

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	06/2007
	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	06/2007
DHHS 254	Referral Form/Authorization for Rehabilitative Services	02/2013
	Medical Necessity Statement for Rehabilitative Services	05/2010
	RBHS Provider Enrollment for LEA	07/2012
	Sample Attestation Letter (two pages)	05/2010
	MAPPS Documentation Points	
	MAPPS Screening Form (four pages)	10/2006
	MAPPS Case Plan	10/2006
	MAPPS Individual or Group Session Form (two pages)	02/2013



**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.

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 - Claim Adjustment Form 130

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

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Grid for Original CCN (15 boxes)

Provider ID:

Grid for Provider ID (6 boxes)

NPI:

Grid for NPI (10 boxes)

Recipient ID:

Grid for Recipient ID (10 boxes)

Adjustment Type:

- Void, Void/Replace

Originator:

- DHHS, MCCS, Provider, MIVS

Reason For Adjustment: (Fill One Only)

- Insurance payment different than original claim, Medicaid paid twice - void only, Keying errors, Incorrect provider paid, Incorrect recipient billed, Incorrect dates of service paid, Voluntary provider refund due to health insurance, Provider filing error, Voluntary provider refund due to casualty, Medicare adjusted the claim, Voluntary provider refund due to Medicare, Other

For Agency Use Only

Analyst ID:

Grid for Analyst ID (6 boxes)

- Hospital/Office Visit included in Surgical Package, Independent lab should be paid for service, Assistant surgeon paid as primary surgeon, Multiple surgery claims submitted for the same DOS, MMIS claims processing error, Rate change, Web Tool error, Reference File error, MCCS processing error, Claim review by Appeals

Comments:

Signature: _____ Date: _____

Phone: _____

**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

Local Education Agency Services
Sample Claim Showing TPL Denial
With NPI

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 0805

PICA										PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> FECA BK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S ID. 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 SEX 01 01 1999 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
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"/>									
CITY Anytown					STATE SC					CITY					STATE				
ZIP CODE 29999					TELEPHONE (Include Area Code) ()					ZIP CODE					TELEPHONE (Include Area Code) ()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE 1									
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. Signature on File										11. INSURED'S POLICY GROUP OR FECA NUMBER A12345									
SIGNED _____ DATE _____										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
14. DATE OF CURRENT: MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 784 5										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO # CHARGES									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
B. PLACE OF SERVICE										23. PRIOR AUTHORIZATION NUMBER									
C. EMG										F. # CHARGES									
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										G. DAYS OR UNITS									
E. DIAGNOSIS POINTER										H. EPSON Family Plan									
I. ID. QUAL.										J. RENDERING PROVIDER ID. #									
1 01 20 07 01 20 07 12 92508										108 00 2 ZZ 1212121212									
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX ID. 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 \$ 108 00									
29. AMOUNT PAID \$ 0 00										30. BALANCE DUE \$ 108 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.)										32. SERVICE FACILITY LOCATION INFORMATION									
SIGNED _____ DATE _____										33. BILLING PROVIDER INFO & PH # (555) 5555555									
a. NPI										ABC School District									
b. 1234567890										111 Main Street									
c. ZZ1212121212										Anytown, SC 22222-2222									

RUN DATE 05/01/2007 000001204

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

CLAIM CONTROL #999999999999999999A

REPORT NUMBER CLM3500

EDIT CORRECTION FORM

PAGE 1136 ECF 1136 PAGE 1 OF 1

ANALYST ID

HIC - 76 PRAC SPEC -

EMC Y

SIGNON ID

DOC IND N

ORIGINAL CCN:

TAXONOMY:

SFL ZIP:

PRV ZIP:

ADJ CCN:

1 2

3 4

5 6 7

8 9

EDITS

PROV/XWALK RECIPIENT

P AUTH TPL

INJURY

EMERG PC COORD

---- DIAGNOSIS ----

INSURANCE EDITS

ID ID

NUMBER

CODE

PRIMARY SECONDARY

CLAIM EDITS

ABC123 1111111111

V71.02 .

NPI: 1234567890

CLAIM EDITS

LINE EDITS

01) 712 951

10 RECIPIENT NAME - DOE, JANE

11 DATE OF BIRTH 01/25/1992

12 SEX F

13

14

LN

15 DATE OF

16 PLACE

17 PROC

18 MOD

19 INDIVIDUAL CHARGE

20 PAY

21 UNITS

** AGENCY USE ONLY **

RES

ALLOWED

NO

SERVICE

CODE

PROVIDER

IND

** APPROVED EDITS **

23

NDC

** REJECTED LINE EDITS **

**

.00 1

02/01/00

99

H2020

HA

900MXH

836.00

017

NPI: 1234567890

TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

2 / /

! CLAIMS/LINE PAYMENT INFO !

