<table>
<thead>
<tr>
<th>Number</th>
<th>Name</th>
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<tbody>
<tr>
<td>DHHS 126</td>
<td>Confidential Complaint</td>
<td>06/2007</td>
</tr>
<tr>
<td>DHHS 130</td>
<td>Claim Adjustment Form 130</td>
<td>03/2007</td>
</tr>
<tr>
<td>DHHS 205</td>
<td>Medicaid Refunds</td>
<td>01/2008</td>
</tr>
<tr>
<td>DHHS 931</td>
<td>Health Insurance Information Referral Form</td>
<td>02/2018</td>
</tr>
<tr>
<td></td>
<td>Reasonable Effort Documentation</td>
<td>04/2014</td>
</tr>
<tr>
<td></td>
<td>Electronic Funds Transfer (EFT) Authorization Agreement</td>
<td>07/2019</td>
</tr>
<tr>
<td></td>
<td>Duplicate Remittance Advice Request Form</td>
<td>09/2017</td>
</tr>
<tr>
<td></td>
<td>Claim Reconsideration Form</td>
<td>11/2018</td>
</tr>
<tr>
<td>CMS-1500</td>
<td>Sample Claim Showing Medicaid and Medicare with NPI</td>
<td>02/2012</td>
</tr>
<tr>
<td>(02/12)</td>
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<td>CMS-1500</td>
<td>Sample Claim Showing Medicaid Only with NPI</td>
<td>02/2012</td>
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<td>(02/12)</td>
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<td>CMS-1500</td>
<td>Sample Claim Showing Medicaid and Private Pay with NPI</td>
<td>02/2012</td>
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<td>and Medicaid Provider ID</td>
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<tr>
<td>CMS-1500</td>
<td>Sample Claim Showing Medicare, Medicaid, Private Pay</td>
<td>02/2012</td>
</tr>
<tr>
<td>(02/12)</td>
<td>with NPI and Medicaid Provider ID</td>
<td></td>
</tr>
<tr>
<td>CMS-1500</td>
<td>Sample Remittance Advice</td>
<td>04/2014</td>
</tr>
<tr>
<td>(02/12)</td>
<td></td>
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</tr>
<tr>
<td>DME 001</td>
<td>Medicaid Certificate of Medical Necessity Equipment/Supplies</td>
<td>04/2018</td>
</tr>
<tr>
<td>DME 003</td>
<td>Medicaid Certificate of Medical Necessity Power/Manual Wheelchairs and/or Accessories</td>
<td>04/2018</td>
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<tr>
<td>DME 004</td>
<td>Medicaid Certificate of Medical Necessity Orthotics, Prosthetics, and Diabetic Shoes</td>
<td>04/2018</td>
</tr>
<tr>
<td>DME 005</td>
<td>Medicaid Certificate of Medical Necessity Enteral Nutrition</td>
<td>04/2018</td>
</tr>
<tr>
<td>DME 006</td>
<td>Medicaid Certificate of Medical Necessity Parenteral Nutrition</td>
<td>04/2018</td>
</tr>
<tr>
<td>DME 007</td>
<td>Medicaid Certificate of Medical Necessity Oxygen</td>
<td>04/2018</td>
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<tr>
<td>DME 008</td>
<td>Certificate of Repair and Labor Cost</td>
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## FORMS

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<thead>
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<th>Number</th>
<th>Name</th>
<th>Revision Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Justification for Home Uterine Activity Monitor/Supplies (HUAM) for Subcutaneous Tocolytic Therapy</td>
<td>02/2013</td>
</tr>
</tbody>
</table>
SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

PROGRAM INTEGRITY

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

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

<table>
<thead>
<tr>
<th>SUSPECTED INDIVIDUAL OR INDIVIDUALS:</th>
</tr>
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<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>NPI or MEDICAID PROVIDER ID: (if applicable)</th>
<th>MEDICAID RECIPIENT ID NUMBER: (if applicable)</th>
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<thead>
<tr>
<th>ADDRESS OF SUSPECT:</th>
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<tr>
<th>NAME OF PERSON REPORTING: (Please print)</th>
<th>SIGNATURE OF PERSON REPORTING:</th>
<th>DATE OF REPORT</th>
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<tbody>
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<tr>
<th>ADDRESS OF PERSON REPORTING:</th>
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</table>

