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<td>DHHS 205</td>
<td>Medicaid Refunds</td>
<td>01/2008</td>
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<td>DHHS 931</td>
<td>Health Insurance Information Referral Form</td>
<td>02/2018</td>
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<td>Reasonable Effort Documentation</td>
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<td>Electronic Funds Transfer (EFT) Authorization Agreement</td>
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<td>Duplicate Remittance Advice Request Form</td>
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<tr>
<td>CMS-1500</td>
<td>Sample Claim Showing Medicaid and Medicare with NPI</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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<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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<td>DME 004</td>
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<tr>
<td>DME 005</td>
<td>Medicaid Certificate of Medical Necessity Enteral Nutrition</td>
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<td>DME 006</td>
<td>Medicaid Certificate of Medical Necessity Parenteral Nutrition</td>
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<td>Medicaid Certificate of Medical Necessity Oxygen</td>
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<td>Certificate of Repair and Labor Cost</td>
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<td>Justification for Home Uterine Activity Monitor/Supplies (HUAM) for</td>
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<td>Subcutaneous Tocolytic Therapy</td>
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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>
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<tr>
<th>SUSPECTED INDIVIDUAL OR INDIVIDUALS:</th>
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<th>NPI or MEDICAID PROVIDER ID: (if applicable)</th>
<th>MEDICAID RECIPIENT ID NUMBER: (if applicable)</th>
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<th>ADDRESS OF SUSPECT:</th>
<th>LOCATION OF INCIDENT:</th>
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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: Originalator:

- Void
- Void/Replace
- DHHS
- MCCS
- Provider
- MIVS

Reason For Adjustment: (Fill One Only)

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

For Agency Use Only

- Hospital/Office Visit included in Surgical Package
- Independent lab should be paid for service
- Assistant surgeon paid as primary surgeon
- Multiple surgery claims submitted for the same DOS
- MMIS claims processing error
- Rate change

Web Tool error
Reference File error
MCCS processing error
Claim review by Appeals

Comments:

Signature: _____________________________ Date: _____________________________

Phone: ________________________________

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>
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<tr>
<th>Patient Name</th>
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<th>Amount of Refund</th>
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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 adjoining 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 SCDOH 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 SCDOHPS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching trace number and your ERA can be directed to the Provider Service Center at 1-888-289-0709.
South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form

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

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

1. Provider Name: ________________________________

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

3. Person to Contact: ____________________ Telephone Number: ________________

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

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

5. Street Address for delivery of request:
   Street: ________________________________
   City: ________________________________
   State: ________________________________
   Zip Code: ____________________________

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

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

___________________________________  _______________________
Authorizing Signature                  Date

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

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. A separate SCDHHS CR form is required for each claim control number (CCN). Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-269-0709. Note: Timely filing guidelines apply.

Section 1: Beneficiary Information
Name [Last, First, MI]: __________________________________________________________________________
Date of Birth: __________ Medical BeneficiaryID: __________

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 (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
Specifying: __________________________
☐ Private Rehabilitative Therapy and Audiological Services
☐ Psychiatric Hospital Services
☐ Rehabilitative Behavioral Health Services (RBHS)
☐ Rural Health Clinic (RHC)
☐ Targeted Case Management (TCM)
☐ Other: __________________________
Section 5: Desired Outcome

Request submitted by:

Print Name: ________________________________

Signature: ________________________________

Date: __________

SCDHHS-CR Form (11/18)
Durable Medical Equipment
Sample Claim Showing Medicaid Only
With NPI

**HEALTH INSURANCE CLAIM FORM**

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

<table>
<thead>
<tr>
<th>1a. INSURED'S ID NUMBER</th>
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5. PATIENT'S NAME (Last Name, First Name, Middle Initial)
   - Doe, John A.

6. PATIENT'S BIRTH DATE
   - 01 01 1947

7. INSURED'S ADDRESS (No., Street)
   - 123 Windy Lane

8. ZIP CODE
   - 29999

9. CITY
   - Anytown

10. IS PATIENT'S CONDITION RELATED TO:
    - a. EMPLOYMENT? (Current or Previous)
        - NO
    - b. AUTO ACCIDENT
        - YES
    - c. OTHER ACCIDENT
        - NO

11. INSURED'S POLICY GROUP OR FEIDA NUMBER

12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

13. OTHER INSURED'S POLICY OR GROUP NUMBER

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY)
   - 01 20 14

15. OTHER DATE
   - 01 20 14

16. DATE OF LAST ADMISSION TO FACILITY OR HOSPITALIZATION DATES RELATED TO CURRENT ILLNESS, INJURY, OR PREGNANCY FROM TO MM DD YY MM DD YY
   - 01 20 14

