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<thead>
<tr>
<th>Number</th>
<th>Name</th>
<th>Revision Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHHS 126</td>
<td>Confidential Complaint</td>
<td>06/2007</td>
</tr>
<tr>
<td>DHHS 130</td>
<td>Claim Adjustment Form 130</td>
<td>03/2007</td>
</tr>
<tr>
<td>DHHS 205</td>
<td>Medicaid Refunds</td>
<td>01/2008</td>
</tr>
<tr>
<td>DHHS 931</td>
<td>Health Insurance Information Referral Form</td>
<td>02/2018</td>
</tr>
<tr>
<td></td>
<td>Reasonable Effort Documentation</td>
<td>04/2014</td>
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<tr>
<td></td>
<td>Electronic Funds Transfer (EFT) Authorization Agreement</td>
<td>08/2019</td>
</tr>
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<td></td>
<td>Duplicate Remittance Advice Request Form</td>
<td>09/2017</td>
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<td></td>
<td>Claim Reconsideration Form</td>
<td>11/2018</td>
</tr>
<tr>
<td>CMS-1500</td>
<td>Sample Claim Showing Medicaid and Medicare with NPI</td>
<td>02/2012</td>
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<td>CMS-1500</td>
<td>Sample Claim Showing Medicaid Only with NPI</td>
<td>02/2012</td>
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<td>CMS-1500</td>
<td>Sample Claim Showing Medicaid and Private Pay with NPI</td>
<td>02/2012</td>
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<td>and Medicaid Provider ID</td>
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<td>02/2012</td>
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<td>with NPI and Medicaid Provider ID</td>
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<td>Medicaid Certificate of Medical Necessity Equipment/Supplies</td>
<td>04/2018</td>
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<tr>
<td>DME 003</td>
<td>Medicaid Certificate of Medical Necessity Power/Manual Wheelchairs and/or Accessories</td>
<td>04/2018</td>
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<tr>
<td>DME 004</td>
<td>Medicaid Certificate of Medical Necessity Orthotics, Prosthetics, and Diabetic Shoes</td>
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<tr>
<td>DME 005</td>
<td>Medicaid Certificate of Medical Necessity Enteral Nutrition</td>
<td>04/2018</td>
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<tr>
<td>DME 006</td>
<td>Medicaid Certificate of Medical Necessity Parenteral Nutrition</td>
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<td>DME 007</td>
<td>Medicaid Certificate of Medical Necessity Oxygen</td>
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<td>DME 008</td>
<td>Certificate of Repair and Labor Cost</td>
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## FORMS

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<tr>
<td></td>
<td>Justification for Home Uterine Activity Monitor/Supplies (HUAM) for Subcutaneous Tocolytic Therapy</td>
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</tbody>
</table>
CONFIDENTIAL COMPLAINT

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

PROGRAM INTEGRITY

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

<table>
<thead>
<tr>
<th>SUSPECTED INDIVIDUAL OR INDIVIDUALS:</th>
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<tbody>
<tr>
<td>NPI or MEDICAID PROVIDER ID: (if applicable)</td>
</tr>
<tr>
<td>ADDRESS OF SUSPECT:</td>
</tr>
<tr>
<td>DATE OF INCIDENT:</td>
</tr>
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</table>

COMPLAINT:

<table>
<thead>
<tr>
<th>NAME OF PERSON REPORTING: (Please print)</th>
<th>SIGNATURE OF PERSON REPORTING:</th>
<th>DATE OF REPORT</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ADDRESS OF PERSON REPORTING:</th>
<th>TELEPHONE NUMBER OF PERSON REPORTING:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>SIGNATURE: (SCDHHS Representative Receiving Report)</td>
</tr>
</tbody>
</table>
South Carolina Department of Health and Human Services - Claim Adjustment Form 130

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

Provider Address:

Provider City, State, Zip: Total paid amount on the original claim:

Original CCN:

Provider ID: NPI:

Recipient ID:

Adjustment Type:  ○ Void  ○ Void/Replace  ○ DHHS  ○ MCCS  ○ Provider  ○ MIVS

Reason For Adjustment: (Fill One Only)

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

For Agency Use Only

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

Comments:

Signature: _____________________________ Date: _____________________________

Phone: _______________________________ 

DHHS Form 130 Revision date: 03-13-2007
South Carolina Department of Health and Human Services
Form for Medicaid Refunds

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

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. Attach appropriate document(s) as listed in item 8.