<table>
<thead>
<tr>
<th>TELEPHONE NUMBER OF PERSON REPORTING:</th>
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<tr>
<th>SIGNATURE: (SCDHHS Representative Receiving Report)</th>
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</table>
South Carolina Department of Health and Human Services
Form for Medicaid Refunds

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

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

1. Provider Name: __________________________

2. Medicaid Legacy Provider # □□□□□□□□
   (Six Characters)

   OR

3. NPI# □□□□□□□□□□□□□□□□□□□□□□ & Taxonomy

4. Person to Contact: ________________________ 5. Telephone Number: ______________________

6. Reason for Refund: [check appropriate box]
   □ Other Insurance Paid (please complete a – f below and attach insurance EOMB)
     a Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
     b Insurance Company Name ________________________________
     c Policy #: ________________________________
     d Policyholder: __________________________________________
     e Group Name/Group: ___________________________________
     f Amount Insurance Paid: ________________________________
   □ Medicare
     ( ) Full payment made by Medicare
     ( ) Deductible not due
     ( ) Adjustment made by Medicare
   □ Requested by DHHS (please attach a copy of the request)
   □ Other, describe in detail reason for refund:
     ______________________________________________________
     ______________________________________________________
     ______________________________________________________

7. Patient/Service Identification:

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

Name on file with the IRS for the above TIN/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 designated above. Credit entries will be made only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider, in the event of excess payment to this bank account. I authorize the Department of Health and Human Services to make an adjusting debit entry to the account up to the amount of the excess payment. Credit entries to the above account are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealment 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 revoking this authorization.

☐ I acknowledge that I have read and understand that payments will be issued only to the bank account of the provider designated to receive payments beginning July 1, 2019 with the transition of Medicaid claims payments to the South Carolina Enterprise Information System (SCS). For more information, please visit https://sphin.sc.dhs.gov/scs or contact 888.289.0709. Providers’ taxpayer identification numbers (either TIN or EIN) and name must be validated with the Internal Revenue Service’s (IRS) prior to SCDHIS issuing Medicaid claims payment. If providers are not able to validate the information, they must provide a document to verify that the provider is eligible for Medicaid, which includes a copy of the IRS confirmation letter. Providers can request an application letter by calling the IRS business and specialty tax line at 800-829-4933, 7 a.m.-7 p.m., Monday-Friday. Please submit the IRS confirmation letter to Provider Enrollment with a subject line of “IRS Confirmation Letter” by scanning/emailing it to Medicaid.Pets@hcsc.com or by fax at 803-264-5915. For questions or assistance, please call the Provider Service Center at 888-289-0709.

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, South Carolina 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 located on the SC DHHS Provider website 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 participant tax number. This transaction will automatically be included in the SCDHIS electronic remittance advice. In order for the matching remittance advice number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding the matching number and your ERA can be directed to the Provider Service Center at 1-888-289-0709.

EFT Enrollment Form

Revision Date: July 1, 2019
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: ________________ 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 (ODSN) Waivers
☐ Durable Medical Equipment (DME)
☐ Early Intervention Services
☐ Enhanced Services
☐ Federally Qualified Health Center (FQHC)
☐ Home Health Services
☐ Hospice Services
☐ Hospital Services
☐ Licensed Independent Practitioner’s Rehabilitative Services (LIPS)
☐ Local Education Agencies (LEA)
☐ Medically Complex Children’s (MCC) Waivers
☐ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
☐ Optional State Supplementation (OSS)
☐ Pharmacy Services
☐ Physicians Laboratories, and Other Medical Professionals Specify: __________________________
☐ Private Rehabilitative Therapy and Audiological Services
☐ Psychiatric Hospital Services
☐ Rehabilitative Behavioral Health Services (RBHS)
☐ Rural Health Clinic (RHC)
☐ Targeted Case Management (TCM)
☐ Other: __________________________________________

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

Request submitted by:

