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<td>DHHS 126</td>
<td>Confidential Complaint</td>
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<td>DHHS 130</td>
<td>Claim Adjustment Form 130</td>
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<td>DHHS 205</td>
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<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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<tr>
<td></td>
<td>Reasonable Effort Documentation</td>
<td>04/2014</td>
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<td>DHHS 126</td>
<td>Duplicate Remittance Advice Request Form</td>
<td>09/2017</td>
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<td>DHHS 130</td>
<td>Claim Reconsideration Form</td>
<td>11/2018</td>
</tr>
<tr>
<td>CMS-1500 (02/12)</td>
<td>Sample Claim Showing Medicaid and Medicare with NPI</td>
<td>02/2012</td>
</tr>
<tr>
<td>CMS-1500 (02/12)</td>
<td>Sample Claim Showing Medicaid Only with NPI</td>
<td>02/2012</td>
</tr>
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<td>CMS-1500 (02/12)</td>
<td>Sample Claim Showing Medicaid and Private Pay with NPI and Medicaid Provider ID</td>
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<td>CMS-1500 (02/12)</td>
<td>Sample Claim Showing Medicare, Medicaid, Private Pay with NPI and Medicaid Provider ID</td>
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<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>
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<td>DME 004</td>
<td>Medicaid Certificate of Medical Necessity Orthotics, Prosthetics, and Diabetic Shoes</td>
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<td>Medicaid Certificate of Medical Necessity Enteral Nutrition</td>
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<tr>
<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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## 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>
**CONFIDENTIAL COMPLAINT**

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

**PROGRAM INTEGRITY**

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

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

---

**SUSPECTED INDIVIDUAL OR INDIVIDUALS:**

<table>
<thead>
<tr>
<th>NPI or MEDICAID PROVIDER ID: (if applicable)</th>
<th>MEDICAID RECIPIENT ID NUMBER: (if applicable)</th>
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<table>
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<table>
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**COMPLAINT:**

---

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

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

Provider Address:

Provider City, State, Zip:  

Total paid amount on the original claim:

Original CCN:

Provider ID:  
NPI:

Recipient ID:

Adjustment Type:
○ Void  ○ Void/Replace

Originator:
○ DHHS  ○ MCCS  ○ Provider  ○ MIVS

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

For Agency Use Only
○ 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

Analyst ID:

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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</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
Duplicate Remittance Advice Request Form

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

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

1. Provider Name: ____________________________________________________________

2. Medicaid Legacy Provider # ____________ (Six Characters)
   NPI# ___________________________ Taxonomy ____________________________

3. Person to Contact: ______________________ Telephone Number: ______________________

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

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

5. Street Address for delivery of request:
   Street: _________________________________________________________
   City: _________________________________________________________
   State: _________________________________________________________
   Zip Code: ____________________________________________________

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

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

________________________________________    __________________________
Authorizing Signature                     Date

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

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

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

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

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

Section 4: Claim Reconsideration Information
What area is your denial related to? (Please select below)
☐ Ambulance Services
☐ 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 (RBBHS)
☐ Rural Health Clinic (RHC)
☐ Targeted Case Management (TCM)
☐ Other: ____________________________
Section 5: Desired Outcome

Request submitted by:

Print Name: ________________________________

Signature: ________________________________  Date: ________
**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12**

<table>
<thead>
<tr>
<th>1. MEDICARE</th>
<th>MEDICAID</th>
<th>TRICARE</th>
<th>CHAMPVA</th>
<th>MEDIGAP</th>
<th>GROUP HEALTH PLAN</th>
<th>FECA</th>
<th>FEDERAL</th>
<th>OTHER</th>
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<tbody>
<tr>
<td>[X] (Medicare)</td>
<td>[X] (Medicaid)</td>
<td>[ ] (Medicare)</td>
<td>[ ] (Medicaid)</td>
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<table>
<thead>
<tr>
<th>2. PATIENT'S 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>
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<tbody>
<tr>
<td>Doe, John A.</td>
<td>01 01 1947 F</td>
<td>013000000A</td>
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<thead>
<tr>
<th>5. PATIENT'S ADDRESS (No., Street)</th>
<th>6. PATIENT'S PERSONAL IDENTIFICATION NUMBER</th>
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<tbody>
<tr>
<td>123 Windy Lane</td>
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<tr>
<th>7. INSURER'S ADDRESS (No., Street)</th>
<th>8. INSURER'S IDENTIFICATION NUMBER</th>
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<table>
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<th>9. CITY</th>
<th>10. ZIP CODE</th>
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<td>Anytown</td>
<td>299999</td>
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<th>11. INSURER'S POLICY NUMBER</th>
<th>12. INSURER'S Identification NUMBER</th>
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<th>14. INSURER'S STATE</th>
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<th>15. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
<th>16. OTHER INSURED'S ADDRESS (No., Street)</th>
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**PHYSICIAN OR SUPPLIER INFORMATION**

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<th>21. BILLING PROVIDER INFO &amp; PH #</th>
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<tr>
<td>DOE123</td>
<td>ABC Medical Supply</td>
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</table>

<table>
<thead>
<tr>
<th>22. SERVICE FACILITY LOCATION INFORMATION</th>
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<td>ABC Medical Supply</td>
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**PER INSURED'S INFORMATION**

