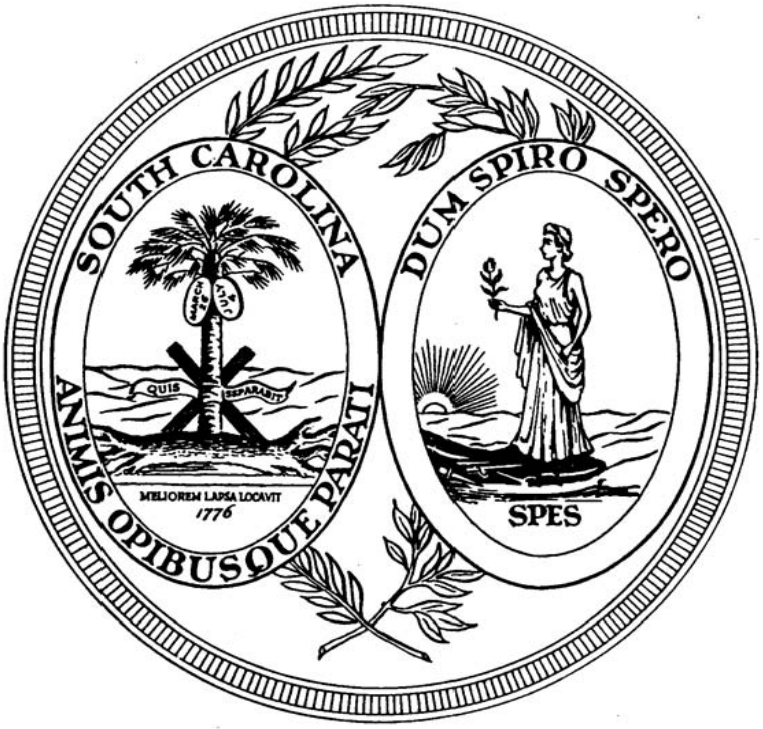
South Carolina
Health & Human Services



SOUTH CAROLINA HEALTHY CONNECTIONS (MEDICAID) PROVIDER MANUAL

DURABLE MEDICAL EQUIPMENT

December 1, 2004
Updated April 1, 2013

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.dhhs.state.sc.us

November 3, 2004

DME 04-06

MEDICAID BULLETIN

TO: **Durable Medical Equipment (DME) Providers**

SUBJECT: **Medicaid Policy Manual for Durable Medical Equipment Providers**

The enclosed new Department of Durable Medical Equipment Medicaid Provider Manual is effective December 1, 2004, and includes all previous HIPAA changes and Medicaid policy bulletins.

This manual is to be used for program information and requirements, billing procedures, and provider services guidelines. **Due to several substantial changes in policy, providers are urged to carefully review this revision.**

In addition to policy changes specific to the DME program area, the new provider manuals for all Medicaid programs have been reformatted to give them a more consistent, standardized layout and to improve navigation and readability. Headings for each subsection appear on the left side of the page, with the corresponding information on the right. "Chapters" are now called "Sections," and the numbering system has been simplified.

The new manuals are organized generally as follows, with each section having its own Table of Contents:

Section 1 - General Information and Administration, contains an overview of the South Carolina Medicaid program, as well as information about record retention, documentation requirements, utilization review, program integrity, and other general Medicaid policies.

Section 2 - Policies and Procedures, describes policies and procedures specific to the DME program.

Section 3 - Billing Procedures, contains billing information that is common to all South Carolina Medicaid programs, as well as program-specific guidelines for claim filing and processing.

Section 4 - contains procedure codes, fee schedules, and other approval codes and modifiers.

Section 5 - Administrative Services, contains contact information for DHHS state and county offices, examples of all forms referenced throughout the manual (as well as some generic forms), and contacts for claim form suppliers/vendors.

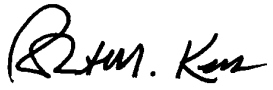
The **appendices** include the following:

- Resolutions for Frequently Occurring Edit Codes
- Claim Adjustment Reasons Codes (CARCs) and Remittance Advise Remark Codes (RARCs)
- Carrier Codes
- Schedule of Copayments

The enclosed compact disc contains a copy of the manual in Portable Document Format (pdf). To access the file, you will need Adobe Acrobat Reader software, which is pre-installed on most computers and also available for free download at **www.adobe.com/support**. The manual is also available on the DHHS Web site.

The policy manual and fee schedule are not subject to copyright regulations and may be reproduced in their entirety.

If you have any questions regarding this provider manual and fee schedule, please contact your program coordinator in the Department of Durable Medical Equipment at (803) 898-2882. Thank you for your continued support of the South Carolina Medicaid program.