NPI:

TAXONOMY:

! !

3 / /

! EDIT PAYMENT DATE !

NPI:

TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

4 / /

NPI:

TAXONOMY:

5 / /

NPI:

TAXONOMY:

6 / /

NPI:

TAXONOMY:

7 / /

NPI:

TAXONOMY:

8 / /

NPI:

TAXONOMY:

NPI:

TAXONOMY:

24

25

26

INS CARR NUMBER

POLICY NUMBER

INS CARR PAID

27 TOTAL CHARGE 836.55

01

28 AMT REC'D INS

02

29 BALANCE DUE 836.55

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 SCHOOL DISTRICT 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 1)

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.

```

# AB0008 ABC SCHOOL DISTRICT                PO BOX 000000                FLORENCE                SC000000000
.121212121234.                                Y
PROVIDER ID.                                PROFESSIONAL SERVICES                PAYMENT DATE                PAGE
+-----+ DEPT OF HEALTH AND HUMAN SERVICES                +-----+
| AB00080000 |                REMITTANCE ADVICE                | 03/26/2007 |                | 1 |
+-----+ SOUTH CAROLINA MEDICAID PROGRAM                +-----+
  
```

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	0406001089000400A				1192.00	243.71	P	1112233333	M CLARK			0.00	
	01		021507	H2020	800.00	117.71	P			HA			0.00
	02		021507	H2021	392.00	126.00	P						0.00
	VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0406001089000400U				1412.00-	273.71-		1112233333	M CLARK				
	01		012107	H2020	1112.00-	143.71-				HA			
	02		012107	H2021	300.00-	130.00-							
	REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0407701389002500A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		012107	H2020	142.50	42.75	P			HA			0.00
	02		012107	H2021	859.00	0.00	R						0.00
	TOTALS			2	2193.50	286.46						0.00	0.00

	\$286.46			
FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".	CERT. PG TOT \$0.00	MEDICAID PG TOT \$286.46		STATUS CODES: P = PAYMENT MADE R = REJECTED S = IN PROCESS E = ENCOUNTER
IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.	CERTIFIED AMT \$0.00	MEDICAID TOTAL 0.00		PROVIDER NAME AND ADDRESS ABC SCHOOL DISTRICT PO BOX 000000 FLORENCE SC 00000-0000
	FEDERAL RELIEF MAXIMUS AMT	CHECK TOTAL		CHECK NUMBER

Sample Remittance Advice (page 2)

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

PROVIDER ID.	CLAIM ADJUSTMENTS	PAYMENT DATE	PAGE
DEPT OF HEALTH AND HUMAN SERVICES 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 I	M F M O	ORG CHECK DATE	ORIGINAL CCN
ABB222222	0406001089000400U				513.00-	197.71-	1112233333	CLARK	M	022807	0404711253670430A
	01		012107	H2020	453.00	160.71- P					
	02		012107	H2021	60.00	33.00- P			HA		
	TOTALS		1		513.00-	193.71-					

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

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

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

NATIONAL PROVIDER IDENTIFIER #

BENEFICIARY'S MEDICAID #

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

REFERRED TO:

AUTHORIZATION DATE:

EXPIRATION DATE:

Last Date of Service

Name			County			Address		
Date of Birth	Sex	Agency Reference No.		City		State	Zip	
Prior Authorization Number <i>(1st two letters reflect the agency's origin. Remaining 5 characters are left up to referring agency or SCDHHS QIO.)</i>				Parent/Guardian				

The provider named above is hereby authorized to render the following service(s) on or within the designated time period for the Medicaid-eligible beneficiary which is not to exceed 6 months. The number of units and staff to provide services should be based on the medical needs of the beneficiary and from the referral source. Please refer to the Rehabilitative Behavioral Health Service Provider Manual for Modifiers and Procedure codes. Only the number of units authorized may be billed.

