### FORMS

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<th>Revision Date</th>
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<td>South Carolina Medicaid MedWatch</td>
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<td>Proton Pump Inhibitors Prior Authorization Request</td>
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<td>Growth Hormone Prior Authorization Request – Adult Treatment</td>
<td>09/2015</td>
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<tr>
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<td>Growth Hormone Prior Authorization Request – Pediatric Treatment</td>
<td>09/2015</td>
</tr>
<tr>
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<td>Antipsychotics for Children Ages ≤ 6 Years</td>
<td>09/2015</td>
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<td>Prior Authorization Request – Hepatitis B</td>
<td>09/2015</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization Request – Hepatitis C</td>
<td>05/2010</td>
</tr>
</tbody>
</table>
STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

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

PROGRAM INTEGRITY

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

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

<table>
<thead>
<tr>
<th>SUSPECTED INDIVIDUAL OR INDIVIDUALS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI or MEDICAID PROVIDER ID: (if applicable)</td>
</tr>
<tr>
<td>ADDRESS OF SUSPECT:</td>
</tr>
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<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>COMPLAINT:</th>
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<table>
<thead>
<tr>
<th>NAME OF PERSON REPORTING: (Please print)</th>
<th>SIGNATURE OF PERSON REPORTING:</th>
<th>DATE OF REPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS OF PERSON REPORTING:</td>
<td>TELEPHONE NUMBER OF PERSON REPORTING:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SIGNATURE: (SCDHHS Representative Receiving Report)</td>
<td></td>
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</table>

SCDHHS Form 126 (revised 06/07)
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>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

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

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

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

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

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

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

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

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

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).
Fax: 803-252-0870  or  Mail: Post Office Box 101110
     Columbia, SC  29211-9804

DHHS 931 – Updated February 2018
Electronic Funds Transfer (EFT) Authorization Agreement

REASON FOR SUBMISSION

☐ Change to Current EFT (i.e., account or bank changes) ☐ Individual ☐ Organization

INIVIDUAL PROVIDER/ORGANIZATION INFORMATION

Doing Business as Name (DBA):

Street:

City: State: Zip Code/Postal Code:

Medicaid Provider Number: National Provider Identifier (NPI):

Designate Tax Identification Number (TIN): ☐ SSN (Individual) ☐ EIN (organization)

SSN: - - - EIN: -

ORGANIZATION/INDIVIDUAL PROVIDER EFT CONTACT INFORMATION

Provider Contact Name:

Telephone Number: Extension:

Email Address:

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name:

Financial Institution Address:

City: State: Zip Code/Postal Code: -

Financial Institution Routing Number (Nine digits):

Provider’s Account Number with Financial Institution (Up to 17 digits):

Type of Account at Financial Institution (TRANSIT CODE):

☐ 22 – Checking Account or ☐ 32 – Savings Account

By signing this form, I authorize the SCDHHS to initiate credit entries, if necessary, debit entries for any credits in error to the checking or savings account at the financial institution identified above. Credit entries will pertain only to the SCDHHS payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the SCDHHS to make an adjusting debit entry to the account up to the amount of the excess payment. Credit entries to the above account are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws. I certify that the information shown is correct and agree to provide 30 days written notice to the address shown below prior to revoking or 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 2010 with the transition of Medicaid claims payments to the South Carolina Enterprise Information System (SCeIS). For more information, please visit https://dss.scdhhs.gov/scceis or contact 888-299-0709.

ALL EFT REQUESTS ARE SUBJECT TO A 30-DAY PRENOTICE PERIOD IN WHICH ALL ACCOUNTS ARE VERIFIED BY THE QUALIFYING FINANCIAL INSTITUTION BEFORE ANY MEDICAID DIRECT DEPOSITS ARE MADE.

Signature of Person Submitting Form (must to sign):

Printed Name of Person Submitting Form:

Submission Date:

SPECIAL INSTRUCTIONS: For questions regarding the status of your EFT update, please contact the Provider Service Center at 888-289-0709. Please refer to the EFT section of the provider enrollment manual found at https://www.scdhhs.gov/provider for instructions on how to complete updates to your EFT information.

Effective Jan 01, 2013, providers can link their EFT with their electronic remittance advice (ERA) by a matching EFT Reassociation Trace Number. This trace number will automatically be included in your electronic remittance advice. In order for this trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding the EFT Reassociation Trace Number and ERA can be directed to the Provider Service Center at 888-289-0709.

