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<thead>
<tr>
<th>Number</th>
<th>Name</th>
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<tr>
<td>DHHS 126</td>
<td>Confidential Complaint</td>
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</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>08/2017</td>
</tr>
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<td></td>
<td>Duplicate Remittance Advice Request Form</td>
<td>09/2017</td>
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<td>Claim Reconsideration Form</td>
<td>05/2018</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>Sample Claim Showing Medicaid Only with NPI</td>
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<td>CMS-1500</td>
<td>Sample Claim Showing Medicaid and Private Pay with NPI and Medicaid Provider ID</td>
<td>02/2012</td>
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<td>Sample Claim Showing Medicare, Medicaid, Private Pay with NPI and Medicaid Provider ID</td>
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<td>Sample Remittance Advice</td>
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<tr>
<td>DME 001</td>
<td>Medicaid Certificate of Medical Necessity Equipment/Supplies</td>
<td>04/2018</td>
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<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>
<td>04/2018</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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<tr>
<td>DME 008</td>
<td>Certificate of Repair and Labor Cost</td>
<td>02/2010</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>
<td>02/2013</td>
</tr>
</tbody>
</table>
STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

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

PROGRAM INTEGRITY

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

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

NPI or MEDICAID PROVIDER ID: (if applicable)  MEDICAID RECIPIENT ID NUMBER: (if applicable)

ADDRESS OF SUSPECT:

LOCATION OF INCIDENT:

DATE OF INCIDENT:

COMPLAINT:

NAME OF PERSON REPORTING: (Please print)  SIGNATURE OF PERSON REPORTING:

ADDRESS OF PERSON REPORTING:

TELEPHONE NUMBER OF PERSON REPORTING:

SIGNATURE: (SCDHHS Representative Receiving Report)

SCDHHS Form 126 (revised 06/07)
South Carolina Department of Health and Human Services - Claim Adjustment Form 130

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

Provider Address:

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

Original CCN:

Provider ID: NPI:

Recipient ID:

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

Originator:

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>
<tr>
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</tr>
</tbody>
</table>

8. Attachment(s): [Check appropriate box]
   □ Medicaid Remittance Advice (required)
   □ Explanation of Benefits (EOMB) from Insurance Company (if applicable)
   □ Explanation of Benefits (EOMB) from Medicare (if applicable)
   □ Refund check

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

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

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

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID
MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS
Beneficiary Name: ___________________________ Date Referral Completed: ______________________
Medicaid ID#: ___________________________ Policy Number: ___________________________
Insurance Company Name: ___________________________ Group Number: ______________________
Insured’s Name: ___________________________ Insured SSN: ___________________________
Employer’s Name/Address: ___________________________

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS
   a. beneficiary has never been covered by the policy – close insurance.
   b. beneficiary coverage ended - terminate coverage (date)
   c. subscriber coverage lapsed - terminate coverage (date)
   d. subscriber changed plans under employer - new carrier is ___________________________
      - new policy number is ___________________________
   e. beneficiary to add to insurance already in MMIS for subscriber or other family member.
      (name) ___________________________

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.
Submit this information to Medicaid Insurance Verification Services (MIVS).
Fax: 803-252-0870 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
**South Carolina Department of Health and Human Services**  
**Electronic Funds Transfer (EFT) Authorization Agreement**

**PROVIDER INFORMATION**  
Provider Name:  
Doing Business As Name (DBA):  
Provider Address:  
   Street:  
   City:  
   State/Province:  
   Zip Code/Postal Code:  
   Medicaid Provider Number:  
Provider Federal Identification Number (TIN) or Employer Identification Number (EIN):  
National Provider Identifier (NPI):  
Provider EFT Contact Information:  
   Provider Contact Name:  
   Telephone Number:  
   Telephone Number Extension:  
   Email Address:  

**FINANCIAL INSTITUTION INFORMATION**  
Financial Institution Name:  
Financial Institution Address:  
   Street:  
   City:  
   State/Province:  
   Zip Code/Postal Code:  
   Financial Institution Routing Number:  
   Type of Account at Financial Institution (select one):  
      Checking  
      Savings  
   Provider’s Account Number with Financial Institution:  
   Account Number Linkage to Provider Identifier (select one):  
      Provider Tax Identification Number (TIN)  
      National Provider Identifier (NPI)  

**REASON FOR SUBMISSION:**  
   New Enrollment  
   Change Enrollment  
   Cancel Enrollment  

By signing this form, I 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 the checking or savings account indicated above at the financial institution identified above. Credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the Department of Health and Human Services 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 thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.