1. Provider Name: ____________________________

2. Medicaid Legacy Provider # [ ] [ ] [ ] [ ] [ ] [ ] [ ]
   (Six Characters)
   OR

3. NPI# [ ] [ ] [ ] [ ] [ ] [ ] [ ] & Taxonomy
   [ ] [ ] [ ] [ ] [ ] [ ] [ ]

4. Person to Contact: ________________________

5. Telephone Number: ______________________

6. Reason for Refund: [check appropriate box]
   [ ] Other Insurance Paid (please complete a – f below and attach insurance EOMB)
   a) Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
   b) Insurance Company Name ___________________________________________
   c) Policy #:__________________________________________________________
   d) Policyholder: ______________________________________________________
   e) Group Name/Group: ________________________________________________
   f) Amount Insurance Paid:______________________________________________

   [ ] Medicare
   ( ) Full payment made by Medicare
   ( ) Deductible not due
   ( ) Adjustment made by Medicare

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

   [ ] Other, describe in detail reason for refund:

   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

7. Patient/Service Identification:

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Medicaid I.D. # (10 digits)</th>
<th>Date(s) of Service</th>
<th>Amount of Medicaid Payment</th>
<th>Amount of Refund</th>
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<tbody>
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</tbody>
</table>

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

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

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

DHHS Form 205 (01/08)
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: ___________________________ Provider ID or NPI: ___________________________
Contact Person: ___________________________ Phone #: ___________________________ Date: ________________

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

Beneficiary Name: ___________________________ Date Referral Completed: ___________________________
Medicaid ID#: ___________________________ Policy Number: ___________________________
Insurance Company Name: ___________________________ Group Number: ___________________________
Insured's Name: ___________________________ Insured SSN: ___________________________
Employer's Name/Address: ___________________________

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

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

       (name) ___________________________

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.
Submit this information to Medicaid Insurance Verification Services (MIVS).
Fax: 803-252-0870     or     Mail: Post Office Box 101110
                               Columbia, SC 29211-9804

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

PROVIDER ____________________________________________  DOS ________________
NPI or MEDICAID PROVIDER ID __________________________
MEDICAID BENEFICIARY NAME _____________________________________________________________
MEDICAID BENEFICIARY ID# ________________________________________________________________
INSURANCE COMPANY NAME _____________________________________________________________
POLICYHOLDER ___________________________________________________________________________
POLICY NUMBER ___________________________________________________________________________
ORIGINAL DATE FILED TO INSURANCE COMPANY __________________________________________
DATE OF FOLLOW UP ACTIVITY _____________________________________________________________

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____________________________________________________________

RESULT:

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

_________________________________________ (SIGNATURE AND DATE)

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

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

**Reason for Submission**

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

## Individual Provider/Organization Information

<table>
<thead>
<tr>
<th>Provider/Organization Legal Business Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doing Business as Name (DBA)</td>
</tr>
<tr>
<td>Street</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>Zip Code/Postal Code</td>
</tr>
</tbody>
</table>

**Medicaid Provider Number**

**National Provider Identifier (NPI)**

**Designate Tax Identification Number (TIN)**

- [ ] SSN (Individual)
- [ ] EIN (Organization)

**SSN**

**EIN**

## Organization/Individual Provider EFT Contact Information

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

## Financial Institution Information

<table>
<thead>
<tr>
<th>Financial Institution Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Institution Address</td>
</tr>
</tbody>
</table>

| City                          |
| State                        |
| Zip Code/Postal Code         |

## Provider's Account Number with Financial Institution

**Financial Institution Routing Number (Nine digits)**

**Provider's Account Number with Financial Institution (Up to 17 digits)**

**Type of Account at Financial Institution (TRANSIT CODE)**

- [ ] 22 – Checking Account
- [ ] 32 – Savings Account

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

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

**All EFT Requests are Subject to a 10-Day Prenote 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/provider](https://www.scdhhs.gov/provider) for instructions on how to complete updates to your EFT information.

Effective Jan 01, 2013, 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**
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.