To process EFT updates, please return this completed form along with verification of your electronic deposit information on your financial institution’s letterhead to:

SCDHHS, Medicaid Provider Enrollment • PO BOX 8809 • Columbia, South Carolina 29202-8809 • FAX 803-870-9022

EFT Authorization Agreement Revision Date: July 30, 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 08/01/17)
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 Audiology Services
□ Psychiatric Hospital Services
□ Rehabilitative/Behavioral Health Services (R/BHS)
□ Rural Health Clinic (RHC)
□ Targeted Case Management (TCM)
□ Other: ____________________________
Section 5: Desired Outcome

Request submitted by:

Print Name: ________________________________

Signature: ________________________________  Date: ________
### NCPDP Universal Claim Form Sample

**Filler Information**

- **Claimant**
  - **Name:** [Print Name]
  - **Address:** [Address]
  - **City:** [City]
  - **State:** [State]
  - **ZIP Code:** [ZIP Code]

- **Employer**
  - **Name:** [Employer Name]
  - **Address:** [Address]
  - **City:** [City]
  - **State:** [State]
  - **ZIP Code:** [ZIP Code]

**Prescription Information**

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Sample Form - Not For Distribution</strong></td>
</tr>
<tr>
<td>2</td>
<td><strong>Sample Form - Not For Distribution</strong></td>
</tr>
</tbody>
</table>

**Claims Reference Information**

- **Date of Injury:** [MM DD CCYY]
- **Claim #:** [Claim Reference ID]

**Incentive/Benefit Information**

- **Prescription I.D.:** [Qual.
  - **Date Written:** [MM DD CCYY]
  - **Date of Service:** [MM DD CCYY]
  - **Fill #:** [Fill #]
  - **Quantity Dispensed:** [QTY Dispensed]
  - **Days Supply:** [Days Supply]

<table>
<thead>
<tr>
<th>DURIPS CODES</th>
<th>PROVIDER I.D.</th>
<th>DIAGNOSIS CODE</th>
<th>QUAL.</th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>B</td>
<td>C</td>
<td></td>
</tr>
</tbody>
</table>

**Other Payer Information**

- **Other Payer Date:** [MM DD CCYY]
- **Other Payer I.D.:** [Qual.]
- **Other Payer Reject Codes:** [Other Payer Reject Codes]
- **Usual & Custom Charge:** [Usual & Cust. Charge]

**Attention Recipient**

Please read Certification Statement on reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.

- Patient/Authorized Representative
# South Carolina Medicaid - MedWatch

## A. Patient Information
1. Patient Name: ________________  
   1. First  2. Last  2. SC Medicaid Recipient's ID #: ________________
3. Date of Birth (mm/dd/yy): ___/___/_____  
4. Sex  
   □ Male  □ Female  5. Weight lbs OR kgs
6. Request Date (mm/dd/yy): ___/___/_____  

## B. Adverse Event or Product Problem
1. □ Adverse Event ~OR~ (please refer to number 2)
2. Outcomes attributed to adverse event (check all that apply)  
   □ Congenital Anomaly  
   □ Death (Date: ___/___/_____)
   □ Disability  
   □ Hospitalization (initial or prolonged)  
   □ Life-threatening  
   □ Required intervention to prevent permanent impairment/damage  
   □ Other: ________________
3. Date of Event (mm/dd/yy): ___/___/_____  
4. Date of this Report (mm/dd/yy): ___/___/_____  
5. Describe Event or Problem:

6. Relevant tests / laboratory data, including dates:

7. Other relevant history, including pre-existing medical conditions (e.g., allergies, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.)

## C. Suspect Medication(s)
1. Drug Name: ________________  
2. Strength: ________________  
3. Therapy Dates (if unknown, give duration)  
   From: ___/___/_____  To: ___/___/_____  (Or: give best estimate)
4. Diagnosis for Use (indication): ________________  
5. Event abated after use stopped or dose reduced?  
   □ Yes  □ No  □ Doesn't Apply  
6. Lot # (if known): ________________
7. Exp. Date (# known): ___/___/_____  
8. Event recurred after reintroduction?  
   □ Yes  □ No  □ Doesn't Apply  
9. NDC # (for product problems only):
10. Concomitant medical products and therapy dates (exclude treatment of event):

## D. Prescribing Physician
Name: ________________  
SC Medical License # (not DEA #): ________________  
Telephone #: ________________  
FAX #: ________________

Signature of Prescriber: ________________

## E. Reporter
1. Name, Address and Phone #: ________________

2. Health professional?  
   □ Yes  □ No
3. Occupation: ________________
4. Also reported to:  
   □ Distributor  
   □ Manufacturer  
   □ User Facility
   If you do NOT want your identity disclosed to the manufacturer, place an "X" in this box: □

Pharmacy Fax Number (if known): (______) ______-________

Submit Requests To: Magellan Medicaid Administration  
Fax: (888) 603-7696  
All Fax requests will be processed in one business day  
To check on the status you may call Telephone: (866) 247-1181  
Web Requests: PA's may be requested on-line see the following website for details: http://southcarolina.fhsc.com/

Revised: May 2010  
MedWatch Form
# South Carolina Medicaid Program

**General Prior Authorization Request Form**

Form must be complete, correct, and legible or the PA process can be delayed.