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<th>23. TOTAL CHARGE</th>
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<th>28. PAYMENT AMOUNT</th>
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<th>29. PATIENT'S AUTHORIZATION</th>
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**NUCC Inocuration Manual available at www.nucc.org**

PLEASE PRINT OR TYPE

**APPROVED CMB-00908-1197 FORM 1500 (02-12)**
**Sample Remittance Advice (page 1)**

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

<table>
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<td>02/14/2014</td>
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<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
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<th>CLAIM</th>
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<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
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**CERTIFIED AMT** | **MEDICAID TOTAL** | **ENCOUNTER** | **FLORENCE** | **SC 00000** |

**STATUS CODES:**

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

**FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: MEDICAID PROVIDER 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>
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| | 02 | 020213 | S9445 | 300.00 | 130.00 | P | | | 000 | 0.00 | 0.00 |

**REPLACEMENT OF ORIGINAL CCN 130471253670430A PAID 20131018**

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| | 02 | 0100313 | S9445 | 859.00 | 0.00 | R | | | 000 | 0.00 | 0.00 |

| | | | | | | | | | | | |

$286.46|

### STATUS CODES:

- **P** = PAYMENT MADE
- **R** = REJECTED
- **S** = IN PROCESS
- **E** = ENCOUNTER

### PHONE THE D.H.H.S. NUMBER

**0.00**

### CERTIFIED AMT MEDICAID TOTAL

**$0.00** | **$286.46**

### PROVIDER NAME AND ADDRESS

**ABC HEALTH PROVIDER**

**PO BOX 000000**

**SC 00000**

**FLORENCE**

**00000**

**00000**

**00000**
Sample Remittance Advice (page 3)
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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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 #: ___________________________

(4) Street address: ___________________________ City: ____________ State: ___ Zip: ______ Local telephone #: ___________________________

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

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

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

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

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

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

__________________________________________________________________________________________

__________________________________________________________________________________________

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

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

__________________________________________________________________________________________

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

__________________________________________________________________________________________

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

__________________________________________________________________________________________

__________________________________________________________________________________________

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

__________________________________________________________________________________________

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

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

(11) Please indicate the prescription date: ______________________

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

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

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

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

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

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

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

SECTION A: MUST BE COMPLETED BY DME PROVIDER

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

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

(2) DOB ___/___/___ Sex: ___ HT: ________(in) WT: ______________Date of Service: ________________________

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

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

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

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

__________________________________________________________________________________________

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

I CERTIFY 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 NP1 # __________

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.
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): ________________________________  

DATE: __________/________/________

(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: __________/________/________  

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 ulcersations  _____Peripheral neuropathy with evidence of callus formation  _____Foot deformity

_____Poor circulation  _____History of partial or complete amputation of the foot  _____History of pre-ulcerative callus
Is additional information attached on a separate sheet?  _____Yes  _____No (If “yes,” enter recipient’s name and Medicaid I.D. number on attachment)

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

(10) Prescription Date: __________/________/________  

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

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

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

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

PHYSICIAN’S SIGNATURE: ________________________________ DATE __________/________/________ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

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

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

SECTION A: MUST BE COMPLETED BY DME PROVIDER

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

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

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

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

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

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

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

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

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

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

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

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 #: __________________

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

<table>
<thead>
<tr>
<th>RECIPIENT’S NAME AND MEDICAID #:</th>
<th>Indicate the patient’s name and his/her Medicaid # (10 digits).</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT DOB, SEX, HEIGHT, WEIGHT:</td>
<td>Indicate patient’s date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.</td>
</tr>
<tr>
<td>DATE OF SERVICES:</td>
<td>Indicate the date of service (DOS). The date of service must be the same as the delivery date.</td>
</tr>
<tr>
<td>PROVIDER ‘ S NAME, DME # AND NPI #:</td>
<td>Indicate the name of the DME company (Provider name), Provider’s DME # and NPI #.</td>
</tr>
<tr>
<td>PROVIDER’S PHYSICAL ADDRESS AND TELEPHONE NUMBER:</td>
<td>Indicate the provider’s physical address (provider’s location) and telephone number.</td>
</tr>
<tr>
<td>PROVIDER SIGNATURE AND DATE:</td>
<td>Signature of DME provider representative and date.</td>
</tr>
<tr>
<td>HCPCS CODES:</td>
<td>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.</td>
</tr>
</tbody>
</table>

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. |
**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 b) ______ % c) ______ / ______ / ______ | 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)

---

| Y N 1 2 3 | 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?

---

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

---

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

---

| Y N D | 5. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D
| ______ LPM | 6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a**X**

**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).

(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, 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.

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

1. **RECIPIENT’S NAME:**

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

3. **BRAND NAME OF EQUIPMENT:**

4. **DATE OF REPAIR AND/OR LABOR:**

5. **SPECIFICALLY IDENTIFY EQUIPMENT TO BE REPAIRED:**

6. **ESTIMATED COST OF REPAIR:**

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

8. **PROVIDER’S NAME:**

   PROVIDER ID and/or NPI:

9. **STREET ADDRESS:**

   CITY:
### INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF REPAIR AND LABOR COST

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

Patient's Name

Medicaid #:

Date Telephone Order/Written Order Given:

Patient's Expected Date of Delivery:

Provider’s NPI or Medicaid ID:

PART II

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

(AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE CHECKED)

• ______ 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)