Written Signature of Person Submitting Enrollment:  
Printed Name of Person Submitting Enrollment:  
Submission Date:  

TO PROCESS YOUR EFT ENROLLMENT OR CHANGE EXISTING INFORMATION, PLEASE RETURN THIS COMPLETED FORM ALONG WITH VERIFICATION OF YOUR ELECTRONIC DEPOSIT INFORMATION ON YOUR FINANCIAL INSTITUTION’S LETTERHEAD TO:  

Department of Health and Human Services  
Medicaid Provider Enrollment  
P.O. BOX 8809, COLUMBIA, S.C.  29202-8809  
FAX (803) 870-9022  

**SPECIAL INSTRUCTIONS:**  
For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDDHS Provider web page for instructions on how to complete updates to your EFT information.

Effective January 01, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDDHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching trace number and your ERA can be directed to the Provider Service Center at 1-888-289-0709.

EFT Enrollment Form  
Revision Date: August 1, 2017
South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form

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

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

1. Provider Name: _____________________________________________________________

2. Medicaid Legacy Provider #: ___________________ (Six Characters)
   NPI# ___________________________ Taxonomy ________________________________

3. Person to Contact: __________________________ Telephone Number: ______________

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

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

5. Street Address for delivery of request:
   Street: _______________________________________________________________
   City: ________________________________________________________________
   State: ______________________________________________________________
   Zip Code: ________________________________

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

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

_________________________ _______________________
Authorizing Signature Date

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

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

Section 1: Beneficiary Information

Name (Last, First, MI): __________________________
Date of Birth: ___________  Beneficiary Medicaid ID: ___________

Section 2: Provider Information

Specify your affiliation: ☐ Physician  ☐ Hospital  ☐ Other (DME, Lab, Home Health Agency, etc.): __________________________
NPI: ______________  Medicaid Provider ID: ___________  Facility/Group/Provider Name: __________________________
Return Mailing Address: ____________________________________________________________
Street or Post Office Box ___________________________  State _______  ZIP ______
Contact: ___________________  Email: ___________________  Telephone #: ___________  Fax #: ___________

Section 3: Claim Information

Communication ID: ___________  CCN: ___________  Date(s) of Service: ___________

Section 4: Claim Reconsideration Information

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

SCDHHS-CR-Form (03/18)
Section 5: Desired Outcome

Request submitted by:

Print Name: ________________________________

Signature: ________________________________ Date: ________
**Health Insurance Claim Form**