_________________________________________ Date

Authorizing Signature
CLAIM RECONSIDERATION FORM

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

Section 1: Beneficiary Information
Name [Last, First, MI]: ________________________________  Medicaid Beneficiary ID: ____________________________
Date of Birth: __________________________

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

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

Section 4: Claim Reconsideration Information
What area is your denial related to? (Please select below)
☐ Ambulance Services
☐ Autism Spectrum Disorder (ASD) Services
☐ Clinic Services
☐ Community Long Term Care (CLTC)
☐ Community Mental Health Services
☐ Department of Disabilities and Special Needs (DDS/N) Waivers
☐ Durable Medical Equipment (DME)
☐ Early Interventions Services
☐ Enhanced Services
☐ Federally Qualified Health Center (FQHC)
☐ Home Health Services
☐ Hospice Services
☐ Hospital Services
☐ Licensed Independent Practitioner’s Rehabilitative Services (LIPS)
☐ Local Education Agencies (LEA)
☐ Medically Complex Children’s (MCC) Waivers
☐ Nursing Facility Services/Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
☐ Optional State Supplementation (OSS)
☐ Pharmacy Services
☐ Physicians Laboratories, and Other Medical Professionals Specify:
☐ Private Rehabilitative Therapy and Audiological Services
☐ Psychiatric Hospital Services
☐ Rehabilitative Behavioral Health Services (RBHS)
☐ Rural Health Clinic (RHC)
☐ Targeted Case Management (TCM)
☐ Other: __________________________

SCDHHS CR Form (11/13)
Section 5: Desired Outcome

Request submitted by:

Print Name: _________________________________

Signature: _________________________________ Date: __________
### Health Insurance Claim Form

#### Patient Information
- **Name:** Doe, John A.
- **Address:** 123 Windy Lane, Anytown, SC 29999
- **Date of Birth:** 01/01/1947
- **Relationship to Insured:** Self

#### Claim Details
- **Claim ID:** 1234567890
- **Policy Group or TIN Number:** 012300000A
- **NPI Number:** 1234567890

#### Diagnosis
- **ICD Code:** B46.0
- **Procedures:** A4253
- **Diagnosis:** 90/00

#### Charges
- **Total Charge:** $90.00
- **Amount Paid:** $22.00

#### Provider Information
- **NPI Number:** 555555555
- **Provider Name:** Doe, John A.
- **Provider Address:** 123 Windy Lane, Anytown, SC 22222

---

**Durable Medical Equipment**

Sample Claim Showing Medicaid and Private Pay with NPI and Medicaid Provider ID.
<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
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<tbody>
<tr>
<td><strong>Patient</strong></td>
<td>Doe, John A.</td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td>123 Windy Lane, Anytown, SC 29999</td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td>ABC Medical Supply</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td>Medicare, Medicaid, Private Pay with NPI and Medicaid Provider ID</td>
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<tr>
<td><strong>Claim Form</strong></td>
<td>HEALTH INSURANCE CLAIM FORM</td>
</tr>
<tr>
<td><strong>Claim Number</strong></td>
<td>1234567890</td>
</tr>
<tr>
<td><strong>Dates</strong></td>
<td>01/20/14 - 01/20/14</td>
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<tr>
<td><strong>Code and Modifier</strong></td>
<td>A4253</td>
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<tr>
<td><strong>Total Charge</strong></td>
<td>$90.00</td>
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<tr>
<td><strong>Amount Paid</strong></td>
<td>$50.00</td>
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<tr>
<td><strong>Service Provider</strong></td>
<td>1234567890</td>
</tr>
<tr>
<td><strong>Instructions</strong></td>
<td>Please print or type</td>
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**Sample Remittance Advice (page 1)**

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

<table>
<thead>
<tr>
<th>PROVIDER ID</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
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<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
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<tr>
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<th>CLAIM</th>
<th>SERVICE RENDERED</th>
<th>AMOUNT</th>
<th>TITLE 19</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
<th>M</th>
<th>TIE. 18</th>
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<td>NUMBER</td>
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- **S** = IN PROCESS
- **E** = ENCOUNTER
- **C** = CERTIFIED AMT
- **M** = MEDICAID TOTAL
- **F** = FLORENCE
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## Sample Remittance Advice (page 2)

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Sample Remittance Advice (page 3)

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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.

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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR EQUIPMENT/SUPPLIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient’s name: _______________________________ Medicaid # (10 digits): _______________________________
(2) DOB: ___/___/______ Sex: __ Male ___ Female HT: _______ (In) WT: __________ Date of Service: ___/___/______
(3) Provider’s name: ___________________________ Provider’s DME #: ___________________________ NPI #: __________
(4) Street address: ______________________________ City: __________________________ State: ____ Zip: ______ Local telephone #: __________________________
(5) Provider’s signature: ___________________________ Date: __________________________
(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT/SUPPLIES:

NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD) __________________ Description(s): __________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

(8) Indicate patient’s ambulatory status while performing activities of daily living: ___ Non-ambulatory ___ Ambulatory, without assistance

___ Ambulatory with the aid of a walker or cane, ___ Ambulatory, with other assistance as described

________________________________________________________________________

Does the patient have decubitus ulcers? ___ Yes ___ No. If yes, circle stage(s): I, II, III, or IV. Indicate the wound size(s):

________________________________________________________________________

Please describe how this equipment / supply is medically necessary, the benefits to the recipient and how long will it take for the benefit to be evident:

________________________________________________________________________

(9) For supplies, please indicate the dressing change required per day, week, month, etc.