Robert M. Kerr
Director

RMK/bgaw

Attachments

NOTE: To receive Medicaid bulletins by email or to sign up for Electronic Funds Transfer of your Medicaid payment, please go to the following link for instructions: http://www.dhhs.state.sc.us/ResourceLibrary/E-Bulletins.htm

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MANAGED CARE SUPPLEMENT

THIRD-PARTY LIABILITY SUPPLEMENT

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
04-01-13	Change Control Record	13	Corrected the Section to "4" for April 1, 2010
04-01-13	1	6	Corrected the URL for MedicaideLearning.com
04-01-13	Appendix 1	2 20, 25, 28 4, 39, 52, 53, 57, 59 73 50, 51 67, 69	• Changed edit code description reference DMR and MR/RD to ID/RD for edit code 052 • Updated CARCs for edit codes 460, 544, 569 • Updated resolutions for edit codes 079, 722, 837, 838, 855, 865, 960 • Added edit codes 820, 821 • Updated edit code 935, 938, 939
04-01-13	Appendix 2	-	Updated carrier code list
03-01-13	2	30	Changed reference to MR/RD to ID/RD
03-01-13	3	4	Changed references to ICF/MR to ICF/IID
03-01-13	5	10	Deleted Jasper County PO Box address
03-01-13	Forms	-	• Added Justification for Home Uterine form • Deleted MR/RD A-5 form
03-01-13	Appendix 1	i 2, 38, 70 38, 54, 70	Deleted Change Log Changed edit code description reference to DMR and MR/RD to ID/RD for edit codes 052, 053, 712, and 953 Updated resolutions for edit codes 714, 851, and 953
03-01-13	Managed Care Supplement	7	Deleted the Department of Alcohol and Other Drug Abuse from agencies exempt from prior authorizations
02-01-13	1	18	Updated URL address for the National Correct Coding Initiative (NCCI)
02-01-13	2	20	Updated National Correct Coding Initiative (NCCI) language
01-04-13	Forms	i, ii	Change header date from 12/01/01 to 12/01/12

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
01-01-13	5	7 9	• Added Chester county Zip+4 code • Updated Greenville PO Box address
01-01-13	Appendix 1	-	Added Change Log for section changes
12-03-12	1	6 7-8 27-32 33-41	• Updated web addresses for provider information and provider training • Revised heading and language to reflect new provider enrollment requirements • Updated Program Integrity language (entire section) • Revised heading and language for Medicaid Anti-Fraud Provisions/Payment Suspension/Provider Exclusions/Terminations (entire section)
12-03-12	3	8 12-13 26, 40, 42 32-33	• Updated National Provider Identifier and Medicaid Provider Number • Updated fields 17, 17b to add requirement for referring or ordering provider NPI • Updated provider information web addresses • Updated Electronic Funds Transfer (EFT)
12-01-12	5	6 21	• Updated web address for provider information • Updated McCormick county office telephone number
12-03-12	Forms	-	Deleted provider enrollment form 219-DME
12-01-12	Appendix 1	24, 26, 27, 32, 33 19, 27, 40, 44, 45, 47, 49, 50, 55, 56, 57, 59, 60, 61,	• Updated CARCs for edit codes 538, 552, 555, 561, 562, 563, 636, 637, 690 • Updated resolutions for edit codes 402, 561, 562, 563, 721, 722, 748, 749, 752, 753, 769, 791, 795, 852, 853, 856, 860, 884, 887, 892, 897, 925, 926
12-01-12	TPL Supplement	8, 9, 17	Updated web addresses for provider information and provider training

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
11-01-12	5	1	Updated Allendale county office address
11-01-12	Appendix 2	-	Updated carrier code list
10-05-12	Forms	-	Updated Duplicate Remittance Advice Request Form
10-01-12	1	4	Replaced back of Healthy Connections Medicaid card
10-01-12	2	12 12-13 13 26	• Removed MCMN and prior authorization address from Limited Rentals • Rename heading to Medicaid Prior Approval (PA) from KePRO and updated section to reflect Medicaid Bulletin dated July 27, 2012 — New Services Performed by KePRO, the Quality Improvement Organization (QIO) for S.C. Medicaid • Add Instructions for obtaining Prior Approval section • Updated Repairs section
10-01-12	4	-	Changed section to include tables for procedure codes that require an MCMN and prior authorization from KePRO
10-01-12	Appendix 1	-	Updated edit code information through document
08-01-12	1	2, 8, 9, 12, 13, 15, 25, 34	Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012
08-01-12	2	1, 18, 24	Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012
08-01-12	3	1, 30, 39, 42-41 8, 26, 31	• Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Updated hyperlinks
08-01-12	5	1	• Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Removed fax request information for SCDHHS forms