Print Name: __________________________________________

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

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

---

**1. MEDICARE MEDICAID**
- Medicare [X]
- Medicaid [ ]
- Medicaid (MEdicaid Card) [ ]

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

**3. PATIENT'S BIRTH DATE**
- 01 01 1947 [X]
- M [X]
- F

**4. INSURED'S ID NUMBER**
- 1234567890

**5. PATIENT'S ADDRESS (No., Street)**
- 123 Windy Lane

**6. CITY**
- Anytown

**7. STATE**
- SC

**8. ZIP CODE**
- 29999

---

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

**10. IS PATIENT'S CONDITION RELATED TO (a) EMPLOYMENT? (Current or Previous)**
- Yes [ ]
- No [X]

**11. IS PATIENT'S CONDITION RELATED TO (b) AUTO ACCIDENT?**
- Yes [ ]
- No [X]

**12. IS PATIENT'S CONDITION RELATED TO (c) OTHER ACCIDENT?**
- Yes [ ]
- No [X]

**13. IS PATIENT'S CONDITION RELATED TO (d) INSURANCE PLAN NAME OR PROGRAM NAME?**
- Yes [ ]
- No [X]

---

**14. IS THERE ANOTHER HEALTH BENEFIT PLAN?**
- Yes [ ]
- No [X]

**15. IS PATIENT ELIGIBLE FOR MEDICAID?**
- Yes [ ]
- No [X]

**16. IS PATIENT ELIGIBLE FOR THE SUPPLIES AND SERVICES?**
- Yes [ ]
- No [X]

---

**17. NAME OF REFERRING PROVIDER OR OTHER SOURCE**
- Doe, John A.

**18. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY**
- MM DD YYYY

**19. OTHER DATE**
- MM DD YYYY

**20. OUTSIDE LAST**
- $ CHARGES

---

**21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Specify all services that apply):**
- ICD-10: A86.6

**22. BILLING PROVIDER INFO & PH#:**
- ABC Medical Supply
  - 111 Main Street
  - Anytown, SC 22222-2222
  - 1234567890
  - ZZ 1212121212

**23. PRIOR AUTHORIZATION NUMBER**
- ZZ 1212121212

**24. DATES OF SERVICE**
- MM DD YYYY

**25. FEDERAL TID NUMBER**
- 5555555555

**26. PATIENT'S ACCOUNT NO.**
- DOE1234

**27. BILLING PROVIDER INFO & PH#:**
- 555-5555

---

**SIGNATURE AND DATE**

---

**NUCC Instruction Manual available at: www.nucc.org**
### HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12**

<table>
<thead>
<tr>
<th>MEDICARE</th>
<th>TRICARE</th>
<th>CHAMPVA</th>
<th>HEALTH PLAN</th>
<th>HMO</th>
<th>PPO</th>
<th>COB</th>
<th>FQHC</th>
<th>Other</th>
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</table>

<table>
<thead>
<tr>
<th>1. PATIENT'S NAME (Last Name, First Name, Middle Initial)</th>
<th>2. PATIENT'S BIRTH DATE</th>
<th>3. PATIENT'S SEX</th>
<th>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
<th>5. INSURED'S ADDRESS (No., Street)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doe, John A.</td>
<td>01 01 1947</td>
<td>M</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. PATIENT'S ADDRESS (No., Street)</th>
<th>7. PATIENT'S PHONE NUMBER</th>
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<tbody>
<tr>
<td>123 Windy Lane</td>
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</table>

<table>
<thead>
<tr>
<th>8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
<th>9. OTHER INSURED'S POLICY OR GROUP NUMBER</th>
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<tbody>
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</table>

**READ BACK OF FORM BEFORE COMPLETING & SENDING THIS FORM**

**SIGNATURE ON FILE**

**DURABLE MEDICAL EQUIPMENT**

**Sample Claim Showing Medicaid and Private Pay with NPI and Medicaid Provider ID**

<table>
<thead>
<tr>
<th><strong>NNUC Instruction Manual available at:</strong> <a href="http://www.nucc.org">www.nucc.org</a></th>
</tr>
</thead>
</table>
**HEALTH INSURANCE CLAIM FORM**