**1. MEDICARE/Medicare (Medicaid)**
   - Medicare
   - Medicaid

**2. PATIENT’S NAME (Last Name, First Name, Middle Initial)**
   - Doe, John A.

**3. PATIENT’S BIRTH DATE**
   - 01-01-1947

**4. PATIENT’S ADDRESS (City, State, Zip Code)**
   - 123 Windy Lane, Anytown, SC 29999

**5. PATIENT’S RELATIONSHIP TO INSURED**
   - Self

**6. PATIENT’S SOCIAL SECURITY NUMBER**
   - 1234567890

**7. INSURED’S ADDRESS (City, State, Zip Code)**
   - (Blank)

**8. RESERVED FOR NUCI USE**
   - (Blank)

**9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)**
   - (Blank)

**10. IS PATIENT’S CONDITION RELATED TO EMPLOYMENT?**
   - Yes

**11. INSURED’S POLICY OR FIDUCARY NUMBER**
   - (Blank)

**12. OTHER CLAIM ID (Designated by NCCI)**
   - (Blank)

**13. überhaupt**
   - (Blank)

**14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/DD/YYYY)**
   - 01/20/2014

**15. OTHER DATE (MM/DD/YYYY)**
   - (Blank)

**16. NAME OF REFERRING PROVIDER OR OTHER SOURCE**
   - (Blank)

**17. ADDITIONAL CLAIM INFORMATION (Designated by NCCI)**
   - (Blank)

**18. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**
   - 846.0

**19. DATES OF SERVICE (MM/DD/YYYY)**
   - 01/20/2014

**20. OUTSIDE LABS/REX & CHARGES**
   - (Blank)

**21. BILLING PROVIDER INFORMATION**
   - ABC Medical Supply
   - 111 Main Street, Anytown, SC 22222-2222
   - 1234567890

**22. SIGNATURE ON FILE**
   - (Blank)

**23. SIGNATURE**
   - (Blank)

**24. SERVICE FACILITY LOCATION INFORMATION**
   - (Blank)

**25. FEDERAL TAX ID NUMBER**
   - 555555555

**26. PATIENT’S ACCOUNT NO.**
   - X

**27. AMOUNT PAID**
   - 90 00

**28. TOTAL CHARGE**
   - 1234567890

**29. COVERAGE/PIP/PER DIEM**
   - X

**30. BILLING PROVIDER INFO & PHONE**
   - ABC Medical Supply
   - 111 Main Street, Anytown, SC 22222-2222
   - 1234567890

**31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS**
   - (Blank)

**32. SERVICE FACILITY LOCATION INFORMATION**
   - (Blank)

**33. SIGNATURE**
   - X

**NCCI Instruction Manual available at: www.nucc.org**

**PLEASE PRINT OR TYPE**

**APPROVED OMB-0998-1197 FORM 1600 (02-12)
**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 2012**

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<th>Field</th>
<th>Value</th>
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<tbody>
<tr>
<td>S. PATIENT'S NAME (Last Name, First Name, Middle Initial)</td>
<td>Doe, John A.</td>
</tr>
<tr>
<td>3. PATIENT'S ADDRESS (No., Street)</td>
<td>123 Windy Lane</td>
</tr>
<tr>
<td>3. PATIENT'S BIRTH DATE</td>
<td>07 01 1947</td>
</tr>
<tr>
<td>B. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</td>
<td></td>
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<tr>
<td>B. OTHER INSURED'S POLICY OR GROUP NUMBER</td>
<td></td>
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<tr>
<td>B. AUTO ACCIDENT</td>
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<tr>
<td>B. OTHER CLAIM ID (Designated by NUCC)</td>
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<tr>
<td>B. INSURANCE PLAN NUMBER OR PROGRAM NAME</td>
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<tr>
<td>10. IS PATIENT'S CONDITION RELATED TO ANOTHER HEALTH BENEFIT PLAN</td>
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<tr>
<td>13. INSURER'S AUTHORIZED PERSON'S SIGNATURE</td>
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<tr>
<td>15. DATE OF EMERGENCY ILLNESS, INJURY, OR PREGNANCY (MM DD YY)</td>
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<tr>
<td>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</td>
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<tr>
<td>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</td>
<td>B46-0</td>
</tr>
<tr>
<td>22. BILLING PROVIDER INFO &amp; PH #</td>
<td>ABC Medical Supply</td>
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<tr>
<td>29. PATIENT'S ACCOUNT NO.</td>
<td>DOE1234</td>
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<tr>
<td>27. ACCEPT ASSIGNMENT</td>
<td>YES</td>
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<tr>
<td>28. TOTAL CHARGE</td>
<td>$90.00</td>
</tr>
<tr>
<td>29. BILLING PROVIDER INFO &amp; PH #</td>
<td>111 Main Street</td>
</tr>
<tr>
<td>30. AMOUNT PAID</td>
<td>$22.00</td>
</tr>
<tr>
<td>31. SERVICE FACILITY LOCATION INFORMATION</td>
<td>Anytown, SC 22222-2222</td>
</tr>
<tr>
<td>32. Render for NUCC Use</td>
<td>1234567890</td>
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**DURABLE MEDICAL EQUIPMENT**