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
		5 7	• Added SCDHHS forms online order information • Updated telephone number for Greenville county office
08-01-12	Forms	-	• Deleted forms 140 and 142 • Updated Duplicate Remittance Advice Request Form
08-01-12	Appendix 1	- 1, 24, 60, 65, 66-67,70-72 15, 31, 69 8, 10, 29, 31 10, 11, 14, 34, 48	• Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Replaced CARC 141 or CARC A1 for edit codes 52, 053, 517, 600, 924-926, 929, 954, 961, 964, 966, 967, 969, 980, 985-987 • Added edit codes 349, 590, 978, 990, 991-995 • Deleted edit codes 166, 205, 573, 574, 593, 596 • Updated resolution for edit codes 170-172, 171, 174, 210, 321, 711, 798
08-01-12	Managed Care Supplement	1-2 7 11 17 19	• Changed Division of Care Management to Bureau of Managed Care • Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Removed language limiting enrollment to 2500 members • Update contact information for Palmetto Physician Connections • Added to “Medicaid” to BlueChoice HealthPlan
08-01-12	TPL Supplement	5, 6, 10,17, 24	Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012
07-01-12	Appendix 1	16, 48 45	• Deleted edit codes 386 and 868 • Added edit codes 837, 838, 839
07-01-12	Appendix 2	-	Updated carrier codes

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
06-01-12	2	13 15 21 30 63	• Updated Prior Approval address • Added section on Prior Authorization for Wheelchairs and Cranial Molding Orthotic Devices • Deleted Waivers section • Deleted Special Features Blood Glucose Monitors • Added Cranial Remolding Orthotic Devices
06-01-12	4	1 20 73-75	• Updated QIO information • Updated code B9998 • Updated pricing on codes
05-01-12	3	8	Updated place of service key 31
05-01-12	Appendix 1	62	Updated edit code 975
04-27-12	2	 12 15 17 41 58 60	Updated the following sections: • Prior Approval • Proof of Delivery • Manual Pricing and Not Otherwise Classified (NOC) Codes • Wheelchairs • Non-Covered Wheelchair Accessory/Attachment • Documentation Requirements for Prior Authorization Review
04-01-12	1	4	Replaced South Carolina Healthy Connections card
04-01-12	5	11 12	• Updated address for Marion County • Updated phone number for Newberry County
02-07-12	Cover	-	Manual cover updated January 1, 2012
02-07-12	Appendix 1	18 24 30	• Updated edit code 402 • Updated edit code 544 • Updated edit code 636, 637, and 642
02-01-12	3	28 30	• Added a note regarding The Web Tool • Updated the Remittance Advice -835 Transaction
02-01-12	5	9	Updated the Fairfield county office number

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
02-01-12	Appendix 1	18 30 42 49	• Updated edit code 402 • Updated edit code 637 • Updated edit code 766 • Updated edit code 867
01-01-12	1	2-5, 20, 24	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
01-01-12	2	25	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
01-01-12	3	- 31	• Updated hyperlinks throughout section • Updated EFT information
01-01-12	5	1	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
01-01-12	Appendix 1	62 - -	• Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11 • Updated CARCs and RARCs throughout the document
01-01-12	Managed Care Supplement	9	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
01-01-12	TPL Supplement	2	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
11-01-11	1	24	Updated TPL contact information
11-01-11	3	39, 48, 50	Updated TPL contact information
11-01-11	TPL Supplement	6, 15 12	• Changed Medicare timely filing requirement to two years and six months • Deleted policy to use Medicaid legacy provider number on the same line as the Medicaid carrier code

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
		3, 17, 19	• Deleted sample legacy number from UB-04 TPL Fields table • Updated TPL contact information
10-01-11	Appendix 1	14, 29 47	• Added edit codes 334 and 584 • Updated edit code 845
09-01-11	1	19	Deleted information regarding National Correct Coding Initiative
09-01-11	2	21 22-30 22 - 23	• Added a "Note" to the Waivers section • Deleted all section content and tables that referenced any specific information related to diapers, under pads, incontinence supplies, etc. • Added new content to the following sections: o Mental Retardation/Related Disabilities (MR/RD) section o Head and Spinal Cord (HASI) Waiver o Mechanical Ventilator Dependent Waiver (VENT) o HIV/AIDS Waiver o Community Choices Waiver o Medically Complex Children's Waiver
09-01-11	4	-	Updated header date to 07/11/11 and procedure codes to reflect Medicaid Bulletin dated July 8, 2011
09-01-11	5	13	Updated zip code for Spartanburg County office
09-01-11	Appendix 1	15, 29, 30	Added edit code 361, 591, 596 and 605
08-01-11	3	-	Updated language throughout section to reflect the current billing policies including claim processing, claim submission, and copayments
08-01-11	Forms	-	Deleted Program Coordinators chart
08-01-11	Appendix 1	8	Updated edit codes 165 and 166
08-01-11	Appendix 3	1	Updated the copayment schedule per the bulletin effective July 11, 2011

