

**FORMS**

<b>Number</b>	<b>Name</b>	<b>Revision Date</b>
DHHS 126	<a href="#">Confidential Complaint</a>	06/2007
DHHS 130	<a href="#">Claim Adjustment Form 130</a>	03/2007
DHHS 205	<a href="#">Medicaid Refunds</a>	01/2008
DHHS 931	<a href="#">Health Insurance Information Referral Form</a>	01/2008
	<a href="#">Reasonable Effort Documentation</a>	05/2007
	<a href="#">Authorization Agreement for Electronic Funds Transfer</a>	03/2011
	<a href="#">Duplicate Remittance Advice Request Form</a>	10/2012
	<a href="#">Sample Edit Correction Form</a>	10/2008
	<a href="#">Sample Remittance Advice (three pages)</a>	06/2007
	<a href="#">Allied Professional Registration Form</a>	09/2012
	<a href="#">LISW Allied Professional Registration Form</a>	09/2012
	<a href="#">Mental Health Form</a>	04/2013



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 (8 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).

<b>Fax:</b>	<b>or</b>	<b>Mail:</b>
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).

<b>Fax:</b>	<b>or</b>	<b>Mail:</b>
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

CARRIER

<input type="checkbox"/> PICA <span style="float: right;"><input type="checkbox"/> PICA</span>											
1. MEDICARE <input type="checkbox"/> (Medicare #)         MEDICAID <input checked="" type="checkbox"/> (Medicaid #)         TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN)         CHAMPVA <input type="checkbox"/> (Member ID#)         GROUP HEALTH PLAN <input checked="" type="checkbox"/> (SSN or ID)         FECA BLKLUNG <input type="checkbox"/> (SSN)         OTHER <input type="checkbox"/> (ID)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>1234567890</b>						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John A.</b>					3. PATIENT'S BIRTH DATE MM DD YY <b>01 01 1999</b>		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) <b>123 Windy Lane</b>					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 <b>Anytown</b>			STATE <b>SC</b>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY		STATE	
ZIP CODE <b>29999</b>		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 <b>A123450A</b>					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					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 <b>0.00</b>					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 <b>401</b>					10d. RESERVED FOR LOCAL USE <b>1</b>					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
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 <b>Signature on File</b> DATE _____										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. _____			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			21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>295 32</b>			22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			23. PRIOR AUTHORIZATION NUMBER		
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE EMG			C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			D. DIAGNOSIS POINTER		
1 01 20 07 01 20 07 11			90804			60 00		2 2		ZZ 12121212 NPI 1234567890	
25. FEDERAL TAX I.D. NUMBER <b>55555555</b>			26. PATIENT'S ACCOUNT NO. <b>DOE1234</b>			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$ <b>60 00</b>		29. AMOUNT PAID \$ <b>0 00</b>
30. BALANCE DUE \$ <b>60 00</b>			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 a. NPI			33. BILLING PROVIDER INFO & PH # (555) 5555555 <b>Jane Smith, MD</b> <b>111 Main Street</b> <b>Anytown, SC 22222-2222</b>		
SIGNED _____ DATE _____			b. _____			a. <b>1234567890</b>		b. <b>ZZ1212121212</b>			

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: PRV ZIP:  
3 4 5 6 7  
P AUTH TPL INJURY EMERG PC COORD  
NUMBER 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 25 26  
INS CARR POLICY INS CARR  
NUMBER NUMBER 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 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 GROUP HOME .121212121234. PROVIDER ID.	Y	PO BOX 000000 FLORENCE SC000000000	PROFESSIONAL SERVICES REMITTANCE ADVICE	PAYMENT DATE 03/26/2007	PAGE 1
DEPT OF HEALTH AND HUMAN SERVICES		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	S T 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	96100	800.00	117.71	P			000		0.00	
	02		021507	90804	392.00	126.00	P			000		0.00	
VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04													
ABB222222	0406001089000400U				1412.00	273.71		1112233333	M CLARK				
	01		012107	90804	1112.00	143.71				000			
	02		012107	96100	300.00	130.00				000			
REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04													
ABB222222	0407701389002500A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		012107	90804	142.50	42.75	P			000		0.00	
	02		012107	96100	859.00	0.00	R			000		0.00	
TOTALS				2	2193.50	286.46						0.00	0.00

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.	CERT. PG TOT \$0.00 CERTIFIED AMT \$0.00 FEDERAL RELIEF	MEDICAID PG TOT \$286.46 MEDICAID TOTAL 0.00 MAXIMUS AMT CHECK TOTAL	STATUS CODES: P = PAYMENT MADE R = REJECTED S = IN PROCESS E = ENCOUNTER CHECK NUMBER	PROVIDER NAME AND ADDRESS ABC GROUP HOME PO BOX 000000 FLORENCE SC 00000-0000
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# 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 I I	M F M O I I D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	0406001089000400U				513.00-	197.71-	1112233333	CLARK	M		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
0.00	\$243.71	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 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

SAMPLE ONLY

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	
YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	ABC GROUP HOME PO BOX 000000 FLORENCE SC 00000-0000	
5293.45	0.00			



**Please return signed original Attestation to:**

**Mailing Address:**

SC Dept. of Health and Human Services c/o  
 Division of Family Services  
 Post Office Box 8206  
 Columbia, South Carolina 29202-8206

**Fax: (803) 255-8204**

**Section I: Demographic Information**

Please Print:

<b>Physician or APRN Name</b>	
<b>Address:</b>	
<b>Facility:</b>	
<b>Telephone:</b>	
<b>National Provider Identifier Number (NPI)</b>	
<b>Fax:</b>	
<b>Email:</b>	

**Section II: Allied Professional Update Form**

The Allied Professional(s) listed below are under my supervision and services rendered and billed to South Carolina Medicaid will be in compliance with the guidelines as provided in the South Carolina Medicaid FQHC or RHC Standard. All allied professionals must be listed and a maximum of three allied professionals are permitted.

Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage and Family Therapist

<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	
<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	
<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	

If there are any changes to this list, i.e. the allied professional's qualifications, physician or APRN information, I will notify South Carolina Medicaid utilizing this form within thirty days (30). Failure to comply shall result in the recoupment for services rendered. My signature and signature date certifies, that the information provided in the **Attestation** is correct.

\_\_\_\_\_  
 Physician or APRN Signature

\_\_\_\_\_  
 Date



Please return signed original Attestation to:

**Mailing Address:**

SC Dept. of Health and Human Services c/o  
 Division of Family Services  
 Post Office Box 8206  
 Columbia, South Carolina 29202-8206

Fax: (803) 255-8204

**Section I: Demographic Information**

Please Print:

<b>LISW-CP Name</b>	
<b>Address:</b>	
<b>Facility:</b>	
<b>Telephone:</b>	
<b>National Provider Identifier Number (NPI)</b>	
<b>Fax:</b>	
<b>Email:</b>	

**Section II: Allied Professional LMSW Update Form**

The Allied Professional(s) LMSW listed below are under my LISW-CP (licensed Independent social worker-clinical practice) supervision and services rendered and billed to South Carolina Medicaid will be in compliance with the guidelines as provided in the South Carolina Medicaid FQHC or RHC Standard. All allied professional(s) LMSW must be listed and a maximum of three LMSW(s) are permitted to be supervised by the LISW-CP.

Licensed Master Social Worker (LMSW)

<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	
<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	
<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	

If there are any changes to this list, i.e. the allied professional's qualifications, LISW-CP information, I will notify South Carolina Medicaid utilizing this form within thirty days (30). Failure to comply shall result in the recoupment for services rendered. My signature and signature date certifies, that the information provided in the **Attestation** is correct.

\_\_\_\_\_  
 LISW-CP Signature

\_\_\_\_\_  
 Date

**South Carolina  
Department of Health and Human Services  
Mental Health Form**

**FILL OUT COMPLETELY TO AVOID DELAYS**

<b>Beneficiary's Name:</b>		<b>Organization NPI:</b>	
<b>Medicaid ID #:</b>		<b>Center's Name:</b>	
<b>Date of Birth:</b>		<b>Service Location Address:</b>	
<b>Individual NPI:</b>		<b>City &amp; State:</b>	

**DSM-IV TR Diagnosis**

Axis I \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Axis II \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Axis III \_\_\_\_\_ / \_\_\_\_\_

**Date first seen:** \_\_\_\_\_      **Date of last service:** \_\_\_\_\_      **# of additional visits requested:** \_\_\_\_\_

*Current Clinical Information:* (Circle each. Scale 0=None, 1=Mild, 2=Moderate, 3=Severe, 4=Extreme)

Aggression	0 1 2 3 4	Depressions	0 1 2 3 4	Relationship Problems	0 1 2 3 4
Alcohol/Substance Use	0 1 2 3 4	Hallucinations	0 1 2 3 4	Side Effects	0 1 2 3 4
Anxiety/Panic	0 1 2 3 4	Impulsivity	0 1 2 3 4	Sleep Effects	0 1 2 3 4
Appetite Disturbance	0 1 2 3 4	Job/School Problems	0 1 2 3 4	Sleep Disturbance	0 1 2 3 4
Attention/Concentration	0 1 2 3 4	Mania	0 1 2 3 4	Weight Loss	0 1 2 3 4
Deficit in ADLs	0 1 2 3 4	Medical Illness	0 1 2 3 4	Other	0 1 2 3 4
Delusions	0 1 2 3 4	Memory	0 1 2 3 4	Current Stressors	0 1 2 3 4

**Services**

- |                                |                                |                                |                                |
|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> 90833 | <input type="checkbox"/> 90846 | <input type="checkbox"/> 90853 | <input type="checkbox"/> 90837 |
| <input type="checkbox"/> 90836 | <input type="checkbox"/> 90847 | <input type="checkbox"/> 90832 | <input type="checkbox"/> H0002 |
| <input type="checkbox"/> 90838 | <input type="checkbox"/> 96101 | <input type="checkbox"/> 90834 |                                |

Current Medications	Name	Dose	Frequency	Side Effects
<input type="checkbox"/> New	1. _____	_____	_____	_____
<input type="checkbox"/> New	2. _____	_____	_____	_____
<input type="checkbox"/> New	3. _____	_____	_____	_____
<input type="checkbox"/> New	4. _____	_____	_____	_____
<b>Compliance</b>	<input type="checkbox"/> >90%	<input type="checkbox"/> 50-90%	<input type="checkbox"/>	<input type="checkbox"/> <50%
<b>Reasons for Noncompliance:</b> _____				

\_\_\_\_\_  
Physician/Non physician Practitioner's Name      (\_\_\_\_\_) \_\_\_\_\_      (\_\_\_\_\_) \_\_\_\_\_  
Phone:      Fax

\_\_\_\_\_  
Physician/Non physician Practitioner's Signature      Date

**Clinical documentation must be submitted with this request and submitted to the QIO using one of the following methods:  
KePRO FAX#: 1-855-300-0082, KePRO Customer Service Phone#: 1-855-326-5216, KePRO website: <http://scdhhs.Kepro.com>.**

**Disclaimer: Authorization indicates that SCDHHS determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary's eligibility and benefit limitations at the time services are rendered. The Physician Assistant is not authorized to sign this form.**

Behavioral Health Services  
Post Office Box 8206  
Columbia, South Carolina 29202-8206