South Carolina Department of Health and Human Services

Medicaid Credit Balance Report—Claim Detail

P.O. Box 8355 | Columbia, SC 29202-8355 | 803-462-2582 (f) | creditbalancemivs@bcbssc.com

Instructions: *Please complete this form, and submit it to the address or fax number appearing above. Please be sure to address your mailing or fax to: MIVS, Attn: Benefit Recovery-Credit Balance Reporting.*

Provider Information

Provider Name: _____

Provider Legacy Number: _____

Provider NPI Number: _____

Provider Type: _____

Quarter Ending Date: (Please circle the appropriate date.)

Q1: March 31 **Q2:** June 30 **Q3:** September 30 **Q4:** December 31

Beneficiary Information

Beneficiary Name: _____

Medicaid ID Number (MID): _____

Claim Control Number (CCN): _____

Admission Date: _____ Discharge Date: _____ Claim Paid Date: _____

Reimbursement Information

Total Amount Medicaid Paid: _____

Amount of Medicaid Credit Balance Repaid: _____

Method of Payment: (Please check one.)

- ☐ Check Enclosed
- ☐ Auto-debit Requested

Amount of Medicaid Credit Balance Outstanding: _____

Reason for Medicaid Credit Balance: (Please check one.)

- ☐ Provider Health
- ☐ Estate
- ☐ Medicare
- ☐ Casualty

_____ _____ _____

Preparer's Name (Please print) Preparer's Signature Date

Preparer's Contact Telephone Number: _____