Sample Claim Showing Medicaid and Private Pay with NPI and Medicaid Provider ID
### Durable Medical Equipment

Sample Claim Showing Medicare, Medicaid and Private Pay with NPI and Medicaid Provider ID

<table>
<thead>
<tr>
<th>1. MEDICARE</th>
<th>2. PATIENT NAME (Last Name, First Name, Middle Initial)</th>
<th>3. PATIENT'S BIRTH DATE</th>
<th>4. INSURER'S NAME (Last Name, First Name, Middle Initial)</th>
<th>16. INSURER'S ID NUMBER (For Program in Item 1)</th>
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<tbody>
<tr>
<td>Medicare</td>
<td>Doe, John A.</td>
<td>01 01 1947</td>
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<td>TRICARE</td>
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<td>CHAMPVA</td>
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<tr>
<th>5. PATIENT'S ADDRESS (No., Street)</th>
<th>6. PATIENT RELATIONSHIP TO INSURED</th>
<th>7. INSURER'S ID NUMBER</th>
<th>8. RESERVED FOR NUCQ USE</th>
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<tbody>
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<td>123 Windy Lane</td>
<td>Spouse</td>
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<th>CITY</th>
<th>STATE</th>
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<th>ZIP CODE</th>
<th>TELEPHONE (Include Area Code)</th>
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<table>
<thead>
<tr>
<th>9. OTHER INSURER'S NAME (Last Name, First Name, Middle Initial)</th>
<th>10. IS PATIENT'S CONDITION RELATED TO (Specify Term or Diagnosis):</th>
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</thead>
<tbody>
<tr>
<td>012345678</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. INSURER'S POLICY OR NPI NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>01200000A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</th>
</tr>
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<table>
<thead>
<tr>
<th>13. PATIENT'S CONDITION RELATED TO (Specify Term or Diagnosis):</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14. DATE OF CURRENT ILLNESS, INJURY, OR MATERNITY (MM DD YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 20 14</td>
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<table>
<thead>
<tr>
<th>15. OTHER DATE (MM DD YY)</th>
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<table>
<thead>
<tr>
<th>16. NAME OF REFERENCING PROVIDER OR OTHER SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>17. ADDITIONAL CLAIM INFORMATION (Designated by NUCQ)</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
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<table>
<thead>
<tr>
<th>19. IS YOUR PATIENT ELIGIBLE FOR MEDICARE BENEFITS FROM THE TIMELY FILED CLAIM?</th>
</tr>
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<tbody>
<tr>
<td>NO</td>
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<table>
<thead>
<tr>
<th>20. OUTSIDE LAB?</th>
<th>$ CHARGES</th>
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<tr>
<td>YES</td>
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<table>
<thead>
<tr>
<th>21. DURATION OR NATURE OF ILLNESS OR INJURY (Specify: [ ] to service line below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD.</td>
</tr>
<tr>
<td>A. 846.0</td>
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<table>
<thead>
<tr>
<th>22. A. DATES OF SERVICE</th>
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<table>
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<th>23. BILLING PROVIDER ID</th>
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<table>
<thead>
<tr>
<th>24. TOTAL CHARGE $</th>
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</thead>
<tbody>
<tr>
<td>90.00</td>
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<table>
<thead>
<tr>
<th>25. AMOUNT PAID $</th>
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<table>
<thead>
<tr>
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<table>
<thead>
<tr>
<th>27. SIGNATURE OF PHYSICIAN OR SUPPLIER</th>
</tr>
</thead>
<tbody>
<tr>
<td>INCLUDING OFFICE OR OFFICE HOURS (I certify that the statements on the reverse apply to this bill and are made in good faith.)</td>
</tr>
<tr>
<td>ABC123 Medical Supply</td>
</tr>
<tr>
<td>111 Main Street</td>
</tr>
<tr>
<td>Anytown, SC 22222-2222</td>
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<table>
<thead>
<tr>
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<table>
<thead>
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<table>
<thead>
<tr>
<th>31. PHYSICIAN OR SUPPLIER SIGNATURE</th>
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<th>34. AMOUNT PAID $</th>
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<table>
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<th>Itemized Charges</th>
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</table>