✓	Service Description	Procedure Code	Modifier	Unit	Total Units Authorized	Frequency
	Assessment Services					
	Behavioral Health Screening	H0002		15 minutes		
	Diagnostic Assessment without medical	90791	AH,HO	Per Encounter		
	Diagnostic Assessment with medical	90792	AF,AM,SA	Per Encounter		
	Psychological Testing / Evaluation	96101	AH	60 minutes		
	Comprehensive Evaluation – Initial	H2000	AH,HO	Per Encounter		
	Comprehensive Evaluation – Follow up	H0031	AH,HO	Per Encounter		
	Treatment Plan Development Services					
	Service Plan Development (Mental Health)	H0032	AH,HO,HN	15 minutes		
	Interdisciplinary Tem-Service Plan Development (Team w/ Client)	99366		Per Encounter		
	Interdisciplinary Tem-Service Plan Development (Team w/o Client)	99367		Per Encounter		
	Therapy Services					
	Individual Psychotherapy	90832, 90834 90837		Per Encounter		
	Group Psychotherapy	90853		Per Encounter		
	Family Psychotherapy w/o client	90846		Per Encounter		
	Family Psychotherapy with client	90847		Per Encounter		
	Community Support Services					
	Crisis Management	H2011		15 minutes		
	Medication Management	H0034		15 minutes		
	Rehabilitative Psychosocial Service	H2017		15 minutes		
	Behavior Modification (B-Mod)	H2014		15 minutes		
	Family Support	S9482		15 minutes		

Authorizing Agency: (One must be marked)

- Department of Social Services
- Department of Mental Health
- Continuum of Care For Emotionally Disturbed Children
- Department of Disabilities and Special Needs
- Department of Juvenile Justice
- School District / Department of Education
- United Way
- SCDHHS Quality Improvement Organization

Authorized Agency Representative

Title

Phone

Signature

Date

State Agency Use Only:

**MEDICAL NECESSITY STATEMENT
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 the ICD.

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

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 or other Licensed Practitioner of the Healing Arts)

 (Professional Title)

 (Please print name signed above)

 (Phone Number)

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

Must be handwritten

Note: The Referral/Authorization for Rehabilitative Services form (DHHS Form 254) and the MNS must be sent to the provider prior to the provision of services, or at the time the services are rendered.



To: Existing and New Local Education Agencies (LEA):

In order to ensure a smooth transition to Rehabilitative Behavioral Health Services (RBHS), please submit the following information to the Division of Family Services as soon as possible:

1. LEA providers must submit a completed Attestation Statement which confirms that you will comply with all RBHS policies and procedures. This letter must be on the organization's letterhead and the statements to which the LEA provider is attesting to may be found in the sample attestation letter attached. The attestation must be signed by the LEA Director.
2. Submit a list detailing the specific RBHS that your LEA intends to provide. The list of RBHS can be found in the RBHS Policy Manual, Section 2 located on the DHHS website at www.scdhhs.gov. DHHS will have the LEA Manual available on line prior to July 1, 2010.
3. Submit a list detailing the licensed professional staff employed that may be supervising or rendering the RBHS. The list must include the staff's name, credentials, professional license held (i.e., LPC), and license number.

Please submit the above-referenced information to the following:

Division of Family Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

or please fax to 803-255-8204

Thank you for your participation.

Sample Attestation Letter

An individual who has the legal authority to obligate the Local Education Agency (LEA) must sign the attestation. The Letter must be on the LEA's letterhead.

<Name of the LEA
<Address and site location of Services
<City, State, Zip Code
<Telephone Number
<Fax Number
<NPI registered with Medicaid
<DHHS prior authorization prefix

To: SC DHHS (Division of Family Services)

I make the following certification concerning Medicaid Rehabilitative Behavioral Health Services. Based upon my personal knowledge and belief, I attest that the <name of LEA> will be in compliance with all of the Medicaid policy requirements set forth in the Rehabilitative Behavioral Health Services Policy Manual, effective July 1, 2010 and agree to comply with all future terms, conditions, standards, and updates as established by the South Carolina Department of Health and Human Services (SCDHHS).

I attest that the <name of LEA> agrees to accept the reimbursement fee schedule determined by the South Carolina Department of Health and Human Services.

I certify that the < name of LEA > acknowledges the right of SCDHHS (or its designee) to conduct an on-site audit at any time to validate compliance with the requirements of Medicaid Rehabilitative Behavioral Health Services and to investigate complaints lodged against < name of LEA >.

I certify that the < name of LEA > is enrolled with the SC Medicaid Program and in good standing.

I certify that the < name of LEA > is in compliance with all applicable sections of the Medicaid policy that govern staff education and qualifications, including work experience, background screenings (i.e., criminal record checks, child abuse/central registry checks, sexual offender registry checks and motor vehicle record checks), training requirements, etc...

