carolina within SC Service Area
- 63 North Carolina outside SC Service Area
- 64 Other

PRACTICE SPECIALTY (ITEM 21)

- 08 Dentistry
- 35 Orthodontics
- 43 Pododontics
- 66 Oral Surgery
- EN Endodontist
- PE Periodontist

CLIA (ITEM 25)

- A Accreditation
- C Compliance
- P PPMP
- R Registration
- T Partial Accredited
- W Waiver

AS A CONDITION OF PARTICIPATION AND PAYMENT, I UNDERSTAND AND AGREE;

- That this agreement shall not be assigned or transferred.
- That upon acceptance of this agreement, the South Carolina Department of Health and Human Services (SCDHHS) will issue a Medicaid provider number, which must be used in filing all claims.
- That services shall be provided to Medicaid recipients in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, as amended, and the Age Discrimination Act of 1975 and any regulations promulgated pursuant to any of these Acts.
- In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 et seq.) and regulations pursuant thereto, (45 CFR Part 80, 1996, as amended). In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 et seq.) and its implementing regulation at 45 CFR Part 80, the provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement.
- That adequate and correct fiscal and medical records shall be kept to disclose the extent of services rendered and to assure that claims for funds are in accordance with all applicable laws, regulations, and policies.
- That all fiscal and medical records shall be retained for a period of three (3) years after last payment was made for services rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the three (3) years, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the three (3) year period, whichever is later.
- That, for the purposes of reviewing, copying, and reproducing documents, access shall be allowed to all records concerning services and payment under this agreement to the SCDHHS, the State Auditor's Office, the South Carolina Attorney General's Office, the Department of Health and Human Services and/or their designee during normal business hours.
- That upon request, information must be furnished regarding any claim for payment to the SCDHHS.
- That requests for reimbursement for services shall reflect any third party payment received and that any payment received subsequent to claims filing shall be reported.
- That Medicaid will reimburse the co-insurance and/or deductible portions (cost sharing) of Medicare claims for recipients with both coverages only if the provider accepts Medicare assignment. Cost sharing is limited by the Medicaid allowed amount for the service.
- That Medicaid reimbursement is always made to the provider of services and that the recipient shall not be billed pending receipt of such payment.
- That Medicaid reimbursement is payment in full and that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient or any other person, family member, relative, organization or entity for care or services to a recipient/patient except as may otherwise be allowed under Federal regulations or in accordance with SCDHHS policy.
- That this statement applies only to those recipients for whom Medicaid claims are filed and that it in no way requires that the provider render services to any Medicaid recipient.
- Either party may terminate this agreement upon providing the other party with thirty (30) days written notice termination. Such termination shall be sent by Certified Mail, Return Receipt Requested, and be effective thirty (30) days after the date of receipt.
- That the provider shall disclose full and complete information as to ownership, business transactions, and criminal activity in accordance with 42 CFR 455.104 through 455.106 (1999). Furthermore, the provider shall disclose any felony convictions under Federal or State law in accordance with 42 CFR 1001.101 Subpart B through 1001.1701 Subpart C (1999).
- That, for any dispute arising under this agreement, the provider shall have as his sole and exclusive remedy the right to request a hearing from SCDHHS within thirty (30) calendar days of the Commission action which he believes himself aggrieved. Such proceedings shall be in accordance with SCDHHS appeals procedures and S.C. Code Ann. 1-23-310 et seq. (1976, as amended). Judicial review of any final agency administrative decision shall be in accordance with S.C. Code Ann. 1-23-380 (1976, as amended).
- That the provider shall safeguard the use and disclosure of information concerning applicants for or recipients of Title XIX (Medicaid) services in accordance with 42 CFR Part 431 Subpart F (1991), SHHSFC's regulation R.126-170, et seq., Code of Laws of South Carolina (1976) Volume 27 as amended, and all applicable State laws and regulations.
- That none of the funds provided under this agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for political office, or otherwise in violation of the "Hatch Act".
- That all services rendered and claims submitted shall be in compliance with all applicable federal and state laws and regulations and in accordance with SCDHHS policies, procedures, and Medicaid Provider Manuals.
- That all information provided on the Medicaid enrollment form is incorporated as a part of this agreement.
- That the provider shall be held personally liable for all claims submitted by him or on his behalf as evidenced by his endorsement of his Medicaid reimbursement check.
- That Medicaid reimbursement (payment of claims) is from state and federal funds and that any falsification (false claims, statement or documents) or concealment of material fact may be prosecuted under applicable state and federal laws.
- That the provider must comply with all requirements of the Americans with Disabilities Act of 1990 (ADA), as applicable.
- That the provider shall comply with all terms and conditions of the Drug Free Workplace Act, S.C. Code Ann. Section 44-107-10 et seq. (1976, as amended) if this agreement is for a stated or estimated value of Fifty Thousand Dollars or more.
- That in accordance with 31 U.S.C. 1352, funds received through this agreement may not be expended to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered Federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. This restriction is applicable to all contractors and subcontractors.
- The Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification: Standard Unique Health Identifier for Health Care Providers regulations (42 CFR 165 Subparts A & D), states that all covered entities: health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a standard transaction must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES) no later than May 23, 2007.
- Pursuant to the Standard Unique Health Identifier regulations (42 CFR 165 Subparts A & D), and if the provider is a covered health care provider as defined in 42 CFR §162.402, the provider agrees to disclose its NPI to SCDHHS once obtained from the NPPES. Provider also agrees to use the NPI it obtained from the NPPES to identify itself on all standard transactions that it conducts with SCDHHS.