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
08-01-11	Managed Care Supplement	1, 5	Updated to reflect the new beneficiary copayment requirements in accordance with Public Notice posted July 8, 2011
07-01-11	5	13	Deleted PO Box address for the Spartanburg County Office
07-01-11	Appendix 1	12 43 56	• Updated resolution for edit code 300 • Added edit codes 840 and 841 • Updated Provider Enrollment Contact information in edit codes 941 and 944
07-01-11	Appendix 3	1	Updated the copayment schedule per the bulletin effective July 8, 2011
06-01-11	2	10 15-16 17 18 16	Updated the following sections: • Medicaid Certification of Medical Necessary (MCMN) • Proof of Delivery • Manual Pricing and Not Otherwise Classified (NOC) • Frequency Limitations Added the following sections: • Auto-Refilling section • National Correct Coding Initiative (NCCI)
06-01-11	5	5	Corrected Abbeville County PO Box Zip+4 Code
05-18-11	4	1	Updated fee schedule approval information
05-01-11	1	8, 11	Added language prohibiting payment to institutions or entities located outside of the United States
05-01-11	Appendix 1	43	Updated edit code 796
04-11-11	4	-	Updated fee schedule to reflect Medicaid Bulletin dated April 7, 2011 – Medicaid Rate Reduction
04-01-11	3	3, 4	Updated Copayment Policy to reflect bulletin dated 3-16-11
04-01-11	5	6	Updated telephone number for Beaufort County
04-01-11	Forms	-	Updated Electronic Funds Transfer Form

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
04-01-11	Appendix 3	-	Updated copay amounts to reflect bulletin dated 3-16-11
03-01-11	1	7, 9	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
03-01-11	2	8	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
03-01-11	3	26, 31, 32	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
03-01-11	5	4 5	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center Added toll free number for Aiken County
03-01-11	Appendix 1	- 67	Added SCDHHS Medicaid Provider Service Center (PSC) information at top of each page in header section Made change to Edit Code 990 description
03-01-11	Appendix 2	-	Updated alpha and numeric carrier code lists to reflect Web site update on 12/14/10
03-01-11	TPL Supplement	17 24, 25	• Changed the name of the Provider Outreach Web site to Provider Enrollment and Education • Updated the descriptions for Form130s
02-01-11	Appendix 1	3	Added edit codes 079 and 080
01-01-11	1	7 19-20	• Updated the South Carolina Medicaid Web-based Claims Submission Tool section • Updated to reflect Medicaid Bulletin dated December 8, 2010 – Information on NCCI Edits
01-01-11	3	26, 29, 30, 32 17, 38 29	• Updated electronic remittance package information • Updated to reflect Medicaid Bulletin dated December 10, 2010 – Reporting Patient Liability on Claims • Updated to reflect Medicaid Bulletin dated December 10, 2010 – Requests for Duplicate Remittance Package

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
01-01-11	5	13	Added toll-free telephone number for Saluda county
01-01-11	Forms	-	Added Duplicate Remittance Request Form
01-01-11	Appendix 1	9	Added edit codes 165 and 166
01-01-11	TPL Supplement	8, 10 8 10 13 15 15	• Removed references to Dental claims • Removed language to contact program areas for missing carrier codes • Added reference to CMS-1500 for correcting edit code 151 on the ECF • Added edit code 165 to other TPL-related insurance edit codes list • Updated Retro Medicare section to include the following: o Changed the timely filing requirement from 90 days of the invoice to 30 days o Added SCDHHS TPL recovery language • Updated the Retro Health and Pay & Chase section
12-01-10	Cover	-	Replaced “Medicaid Provider Manual” with “South Carolina Healthy Connections (Medicaid)”
12-01-10	Appendices	-	Replaced “South Carolina Medicaid” with “South Carolina Healthy Connections (Medicaid)” in the headers
12-01-10	Supplements	-	Replaced “South Carolina Medicaid” with “South Carolina Healthy Connections (Medicaid)” in the headers
11-01-10	Appendix 1	8 16 32 51 52	• Edit code 202: added information to Resolution section • Edit codes 421 and 424 deleted • Edit code 733 information updated in Resolution section: “Adjust the net charge in field” changed from 26 to 29 • Deleted edit code 959 • Deleted edit codes 962 and 963

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
11-01-10	TPL Supplement	3, 8, 13-14, 18-19 6, 15-17	• Updated to reflect Medicaid Bulletin dated July 8, 2010 – Transfer of the Dental Program Administration to DentaQuest • Updated to reflect Medicaid Bulletin dated September 13, 2010 – Changes to the Third Party Liability Medicare Recovery Cycle
10-01-10	1	- 1 7 10	• Removed all reference to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program • Updated Program Description section • Updated the SC Medicaid Web-Based Claims Submission Tool section to reflect Medicaid Bulletin dated July 8, 2010-Transfer of the Dental Program Administration to DentaQuest • Updated Freedom of Choice section
10-01-10	5	11	Correct McCormick county office street address
10-01-10	Managed Care Supplement	- 1 2 3 4 5 6 13 17	• Removed all references to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program • Updated Managed Care Overview • Updated Managed Care Organizations and Core Benefits paragraphs • Updated MCO Program ID card paragraph • Updated MHN Program ID card paragraph • Updated Core Benefits • Updated Exempt Services • Updated Overview • Deleted “Medicaid Managed” from “Current Medicaid Managed Care Organizations” heading and following paragraph
09-01-10	3	 27 27 44	Updated the following sections to reflect Medicaid Bulletin dated July 8, 2010 – Transfer of the Dental Program Administration to DentaQuest: • Companion Guides • South Carolina Medicaid Web-based Claims Submission Tool • Claim-Level Adjustments

