Hardship Waiver Exception Request

Date: _____

Contact Name _____

Organization Name _____

Address _____

City _____ State _____Zip_____

Phone Number: ( ) _____ - _____

NPI: _____

EIN: _____

Provider Type/Specialty _____

Application Reference ID _____

Reason for Waiver Request:

This request must document the basis for the waiver request including a discussion of the impact on beneficiary access to care if the fee is imposed. Include any comments on the financial or legal records that might be needed to make a determination of hardship. Examples of sufficient documentation to support the request may include historical cost reports, recent financial reports, income statements, cash flow statement and/or tax returns.

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Medicaid Claims Control System
Medicaid Provider Enrollment
P.O. Box 8809 • Columbia, South Carolina 29202-8809
(888) 289-0709 FAX (803) 870-9022

If you have any questions or need additional information, please contact Medicaid Provider Enrollment at (888) 289-0709, Option 4.

Please return the completed Hardship Waiver Exception Request to SC Medicaid via fax (803) 870-9022.

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