COUNTY CODES (Item 15)

01	Abbeville	24	Greenwood
02	Aiken	25	Hampton
03	Allendale	26	Horry
04	Anderson	27	Jasper
05	Bamberg	28	Kershaw
06	Barnwell	29	Lancaster
07	Beaufort	30	Laurens
08	Berkeley	31	Lee
09	Calhoun	32	Lexington
10	Charleston	33	McCormick
11	Cherokee	34	Marion
12	Chester	35	Marlboro
13	Chesterfield	36	Newberry
14	Clarendon	37	Oconee
15	Colleton	38	Orangeburg
16	Darlington	39	Pickens
17	Dillon	40	Richland
18	Dorchester	41	Saluda
19	Edgefield	42	Spartanburg
20	Fairfield	43	Sumter
21	Florence	44	Union
22	Georgetown	45	Williamsburg
23	Greenville	46	York
60	Georgia within SC service area		
61	Georgia outside SC service area		
62	North Carolina within SC service area		
63	North Carolina outside SC service area		
64	Other		

STATE LICENSE BOARD (Item 23)

01	Alabama	27	Nebraska
02	Alaska	28	Nevada
03	Arizona	29	New Hampshire
04	Arkansas	30	New Jersey
05	California	31	New Mexico
06	Colorado	32	New York
07	Connecticut	33	North Carolina
08	Delaware	34	North Dakota
09	Florida	35	Ohio
10	Georgia	36	Oklahoma
11	Hawaii	37	Oregon
12	Idaho	38	Pennsylvania
13	Illinois	39	Rhode Island
14	Indiana	40	South Carolina
15	Iowa	41	South Dakota
16	Kansas	42	Tennessee
17	Kentucky	43	Texas
18	Louisiana	44	Utah
19	Maine	45	Vermont
20	Maryland	46	Virginia
21	Massachusetts	47	Washington
22	Michigan	48	West Virginia
23	Minnesota	49	Wisconsin
24	Mississippi	50	Wyoming
25	Missouri	51	Canada
26	Montana		

**PRIMARY & SECONDARY SPECIALTY
(Item 25 & 26)**

08	Dentistry
35	Orthodontics
43	Pedodontics
66	Oral Surgery
EN	Endodontist
PE	Periodontist

CLIA (Item 30)

A	Accreditation
C	Compliance
P	PPMP
R	Registration
T	Partial Accredited
W	Waiver

PRIOR AUTHORIZATION

1 CLAIM CONTROL NUMBER (DO NOT WRITE IN THIS SPACE)

TYPEWRITER ALIGNMENT
USE CAPITAL LETTERS ONLY

PROVIDER INFORMATION

PROVIDERS NAME

NPI

OWN REFERENCE #

DATE SUBMITTED

STREET ADDRESS

CITY/STATE/ZIP

NAME AND CITY OF MEDICAL PROVIDER

PRIOR AUTHORIZATION #

RECIPIENT INFORMATION

RECIPIENT NAME (FIRST, MIDDLE INITIAL, LAST)

