

FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	Reasonable Effort Documentation	05/2007
	Authorization Agreement for Electronic Funds Transfer	03/2011
	Duplicate Remittance Advice Request Form	10/2012
CMS-1500	Sample Claim Showing TPL Denial with NPI	08/2005
	Sample Edit Correction Form	10/2008
	Sample Remittance Advice (three pages)	06/2007
DHHS 254	Referral Form/Authorization For Rehabilitative Services	02/2013
	Psychological Testing/Evaluation Example	05/2010
	Treatment Plan Example	04/2010
	Clinical Service Note Example	05/2010
	Medical Necessity Statement for Rehabilitative Services	06/2012
	LIPS Referral Form	06/2012
	LIPS Authorization Form (two pages)	06/2012



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

PROGRAM INTEGRITY

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

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

NPI or MEDICAID PROVIDER ID: (if applicable)

MEDICAID RECIPIENT ID NUMBER: (if applicable)

ADDRESS OF SUSPECT:

LOCATION OF INCIDENT:

DATE OF INCIDENT:

COMPLAINT:

NAME OF PERSON REPORTING: (Please print)

SIGNATURE OF PERSON REPORTING:

DATE OF REPORT

ADDRESS OF PERSON REPORTING:

TELEPHONE NUMBER OF PERSON REPORTING:

SIGNATURE: (SCDHHS Representative Receiving Report)

**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:

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

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



**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:	or	Mail:
803-252-0870		Post Office Box 101110
		Columbia, SC 29211-9804

**III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN
(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)**

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax:	or	Mail:
803-255-8225		Post Office Box 8206, Attention TPL
		Columbia, SC 29202-8206



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION**

PROVIDER _____ **DOS** _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

**I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT
RESPONSE FROM THE PRIMARY INSURER.**

(SIGNATURE AND DATE)

**ATTACH A COPY OF FORM TO THE APPROPRIATE CLAIM OR ECF AND FORWARD TO
YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.**

South Carolina
Department of Health and Human Services
Electronic Funds Transfer (EFT) Authorization Agreement

PROVIDER INFORMATION

Provider Name _____
Medicaid Provider Number _____
Provider NPI Number _____
Provider Address _____
City _____ State _____ Zip _____

BANKING INFORMATION *(Please include a copy of the electronic deposit information on bank letterhead. This is required and the information will be used to verify your bank account information).*

Financial Institution Name _____
Financial Institution Address _____
City _____ State _____ Zip _____
Routing Number (nine digit) _____
Account Number _____

Type of Account (check one) Checking Savings

I (we) hereby 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 my account indicated below and the financial institution named below, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.

I (we) understand that credit entries to the account of the above named payee 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 (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

Contact Name: _____ Phone Number: _____

Signed _____ (Signature)
_____ (Print)

Title _____ Date _____

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.

RETURN COMPLETED FORM & BANK VERIFICATION DOCUMENT TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 870-9022

**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 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:** _____ 4. **Telephone Number:** _____

5. **Requesting:**
 Complete Remittance Package **Remittance Pages Only** **Edit Correction Pages Only**

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

7. **Street Address for delivery of request:**
Street: _____
City: _____
State: _____
Zip Code: _____

8. **Charges for a duplicate remittance advice 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