<table>
<thead>
<tr>
<th>36. SIGNATURE OF PHYSICIAN OR SUPPLIER</th>
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<tbody>
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</tbody>
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<table>
<thead>
<tr>
<th>37. SERVICE FACILITY LOCATION INFORMATION</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>38. TOTAL CHARGE $</th>
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<table>
<thead>
<tr>
<th>39. AMOUNT PAID $</th>
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<tbody>
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<table>
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<table>
<thead>
<tr>
<th>41. SIGNATURE OF PHYSICIAN OR SUPPLIER</th>
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<tbody>
<tr>
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</tbody>
</table>
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>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB00080000</td>
<td>REMITTANCE ADVICE</td>
<td>02/14/2014</td>
<td>1</td>
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</table>

<table>
<thead>
<tr>
<th>PROVIDERS</th>
<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>TLE. 18</th>
<th>COPAY</th>
<th>TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>OWN REF.</td>
<td>REFERENCE</td>
<td>DATE(S)</td>
<td>BILLED</td>
<td>PAYMENT</td>
<td>ID.</td>
<td>F M</td>
<td>0 ALLOWED</td>
<td>AMT</td>
<td>PAYMENT</td>
<td></td>
</tr>
<tr>
<td>NUMBER</td>
<td>NUMBER</td>
<td>PY IND</td>
<td>MMDDYY</td>
<td>PROC.</td>
<td>MEDICAID</td>
<td>NUMBER</td>
<td>I I LAST NAME</td>
<td>M</td>
<td>TLE. 18</td>
<td>COPAY</td>
</tr>
<tr>
<td>ABB1AA</td>
<td>1403004803012700A</td>
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<td>101713</td>
<td>71010</td>
<td>27.00</td>
<td>6.72</td>
<td>P</td>
<td>1112233333</td>
<td>M</td>
<td>CLARK</td>
</tr>
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<td>1403004804012700A</td>
<td>01</td>
<td>101713</td>
<td>74176</td>
<td>259.00</td>
<td>0.00</td>
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<td>1112233333</td>
<td>M</td>
<td>CLARK</td>
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<td>M</td>
<td>CLARK</td>
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<tr>
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<td>071913</td>
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</tbody>
</table>

For an explanation of the error codes listed on this form, refer to: "MEDICAID Provider Manual". If you still have questions regarding claims in that manual, phone the D.H.H.S. number specified for inquiry of claims in that manual.
Sample Remittance Advice (page 2)

This page of the sample Remittance Advice shows a paid claim, as well as a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle.

<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB00080000</td>
<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
<td>REMITTANCE ADVICE</td>
<td>02/28/2014</td>
<td>1</td>
</tr>
</tbody>
</table>

**PROVIDERS**

<table>
<thead>
<tr>
<th>OWN REF.</th>
<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>TLE. 18</th>
<th>COPAY</th>
<th>TITLE</th>
</tr>
</thead>
<tbody>
<tr>
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<td>021814</td>
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<td>1112233333</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VOID OF ORIGINAL CCN 1328300224813300A PAID 20131018</td>
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<table>
<thead>
<tr>
<th>OWN REF.</th>
<th>CLAIM</th>
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<th>AMOUNT</th>
<th>TITLE 19</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
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<th>TLE. 18</th>
<th>COPAY</th>
<th>TITLE</th>
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<tr>
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<tr>
<td>REPLACEMENT OF ORIGINAL CCN 1304711253670430A PAID 20131018</td>
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<table>
<thead>
<tr>
<th>OWN REF.</th>
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<th>TITLE 19</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
<th>M</th>
<th>TLE. 18</th>
<th>COPAY</th>
<th>TITLE</th>
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<td></td>
</tr>
<tr>
<td>VOID OF ORIGINAL CCN 1328300224813300A PAID 20131018</td>
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<td></td>
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</tbody>
</table>