RECIPIENT ID NUMBER

SEX

BIRTH DATE

SERVICE INDICATOR

SERVICE CODE

MODIFIER

TYPE OF SALE

REQUESTED # BILLINGS

EPSDT REFERRAL

PROPOSED CHARGE

SERVICE NAME

TOOTH #

TOOTH SURFACES

AUTHORIZED # BILLINGS

ALLOWED # BILLINGS

DELETE

AUTHORIZED CHARGE

EXPIRATION DATE

SERVICE INDICATOR

SERVICE CODE

MODIFIER

TYPE OF SALE

REQUESTED # BILLINGS

EPSDT REFERRAL

PROPOSED CHARGE

SERVICE NAME

TOOTH #

TOOTH SURFACES

AUTHORIZED # BILLINGS

ALLOWED # BILLINGS

DELETE

AUTHORIZED CHARGE

EXPIRATION DATE

SERVICE INDICATOR

SERVICE CODE

MODIFIER

TYPE OF SALE

REQUESTED # BILLINGS

EPSDT REFERRAL

PROPOSED CHARGE

SERVICE NAME

TOOTH #

TOOTH SURFACES

AUTHORIZED # BILLINGS

ALLOWED # BILLINGS

DELETE

AUTHORIZED CHARGE

EXPIRATION DATE

SERVICE INDICATOR

SERVICE CODE

MODIFIER

TYPE OF SALE

REQUESTED # BILLINGS

EPSDT REFERRAL

PROPOSED CHARGE

SERVICE NAME

TOOTH #

TOOTH SURFACES

AUTHORIZED # BILLINGS

ALLOWED # BILLINGS

DELETE

AUTHORIZED CHARGE

EXPIRATION DATE

SERVICE INDICATOR

SERVICE CODE

MODIFIER

TYPE OF SALE

REQUESTED # BILLINGS

EPSDT REFERRAL

PROPOSED CHARGE

SERVICE NAME

TOOTH #

TOOTH SURFACES

AUTHORIZED # BILLINGS

ALLOWED # BILLINGS

DELETE

AUTHORIZED CHARGE

EXPIRATION DATE

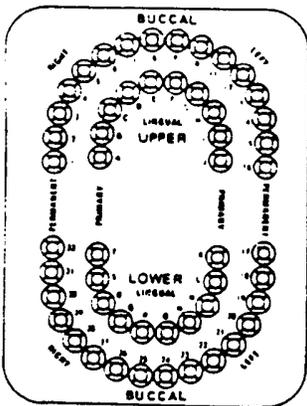
DOCUMENTATION ATTACHED

TOTAL LINES ENTERED

TOTAL PROPOSED CHARGES

TOTAL AUTHORIZED CHARGES

EXPLAIN MEDICAL NECESSITY FOR EACH PROCEDURE BELOW



X

X

93 REVIEWED BY (FOR DEPARTMENT USE ONLY)

94 PROVIDERS SIGNATURE

Request for Taxpayer Identification Number and Certification

**Give form to the
 requester. Do not
 send to the IRS.**

Print or type See Specific Instructions on page 2.	Name	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶	
	<input type="checkbox"/> Exempt from backup withholding	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 3.

Social security number

or

Employer identification number

Note: If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here	Signature of U.S. person ▶	Date ▶
------------------	----------------------------	--------

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note: If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515**, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien.

Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a **nonresident alien or a foreign entity** not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments (29% after December 31, 2003; 28% after December 31, 2005). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will **not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate **Instructions for the Requester of Form W-9**.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note: *You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).*

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note: *If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.*

Exempt payees. Backup withholding is **not required** on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2);
2. The United States or any of its agencies or instrumentalities;
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities;
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities; or
5. An international organization or any of its agencies or instrumentalities.

Other payees that **may be exempt** from backup withholding include:

6. A corporation;
7. A foreign central bank of issue;
8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States;

9. A futures commission merchant registered with the Commodity Futures Trading Commission;
10. A real estate investment trust;
11. An entity registered at all times during the tax year under the Investment Company Act of 1940;
12. A common trust fund operated by a bank under section 584(a);
13. A financial institution;
14. A middleman known in the investment community as a nominee or custodian; or
15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, **1** through **15**.

If the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13 . Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt recipients 1 through 7 ²

¹ See **Form 1099-MISC**, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are **not exempt** from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner **LLC** that is disregarded as an entity separate from its owner (see **Limited liability company (LLC)** on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note: See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5**, Application for a Social Security Card, from your local Social Security Administration office or get this form on-line at www.ssa.gov/online/ss5.html. You may also get this form by calling 1-800-772-1213. Use **Form W-7**, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or **Form SS-4**, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at www.irs.gov.