________________________________________________________________________

Is additional information attached on separate sheet? ___ Yes ___ No (If “yes,” enter recipient’s name & I.D. Medicaid number on attachment)

(10) Please indicate the date that the patient was seen for the equipment/supplies prescribed: __________________________

(11) Please indicate the prescription date: __________________________

(12) Duration of need (maximum of 12 months):

(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(13) PHYSICIAN’S NAME: ___________________________ PHYSICIAN’S NPI #: ___________________________

PHYSICIAN’S SIGNATURE ___________________________ DATE ___/___/______ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

DME 001 - Dated 04/01/18
INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR EQUIPMENT/SUPPLIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT’S NAME AND MEDICAID #: Indicate the patient’s name and his/her Medicaid # (10 digits).

PATIENT DOB, SEX, HEIGHT, WEIGHT: Indicate patient’s date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.

DATE OF SERVICE: Indicate the date of service (DOS). The date of service must be the same as the delivery date.

PROVIDER’S NAME, DME # AND NPI #: Indicate the name of the DME company (Provider name), Provider’s DME# and NPI#.

PROVIDER’S PHYSICAL ADDRESS AND TELEPHONE NUMBER: Indicate the provider’s physical address (provider’s location) and telephone number.

PROVIDER SIGNATURE AND DATE: Signature of DME provider representative and date.

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES: In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).

QUESTION SECTION: These fields are used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.

DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED: Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.

PRESCRIPTION DATE: Indicate the prescription date. The prescription date must be within 90 days of the date of treating/ordering physician’s signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.

PHYSICIAN ATTESTATION: The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A and B the physician’s must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician’s signature also certifies the item(s) order is medically necessary for this patient.
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR POWER/MANUAL WHEELCHAIRS AND/OR ACCESSORIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient’s name: ___________________________________________ Medicaid # (10 digits) ____________________________

(2) DOB ___/___/___ Sex: ___ HT: _______ (in) WT: __________ Date of Service: __________________________

(3) Provider’s name: __________________________________________ Provider’s DME #: __________________ NPI #: ___________

(4) Street address: __________________________ City: __________ State: __ Zip: __________ Local telephone #: __________

(5) Provider’s signature: __________________________________________ Date: __________________________

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN ON: __________________________________________

__________________________________________

__________________________________________

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

I ATTEST THAT THE PT/OT THERAPIST AND/OR THE TREATING/ORDERING PHYSICIAN HAS NO FINANCIAL RELATIONSHIP WITH MY COMPANY.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD): _______ Diagnosis(s): __________________________________________________________

(8) Indicate the patient’s mobility limitation & explain how it interferes with the performance of activities of daily living (ADLs):

__________________________________________

• Explain why a cane or walker is not sufficient to meet the patient’s mobility needs in the home:

__________________________________________

• Explain why a manual wheelchair is not sufficient to meet the patient’s mobility needs in the home:

__________________________________________

• How long has the condition been present and what is the patient’s clinical progression:

__________________________________________

• Indicate any related diagnosis and all other interventions tried and the results:

__________________________________________

• Has the patient ever used a walker, manual or power wheelchair and what were the results?

__________________________________________

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: __________________________

(10) Prescription Date: __________________________

(11) Duration of need (Maximum of 12 months): __________________________

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) PRINT PHYSICIAN’S NAME: ___________________________ PHYSICIAN’S NPI # __________

PHYSICIAN’S SIGNATURE: __________________________________________ DATE __/__/______ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

DME 003 – Dated 04/01/18
INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR POWER/MANUAL WHEELCHAIRS AND/OR ACCESSORIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT’S NAME AND MEDICAID #: Indicate the patient’s name and his/her Medicaid # (10 digits).

PATIENT DOB, SEX, HEIGHT, WEIGHT: Indicate patient’s date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.

DATE OF SERVICE: Indicate the date of service (DOS). The date of service must be the same as the delivery date.

PROVIDER’S NAME, DME # AND NPI#: Indicate the name of the DME company (Provider name), Provider’s DME# and NPI#.

PROVIDER’S PHYSICAL ADDRESS AND TELEPHONE NUMBER: Indicate the provider’s physical address (provider’s location) and telephone number.