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
09-01-10	4	2 34 47 76 90 126-127 130	• Deleted code A4232 • Added code E0482 • Updated frequency for E1007 to 3 Yr • Added code L0552 • For code L0623, changed MCMN column to "*" • Updated codes L6694, L6695, L6696, L6697, and L6698 units to 2 and frequency to 1 Yr • Updated frequency for S8999 to 1 Yr
09-01-10	5	5 8 11	• Removed County Commissioner's Building from the Aiken County address • Deleted Dorchester County physical address telephone number • Removed Highway 28 N from the McCormick County address
09-01-10	Appendix 1	9 -	• Added edit code 225 • Removed all references to the ADA Claim in the Resolution column
09-01-10	TPL Supplement	12 13 18	• Updated the Dental Paper Claims section to delete paper claims submission instructions and added the DentaQuest contact information • Updated the Web-Submitted Claims section with the exception to Dental claims • Updated the TPL Resources section to include the DentaQuest contact information for TPL questions
08-01-10	5	5, 8, 11-13 6	• Updated the zip codes for Aiken, Edgefield, McCormick, Newberry, and Saluda counties • Updated the address for Barnwell County • Updated the telephone number for Beaufort County
08-01-10	Appendix 1	20 51, 52 59	• Deleted edit code 520 • Deleted Provider Enrollment e-mail address from codes 941 and 944 • Changed resolution for edit code 994
07-01-10	5	-	Updated telephone numbers and zip codes for multiple county offices

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
07-01-10	Appendix 1	32 35	• Updated edit code 714 • Updated edit code 738
07-01-10	Appendix 2	21, 22, 25, 63, 89	Changed First Health to Magellan Medicaid Administration
06-01-10	4	4 20 29 & 31	Deleted Procedure Code A4365 Updated Procedure Code B4104 Updated Procedure Codes E0194 & E0277
06-01-10	Managed Care Supplement	1 3 17 20, 23, 25	• Updated Managed Care Overview section • Updated Manage Care Organization (MCO), Core Benefits section • Updated the Managed Care Disenrollment Process, Overview section • Updated to reflect Medicaid Bulletin dated March 18, 2010 — Managed Care Organizational Change
05-01-10	5	1	• Removed references to sample form at the end of this section • Replaced references to sample form in the Forms section of this manual
04-01-10	4	4 20 95	• Deleted code A365 • Removed prior authorization requirement for B4101 (MCMN column) • Added code L1005
04-01-10	Forms	-	Corrected spacing on MCMN forms
03-01-10	Cover	-	Replaced the manual cover
03-01-10	Change Control Record	1	Added Time Limit for Submitting Claims Medicaid Bulletin date to section 1 and section 3 entries dated 12-01-09
03-01-10	2	2 10	• Added new sections for in-state and out-of-state providers • Updated the Medicaid Certificate of Medical Necessity (MCMN) section

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
03-01-10	3	3,5	Removed modem as an electronic claims transmission method
02-02-10	2	1 8-10	• Updated DME Overview section • Updated Medical Certification of Medical Necessary (MCMN) section
02-02-10	Forms	-	Updated the following forms: DME 001, DME 003, DME 004, DME 005 DME 006, DME 007 DME 008
02-01-10	Appendix 1	13 36	• Added New Edit Codes 356,357 and 358 • Updated Edit Code 738
02-01-10	Appendix 2	All	Updated Carrier Code List
01-01-10	4	12, 17, 56, 65, 87, 97, 98, 104, 106-108, 126	Deleted the following procedure codes: A6200, A6201, A6202, A6542, E2223, E2393, 0210, L1800, L1815, L1901, L2770, L3651, L3652, L3700, L3701, L3909, L3911, and L6639
01-01-10	5	5 10 12	• Updated Physical Address for Allendale County Office • Replaced Jasper County DSS with Jasper County DHHS • Replaced Orangeburg County DSS with Orangeburg County DHHS
01-01-10	Appendix 1	49	Updated Edit Code 932
12-01-09	1	8 25	• Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package • Updated Timely Filing for Submitting Claims section to reflect Medicaid Bulletin dated November 24, 2009
12-01-09	3	1-3 26, 28-32	• Updated Claim Filing Timeliness section to reflect Medicaid Bulletin dated November 24, 2009

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
			• Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package
12-01-09	5	8	Updated the Dorchester County office street address
12-01-09	Appendix 1	- - 18, 19 20	• Replaced CARC 17 with CARC 16 • Updated CARC A1 • Updated codes 509 and 510 • Added code 533
11-01-09	Appendix 2	All	Updated carrier code list
10-07-09	Forms	-	Correct revision dates on the Table of Contents
10-01-09	1	3-4 4-6 8 25	• Updated the Medicare/Medicaid Eligibility section to include Qualified Medicare Beneficiaries (QMBs) • Updated SC Medicaid Healthy Connections language throughout section • Updated South Carolina Medicaid Bulletins and Newsletters • Changed heading to Medicare Cost Sharing Claims
10-01-09	2	16 32	• Updated the reimbursement percentage rates for Manually Priced and Not Otherwise Classified (NOC) codes • Added Qualified Medicare Beneficiary subsection
10-01-09	4	ALL	Update fee schedule
10-01-09	5	10 11 12	• Updated physical address for Jasper County office • Updated telephone number for Lexington County office • Updated zip codes for Orangeburg County office
10-01-09	Forms	-	• Corrected revision date to form DME 001 • Added revision date on form DME 007