1500

HEALTH INSURANCE CLAIM FORM

Sample Claim Showing TPL Denial With NPI

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																																												
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890																																												
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John A.										3. PATIENT'S BIRTH DATE MM DD YY 01 01 1999					SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																		
5. PATIENT'S ADDRESS (No., Street) 123 Windy Lane										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																		
CITY Anytown					STATE SC					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY					STATE																																		
ZIP CODE 29999					TELEPHONE (Include Area Code) ()					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE					TELEPHONE (Include Area Code) ()																																		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																		
a. OTHER INSURED'S POLICY OR GROUP NUMBER A123450A										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY										SEX M <input type="checkbox"/> F <input type="checkbox"/>																								
b. OTHER INSURED'S DATE OF BIRTH MM DD YY										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										b. EMPLOYER'S NAME OR SCHOOL NAME																																		
c. EMPLOYER'S NAME OR SCHOOL NAME 0.00										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																																		
d. INSURANCE PLAN NAME OR PROGRAM NAME 401										10d. RESERVED FOR LOCAL USE 1										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED																																												
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI					17b. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																		
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO										\$ CHARGES																																		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 295 32										22. MEDICAID RESUBMISSION CODE										ORIGINAL REF. NO.																																		
2. 3. 4.										23. PRIOR AUTHORIZATION NUMBER																																												
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE EMG					C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER					E. DIAGNOSIS POINTER					F. \$ CHARGES					G. DAYS OR UNITS					H. EPBDT Family Plan					I. ID. QUAL.					J. RENDERING PROVIDER ID. #									
1 01 20 07 01 20 07 11										90804										60 00					2					ZZ					1212121212																			
2																														NPI																								
3																																			NPI																			
4																																								NPI														
5																																													NPI									
6																																													NPI									
25. FEDERAL TAX I.D. NUMBER 555555555										SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. DOE1234					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 60 00					29. AMOUNT PAID \$ 0 00					30. BALANCE DUE \$ 60 00																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.										33. BILLING PROVIDER INFO & PH # (555) 5555555 Jane Smith, MD 111 Main Street Anytown, SC 22222-2222 a. 1234567890 b. ZZ1212121212																																		

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

RUN DATE 05/01/2007 000001204
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 76 SPEC -

CLAIM CONTROL #9999999999999999A
PAGE 1136 ECF 1136 PAGE 1 OF 1

ANALYST ID
SIGNON ID

TAXONOMY:

1 2
PROV/XWALK RECIPIENT
ID ID
ABC123 1111111111
NPI: 1234567890

SFL ZIP:

3 4
P AUTH TPL
NUMBER

PRV ZIP:

5 6 7
INJURY EMERG PC COORD
CODE

DOC IND N

8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
871.3 .

ORIGINAL CCN:

ADJ CCN:

EDITS
INSURANCE EDITS

CLAIM EDITS

LINE EDITS

01) 234

10 RECIPIENT NAME - DOE, JANE

11 DATE OF BIRTH 01/25/1992 12 SEX F

13 14 15 16 17 18 19 20 21 22
RES ALLOWED LN DATE OF PLACE PROC MOD INDIVIDUAL CHARGE PAY UNITS
NO SERVICE CODE PROVIDER IND

23
NDC

** AGENCY USE ONLY **
** APPROVED EDITS **
** REJECTED LINE EDITS **

.00 1 02/01/04 96100 000 000 30.00 001
NPI: 1234567890 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24
INS CARR
NUMBER

25
POLICY
NUMBER

26
INS CARR
PAID

27 TOTAL CHARGE 90.00

01

28 AMT REC'D INS

02

29 BALANCE DUE 90.00

03

30 OWN REF # 012345

RESOLUTION DECISION ____

ADDITIONAL DIAG CODES:

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
ABC GROUP HOME
PO BOX 00000
ANYWHERE XO 00000-0000

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

Sample Remittance Advice (page 2)

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

PROVIDER ID.	DEPT OF HEALTH AND HUMAN SERVICES	CLAIM ADJUSTMENTS	PAYMENT DATE	PAGE
AB11110000	SOUTH CAROLINA MEDICAID PROGRAM		03/26/2007	2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	M I	O D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	0406001089000400U		012107	90804	513.00-	197.71-	1112233333	CLARK	M		022807	0404711253670430A
	01		012107	90804	453.00	160.71-	P				000	
	02		012107	96100	60.00	33.00-	P				000	
	TOTALS		1		513.00-	193.71-						

SAMPLE ONLY

DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
	\$243.71	0.00	0.00	0.00
0.00	ADJUSTMENTS	MAXIMUS AMT	PROVIDER NAME AND ADDRESS	
	\$193.71		ABC GROUP HOME	
YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PO BOX 000000	
0.00	\$50.00	4197304	FLORENCE SC 00000-0000	

Sample Remittance Advice (page 3)

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.