## I. BENEFICIARY INFORMATION

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Medicaid ID #</th>
<th>Date of Birth (MM/DD/YYYY)</th>
<th>Sex</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Male</td>
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</table>

## II. PRESCRIBER’S INFORMATION

<table>
<thead>
<tr>
<th>Prescriber’s First Name</th>
<th>Prescriber’s Last Name</th>
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<table>
<thead>
<tr>
<th>National Provider ID # (NPI)</th>
<th>Prescriber’s Specialty</th>
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</table>

<table>
<thead>
<tr>
<th>Prescriber’s Phone Number</th>
<th>Prescriber’s Fax Number</th>
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<table>
<thead>
<tr>
<th>Prescriber’s Office Staff Member Completing This Form</th>
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<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Phone</th>
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</table>

## III. DRUG INFORMATION

Prior Authorization requested for the following: (Please check appropriate PA type)

- [ ] Orlistat
  - (Please include information regarding height, weight, diet plans, nutritional counseling, etc., with all orlistat requests)
- [ ] Quantity Limits
- [ ] PDE5 Inhibitor for Pulmonary Arterial Hypertension
- [ ] Other: ____________________________

**NOTE:**

- “Brand Medically Necessary” PA requests require a South Carolina MedWatch form.
- “Growth Hormone” PA requests require a Growth Hormone request form.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dose</th>
<th>Strength</th>
<th>Duration</th>
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<tr>
<th>Diagnosis</th>
<th>ICD Code</th>
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Diagnostic Procedures and Findings (please list dates):

<table>
<thead>
<tr>
<th>Medical Justification for Product Use</th>
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</table>

PRESCRIBER’S SIGNATURE: ____________________________ DATE: ____________

**MAGELLAN RX MANAGEMENT USE ONLY:**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Comments:</th>
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<tr>
<th>MAP RPh/Tech:</th>
<th>NDC:</th>
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</table>
SOUTH CAROLINA MEDICAID PROGRAM
PRIOR AUTHORIZATION REQUEST – PROTON PUMP INHIBITORS

PRESCRIBER: 
NAME: 
FIRST (LAST)

National Provider ID #: 
PHONE #: 
PHONE #: 
FAX #: 

BENEFICIARY: 
NAME: 
FIRST (LAST)

MEDICAID #: 
DATE OF BIRTH: ___/___/___ SEX: □ M □ F

PRESCRIBER’S OFFICE STAFF MEMBER COMPLETING FORM:

PHARMACY: 
PHONE: (___)

Patient’s Diagnosis:

Have any recent GI procedures been performed? (Check and complete ALL that apply.)

Procedure: Upper GI Series Barium Swallow Endoscopy
Date of Procedure: ___/___/___ ___/___/___ ___/___/___
Findings: ________________________________ ________________________________ ________________________________

Has the Patient had a failure (4 week trial) on an acute dose of an H2 Receptor Antagonist in the past 2 years? □ Yes □ No
If Yes, Medication Name: __________________ Streak: _____ Frequency: ______ Date of trial: ___/___/___

Is the Patient H. Pylori positive? □ Yes □ No Date: ___/___/___

Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

SUBMIT REQUESTS TO: MAGELLAN MEDICAID ADMINISTRATION
FAX: (888) 603-7696
All Fax requests will be processed in one business day. To check on the status you may call TELEPHONE: (866) 247-1181
WEB REQUESTS: PA’s may be requested online see the following website for details: http://southcarolina.fhsc.com/

October 2019 
Proton Pump Inhibitors - PA Form
**South Carolina Medicaid Program**  
**Prior Authorization Request Form**  
**Human Growth Hormone – Adult Treatment**

Form must be complete, correct, and legible or the PA process can be delayed.

