

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 Medicare Denial with NPI	08/2005
CMS-1500	Sample Claim Showing Medicare Denial with NPI and Medicaid Provider ID	08/2005
	Sample Edit Correction Form	10/2008
	Sample Remittance Advice	06/2007
DHHS 168IS	Physician Certification of Incontinence Form	05/2013



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

For Agency Use Only

Analyst ID:

Grid for Analyst ID (5 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

Home Health Services
Sample Claim Showing Medicare Denial
with NPI

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/05

Form containing fields for patient information (name, address, birth date), insurance details (policy number, group), and provider information (signature, NPI, address). Includes a table for services rendered with columns for date, procedure, charges, and provider ID.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Home Health Services
Sample Claim Showing Medicare Denial
with NPI and Medicaid Provider ID

CARRIER

Form with fields for patient information (Name: Doe, John A., Birth Date: 01/01/1947), insurance details (Medicare/Medicaid), provider information (Signature on File, NPI: 1234567890), and a table of services with charges (Total Charge: \$300.00).

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

RUN DATE 05/01/2007 000001204

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

CLAIM CONTROL #9999999999999999A

REPORT NUMBER CLM3500

EDIT CORRECTION FORM

PAGE 1136 ECF 1136 PAGE 1 OF 1

ANALYST ID

HIC - 60 PRAC SPEC - 12

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

569.81

NPI: 1234567890

CLAIM EDITS

LINE EDITS

01) 892

10 RECIPIENT NAME - DOE, JANE

11 DATE OF BIRTH 01/25/1992

12 SEX F

13

14

LN

15

16

17

18

19

20

21

22

** AGENCY USE ONLY **

RES

ALLOWED

NO

DATE OF SERVICE

PLACE

PROC

MOD

INDIVIDUAL PROVIDER

CHARGE

PAY

UNITS

** APPROVED EDITS **

23

NDC

** REJECTED LINE EDITS **

**

.00 1

01/02/04

12

T1030

000

HHA000

100.00

1.000

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

NPI: 1234567890

TAXONOMY:

! CLAIMS/LINE PAYMENT INFO !

2

/

/

! !

NPI:

TAXONOMY:

! EDIT PAYMENT DATE !

3

/

/

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

NPI:

TAXONOMY:

4

/

/

NPI:

TAXONOMY:

5

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NPI:

TAXONOMY:

6

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NPI:

TAXONOMY:

7

/

/

NPI:

TAXONOMY:

8

/

/

NPI:

TAXONOMY:

24

25

26

INS CARR NUMBER

POLICY NUMBER

INS CARR PAID

27 TOTAL CHARGE 100.00

01

28 AMT REC'D INS

02

29 BALANCE DUE 100.00

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:
CORRECTIVE HOME HEALTH
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 ACME Home Health .121212121234. PROVIDER ID.	Y	PO BOX 000000 FLORENCE SC000000000	DEPT OF HEALTH AND HUMAN SERVICES REMITTANCE ADVICE	PAYMENT DATE 03/26/2007	PAGE 1
SOUTH CAROLINA MEDICAID PROGRAM					

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 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	V2624	800.00	117.71 P			OHH			0.00
	02		021507	V2623	392.00	126.00 P			OHH			0.00
VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0406001089000400U				1412.00-	273.71-	1112233333	M CLARK				
	01		012107	V2624	1112.00-	143.71-			OHH			
	02		012107	V2623	300.00-	130.00-			OHH			
REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0407701389002500A				1001.50	42.75 P	1112233333	M CLARK			0.00	
	01		012107	V2624	142.50	42.75 P			OHH			0.00
	02		012107	V2623	859.00	0.00 R			OHH			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".

IF YOU STILL HAVE QUESTIONS+
PHONE THE D.H.H.S. NUMBER
SPECIFIED FOR INQUIRY OF
CLAIMS IN THAT MANUAL.

FEDERAL RELIEF

CERT. PG TOT

\$0.00

CERTIFIED AMT

\$0.00

MAXIMUS AMT

MEDICAID PG TOT

\$286.46

MEDICAID TOTAL

0.00

CHECK TOTAL

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

CHECK NUMBER

PROVIDER NAME AND ADDRESS

ACME HOME HEALTH SERVICES
PO BOX 000000
FLORENCE SC 00000-0000

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 S PAYMENT T MEDICAID S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME I I	M F M I I	ORG O D	CHECK DATE	ORIGINAL CCN
ABB222222	0406001089000400U				513.00-	197.71-	1112233333	CLARK	M		022807	0404711253670430A
	01		012107	V2624	453.00	160.71-	P			OHH		
	02		012107	V2623	60.00	33.00-	P			OHH		
	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- +-----+	+-----+ +-----+	+-----+ ACME HOME HEALTH SERVICES +-----+	
YOUR CURRENT DEBIT BALANCE	+-----+ 0.00 +-----+	+-----+ CHECK TOTAL	+-----+ CHECK NUMBER	+-----+ PO BOX 000000 FLORENCE SC 00000-0000 +-----+
		+-----+ \$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

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



PHYSICIAN CERTIFICATION OF INCONTINENCE

TO: _____ FROM _____
(Name of Physician)

(Address)

(City, State) (ZIP)

BENEFICIARY'S NAME: _____

SOCIAL SECURITY #: _____ DOB _____

Please complete the areas below and return to the "FROM" address above. This beneficiary is requesting incontinence supplies (includes diapers/briefs/pull-ups, wipes, and/or underpads) through the Medicaid Home Health benefit. In order to qualify the beneficiary must have one of the following conditions. Please check any that apply. The form must be fully completed.

- Incontinent of bladder
- Incontinent of bowel

How long is this condition likely to continue? _____

What is the diagnosis related to incontinence?

Does this beneficiary use any appliances (e.g. catheter, ostomy) to prevent incontinence? If so, please list _____

Comments: _____

Please indicate **one** of the following:

- Incontinence Supplies are **NOT** medically necessary.
- Incontinence Supplies are **MEDICALLY NECESSARY** for this Medicaid beneficiary.

Physician's Signature: _____ Date: _____