**TOTALS:**

- Certified Amount: $2,866.46
- Medicaid Total: $2,866.46

**ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".**

- P = Payment Made
- R = Rejected
- S = In Process
- E = Encounter

**IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER**

- Provider Name and Address: ABC Health Provider, PO Box 000000, Florence SC 00000

**CERTIFIED AMT MEDICAID TOTAL**

- Certified Amount: $2,866.46
- Medicaid Total: $2,866.46
**Sample Remittance Advice (page 3)**

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

<table>
<thead>
<tr>
<th>PROVIDER ID</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>CLAIM</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB11110000</td>
<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
<td></td>
<td>02/28/2014</td>
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</table>

<table>
<thead>
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<th>PROVIDER</th>
<th>CLAIM</th>
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<th>TITLE 19</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
<th>MEDICAID</th>
<th>NUMBER</th>
<th>LAST NAME I I D</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
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<td>02/28/2014</td>
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<table>
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<tr>
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<th>PY</th>
<th>DATE(S)</th>
<th>BILLED</th>
<th>PAYMENT</th>
<th>ID.</th>
<th>F M</th>
<th>O</th>
<th>CHECK</th>
<th>ORIGINAL CCN</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>NUMBER</th>
<th>NUMBER</th>
<th>INDDDDYY</th>
<th>PROC.</th>
<th>MEDICAID</th>
<th>NUMBER</th>
<th>LAST NAME I I D</th>
<th>DATE</th>
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<tbody>
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| ABB222222 | 140520000777000000 | 513.00 | 197.71 | P | 1122333333 | CLARK | M | 131018 | 1328300224813300A |
| 01 | 100213 | S0315 | 453.00 | 160.71 | P | 000 |
| 02 | 100213 | S9445 | 60.00 | 33.00 | P | 000 |
| **TOTALS** | | | **513.00** | **193.71** | |

<table>
<thead>
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<th>PROVIDER</th>
<th>DEBIT BALANCE</th>
<th>MEDICAID TOTAL</th>
<th>CERTIFIED AMT</th>
<th>TO BE REFUNDED</th>
<th>INCENTIVE</th>
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<tbody>
<tr>
<td></td>
<td>$243.71</td>
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<table>
<thead>
<tr>
<th>CREDIT AMOUNT</th>
<th>REMITTANCE</th>
<th>ADJUSTMENTS</th>
<th>PROVIDER NAME AND ADDRESS</th>
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</thead>
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<td>$150.00</td>
<td>$50.00</td>
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<tr>
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<td>4197304</td>
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<td>FLORENCE SC 00000</td>
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</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB11110000</td>
<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
<td></td>
<td>3</td>
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<table>
<thead>
<tr>
<th>PROVIDERS</th>
<th>CLAIM</th>
<th>SERVICE</th>
<th>PROC / DRUG</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
<th>ORIG.</th>
<th>ORIGINAL</th>
<th>DEBIT / CREDIT</th>
<th>AMOUNT</th>
<th>REFUND</th>
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<tbody>
<tr>
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<td>1404900004000100U</td>
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<tr>
<td>TPL 4</td>
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<td>DEBIT</td>
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<td>-</td>
<td>-</td>
<td>-</td>
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</table>

MEDICAID TOTAL
CERTIFIED AMT
+-------------+     +-------------+   +-------------+      IN THE FUTURE
PROVDER                     DEBIT BALANCE  TO BE REFUNDED
INCENTIVE                   PRIOR TO THIS
CREDIT AMOUNT               REMITTANCE
+-------------+     +-------------+     +---------+       | ABC HEALTH PROVIDER |
| 0.00        | 0.00         | -4338.95    | 0.00    | ABC HEALTH PROVIDER |
YOUR CURRENT                CHECK TOTAL
DEBIT BALANCE CHECK NUMBER
+-------------+     +-------------+     +---------+       | FLORENCE      |
| 0.00        | 0.00         | 0.00        |        | SC 00000    |

PAGE TOTAL: 4338.95  0.00
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: __ 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 PROEDURE 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.

DME 001 - Dated 04/01/18
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.

LATTEST 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 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)

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 the 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, PROSTHETICS 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, PROSTHETICS, 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/OFFERING 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.