PROVIDER SIGNATURE AND DATE: Signature of DME provider representative and date.

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES: In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).

QUESTION SECTION: This information is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.

DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED: Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.

PRESCRIPTION DATE: Indicate the prescription date. The prescription date must be within 90 days of the date of treating/ordering physician’s signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.

PHYSICIAN ATTESTATION: The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A and B the physician’s must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician’s signature also certifies the item(s) order is medically necessary for this patient.

DME 003 – Dated 04/01/18
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICAID CERTIFICATE OF
MEDICAL NECESSITY FORM FOR ORTHOTICS, PROSTHECTICS AND DIABETIC SHOES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient’s name: __________________________ Medicaid # (10 digits): _______________________

(2) DOB: ____ / ____ / _____ Sex: ____ HT: _______ (in) WT: ______ Date of Service: ____________

(3) Provider’s name: __________________________ Provider’s DME #: __________________________ NPI #: __________________________

(4) Street address: ___________________________ City: ___________________________ State: _______ Zip: _______ Local telephone #: __________________________

(5) Provider’s signature: __________________________ Date: ____________

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR ORTHOTICS, PROSTHECTICS, AND/OR DIABETIC SHOES.

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD): __________ Diagnosis (s):

___________________________________________________________________________

___________________________________________________________________________

(8) Give a detailed description of the severity of the recipient’s condition(s) as related to orthotics, prosthetics, and/or diabetic shoes.

Orthotics and/or Prosthetics

___________________________________________________________________________

Diabetic Shoes: Does the patient have one or more of the following conditions? Check all that apply:

_____ History of previous foot ulcerations  _____ Peripheral neuropathy with evidence of callus formation  _____ Foot deformity

_____ Poor circulation  _____ History of partial or complete amputation of the foot  _____ History of pre-ulcerative callus

Is additional information attached on a separate sheet? _____ Yes _____ No (If “yes,” enter recipient’s name and Medicaid I.D. number on attachment)

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed:

___________________________________________________________________________

(10) Prescription Date:

___________________________________________________________________________

(11) Duration of need (Maximum of 12 months):

(Please indicate duration by months, not to exceed 12).

___________________________________________________________________________

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) PRINT PHYSICIAN’S NAME: __________________________ PHYSICIAN’S NPI #: __________________________

___________________________________________________________________________

___________________________________________________________________________

PHYSICIAN’S SIGNATURE: __________________________ DATE _____ / _____ / _____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

DME 004 – Dated 04/01/18
INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR ORTHOTICS, PROSTHETICS AND DIABETIC SHOES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT’S NAME AND MEDICAID #: Indicate the patient’s name and his/her Medicaid # (10 digits).

PATIENT DOB, SEX, HEIGHT, WEIGHT: Indicate patient’s date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.

DATE OF SERVICE: Indicate the date of service (DOS). The date of service must be the same as the delivery date.

PROVIDER’S NAME, DME # AND NPI#: Indicate the name of the DME company (Provider name), Provider’s DME# and NPI#.

PROVIDER’S PHYSICAL ADDRESS AND TELEPHONE NUMBER: Indicate the provider’s physical address (provider’s location) and telephone number.

PROVIDER SIGNATURE AND DATE: Signature of DME provider representative and date.

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES: In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).

QUESTION SECTION: This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.

DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED: Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.

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EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.

PHYSICIAN ATTESTATION: The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A and B the physician’s must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician’s signature also certifies the item(s) order is medically necessary for this patient.

DME 004 – Dated 04/01/18
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR ENTERAL NUTRITION

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient’s name: __________________________ Medicaid # (10 digits): __________________________

(2) DOB: __/__/____ Sex: ___ HT: _______ (in) WT: _______ Date of Service: __________________________

(3) Provider’s name: __________________________ Provider’s DME #: __________________________ NPI #: __________________________

(4) Street address: __________________________ City: __________________________ State: _______ Zip: _______ Local telephone #: __________________________

(5) Provider’s signature: __________________________ Date: __________________________

(6) LIST ALL PROCEDURE CODES ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR ENTERAL NUTRITION.

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: IF FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD): _______ Diagnosis(s): __________________________

________________________

________________________

________________________

(8) Does the patient have permanent non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel? Yes____ No____.

Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient’s over all health status? Yes____ No____.

Product name(s): __________________________

Total calories Per Day: __________________________

The method of administration: Syringe _____ Gravity _____ Pump _____ Does not apply ____.