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
10-01-09	Appendix 1	3 60	• Updated edit code 065 • Updated edit code 852
09-08-09	Managed Care Supplement	20	Replaced the Absolute Total Care Medicaid beneficiary card sample
09-01-09	2	9, 11 34 35 37	• Updated Medicaid Certificate of Medical Necessity subsection • Replaced code E1340 with K0739 effective April 1, 2009 • Deleted last paragraph under Repairs subsection • Updated Diabetic Supplies subsection
09-01-09	4	48	Deleted codes E1017 and E1018
09-01-09	Managed Care Supplement	21 20, 25	• Removed all references to CHCcares to reflect Medicaid Bulletin dated August 3, 2009 • Updated Absolute Total Care entries as following: o Changed the company's name to Absolute Total Care o Replaced the beneficiary card samples o Corrected contact information
08-01-09	2	12 45-56	• Updated Capped Rental subsection • Updated the effective date and Medicare frequency limitations for codes B4081, B4082, B4083, B4087, and B4088.
08-01-09	4	20, 34, 136-137 53 77, 78	• Updated units and frequencies for codes B4087, B4088, B9998, E0470-E0472, E0601, T4521-T4523, X1939, X9202 • Deleted code E1340 • Added codes K0003-K005 (for modifier NU), K0462, K0739
08-01-09	5	14	Updated telephone number for York County office
08-01-09	Appendix 1	3	Updated edit code 062
08-01-09	Appendix 2	-	Updated carrier code list

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
07-01-09	4	8	Corrected price for procedure code E4495
07-01-09	5	6, 12 8 9	• Updated address for Bamberg and Orangeburg County offices • Updated office zip code for Darlington County • Updated telephone number for Fairfield County office
06-01-09	4	33 45	• Updated procedure code E0441, E0442, E0443, and E0444, modifier 00 to modifier NU • Updated procedure code E0971, modifier LL to 1 Mo
06-01-09	TPL Supplement	19	Updated Department of Insurance Web site address
05-01-09	1	1-6, 11 2 3 5 28-33	• Updated to reflect managed care policies and procedures effective May 1, 2009 • Updated the Eligibility subsection • Added the beneficiary contact telephone number to the South Carolina Healthy Connections Medicaid Card subsection • Removed the program start date from the SC Healthy Connections Kids SCHIP Dental Coverage subsection • Updated the Medicaid Program Integrity subsection
05-01-09	2	30-31	Updated to reflect managed care policies and procedures effective May 1, 2009
05-01-09	5	14	Updated telephone number for Union County office
05-01-09	Appendix 1	43	Deleted edit code 694
05-01-09	Appendix 2	-	Updated list of carrier codes
05-01-09	Managed Care Supplement	-	Updated supplement to include general policies and procedures effective May 1, 2009
04-01-09	1	2, 3, 8	Updated hyperlinks

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
04-01-09	2	3, 4 12 14 17 18 22, 23, 25 26, 28 29, 30 34 35-36 38-39 45 47 47-48 49, 51. 54 52-57, 56 60 63	• Updated Operating Procedures subsection • Added procedure code E0601 • Updated documentation requirement in Prior Approval subsection • Updated Frequency Limitations • Added note to Miscellaneous Procedure Codes subsection • Added minimum area for diapers and underpads • Added Medically Complex Children's Waiver subsection • Updated Warranties subsection • Added note to Repairs subsection • Added Diabetic Supplies and External Insulin Infusion Pump subsections • Added codes E0441 and E0442 • Change frequency limits to 12 for codes B4087 and B4088 • Added Hospital Beds and Bariatric Beds subsections • Under Power Wheelchairs subsection: o Added physician's prescription to documentation requirements o Added documentation requirement to include serial number for manufacturer information o Removed push-rim manual wheelchair policy • Removed procedure codes form within text • Updated last paragraph • Under Negative Pressure Wound VAC subsection: o Replaced code A6551 with A7000 o Updated Continued Wound Vac Coverage subsection o Updated Wound Vac Supplies subsection • Under Non-Covered Items, added Wheelchair Accessories subsection
04-01-09	3	6-8, 26, 31, 39, 42	Updated hyperlinks