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 overall 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 ID. 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 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.

DME 005 – Dated 04/01/18
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.

DME 006 – Dated 04/01/18
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:

__________________________

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

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

__________________________

__________________________

__________________________

(8) ANSWERS

<table>
<thead>
<tr>
<th>ANSWER QUESTIONS 1-9. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ________ mm Hg b) ________ % c) _<strong><strong><strong>/</strong></strong></strong></td>
</tr>
</tbody>
</table>

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)

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?

Y N 1 2 3

3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep

XXXXXXX
XXX

4. Physician/provider performing test in Question 1 (and, if applicable, Question 7) Print/type name and address below

NAME: ___________________________ ADDRESS: ___________________________

5. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D

Y N D

6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter an "X"

__________________________ LPM

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

Y N 7

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 here to 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/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, 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.

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 MCMN’s 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 ordered 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 007 – Dated 04/01/18
<table>
<thead>
<tr>
<th>TO BE COMPLETED BY ENROLLED DME PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) RECIPIENT'S NAME:</td>
</tr>
<tr>
<td>(2) RECIPIENT'S MEDICAID # (10 DIGITS):</td>
</tr>
<tr>
<td>(3) BRAND NAME OF EQUIPMENT:</td>
</tr>
<tr>
<td>(4) DATE OF REPAIR AND/OR LABOR:</td>
</tr>
<tr>
<td>(5) SPECIFICALLY IDENTIFY EQUIPMENT TO BE REPAIRED:</td>
</tr>
<tr>
<td>(6) ESTIMATED COST OF REPAIR:</td>
</tr>
<tr>
<td>(7) GIVE A DETAILED DESCRIPTION OF THE TYPE OF REPAIR AND/OR LABOR TO BE PERFORMED ON EQUIPMENT:</td>
</tr>
<tr>
<td>(8) PROVIDER'S NAME:</td>
</tr>
<tr>
<td>PROVIDER ID and/or NPI:</td>
</tr>
<tr>
<td>(9) STREET ADDRESS:</td>
</tr>
<tr>
<td>CITY:</td>
</tr>
</tbody>
</table>

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

LINE 1  RECIPIENT'S NAME  Enter recipient’s full name.

LINE 2  RECIPIENT'S MEDICAID #  Enter recipient’s 10-digit Medicaid number.

LINE 3  BRAND OF EQUIPMENT  Enter the brand name of the equipment you are repairing.

LINE 4  DATE OF REPAIR AND/OR LABOR  Enter the date the repair and/or labor was performed.

LINE 5  SPECIFICALLY IDENTIFY EQUIPMENT TO BE REPAIRED  Specify equipment being repaired.

LINE 6  ESTIMATED COST OF REPAIRED  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.

LINE 7  GIVE A DETAILED DESCRIPTION OF THE TYPE OF REPAIR AND/OR LABOR TO BE PERFORMED ON EQUIPMENT  Give a detailed description of what type of repair was performed.

LINE 8  PROVIDER'S NAME & PROVIDER ID AND/OR NPI  Enter provider’s name and Medicaid DME number and/or National Provider Identifier.

LINE 9  STREET ADDRESS AND CITY  Enter provider’s street address and city.
STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

JUSTIFICATION FOR HOME UTERINE ACTIVITY
MONITOR/SUPPLIES (HUAM)
FOR SUBCUTANEOUS TOCOTYLIC THERAPY

PART I – (ALL INFORMATION MUST BE PRINTED)

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Medicaid #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Telephone Order/Written Order Given:</td>
<td></td>
</tr>
<tr>
<td>Patient’s Expected Date of Delivery:</td>
<td></td>
</tr>
<tr>
<td>Provider’s NPI or Medicaid ID:</td>
<td></td>
</tr>
</tbody>
</table>

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)

- [ ] Has experienced idiopathic pre-term labor that has required or will require hospitalization for IV tocolytic therapy.
- [ ] Multiple gestation, three (3) or more fetuses, that has required or will require hospitalization for IV tocolytic therapy.
- [ ] 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)