I attest that the < name of LEA > meets all of the applicable state licensure requirements and insurance coverage as applicable during the terms of Medicaid enrollment.

I certify to the best of my knowledge and belief that < name of LEA > and/or its Principals are not presently debarred or suspended.

In addition, I will notify the SC Medicaid Program if I vacate this position so that an attestation can be submitted by my successor. I will also notify the participating state agencies and other agencies as appropriate if it is my belief that < name of LEA > is out of compliance with the Medicaid requirements .

Signature,

<Printed Name>

<Title>

<Date>

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES DOCUMENTATION POINTS

S9445-FP — Patient Education, not otherwise classified, non-physician provider, Individual, per session. Address a minimum of three (3) documentation points from the list below plus the client's response.

S9446-FP — Patient Education, not otherwise classified, non-physician provider, Group, per session. Address a minimum of five (5) documentation points from the list below plus the client's response.

- 1) Discussion of adolescent development as it relates to human growth, development, sexuality, and pregnancy prevention
- 2) Information on the importance of family planning, responsible sexual behavior, and its effect on overall reproductive health
- 3) Discussion of the benefits of abstinence as it relates to normal growth and development for teens and pregnancy prevention
- 4) Discussion of the benefits of delaying sexual activity as it relates to healthier birth outcomes and pregnancy prevention
- 5) Discussion of the benefits of delaying pregnancy
- 6) Discussion of the long- and short-term health risks related to early sexual activity
- 7) Discussion of birth control methods, including abstinence, and the options available
- 8) Instruction on the proper and appropriate use of birth control methods
- 9) Importance of compliance with prescribed family planning methods and follow-up medical visits
- 10) Information on the benefits and risks of long-term birth control methods
- 11) Identification of family planning problems
- 12) Discussion of the availability of other health care resources related to family planning
- 13) Information on STDs and prevention of STDs as it relates to reproductive health and family planning

SCREENING FORM

1. Name of Participant: (First, Middle Initial, Last) _____

2. Case Number Identification:

Medicaid Number	
Social Security Number	
Patient Account Number	

3. Eligibility: Medicaid Foster Care Child Protective Services

4. Date of Assessment: (Month, Date, Year) _____

5. Age of Participant: _____ Date of Birth: (Month, Date, Year) _____

6. Gender of Participant: Male Female

7. Racial or Ethnic Background of Participant: (Check one)

- White or Anglo, Not of Hispanic Origin Asian or Pacific Islander Black, Not of Hispanic Origin
 Hispanic American Indian Other: _____

8. Parent/Guardian: _____ SSN: _____

Environmental

9. Address of Participant:

Street Address:		
Mailing Address: (If Different from Street Address)		
City/Town:	State:	Zip Code:
Telephone: (Home)	(Other)	<input type="checkbox"/> No Telephone

10. Household Members:

Name	Relationship to Participant	Age	Grade	School or Place of Employment of Household Members

11. Financial Support: (Check All That Apply)

- Employment Unemployment Benefits Family Independence Food Stamps
 Social Security Disability Other: (Specify) _____

12. Dwelling and Living Conditions:

- Apartment House Manufactured Home Public Housing
 Own Rent Housing Assistance Other: _____
 Condition of the Home: _____

13. Access to Transportation: (Check One)

- Have Transportation No Transportation Have Access to Transportation No Access to Transportation

14. Name of the Head of Household: _____ SSN: _____

15. Household Income: (Check One)

- Less than \$9,900 \$10,000 - \$12,000 \$12,001 - \$14,999 Over \$15,000

16. Employment Status of the Mother/Guardian: Full-Time Part-Time Not Employed Other: _____

17. Employment Status of the Father/Guardian: Full-Time Part-Time Not Employed Other: _____

18. Marital Status of Parent (s): Married Single Separated Widowed Other: _____

19. Does Parent (s), guardian or other household member have a history of drug/alcohol abuse?

- Yes No Unknown

If yes, specify name of individual and relationship to participant: _____

Type of drug/alcohol: _____

Referral/ Health Risk Factors

20. What was the referral source for MAPPS? (Check One)

- DSS Teacher Counselor Relative Friend Other: (Specify) _____

21. Referral Risk Factor (s): (Check All That Apply)

- Parent (s) were Teen Parents Sibling is Pregnant and/or Teen Parent Participant is a Teen Parent
 Peer Pressure to engage in sexual activity is identified as a problem by the adolescent
 Participant is Sexually Active and/or has a history of Sexual Abuse