PROVIDER ID.	DEPT OF HEALTH AND HUMAN SERVICES	ADJUSTMENTS	PAYMENT DATE	PAGE
AB11110000	SOUTH CAROLINA MEDICAID PROGRAM		03/26/2007	3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME F M LAST NAME I I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	0408600003700000U	-						DEBIT	-2389.05	
TPL 4	0408600004700000U	-						DEBIT	-1949.90	
TPL 5	0408600005700000U	-						DEBIT	-477.25	
TPL 6	0408600006700000U	-						DEBIT	-477.25	
PAGE TOTAL:									5293.45	0.00

SAMPLE ONLY

DEBIT BALANCE PRIOR TO THIS REMITTANCE	+-----+ 0.00 +-----+	MEDICAID TOTAL	+-----+ 0.00 +-----+	CERTIFIED AMT	+-----+ 0.00 +-----+	FEDERAL RELIEF	+-----+ 0.00 +-----+	TO BE REFUNDED IN THE FUTURE	+-----+ 0.00 +-----+
0.00		ADJUSTMENTS	+-----+ 0.00 +-----+	MAXIMUS AMT	+-----+ 0.00 +-----+	PROVIDER NAME AND ADDRESS			
YOUR CURRENT DEBIT BALANCE	+-----+ 5293.45 +-----+	CHECK TOTAL	+-----+ 0.00 +-----+	CHECK NUMBER	+-----+ ABC GROUP HOME PO BOX 000000 FLORENCE SC 00000-0000 +-----+				

Psychological Testing/Evaluation Example

CLIENT'S NAME: _____

MEDICAID NUMBER: _____

DIAGNOSIS CODE: _____

<u>DATE</u>	<u>TIME</u>	<u>TEST</u>	<u>BILL TIME</u>	<u>UNITS</u>
_____	_____	DIAGNOSTIC INTERVIEW	X MINS	X
_____	_____	WISC-III	Y MINS	Y
_____	_____	WPPSI-R	Z MINS	Z
_____	_____	WAIS-R	A MINS	A
_____	_____	KBIT	B MINS	B
_____	_____	PPVT-R	C MINS	C
_____	_____	BEERY DTVM	*	*
_____	_____	BENDER-GESTALT	*	*
_____	_____	WIAT	*	*
_____	_____	WRAT-3	*	*
_____	_____	BURKS BEH RATING SCALE	*	*
_____	_____	ADDES-HOME VERSION	*	*
_____	_____	MMPI-A	*	*
_____	_____	MMPI-2	*	*
_____	_____	BECK DEPRESSION INV	*	*
_____	_____	BECK ANXIETY INV	*	*
_____	_____	BECK HOPELESSNESS SCALE	*	*
_____	_____	REYNOLDS CHILD DEP SCALE	*	*
_____	_____	REYNOLDS ADOL DEP SCALE	*	*
_____	_____	CHILDREN'S DEPRES. INV	*	*
_____	_____	REYNOLDS SUICIDE IDEA	*	*
_____	_____	RCMAS	*	*
_____	_____	ROBERTS APPERCEPTION	*	*
_____	_____	RORSCHACH INKBLOT	*	*
_____	_____	SENTENCE COMPLETION	*	*
_____	_____	KINETIC FAMILY DRAWING	*	*
_____	_____	FACES	*	*
_____	_____	ISEL	*	*
_____	_____	FAMILY EVAL SCALE	*	*
_____	_____	OTHER	*	*

PSYCHOLOGIST'S SIGNATURE: _____

DATE: _____

NOTE: THIS SAMPLE IS INTENDED AS A GUIDE TO ASSIST PROVIDERS IN IDENTIFYING MEDICAID DOCUMENTATION REQUIREMENTS. EACH PROVIDER SHOULD TAILOR HIS/HER DOCUMENTATION TO APPROPRIATELY REFLECT THE SERVICES RENDERED.

Revised 05/2010

INDIVIDUAL PLAN OF CARE

Beneficiary: _____ Birth Date: / /
 Medicaid ID#: _____
 Diagnosis: _____

Reasons for Referral / Presenting Problems:

Goals/ Objectives	Specific Intervention	Criteria for Achievement	Frequency	Target Date	Completion Date
1				/ /	/ /
2.				/ /	/ /
3.				/ /	/ /
4.				/ /	/ /

SAMPLE ONLY

Individual Plan of Care
(04/2010 Version)

 Primary Caregiver Signature Date Authorized Clinical Staff Signature /Title Signature Date

 Other Caregiver Signature Date Beneficiary's Signature Date

**MEDICAL NECESSITY STATEMENT PHYSICIAN REFERRALS
FOR
REHABILITATIVE SERVICES**

Beneficiary's Name: _____ Social Security Number: _____

Date of Birth: _____ Medicaid Number: _____

Diagnosis code(s): _____

[Diagnosis codes must be based on the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* or the *International Classification of Diseases (ICD)*.]