### I. BENEFICIARY INFORMATION

<table>
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<tr>
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### II. PRESCRIBER’S INFORMATION

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### III. DRUG INFORMATION

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<th>Strength</th>
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* If request is for a non-preferred agent, please include clinical criteria for this particular agent over one of the following: Genotropin®, Norditropin®, Salzinen®

**Dosage Schedule:**

**Diagnosis:**

Initiation of Therapy:  
- Yes
- No

Continuation of Therapy:  
- Yes
- No

**Provocation Stimulation Test and Findings**

1. Is patient receiving full supplementation of deficient pituitary hormones?  
   - Yes
   - No

   1a. If YES, please list:

2. Does the patient have reduced bone mineral density (BMD) using the WHO criteria?  
   - Yes
   - No

   2a. If YES, please provide T-Score:

3. Does the patient have a high-risk lipid profile?  
   - Yes
   - No

   3a. If YES, please provide total cholesterol or LDL level:

4. Does the patient have at least 2 pituitary hormone deficiencies other than Growth Hormone?  
   - Yes
   - No

   4a. If YES, please list:

5. For renewal, is the patient showing improvement?  
   - Yes
   - No

   5a. Increase in BMD per DEXA scan?  
   - Yes
   - No

5b. Reduction in lipid panel?  
   - Yes
   - No

**Document percent reduction:**

---

**PRESCRIBER’S SIGNATURE:**

**DATE:**

Fax completed forms to Magellan Rx Management.  
All fax requests will be processed in one business day.  
To check the status of your request, please call or visit our website.  
Revised: September 2015
# Prior Authorization Request Form

**South Carolina Medicaid Program**

**Human Growth Hormone – Pediatric Treatment**

Form must be complete, correct, and legible or the PA process can be delayed.

## I. BENEFICIARY INFORMATION

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<td>Prescriber's Specialty</td>
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<td></td>
<td>(Note: Must be a Nephrologist or Pediatric Endocrinologist)</td>
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<tr>
<td>Prescriber's Phone Number</td>
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<td>Prescriber's Fax Number</td>
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<td>Prescriber's Office Staff Member Completing This Form</td>
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<tr>
<td>Dose Schedule</td>
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<td>ICD Code</td>
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<td>Diagnosis</td>
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<td>Birth Weight</td>
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<tr>
<td>Gestational Age at Birth</td>
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<tr>
<td>Last Recorded Height</td>
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<td>Date of Measurement</td>
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<td>Last Recorded Weight</td>
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<td>Date of Measurement</td>
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<tr>
<td>Biological Mother’s Height</td>
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<td>Biological Father’s Height</td>
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<tr>
<td>Therapy</td>
<td>Initiation</td>
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<td></td>
<td>Continuation</td>
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<td>Bone Age Studies Results</td>
<td>Open</td>
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<td></td>
<td>Closed</td>
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<tr>
<td>Epiphyses</td>
<td></td>
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<tr>
<td>Has patient been evaluated by:</td>
<td>Endocrinologist</td>
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<td></td>
<td>Pediatric Nephrologist</td>
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<tr>
<td>Current Growth Velocity</td>
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**PLEASE ATTACH COPIES OF GROWTH CHARTS TO THIS REQUEST.**

**PRESCRIBER'S SIGNATURE:**

Date

Fax completed forms to Magellan Rx Management.
All fax requests will be processed in one business day.
To check the status of your request, please call or visit our website.
**Revised: September 2015**

Fax: 888-603-7696
Phone: 866-247-1181
Website: [http://southcarolina.fhsc.com/](http://southcarolina.fhsc.com/)
### South Carolina Medicaid Program

**Prior Authorization Request Form**

**Antipsychotics – Children ≤ 6 Years**

Form must be complete, correct, and legible or the PA process can be delayed.

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**III. DRUG INFORMATION**

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**Dosage Schedule:**

**Diagnosis:**

1. Is the Prescriber a Psychiatrist? Or, has the Prescriber consulted with a Psychiatrist before requesting this medication?  
   - Yes  
   - No

2. Has the patient received a developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target and treatment plans clearly identified and documented?  
   - Yes  
   - No

3. Has informed consent for this medication been obtained from the parent or guardian?  
   - Yes  
   - No

4. Has a family assessment been performed (including parental psychopathology and treatment needs) and have family functioning and parent-child relationship been evaluated?  
   - Yes  
   - No

5. Psychosocial treatment has been in place for at least 12 weeks without adequate clinical response and psychosocial treatment with parental involvement will continue for the duration of medication therapy.  
   - Select YES, if this statement is true.