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
   - ABC Medical Supply

18. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO MM DD YY
   - 01 20 14

19. CLAIM CODES (Designated by NUCC)
   - I

20. OUTSIDE LAB
    - YES
    - NO

21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

22. BILLING PROVIDER INFO & PHNS
    - ABC Medical Supply
    - 111 Main Street
    - Anytown, SC 22222-2222
    - 1234567890

23. PRIOR AUTHORIZATION NUMBER

24. DATES OF SERVICE MM DD YY
   - 01 20 14

25. TOTAL CHARGE
    - 90.00

26. AMOUNT PAID
    - 0.00

27. FEDERAL TAX ID NUMBER
   - 555555555

28. PATIENT'S ACCOUNT NO.
   - DOE1234

29. SIGNED
   - NPI

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DISCREPANCIES OR CREDENTIALS
    - YES

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PHNS
    - ABC Medical Supply
    - 111 Main Street
    - Anytown, SC 22222-2222
    - 1234567890

34. SIGNED
   - NPI

**NUCC INSTRUCTION MANUAL AVAILABLE AT: www.nucc.org**
**HEALTH INSURANCE CLAIM FORM**

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

**Form Instructions**
- **Signature on File:** Document is signed by the insurance company
- **Read Before Filling Out:** Required information for processing

**Fields:**
- Patient's Name: Doe, John A.
- Address: 123 Windy Lane
- City: Anytown
- Zip Code: 29999

**Form Details:**
- **Medical/Provider Information:**
  - NPI: 1234567890
  - Claim Status: Approved
  - Provider ID: ABC123

**Notes:**
- Durable Medical Equipment
- Medicaid and Private Pay
- With NPI and Medicaid Provider ID

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

**PLEASE PRINT OR TYPE**
The page of the sample Remittance Advice shows a paid claim, suspended claim and rejected claim.

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<th>PROVIDER ID.</th>
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| ABB2AA | 1403004804012700A | 01 | 101713 | 74176 | 259.00 | 0.00 | S | 1112233333 | M CLARK | 026 | 0.00 | 0.00 |
| ABB3AA | 1403004805012700A | 01 | 071913 | A5120 | 24.00 | 0.00 | R | 1112233333 | M CLARK | 000 | 0.00 | 0.00 |
|         | 02 | 071913 | A4927 | 12.00 | 0.00 | R | 1112233333 | M CLARK | 000 | 0.00 | 0.00 |

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</table>
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>
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<td>REMITTANCE ADVICE</td>
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<th>TITLE 19</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
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</table>

| CHECK TOTAL | CHECK NUMBER | $286.46 | |

For an explanation of the status codes, refer to: "MEDICAID PROVIDER MANUAL". Phone the D.H.H.S. number specified for inquiry of claims in that manual.
### 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>PAYMENT DATE</th>
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<tr>
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<th>TITLE</th>
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- **PAYMENT DATE:** 02/28/2014
- **PAGE:** 2

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<th>DATE(S)</th>
<th>BILLED</th>
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<th>O</th>
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- **TOTALS:** 1 | 513.00 | 197.71 |

### Remittance Details

- **Provider ID:** AB11110000
- **Debit Balance:** $193.71
- **Medicaid Total:** $243.71
- **Certified Amount:** $193.71
- **To Be Refunded:** $0.00
- **In The Future:** $0.00

- **Adjustments:** $0.00

- **Incentive:** $243.71
- **Credit Amount:** $193.71
- **Remittance:** $0.00

- **Your Current:** $0.00
- **Debit Balance:** $50.00
- **Check Total:** $4197304
- **Check Number:** 131018

- **Provider Name and Address:**
  - **Provider:** ABC HEALTH PROVIDER
  - **Address:** PO BOX 000000
  - **City:** FLORENCE
  - **State:** SC 00000

---

This page of the sample Remittance Advice shows a claim-level Void without a corresponding Replacement claim.
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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<tr>
<th>PROVIDER ID.</th>
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MEDICAID TOTAL     CERTIFIED AMT                         TO BE REFUNDED
PROVDER                     DEBIT BALANCE      +-------------+     +-------------+   +-------------+      IN THE FUTURE
INCENTIVE                   PRIOR TO THIS      |         0.00|     |         0.00|   |         0.00|        +----------+
CREDIT AMOUNT               REMITTANCE         +-------------+     +-------------+   +-------------+     PROVIDER NAME AND ADDRESS
|     -4338.95|     |         0.00|   +---------------------------------+
|     0.00|     |         0.00|     |         |       |                                 |
|                          |     |         0.00|     |         |       |                                 |

YOUR CURRENT       CHECK TOTAL       CHECK NUMBER      | 0.00|     |         |   | PO BOX 000000                  |
DEBIT BALANCE              | 0.00|     |         |     | FLORENCE            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 #: __________________________

(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/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.