I recommend that the above-named Medicaid beneficiary receive Rehabilitative Services(s) for the maximum reduction of emotional, behavioral, and functional developmental delays and restoration of the beneficiary to his or her best possible functioning level. This beneficiary meets the Medical Necessity criteria for Rehabilitative Services as evidenced by a Psychiatric diagnosis from the current edition of the DSM or ICD.

Indicate the specific Rehabilitative Service(s) being recommended on each line below.

Rehabilitative Service(s): _____, _____, _____

Rehabilitative Service(s): _____, _____, _____

Rehabilitative Service(s): _____, _____, _____

Identify the Beneficiary's problem areas for Rehabilitative Services listed above. The recommendation must be based on recent clinical information, staffing recommendations, review(s) of treatment history and/ or evaluation(s) made within federal and state standards

 (Signature of Physician)

 (Professional Title)

 (Please print name signed above)

 Phone Number)

Signature Date: _____ (Services must be initiated within 45 calendar days.)

Must be handwritten

 Name of referred LIP

 Fax # of LIP

 NPI of referred LIP

**SEND REQUESTS TO: KePRO
 FAX (855-300-0082), PHONE (855-326-5219) OR VIA WEB PORTAL (<http://scdhhs.kepro.com>)**

Note: The Referral/Authorization for Rehabilitative Services form (the KePro Prior Authorization form) and the MNS must be sent to the provider prior to the provision of services, or at the time the services are rendered.



**REFERRAL FOR
LICENSED INDEPENDENT PRACTITIONER SERVICES (LIPS)**

**ONLY TO BE USED BY THE PHYSICIAN FOR SERVICES NOT REQUIRED TO
BE LISTED ON THE INDIVIDUAL PLAN OF CARE**

Beneficiary Name: _____ Beneficiary Medicaid ID#: _____
Referred To: _____ Practitioner NPI: _____
Address: _____ Phone#: _____ Fax#: _____
City/State/Zip Code: _____

Requested service for referral (check item):	<u>Number of Units Billed</u>
<input type="checkbox"/> Crisis Management (H2011) in 15-minute increments	_____
<input type="checkbox"/> Behavioral Health Screening (H0002) in 15-minute increments	_____
<input type="checkbox"/> Psychological Evaluation and Testing (96101) in 60 minutes increments	_____
<input type="checkbox"/> Diagnostic Assessment – Initial Comprehensive (H2000) per encounter	_____

Reason for referral (check item):

An emergency situation/crisis Information to assist with determining Medical Necessity

Physician's Name: _____ Physician's NPI: _____
(Please print)
Physician's Signature: _____ Signature Date: _____
Physician's Phone #: _____ Physician's Fax #: _____

**SEND REQUESTS TO: KePRO
FAX (855-300-0082), PHONE (855-326-5219) OR VIA WEB PORTAL (<http://scdhhs.kepro.com>)**

SEND A COPY/FAX TO THE LIP

FILL OUT COMPLETELY TO AVOID DELAYS/DENIALS

Client name: _____ Address _____ DOB _____

Medicaid ID # _____ Service Address Location: _____

Licensed Independent Practitioner (LIP) referred to: _____ Ind. NPI #: _____
 FAX _____

Current clinical information: Make a selection below by circling the appropriate choice on the scale. 0=None 1=Mild 2=Moderate 3=Severe 4=Extreme

	0	1	2	3	4		0	1	2	3	4						
Aggression						Depression						Relationship Problems					
Abuse (PTSD)						Harm to self						Medical Illness					
Anxiety Panic						Harm to others						Memory deficit					
Appetite Disturbance						Hallucinations						Sleep disturbance					
Attention/Concentration						Impulsivity						Substance Abuse					
Deficits in ADLs						Job/School Problems						Other (note below)					
Delusions						Mania						Current Stressors					

If harm self or others, is there a plan: Yes or No (provide supporting documentation) _____

If other or current stressor listed as a 3 or 4 please list: _____

Psychiatric Hospitalization: Yes No If Yes indicate dates: _____

Treatment/Discharge Planning Goals:

(examples of treatments can include Behavior modification, client centered, CBT, Family Therapy, Interpersonal, Medication Management or Other. If other, please be specific and provide explanation below.)

DSM IV TR: Diagnosis (es)	Goals	Type of Treatment Interventions (see above)	Outcomes Progress/Anticipated Discharge
Axis I	1.	1.	1.
Axis II	2.	2.	2.
Axis III	3.	3.	3.