Does the patient have a documented allergy or intolerance to semi-synthetic nutrients? Yes____ No____.

Is additional information attached on separate sheet? Yes____ No____ (If “yes,” enter recipient’s name & Medicaid I.D. number on attachment)

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: __________________________

(10) Enter the prescription date: __________________________

(11) Duration of need (Maximum of 12 months): __________________________

(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify the requested equipment/supplies are appropriate for the patient.

(12) PRINT PHYSICIAN’S NAME: ___________________________________________ PHYSICIAN’S NPI #: __________________________

PHYSICIAN’S SIGNATURE __________________________________ DATE / / / (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

DME 005—Dated 04/01/18
INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR ENTERAL NUTRITION

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT’S NAME AND MEDICAID #: Indicate the patient’s name and his/her Medicaid # (10 digits).

PATIENT DOB, SEX, HEIGHT, WEIGHT: Indicate patient’s date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.

DATE OF SERVICE: Indicate the date of service (DOS). The date of service must be the same as the delivery date.

PROVIDER’S NAME, DME # AND NPI #: Indicate the name of the DME company (Provider name), Provider’s DME # and NPI #.

PROVIDER’S PHYSICAL ADDRESS AND TELEPHONE NUMBER: Indicate the provider’s physical address (provider’s location) and telephone number.

PROVIDER SIGNATURE AND DATE: Signature of DME provider representative and date.

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES: In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).

QUESTION SECTION: This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.

DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED: Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.

PRESCRIPTION DATE: Indicate the prescription date. The prescription date must be within 90 days of the date of treating/ordering physician’s signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.

PHYSICIAN ATTESTATION: The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A and B the physician’s must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician’s signature also certifies the item(s) order is medically necessary for this patient.
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM  
FOR PARENTERAL NUTRITION

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient’s name: ______________________________  Medicaid # (10 digits): ____________________________

(2) DOB: __/__/____  Sex: ___  HT: __________ (in)  WT: __________  Date of Service: ________________

(3) Provider’s name: ______________________________  Provider’s DME #: _____________________________  NPI #: ____________________________

(4) Street address: ______________________________  City: __________________  State: ______  Zip: ______  Local telephone #: ______________

(5) Provider’s signature: __________________________  Date: ____________

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR PARENTERAL NUTRITION:

________________________________________________________________________________________

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD): ____________________________

Diagnosis (s): _____________________________________________

_________________________________________________________

_________________________________________________________

(8) Does the patient have severe permanent disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength commensurate with the patient’s overall health status?  Yes _____  No _____.

Formula components:

Amino Acid. ___________ (ml/day) ___________ concentration% ___________ gms protein/day

Dextrose. ___________ (ml/day) ___________ concentration%

Lipids. ___________ (ml/day) ___________ days/weeks ___________ concentration%.

Check the method of administration: Central line ______  Hemodialysis access line ______  Peripherally inserted catheter (PIC) _____

Is additional information attached on separate sheet?  Yes ___  No ___. (If “yes”, enter recipient’s name & Medicaid I.D. number on attachment)

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: ________________

(10) Enter the prescription date: ______________________

(11) Duration of need (Maximum of 12 months):

( Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) PRINT PHYSICIAN’S NAME: ____________________________  PHYSICIAN’S NPI #: ____________________________

PHYSICIAN’S SIGNATURE: ___________________________ DATE: _____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE).

PLEASE REFER TO THE MEDICAID CMN POLICY IN SECTION 2 OF THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR PARENTERAL NUTRITION
DME 006 – Dated 04/01/18
SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT’S NAME AND
MEDICAID #: Indicate the patient’s name and his/her Medicaid # (10 digits).

PATIENT DOB, SEX, HEIGHT, WEIGHT: Indicate patient’s date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.

DATE OF SERVICES: Indicate the date of service (DOS). The date of service must be the same as the delivery date.

PROVIDER’S NAME, DME # AND NPI #: Indicate the name of the DME company (Provider name), Provider’s DME # and NPI #.

PROVIDER’S PHYSICAL ADDRESS AND TELEPHONE NUMBER: Indicate the provider’s physical address (provider’s location) and telephone number.

PROVIDER SIGNATURE AND DATE: Signature of DME provider representative and date.

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES: In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).

QUESTION SECTION: This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.

DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED: Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.

PRESCRIPTION DATE: Indicate the prescription date. The prescription date must be within 90 days of the date of treating/ordering physician’s signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.