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

**S.C. Medicaid Dental Program
Referral Form for Broken Appointments**

This form is used to refer Medicaid beneficiaries who are non-compliant. The referral will be followed up by appropriate Department of Health and Environmental Control (DHEC) staff and efforts will be made to encourage beneficiary compliance. Please provide as much information as you can to assist in contacting the beneficiary or the beneficiary's parent/guardian.

Dentist _____

Phone Number _____

Dental Office Contact Person _____

Beneficiary's Name	Medicaid ID Number	Date of Birth
Beneficiary's Phone Number	Beneficiary's Address	
Parent/Caregiver's Name		
<i>CHECK ONE BLOCK BELOW</i>		
Missed Sedation/Complex/Emergency Appointment (URGENT)	<input type="checkbox"/>	
Missed Restorative Appointment (Moderate)	<input type="checkbox"/>	
Missed Preventive Appointment (Minor)	<input type="checkbox"/>	
Reason Given for Missed Appointment:		
Other Concerns/Comments:		

Beneficiary's Name	Medicaid ID Number	Date of Birth
Beneficiary's Phone Number	Beneficiary's Address	
Parent/Caregiver's Name		
<i>CHECK ONE BLOCK BELOW</i>		
Missed Sedation/Complex/Emergency Appointment (URGENT)	<input type="checkbox"/>	
Missed Restorative Appointment (Moderate)	<input type="checkbox"/>	
Missed Preventive Appointment (Minor)	<input type="checkbox"/>	
Reason Given for Missed Appointment:		
Other Concerns/Comments:		

1500

EXAMPLE DENTAL CLAIM FORM
REPORTING THIRD-PARTY AND/OR MEDICARE PAYMENTS OR DENIALS
ORAL AND MAXILLOFACIAL SURGEONS ONLY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/GROUP HEALTH PLAN/FECA BLK/LUNG/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS; 22. MEDICAID RESUBMISSION CODE; 23. PRIOR AUTHORIZATION NUMBER; 24. TABLE OF SERVICE; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Remittance Advice

PROVIDER ID.	PROFESSIONAL SERVICES	PAYMENT DATE	PAGE
-----+ 1111111111	DEPT OF HEALTH AND HUMAN SERVICES	-----+ 03/26/2008	-----+ 1
-----+	REMITTANCE ADVICE	-----+	-----+
-----+	SOUTH CAROLINA MEDICAID PROGRAM	-----+	-----+

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
T22222222	44444444444444444444B	01	021508	D1120	35.00	31.00	P	1234567890	JOHN DOE	000		0.00	0.00
		02	021508	D1203	17.00	17.00	P			000		0.00	0.00
TOTALS				2	52.00	48.00						0.00	0.00

	\$48.00			
FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".	CERT. PG TOT	MEDICAID PG TOT	STATUS CODES:	
	\$0.00	\$48.00	P = PAYMENT MADE	
	CERTIFIED AMT	MEDICAID TOTAL	R = REJECTED	
IF YOU STILL HAVE QUESTIONS	\$0.00	\$0.00	S = IN PROCESS	
PHONE THE D.H.H.S. NUMBER	FEDERAL RELIEF	MAXIMUS AMT	E = ENCOUNTER	
SPECIFIED FOR INQUIRY OF	0.00	0.00	PROVIDER NAME AND ADDRESS	
CLAIMS IN THAT MANUAL.	CHECK TOTAL	CHECK NUMBER	SMILE DENTAL PRACTICE	
	0.00	0.00	111 DENTAL ST	
	0.00	0.00	ANYWHERE , SC 29532-1111	

Sample Remittance Advice —Void/Replacement

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.

Z11111 JANE DOE DDS
 .9999999999999999
 PROVIDER ID.

Y

PROFESSIONAL SERVICES

PAYMENT DATE

PAGE

```

+-----+ DEPT OF HEALTH AND HUMAN SERVICES +-----+
| 1111111111 | REMITTANCE ADVICE | 03/26/2008 | 1 |
+-----+ SOUTH CAROLINA MEDICAID PROGRAM +-----+
    
```

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
T22222222	444444444444444444B				1192.00	243.71 P	1234567890	M JONES			0.00	
	01		021508	D0428	800.00	117.71 P						0.00
	02		021508	D0425	392.00	126.00 P						0.00
VOID OF ORIGINAL CCN 9999999999999999B PAID 02/28/04												
T33333333	5555555555555555U				1412.00-	273.71-	8888888888	M JONES				
	01		012108	D0425	1112.00-	143.71-						
	02		012108	D0434	300.00-	130.00-						
REPLACEMENT OF ORIGINAL CCN 9999999999999999B PAID 02/28/04												
T33333333	6666666666666666B				1001.50	42.75 P	8888888888	M JONES			0.00	
	01		012108	D0425	142.50	42.75 P						0.00
	02		012108	D0434	859.00	0.00 R						0.00
TOTALS				2	2193.50	286.46					0.00	0.00