1. **MEDICAID**: 
   - **Name**: Doe, John A.
   - **Address**: 123 Windy Lane
   - **State**: SC
2. **INNUMBER**
   - **Date**: 01/01/1947
   - **Sex**: M
3. **INSURED'S ID. NUMBER**: 1234567890
4. **POLICY GROUP OR RICHA NUMBER**: 012000000A
5. **INSURED'S DATE OF BIRTH**: 00/00
6. **DISABILITY PLAN**: 0000
7. **INSURED'S POLICY OR GROUP NUMBER**: 0123456789
8. **INSURED'S NAME**: Doe, John A.
9. **INSURED'S ADDRESS**: 123 Windy Lane
10. **INSURED'S SOCIAL SECURITY NUMBER**: 123-45-6789
11. **INSURED'S DATE OF BIRTH**: 00/00
12. **INSURED'S POLICY OR GROUP NUMBER**: 0123456789
13. **INSURED'S ADDRESS**: 123 Windy Lane
14. **INSURED'S SOCIAL SECURITY NUMBER**: 123-45-6789
15. **INSURED'S NAME**: Doe, John A.
16. **INSURED'S ADDRESS**: 123 Windy Lane

---

**IDENTIFICATION INFORMATION**

1. **PATIENT'S NAME**: Doe, John A.
2. **PATIENT'S ADDRESS**: 123 Windy Lane
3. **PATIENT'S SOCIAL SECURITY NUMBER**: 123-45-6789
4. **PATIENT'S DATE OF BIRTH**: 01/01/1947
5. **PATIENT'S GENDER**: M
6. **PATIENT'S RELATIONSHIP**: Self
7. **PATIENT'S INSURANCE**: 1234567890
8. **PATIENT'S PHONE**: 0123456789
9. **PATIENT'S EMAIL**: john.doe@example.com
10. **PATIENT'S ADDRESS**: 123 Windy Lane
11. **PATIENT'S SOCIAL SECURITY NUMBER**: 123-45-6789
12. **PATIENT'S DATE OF BIRTH**: 01/01/1947
13. **PATIENT'S GENDER**: M
14. **PATIENT'S RELATIONSHIP**: Self
15. **PATIENT'S INSURANCE**: 1234567890
16. **PATIENT'S PHONE**: 0123456789
17. **PATIENT'S EMAIL**: john.doe@example.com
18. **PATIENT'S ADDRESS**: 123 Windy Lane

---

**DIAGNOSIS INFORMATION**

1. **DIAGNOSIS CODE**: 846.0
2. **DIAGNOSIS DESCRIPTION**: Heart Disease
3. **DIAGNOSIS DATE**: 01/01/2014
4. **DIAGNOSIS PROVIDER**: ABC Medical Supply
5. **DIAGNOSIS LOCATION**: 111 Main Street
6. **DIAGNOSIS STATE**: SC
7. **DIAGNOSIS ZIP CODE**: 22222-2222
8. **DIAGNOSIS PHONE**: 1234567890
9. **DIAGNOSIS EMAIL**: john.doe@example.com
10. **DIAGNOSIS ADDRESS**: 123 Windy Lane

---

**TREATMENT INFORMATION**

1. **TREATMENT CODE**: A4253
2. **TREATMENT DESCRIPTION**: Medical Treatment
3. **TREATMENT DATE**: 01/01/2014
4. **TREATMENT PROVIDER**: ABC Medical Supply
5. **TREATMENT LOCATION**: 111 Main Street
6. **TREATMENT STATE**: SC
7. **TREATMENT ZIP CODE**: 22222-2222
8. **TREATMENT PHONE**: 1234567890
9. **TREATMENT EMAIL**: john.doe@example.com
10. **TREATMENT ADDRESS**: 123 Windy Lane

---

**FINANCIAL INFORMATION**

1. **AMOUNT CHARGED**: $90.00
2. **AMOUNT PAID**: $50.00
3. **TOTAL AMOUNT DUE**: $40.00
4. **INSURANCE COMPANY**: ABC Medical Supply
5. **INSURANCE ADDRESS**: 111 Main Street
6. **INSURANCE PHONE**: 1234567890
7. **INSURANCE EMAIL**: john.doe@example.com
8. **INSURANCE ADDRESS**: 123 Windy Lane
Sample Remittance Advice (page 1)

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

<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>PROFESSIONAL SERVICES</th>
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<th>TITLE 19</th>
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<th>RECIPIENT NAME</th>
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<th>COPAY</th>
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<td>R - REJECTED</td>
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## 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.