AFFIRM 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, 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 #: ____________________________

(4) Provider’s NPI #: ____________________________

(5) Street address: ____________________________ City: ____________________________ State: _______ Zip: _______ Local telephone #: _______

(6) Provider’s signature: ____________________________ Date: __________

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 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)

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.

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 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 # ____________

________________________________________________________________________

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:

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)

| a) ____ mm Hg | 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) |
| b) ___ % | |
| c) / / | |

| Y N | 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? |
| 1 2 3 | |

| XXXXXXXXXX | 4. Physician/provider performing test in Question 1 and, if applicable, Question 7 Print/type name and address below |
| XXXXXXXXXX | |
| XXXXXXXXXX | NAME: ____________________________ ADDRESS: ____________________________ |

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

| Y N 7 | 6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "X" |

| Y N D | 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):

(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/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, 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, dietitian) 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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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 007 – Dated 04/01/18
<p>| | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>TO BE COMPLETED BY ENROLLED DME PROVIDER</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(1) RECIPIENT’S NAME:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(2) RECIPIENT’S MEDICAID # (10 DIGITS):</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>(3) BRAND NAME OF EQUIPMENT:</strong></td>
<td><strong>(4) DATE OF REPAIR AND/OR LABOR:</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>(5) SPECIFICALLY IDENTIFY EQUIPMENT TO BE REPAIRED:</strong></td>
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</tr>
<tr>
<td><strong>(6) ESTIMATED COST OF REPAIR:</strong></td>
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</tr>
<tr>
<td><strong>(7) GIVE A DETAILED DESCRIPTION OF THE TYPE OF REPAIR AND/OR LABOR TO BE PERFORMED ON EQUIPMENT:</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>(8) PROVIDER’S NAME:</strong></td>
<td></td>
<td><strong>PROVIDER ID and/or NPI:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>(9) STREET ADDRESS:</strong></td>
<td></td>
<td><strong>CITY:</strong></td>
<td></td>
</tr>
<tr>
<td>LINE 1</td>
<td>RECIPIENT’S NAME</td>
<td>Enter recipient’s full name.</td>
<td></td>
</tr>
<tr>
<td>LINE 2</td>
<td>RECIPIENT’S MEDICAID #</td>
<td>Enter recipient’s 10-digit Medicaid number.</td>
<td></td>
</tr>
<tr>
<td>LINE 3</td>
<td>BRAND OF EQUIPMENT</td>
<td>Enter the brand name of the equipment you are repairing.</td>
<td></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>
<td></td>
</tr>
<tr>
<td>LINE 5</td>
<td>SPECIFICALLY IDENTIFY EQUIPMENT TO BE REPAIRED</td>
<td>Specify equipment being repaired.</td>
<td></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>
<td></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>
<td></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>
<td></td>
</tr>
<tr>
<td>LINE 9</td>
<td>STREET ADDRESS AND CITY</td>
<td>Enter provider’s street address and city.</td>
<td></td>
</tr>
</tbody>
</table>
# JUSTIFICATION FOR HOME UTERINE ACTIVITY MONITOR/SUPPLIES (HUAM) FOR SUBCUTANEOUS TOCOLOYTIC 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)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Has experienced idiopathic pre-term labor that has required or will require hospitalization for IV tocolytic therapy.</td>
</tr>
<tr>
<td></td>
<td>Multiple gestation, three (3) or more fetuses, that has required or will require hospitalization for IV tocolytic therapy.</td>
</tr>
<tr>
<td></td>
<td>Patient has uterine anomalies or placenta previa that has required or will require hospitalization for IV tocolytic therapy.</td>
</tr>
</tbody>
</table>

## 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

<table>
<thead>
<tr>
<th>Physician Certification</th>
</tr>
</thead>
</table>
| 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. |

<table>
<thead>
<tr>
<th>Ordering/Treating Physician’s Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician NPI/License #:</td>
<td>Phone #:</td>
</tr>
</tbody>
</table>

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

(Revised 02/13)