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 \$0.00 FEDERAL RELIEF 0.00	MEDICAID PG TOT \$286.46 MEDICAID TOTAL 0.00 CHECK TOTAL 0.00	STATUS CODES: P = PAYMENT MADE R = REJECTED S = IN PROCESS E = ENCOUNTER	PROVIDER NAME AND ADDRESS JANE DOE DDS 111 DENTAL ST ANYWHERE , SC 29532-1111
--	---	--	--	--

Sample Remittance Advice —Void Only

This page of the sample Remittance Advice shows claim-level Voids without corresponding Replacement claims.

PROVIDER ID.	DEPT OF HEALTH AND HUMAN SERVICES	CLAIM ADJUSTMENTS	PAYMENT DATE	PAGE
1111111111	SOUTH CAROLINA MEDICAID PROGRAM		03/26/2008	2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY	SERVICE RENDERED DATE(S) MMDDYY	IND	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME I I	M	F	M	O	D	ORG CHECK DATE	ORIGINAL CCN
T22222222	7777777777777777U					513.00-	197.71-	1122334455	JONES	M					022804	55555522222222D
	01		012108		D0425	453.00	160.71-	P								
	02		012108		D0434	60.00	33.00-	P								
T22222222	8888888888888888U					513.00-	197.71-	6677889900	JONES	M					022804	666666666622222D
	01		012108		D0425	453.00	160.71-	P								
	02		012108		D0434	60.00	33.00-	P								
T22222222	0000000000000000U					513.00-	197.71-	9876543210	JONES	M					022804	777777772222222D
	01		012108		D0425	453.00	160.71-	P								
	02		012108		D0434	60.00	33.00-	P								
	TOTALS				3	1539.00-	593.13-									

	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
DEBIT BALANCE PRIOR TO THIS REMITTANCE	0.00	0.00	0.00	0.00
0.00	ADJUSTMENTS	MAXIMUS AMT	PROVIDER NAME AND ADDRESS	
YOUR CURRENT DEBIT BALANCE	593.13	0.00	JANE DOE DDS 111 DENTAL ST ANYWHERE , SC 2222-1111	
	CHECK TOTAL	CHECK NUMBER		

Sample Remittance Advice —Gross Level Adjustments

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
Z11111	SOUTH CAROLINA MEDICAID PROGRAM		03/26/2008	3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME I I	ORIG. F M CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	0000000000001111U	-						DEBIT	-2389.05	
TPL 4	0000000000002222U	-						DEBIT	-1949.90	
TPL 5	0000000000003333U	-						DEBIT	-477.25	
TPL 6	0000000000004444U	-						DEBIT	-477.25	
PAGE TOTAL:								5293.45	0.00	

	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
DEBIT BALANCE PRIOR TO THIS REMITTANCE	+-----+ 0.00 +-----+	+-----+ 0.00 +-----+	+-----+ 0.00 +-----+	+-----+ 0.00 +-----+
+-----+ 0.00 +-----+	ADJUSTMENTS	MAXIMUS AMT	PROVIDER NAME AND ADDRESS	
YOUR CURRENT DEBIT BALANCE	+-----+ 0.00 +-----+	+-----+ 0.00 +-----+	JANE DOE DDS 111 DENTAL ST ANYWHERE , SC 29202-1111	
+-----+ 5293.45 +-----+	CHECK TOTAL	CHECK NUMBER		
	+-----+ 0.00 +-----+	+-----+ +-----+		

Sample ECF for American Dental Association 2006 Claim Form

RUN DATE 05/01/2007 000099822
 REPORT NUMBER CLM3500
 ANALYST ID PROV
 SIGNON ID

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
 EDIT CORRECTION FORM
 DENTAL - 31
 CLAIM RESTART DATE / / DOC IND N

CLAIM CONTROL #0000000000000000B
 PAGE 44802 ECF 44802 PAGE 1 OF 1
 EMC
 ORIGINAL CCN:
 ADJ CCN:

TAXONOMY: PRV ZIP: 29526
 1 2 3 4 5 6 7 8 9
 PROV/XWALK P AUTH# OWN REF# RECIPIENT ID TPL INJURY EPSDT DIAGNOSIS RECIPIENT NAME INSURANCE EDITS
 ZA1111 1111111111 N V72.2 NEED A NAME 01-400 01-733
 NPI: 2222222222