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<thead>
<tr>
<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
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<td>AB00800000</td>
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### Providers

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<th>RECIPIENT NAME</th>
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<th>TLE. 18</th>
<th>COPAY</th>
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### Void of Original

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### Replacement of Original

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<td>1112333333</td>
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</tbody>
</table>

### Total

- **CERTIFIED PG TOT:** $286.46
- **MEDICAID PG TOT:** $286.46

### Status Codes

- **P** - Payment Made
- **R** - Rejected
- **E** - Encounter

### Provider Information

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

### Contact Information

- **If you still have questions:** Phone the D.H.H.S. Number

### Table Examples

- **Specified for Inquiry of:**
  - **Check Total:**
  - **Check Number:**

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For an explanation of the error codes listed on this form refer to: "MEDICAID PROVIDER MANUAL".

Certified Medicaid paid 20131018.

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### Sample Remittance Advice (page 3)

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

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<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PAYMENT DATE</th>
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**TOTALS**

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**To Be Refunded**

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**In The Future**

| ADJUSTMENTS | | 0.00 |
|-------------| |      |

**Provider Name and Address**

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Sample Remittance Advice (page 4)

This page of the sample Remittance Advice shows four gross-level adjustments. Gross-level adjustments always appear on the final page of the Remittance Advice.

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PAGE TOTAL: 4338.95  0.00
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR EQUIPMENT/SUPPLIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

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

(2) DOB: ________/______/______ Sex: ______ HT: ________ (In) WT: ________ Date of Service: ________/______/______

(3) Provider’s name: ___________________________ Provider’s DME #: ____________________ NPI #: __________

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

(5) Provider’s signature: ________________________ Date: _____________________________

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

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

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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 hereeto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(13) PHYSICIAN’S NAME: ___________________________________________ PHYSICIAN’S NPI #: __________

PHYSICIAN’S SIGNATURE ______________________________________ DATE __/__/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

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

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

SECTION A: MUST BE COMPLETED BY DME PROVIDER

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

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

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

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

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

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

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician.

Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.

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

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

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

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

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

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

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

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

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

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

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

(3) Provider’s name: ___________________________ Provider’s DME #: ______________ NPI #: ____________

(4) Street address: _____________________________ City: __________________ State: ______ Zip: ______ Local telephone #: __________________________

(5) Provider’s signature: ___________________________ Date: __________________

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

________________________________________________________

________________________________________________________

________________________________________________________

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

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

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

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

________________________________________________________________________________________

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

________________________________________________________________________________________

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

________________________________________________________________________________________

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

________________________________________________________________________________________

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

________________________________________________________________________________________

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

________________________________________________________________________________________

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

________________________________________________________________________________________

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

________________________________________________________________________________________

(10) Prescription Date: __________________________

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

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

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

________________________________________________________________________________________

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

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

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

SECTION A: MUST BE COMPLETED BY DME PROVIDER

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

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

(2) DOB: __ / __ / ___ Sex: __ HT: ___ (in) WT: ___ Date of Service: ________________________________

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

(4) Street address: ________________________________ City: ________________________________ State: ___ Zip: ___ Local telephone #: ________________________________

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

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

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

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

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

_________________________________________________________

_________________________________________________________

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

Orthotics and/or Prosthetics

_________________________________________________________

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

_____History of previous foot ulcerations  _____Peripheral neuropathy with evidence of callus formation  _____Foot deformity

_____Poor circulation  _____History of partial or complete amputation of the foot  _____History of pre-ulcerative callus

Is additional information attached on a separate sheet? _____Yes _____No (If “yes,” enter recipient’s name and Medicaid I.D. number on attachment)