PHYSICIAN ATTESTATION: The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A and B the physician’s must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician’s signature also certifies the item(s) order is medically necessary for this patient.
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM  
FOR OXYGEN

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

1) Recipient’s name: ___________________________ Medicaid #: (10 digits): __________________

2) DOB: ___/_/____ Sex: ___ HT: ___(in) WT: ___ Date of service: ___/_/____

3) Provider’s name: ___________________________ Provider’s DME #: __________________ NPI #: _____________

4) Street address: ___________________________ City: ___________ State: __ Zip: ___________ Local telephone #: _____________

5) Provider’s signature: _________________________ Date: ____________

6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789</td>
<td>Ongoing care for oxygen therapy</td>
</tr>
<tr>
<td>987654321</td>
<td>Supplemental oxygen for sleep</td>
</tr>
<tr>
<td>213456789</td>
<td>Oxygen therapy for other purposes</td>
</tr>
</tbody>
</table>

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

7) Diagnosis codes (ICD) __________ (Descriptions): __________

8) ANSWERS | ANSWER QUESTIONS 1-9. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted)

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>mm Hg</td>
<td>1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test, Enter date of test (c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b)</td>
<td>%</td>
<td>2. Was the test in Question 1 performed EITHER with the patient in a chronic stable state as an outpatient OR within two days prior to discharge from an inpatient facility to home?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>c)</td>
<td>/ /</td>
<td>3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>d)</td>
<td>XXXXXXX</td>
<td>4. Physician/provider performing test in Question 1 (and, if applicable, Question 7) Print/type name and address below</td>
<td>XXXXXXX</td>
<td>XXXXXXX</td>
</tr>
<tr>
<td>e)</td>
<td>NAME:</td>
<td>ADDRESS:</td>
<td>NAME:</td>
<td>ADDRESS:</td>
</tr>
<tr>
<td>f)</td>
<td>Y</td>
<td>N</td>
<td>D</td>
<td>LPM</td>
</tr>
</tbody>
</table>

IF PO2 = 56-60 OR OXYGEN SATURATION = < 89%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.

| Y | N | 7. Does the patient have dependent edema due to congestive heart failure? |
| Y | N | D | 8. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement? |
| Y | N | D | 9. Does the patient have a hematocrit greater than 56%? |

NAME OF PERSON ANSWERING SECTION C QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: ___________________________ TITLE: ___________________________ EMPLOYER: ___________________________

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: ____________

(10) Please indicate the Prescription date: ____________

(11) Duration of need (maximum of 12 months):

(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereon has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) Print Physician’s Name: ___________________________ Physician’s NPI #: ___________________________

Physician’s Signature: ___________________________ Date: ___/_/_____ (Signature and date stamps are not acceptable)

DME 007 - Dated 04/01/18
PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR OXYGEN

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT’S NAME AND MEDICAID #: Indicate the patient’s name and his/her Medicaid # (10 digits).

PATIENT DOB, SEX, HEIGHT, WEIGHT: Indicate patient’s date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.

DATE OF SERVICE: Indicate the date of service (DOS). The date of service must be the same as the delivery date.

PROVIDER’S NAME, DME # AND NPI #: Indicate the name of the DME company (Provider name), Provider’s DME # and NPI #.

PROVIDER’S PHYSICAL ADDRESS AND TELEPHONE NUMBER: Indicate the provider’s physical address (provider’s location) and telephone number.

PROVIDER SIGNATURE AND DATE: Signature of DME provider representative and date.

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/OORDERING PHYSICIAN:

DIAGNOSIS CODES: In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).

QUESTION SECTION: This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, circling “Y” for yes, “N” for no, or “D” for does not apply.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the question of Section B, he/she must print his/her name, give his/her professional title and name of his/her employer where indicated. If the physician is answering the question, this space may be left blank.

DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED: Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.

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PHYSICIAN ATTESTATION: The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A and B the physician’s must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician’s signature also certifies the item(s) order is medically necessary for this patient.