6. Is the requested medication the only antipsychotic medication the patient will be receiving?  
   - Yes  
   - No

7a. If NO to the question above, is one agent being tapered while titrating another?  
   - Yes  
   - No

7b. Is this request for continuation of an established therapy? Or, for continuation of therapy initiated during an in-patient hospitalization?  
   - Yes  
   - No

7a. If YES to the question above, please document the specific medication:

8. If Tourette’s is listed as the diagnosis, please answer the following questions:

   8a. Has the patient failed treatment with previous therapy (such as clonidine or guanfacine)?  
      - Yes  
      - No

   8b. If YES to the question above, please document the specific medication:

---

**PRESCRIBER’S SIGNATURE:**

**DATE:**

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Fax: 888-603-7696  
Phone: 866-247-1181  
Website: [http://southcarolina.fhs.com/](http://southcarolina.fhs.com/)

Revised: September 2015
South Carolina Medicaid Program
Prior Authorization Request Form
Hepatitis B
Form must be complete, correct, and legible or the PA process can be delayed.

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1. Has the patient had an HIV screen?
   1a. If YES, please document results: [ ] Yes [ ] No

2. Has the patient had a liver biopsy?
   2a. If YES, please document results: [ ] Yes [ ] No

3. Does the patient have compromised renal function?
   3a. If YES, please provide creatinine clearance rate: [ ] Yes [ ] No

** Please attach a copy of lab results noted above with this form for our records **

4. Does the patient have autoimmune hepatitis? [ ] Yes [ ] No
5. Is the patient (or patient’s partner) pregnant? [ ] Yes [ ] No
6. Is there a history of kidney, lung, or heart transplant? [ ] Yes [ ] No
7. Does the patient have uncontrolled depression? [ ] Yes [ ] No
8. Does the patient have severe HTN, heart failure, or CAD? [ ] Yes [ ] No

South Carolina Medicaid has instituted a program to more closely monitor Hepatitis B patients in an attempt to improve medication compliance. To assist in the program, please provide the patient’s phone number(s).

Phone Number #1: ___________________________ Phone #2: ___________________________

Preparer’s Signature: ___________________________ Date: ___________________________

Fax completed forms to Magellan Rx Management.
All fax requests will be processed in one business day.
To check the status of your request, please call or visit our website.
Revised: September 2015

Fax: 888-603-7691
Phone: 866-247-1181
Website: http://southcarolina.fhsc.com/
# SOUTH CAROLINA MEDICAID PROGRAM
## PRIOR AUTHORIZATION REQUEST – HEPATITIS C

**PRESCRIBER:**

**NAME:**

(First) ____________________________ (Last) ____________________________

**National Provider ID #:**

**PHONE #:** (___) ________________

**FAX #:** (___) ________________

**BENEFICIARY:**

**NAME:**

(First) ____________________________ (Last) ____________________________

**MEDIACID #:**

**DATE OF BIRTH:** ___/___/___  **SEX:** ☐ M ☐ F

**REQUEST DATE:** ___/___/___

**PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM:**

**PHARMACY:**

______________________________  **PHONE:** (___) ________________

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<thead>
<tr>
<th>DRUG NAME</th>
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**DIAGNOSIS:**

______________________________

**GENOTYPE:**

______________________________

**INITIAL VIRAL LOAD:** ________________  **DATE TAKEN:** ___/___/___

**HAS THE PATIENT HAD A LIVER BIOPSY?** ☐ Yes ☐ No

If yes, please document results:

**(Please attach a copy of lab results noted above with this form for our records)**

1. Does the patient have autoimmune hepatitis? ☐ Yes ☐ No
2. Is the patient (or patient’s partner) pregnant? ☐ Yes ☐ No
3. Does the patient have a hemoglobinopathy? ☐ Yes ☐ No
   (e.g., sickle cell, thalassemia)
4. Is there a history of kidney, lung or heart transplant? ☐ Yes ☐ No
5. Does the patient have untreated hyperthyroidism? ☐ Yes ☐ No
6. Does the patient have uncontrolled depression? ☐ Yes ☐ No
7. Does the patient have severe HTN, heart failure or CAD? ☐ Yes ☐ No
8. Is the patient going to be taking a Ribavirin? ☐ Yes ☐ No
   If not, please explain contraindication:

South Carolina Medicaid has instituted a program to more closely monitor Hepatitis C patients in an attempt to improve medication compliance. To assist in the program, please provide the patient’s phone number(s):

Submit requests to:

MAGELAN MEDICAID ADMINISTRATION

FAX: (888) 603-7696

All Fax requests will be processed in one business day. To check on the status you may call TELEPHONE: (866) 247-1181

WEB REQUESTS: PA’s may be requested on-line see the following website for details: [http://southcarolina.fhsc.com/](http://southcarolina.fhsc.com/)

Revised: May 2010

Hepatitis C