11	12	13	14	15	16	17	18	19	20	21	22	23	24
RES	ALLOWED	LN	INDIVIDUAL	DATE OF	TOOTH	TOOTH	PLACE	PROC	MOD	UNITS	CHARGE	EDITS	
		NO	PROV/XWALK	SERVICE	NUMBER	SURFACES		CODE					
	.00	1	ZA0000	03/13/07			3	D0120	000	001	47.00	*****	
	.00	2	ZA0000	03/13/07			3	D1120	000	001	45.00	** AGENCY USE ONLY **	
	.00	3	ZA0000	03/13/07			3	D0272	000	001	32.00	** APPROVED EDITS **	
	.00	4	ZA0000	03/13/07			3	D1203	000	001	25.00	** REJECTED LINE EDITS **	
		5		/ /								*****	
		6		/ /								!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!	
		7		/ /								! CLAIMS/LINE PAYMENT INFO !	
		8		/ /								! EDIT PAYMENT DATE !	
		9		/ /								!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!	
		10		/ /									

22	23	24	25	26	27
INS CARR	POLICY	INS CARR	TOTAL CHARGE	AMT REC'D INS	BALANCE DUE
NUMBER	NUMBER	PAID			
01	4267887103		149.00	.00	
02					

RESOLUTION DECISION _____ RETURN TO: MEDICAID CLAIMS RECEIPT
 P. O. BOX 2136
 COLUMBIA, S.C. 29202-2136
 INSURANCE POLICY INFORMATION

PROVIDER:
 ACME PEDIATRIC DENTAL
 111 OAK STREET
 CONWAY SC 00000-0000

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
 * INDICATES A SPLIT CLAIM

Sample ECF for the CMS-1500 Claim Form

RUN DATE 12/01/2007 000008032
 REPORT NUMBER CLM3500
 ANALYST ID
 SIGNON ID
 TAXONOMY:
 1 2
 PROV/XWALK RECIPIENT
 ID ID
 ZX0000 1111111111
 NPI: 1234567890

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
 EDIT CORRECTION FORM
 HIC - 21 PRAC SPEC - 54
 DOC IND N

CLAIM CONTROL #0000000000000000A
 PAGE 7641 ECF 7641 PAGE 1 OF 1
 EMC Y
 ORIGINAL CCN:
 ADJ CCN:

SFL ZIP: 30901 PRV ZIP:
 3 4 5 6 7 8 9
 P AUTH TPL INJURY EMERG PC COORD ---- DIAGNOSIS ----
 NUMBER CODE PRIMARY SECONDARY
 170.1 .

EDITS
 INSURANCE EDITS
 CLAIM EDITS

LINE EDITS
 01) 852

10 RECIPIENT NAME - NEED A NAME 11 DATE OF BIRTH 03/23/1949 12 SEX M

13 RES	14 ALLOWED	15 LN NO	16 DATE OF SERVICE	17 PLACE	18 PROC CODE	19 INDIVIDUAL PROVIDER	20 CHARGE IND	21 PAY	22 UNITS
--------	------------	----------	--------------------	----------	--------------	------------------------	---------------	--------	----------

 ** AGENCY USE ONLY **
 ** APPROVED EDITS **
 ** REJECTED LINE EDITS **

.00	1	09/05/07	11	99204		ZA0000	50.00	1.000	
NPI: 1111111111	2	/ /			TAXONOMY: 200000000X				
NPI:	3	/ /			TAXONOMY:				
NPI:	4	/ /			TAXONOMY:				
NPI:	5	/ /			TAXONOMY:				
NPI:	6	/ /			TAXONOMY:				

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
 ! CLAIMS/LINE PAYMENT INFO !
 !
 ! EDIT PAYMENT DATE !
 ! 01-852 09/29/06 !
 !!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID	27 TOTAL CHARGE	28 AMT REC'D INS	29 BALANCE DUE	30 OWN REF #
01 620	250063050A	8.82	50.00	8.82	50.00	JOHNDOE

RESOLUTION DECISION ____

ADDITIONAL DIAG CODES:

RETURN TO:
 MEDICAID CLAIMS RECEIPT
 P. O. BOX 1412
 COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
 ACME DENTAL
 P O BOX 1111
 AUGUSTA GA 00000-0000

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
 * INDICATES A SPLIT CLAIM