DME 007 – Dated 04/01/18
TO BE COMPLETED BY ENROLLED DME PROVIDER

(1) RECIPIENT’S NAME:

(2) RECIPIENT’S MEDICAID # (10 DIGITS):

(3) BRAND NAME OF EQUIPMENT:

(4) DATE OF REPAIR AND/OR LABOR:

(5) SPECIFICALLY IDENTIFY EQUIPMENT TO BE REPAIRED:

(6) ESTIMATED COST OF REPAIR:

(7) GIVE A DETAILED DESCRIPTION OF THE TYPE OF REPAIR AND/OR LABOR TO BE PERFORMED ON EQUIPMENT:

(8) PROVIDER’S NAME: PROVIDER ID and/or NPI:

(9) STREET ADDRESS: CITY:

DME 008 – Dated 01/01/11
INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF REPAIR AND LABOR COST

<table>
<thead>
<tr>
<th>LINE 1</th>
<th>RECIPIENT’S NAME</th>
<th>Enter recipient’s full name.</th>
</tr>
</thead>
<tbody>
<tr>
<td>LINE 2</td>
<td>RECIPIENT’S MEDICAID #</td>
<td>Enter recipient’s 10-digit Medicaid number.</td>
</tr>
<tr>
<td>LINE 3</td>
<td>BRAND OF EQUIPMENT</td>
<td>Enter the brand name of the equipment you are repairing.</td>
</tr>
<tr>
<td>LINE 4</td>
<td>DATE OF REPAIR AND/OR LABOR</td>
<td>Enter the date the repair and/or labor was performed.</td>
</tr>
<tr>
<td>LINE 5</td>
<td>SPECIFICALLY IDENTIFY EQUIPMENT TO BE REPAIRED</td>
<td>Specify equipment being repaired.</td>
</tr>
<tr>
<td>LINE 6</td>
<td>ESTIMATED COST OF REPAIRED</td>
<td>Enter estimated cost of repair. This cost must be itemized if you are repairing more than one item. Please use the additional space at the bottom of this form if needed.</td>
</tr>
<tr>
<td>LINE 7</td>
<td>GIVE A DETAILED DESCRIPTION OF THE TYPE OF REPAIR AND/OR LABOR TO BE PERFORMED ON EQUIPMENT</td>
<td>Give a detailed description of what type of repair was performed.</td>
</tr>
<tr>
<td>LINE 8</td>
<td>PROVIDER’S NAME &amp; PROVIDER ID AND/OR NPI</td>
<td>Enter provider’s name and Medicaid DME number and/or National Provider Identifier.</td>
</tr>
<tr>
<td>LINE 9</td>
<td>STREET ADDRESS AND CITY</td>
<td>Enter provider’s street address and city.</td>
</tr>
</tbody>
</table>

DME 008 – Dated 01/01/11
# JUSTIFICATION FOR HOME UTERINE ACTIVITY MONITOR/SUPPLIES (HUAM) FOR SUBCUTANEOUS TOCOLYTIC THERAPY

## PART I – (ALL INFORMATION MUST BE PRINTED)

- **Patient’s Name**
- **Medicaid #:**
- **Date Telephone Order/Written Order Given:**
- **Patient’s Expected Date of Delivery:**
- **Provider’s NPI or Medicaid ID:**

## PART II

The patient must have a gestational age of at least 24 weeks, but not more than 35 weeks AND meet AT LEAST ONE of the following criteria which necessitates a home uterine activity monitor/supplies and/or subcutaneous tocolytic therapy:

**[AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE CHECKED]**

1. Has experienced idiopathic pre-term labor that has required or will require hospitalization for IV tocolytic therapy.
2. Multiple gestation, three (3) or more fetuses, that has required or will require hospitalization for IV tocolytic therapy.
3. Patient has uterine anomalies or placenta previa that has required or will require hospitalization for IV tocolytic therapy.

## PART III

Additionally, the patient must also meet ALL of the following criteria:

1. The patient has been diagnosed with pre-term labor based on uterine activity and/or cervical changes.
2. The patient has been stabilized by tocolytic medication.
3. There are no contraindications to the continuation of this pregnancy.
4. There is no fetal distress.
5. The patient’s membranes are intact.
6. The patient is on homebound status and is agreeable to bed rest activities.
7. The patient has a telephone and is agreeable to daily phone contact and frequent physician follow-up.
8. The patient would have to be hospitalized for uterine activity monitoring and/or subcutaneous tocolytic therapy, if this service were not offered.
9. If the patient is hospitalized, this service will allow her to be discharged.
10. The patient is assigned to a delivering physician who has back up coverage in his/her absence.

## PART IV

**Physician Certification**

I, __________________________ (Ordering/Treating Physician’s Name) certify that __________________________ (Patient’s Name), qualifies for Home Uterine Activity Monitoring/Supplies for Subcutaneous Tocolytic Therapy based on medical necessity and that the patient meets the above criteria.

- **Ordering/Treating Physician’s Signature:**
- **Date:**
- **Physician UPIN/License #:**
- **Phone #:**

This form **MUST** be signed within 60 days of ordering service.

(Revised 02/13)