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
04-01-09	4	1	Added note to Price column statement
04-01-09	5	11	Updated telephone number for Lexington County office
03-01-09	2	4, 16	Updated hyperlinks
03-01-09	4	39	Added units for E0705 NU, LL, UE
03-01-09	5	3, 4 8 5, 11-13	• Updated hyperlinks • Corrected Dorchester County's Orangeburg Road telephone number • Change DSS to DHHS in addresses for Abbeville, McCormick, Newberry, and Saluda counties
03-01-09	Forms	-	Added Meghan Loskill to the South Carolina Department of Durable Medical Equipment Program Coordinators
03-01-09	Appendix 1	43 72	• Added new edit codes 693 and 694 • Changed edit code 945 Resolution to input "26"modifier in field 18
03-01-09	Managed Care Supplement	1, 7, 10, 17, 23, 25-30, 35	Updated hyperlinks
03-01-09	TPL Supplement	8, 9, 19	Updated hyperlinks
02-01-09	2	39	Updated last paragraph of Oxygen section
02-01-09	4	18 33 35 72 131 132	• Updated units for A7003 and A7004 • Added codes E0443 and E0444 • Deleted E0483 – NU and E0483 – UE • Updated units and frequency for K0001, K0003, and K0004 • Added ** to MCMN for S1040 • Updated units and frequency for S9001
02-01-09	5	5	Updated Allendale County office PO Box zip code

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
02-01-09	Forms	-	Updated Authorization Agreement for Electronic Funds Transfer (EFT) form
02-01-09	Appendix 2	-	Updated list of carrier codes
01-01-09	1	8	Updated hyperlink for bulletin.scdhhs.gov
01-01-09	4	2 18 72 - 73	• Deleted A4245 • Updated A7003, A7004 • Deleted some information for K002, K003, K004, K005, K006, K007, K009
01-01-09	5	11	Updated Lee County office address
01-01-09	Forms	-	Updated Program Coordinators contact sheet
12-01-08	2	16	Revised 25% to 22% and 90% to 87%
12-01-08	4	-	Updated fees throughout table
12-01-08	Forms	-	Revised form DME 001
11-01-08	1	8	Added e-bulletin information to reflect Medicaid Bulletin dated August 26, 2008
11-01-08	2	23, 24, 26	Updated rates and reimbursements
11-01-08	2	14	Revised verbiage in Prior Approval section.
11-01-08	3	29, 31	Added EFT information to reflect Medicaid Bulletin dated August 26, 2008
11-01-08	4	-	Updated schedule for the following codes: T4524, T4523, T4522, T4521, T4533, T4528, T4527, T4526, T4525, T4534, T4535, T4530, T4529, T5999, A4554
11-01-08	Forms	-	• Added the listing of DME Program Coordinators • Updated CMN forms
10-01-08	3	33	Changed ECF field 1 to Prov/Xwalk ID

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
10-01-08	4	-	Updated section from bulletin dated September 10, 2008
10-01-08	5	9, 13	• Updated address for Lake City • Updated phone number for Sumter County office
10-01-08	Forms	-	• Revised ECF example to show update for field 1 • Deleted DME Program Coordinators Form and Map
10-01-08	Appendix 1	-	Updated edit codes 007, 059, 112, 219, 308, 339, 386, 403, 710, 722, 786, 798, 799, 843, 844, 845, 912, 914, 928, 941, 942, 943, 945, 952
09-01-08	5	6	Updated phone number for Berkeley County office
09-01-08	5	10	Updated phone number for Kershaw County office
09-01-08	Appendix 1	17	Added Edit Code 318
08-01-08	Appendix 1	3	Updated Edit Code 062
08-01-08	5	7	Deleted PO Box for Chester County
07-01-08	2	40 40	• Deleted code B4086 • Added codes B4087 and B4088
07-01-08	4	-	Updated section from bulletin dated May 28, 2008
07-01-08	5	11	Deleted PO Box for Lancaster County
07-01-08	Forms	-	Updated instructions on reverse side on form DME 001
07-01-08	Managed Care Supplement	27	Replaced Web site address for BlueChoice
06-01-08	3	8, 15, 16, 18, 19, 31	Updated NPI policy and form instructions to reflect May 23, 2008, deadline requiring NPI only on claims for typical providers

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
06-01-08	5	12	Updated telephone number for Orangeburg county office
06-01-08	Form	-	• Deleted sample claim form showing NPI and Medicaid Provider ID • Updated DHHS Form 214 to reflect May 23, 2008, deadline requiring NPI only
06-01-08	Appendix 1	30, 39, 42	• Added new edit code 529 • Deleted NPI warning edits 578, 579, 580, 581, 582, 583, 692
06-01-08	TPL Supplement	-	Updated Example Dental Claim Form Reporting Third-Party for Medicare Information to show NPI only; change/removed sample entries for fields 8, 15, 23, and 49; and added a tooth number to line 4
05-01-08	Managed Care Supplement	-	Revised supplement to include general policies and procedures effective May 1, 2008 and updated the SCDHHS-approved MCO contractors section
04-01-08	4	29	Updated modifier for procedure code E0168
04-01-08	5	8	Updated address and phone number for Dorchester County office
04-01-08	Appendix 1	4, 13, 20, 33	Added new edit codes 062, 219, 339, 528
04-01-08	TPL Supplement	2 3, 8, 15 12 29	• Updated reference to Medicaid card name • Changed references to location of form from Section 5 to Forms section • Updated field numbers for occurrence codes on UB-04 • Replaced sample ADA form with more attractive version
03-01-08	1	3-5 7	• Replaced sample Partners for Health Medicaid card with new Healthy Connections card and updated card information. • Deleted information about location of supervising entities – requirements will be included in Section 2 where applicable