22. Is the participant currently sexually active? Yes No

If no, has the participant ever been sexually active? Yes No

23. Has the participant ever been an expecting parent (abortion/fetal death)? Yes No

24. Has the participant ever used a birth control method? Yes No

Method Used: (Check All That Apply)

- Birth Control Pills Condom Depo-Provera Shot Diaphragm IUD Norplant
 Rhythm Other: _____

25. Does the participant understand or know the health risks associated with having sex? Yes No

26. Has the participant ever had a STD? Yes No If yes, specify: _____

27. Has the participant ever experimented with alcohol, tobacco, and/or other drugs? Yes No

If yes, what kind? _____

Educational/Career

28. Name of school the participant attends: _____

29. Present grade of participant: _____

30. Special needs of the participant: (Check All That Apply)

None Attention Deficit Disorder (ADD) Learning Disability Emotionally Handicapped

Other: (Specify) _____

31. What are the parent/guardian's educational/career goals for the participant? (Check One)

Partial High School High School Diploma College (B.S., etc.) Professional Degree (Ph.D., etc.)

Technical School Work Don't Know Other: _____

What are the participant's education/career goals? (Check One)

Partial High School High School Diploma College (B.S., etc.) Professional Degree (Ph.D., etc.)

Technical School Work Don't Know Other: _____

32. Does the participant engage in extracurricular activities? Yes No

If yes, list activities: _____

33. How does the participant spend his/her free time?

After School: _____

Weekends: _____

34. Does the participant have any household rules to follow? Yes No

If yes, what are some household rules that the participant has to follow? (Keep Room Clean, Do Housework, Wash Dishes or Cook, Curfew, No Dating, Do School Work, etc.)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Does the participant abide by the rules? Always Most of the time Sometimes Rarely Not at all

35. Do the household rules cause any conflict for the parent/guardian and the participant? Yes No

If yes, explain: _____

What are the parent/guardian's and the participant's feelings about the household rules? _____

36. Does the participant have a curfew? Yes No

If yes, specify time and day (s) of the week: _____

Does the participant adhere to the curfew? Always Most of the time Sometimes Rarely Not at all

37. Does participant have friends? Yes No

If yes, gender and age? _____

When they spend time together, what do they do? _____

How does the participant get along with friends? _____

38. How does the participant get along with adults? (Including teachers) _____

CASE PLAN
Treatment Protocol (T1023-FP)

Participant's Name _____ Medicaid Number _____

Needs Statement: _____

Plan of Care: _____

Goals and Objectives	Frequency	Completion Date

This ICP will be reviewed on (6 months from ICP date): _____

Date Reviewed: _____ (Review case plan during Individual Session)

Participant's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

(Provider of Service)
Licensed/Certified Signature: _____

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES

Individual or Group Session Form

Participant's Name: _____

Date of Service: _____ **DOB:** _____ **Age:** _____

Medicaid Number: _____ **Individual** **Group**

Place: Participant's Home Office School Other **Units of Service:** _____

Risk Factors: (Check All That Apply)

- Participant is a Teen Parent Peer Pressure to engage in sexual activity is identified as a problem by the adolescent
- Participant is sexually and/or has a history of sexual abuse

A narrative description of services must be provided. Documentation of session must support time billed and points discussed. Check the Documentation Points discussed:

- 1. Discussion of adolescent development as it relates to human growth, development, sexuality, and pregnancy prevention
- 2. Information on the importance of family planning, responsible sexual behavior, and its affect on overall reproductive health
- 3. Discussion of the benefits of abstinence as it relates to normal growth and development for teens and pregnancy prevention
- 4. Discussion of the benefits of delaying sexual activity as it relates to healthier birth outcomes and pregnancy prevention
- 5. Discussion of the benefits of delaying pregnancy
- 6. Discussion of the long and short-term health risks related to early sexual activity
- 7. Discussion of birth control methods, including abstinence, and the options available
- 8. Instruction on the proper and appropriate use of birth control methods
- 9. Importance of compliance with prescribed family planning methods and follow up medical visits
- 10. Information on the benefits and risks of long term birth control methods
- 11. Identification of family planning problems
- 12. Discussion of the availability of other health care resources related to family planning
- 13. Information on STDs and prevention of STDs as it relates to reproductive health and family planning