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

(10) Prescription Date: ________________________________

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

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

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

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

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

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

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

SECTION A: MUST BE COMPLETED BY DME PROVIDER

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

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

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

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

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

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

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

SECTION B: MUST BE COMPLETED BY TREATING/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 overall health status? Yes _______ No _______

Product name (s): _________________________________________________________

Total calories Per Day: ____________________________________________________

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

Does the patient have a documented allergy or intolerance to semi-synthetic nutrients? Yes ______ No ______

Is additional information attached on separate sheet? Yes __ No ______ (If “yes,” enter recipient’s name & Medicaid 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 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/OORDERING PHYSICIAN:

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

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

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) __________ concentration%

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

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

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

(10) Enter the prescription date: ____________________________

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

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

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

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

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

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

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR PARENTERAL NUTRITION

DME 006 – Dated 04/01/18
SECTION A: MUST BE COMPLETED BY DME PROVIDER

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

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

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

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

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

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

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

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

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

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

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

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

EST. LENGTH OF NEED:  Indicate the estimated length of need (the length of time the physician expects the patient to require use of the 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

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

1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test, enter date of test (c).

2. Was the test in Question 1 performed EITHER with the patient in a chronic stable state as an outpatient OR within two days prior to discharge from an inpatient facility to home?

Y N

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

1 2 3

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

NAME: ___________________________ ADDRESS: ___________________________

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

Y N D

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

__________ LPM

7. Does the patient have dependent edema due to congestive heart failure?

Y N 7

8. Does the patient have cor pulmonale or pulmonary hypertension documented by pulmonary flow or by an echo-cardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?

Y N D

9. Does the patient have a hemoglobin greater than 56%?

Y N D

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

NAME: ___________________________ TITLE: ___________________________ EMPLOYER: ___________________________

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

(10) Please indicate the Prescription date:

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

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

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached 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)

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

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR OXYGEN

SECTION A: MUST BE COMPLETED BY DME PROVIDER

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

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

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

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

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

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

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

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

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

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

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, 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 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
**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**DIVISION OF DURABLE MEDICAL EQUIPMENT**  
**CERTIFICATE OF REPAIR AND LABOR COST**

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<tr>
<td><strong>TO BE COMPLETED BY ENROLLED DME PROVIDER</strong></td>
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<tr>
<td>(1) RECIPIENT'S NAME:</td>
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<td>(2) RECIPENT'S MEDICAID # (10 DIGITS):</td>
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<tr>
<td>(3) BRAND NAME OF EQUIPMENT:</td>
<td>(4) DATE OF REPAIR AND/OR LABOR:</td>
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<tr>
<td>(5) SPECIFICALLY IDENTIFY EQUIPMENT TO BE REPAIRED:</td>
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<td>(6) ESTIMATED COST OF REPAIR:</td>
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<tr>
<td>(7) GIVE A DETAILED DESCRIPTION OF THE TYPE OF REPAIR AND/OR LABOR TO BE PERFORMED ON EQUIPMENT:</td>
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<tr>
<td>(8) PROVIDER’S NAME:</td>
<td>PROVIDER ID and/or NPI:</td>
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<tr>
<td>(9) STREET ADDRESS:</td>
<td>CITY:</td>
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<td>LINE</td>
<td>DESCRIPTION</td>
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<td>1</td>
<td>RECIPIENT’S NAME</td>
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<td>2</td>
<td>RECIPIENT’S MEDICAID #</td>
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<td>DATE OF REPAIR AND/OR LABOR</td>
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<td>5</td>
<td>SPECIFICALLY IDENTIFY EQUIPMENT TO BE REPAIRED</td>
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<td>7</td>
<td>GIVE A DETAILED DESCRIPTION OF THE TYPE OF REPAIR AND/OR LABOR TO BE</td>
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<td>PERFORMED ON EQUIPMENT</td>
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<td>8</td>
<td>PROVIDER’S NAME &amp; PROVIDER ID AND/OR NPI</td>
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<td>9</td>
<td>STREET ADDRESS AND CITY</td>
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</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)