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
03-01-08	3	9-19 All	• Updated NPI policy and form instructions to reflect March 1, 2008, deadline requiring NPI on claims for typical providers (with or without Medicaid legacy number). • Standardized formatting
03-01-08	4	40	Removed edit codes E0636 and E0639
03-01-08	Forms	-	Replaced Form 931 with new version dated January 2008
03-01-08	Appendix 1	59 70	• Added edit code 808 • Revised edit code 943 description and status (from warning to active)
03-01-08	TPL Supplement	9 21-22	• Added information on carrier code "CAS" for open casualty cases • Replaced Form 931 samples with new versions
02-01-08	3	11 35, 38 51	• Corrected instructions for field 10b • Standardized references to six-character legacy provider number • Corrected mailing address for refunds
02-01-08	5	1	Removed "including Partners for Health" from first paragraph
02-01-08	Forms	-	Corrected mailing address for Medicaid Refunds Form 205
01-01-08	5	10	Updated address Lancaster County office
01-01-08	Managed Care Supplement	1 3	• Removed PhyTrust from the list of MHNs • Added Carolina Crescent to the list of MCOs
12-01-07	4	164	Updated procedure code T5999
12-01-07	5	8, 10, 12	• Updated addresses for Edgefield, Lancaster and Oconee County offices • Updated zip code for Kershaw County
12-01-07	Forms	-	Updated chart and map for DME Program Coordinators

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
11-01-07	4	141 159, 165	• Corrected Mo/Yr column for procedure code L5685 • Updated reimbursements S5160, X1939, and X9202 in accordance with Medicaid Bulletins dated September 24, 2007
11-01-07	5	9, 10 10	• Updated telephone numbers for Florence and Kershaw counties • Updated Horry County address to 1601 11th Ave., 1st Floor
11-01-07	Appendix 1	All	• Corrected ECF field numbers throughout edit resolution instructions • Added new edit code 107
11-01-07	Appendix 2	All	Updated list of carrier codes
10-01-07	1	1-2 3 4 12 15 25	• Removed PEP information • Added information about managed care enrollment broker and Managed Care Supplement • Removed managed care sample cards (cards and other information will appear in the new Managed Care Supplement). • Clarified that “days” refers to business days • Clarified which sections of manual may contain PA information • Expanded provider list under Program Integrity
10-01-07	2	26, 27	Removed PEP information from Managed Care section
10-01-07	3	13, 51	• Removed PEP information • Added 90-day time limit for reversing refunds
10-01-07	4	39, 44, 141	• Updated procedure codes for E0618, E0781, E0784, L5685
10-01-07	Appendix 1	26 38-40, 43, 70	• Corrected description for edit code 502 • Added NPI warning edits 578-583, 692, 943
10-01-07	-	-	Added Managed Care Supplement

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
10-01-07	TPL Supplement	15-17	• Added 90-day time limit for reversing refunds • Added information on Part B timely filing schedule to explain which claims are pulled into Retro Medicare
09-01-07	4	25-26, 38, 48-49, 72-73	Updated procedure codes for E0110, E0112, E0114, E0562, E0960, E2375
08-01-07	4	4, 28, 159, 164	Corrected procedure codes for A4349, E0155, S1040, and T4521-T4533
07-01-07	1	All	Revised policies and procedures throughout section
07-01-07	4	-	Updated procedure code descriptions, pricing, and requirements in accordance with Medicaid Bulletin dated June 14, 2007.
07-01-07	Forms	-	Updated DHHS Form 205
07-01-07	Appendix 2	-	Updated list of carrier codes
06-01-07	Appendix 1	All	Updated list of edit codes
06-01-07	TPL Supplement	All	• Updated all sample forms and claims with new versions • Updated form completion instructions to match new form versions
06-01-07	2	All	Changed references to location of forms from “Section 5” to “Forms section”
06-01-07	3	-	Removed Time Restricted Supplement
06-01-07	3	All	• Updated form completion instructions for new CMS-1500 and Form 130 versions • Updated ECF and RA descriptions • Added information about National Provider Identifier • Replaced Reference to Forms 110 and 120 with Form 115 • Clarified retroactive eligibility policy • Updated ECF correction instructions • Added CPT and HCPCS ordering information

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
			• Made minor editorial changes throughout section
06-01-07	Forms		• Updated DHHS forms to add National Provider Identifier field • Updated sample claims to new CMS-1500 version • Updated ECF and remits to new versions • Updated Justification for Home Uterine Activity Monitor/Supplies (HUAM) for Subcutaneous Tocolytic Therapy • Updated Certificate of Repair and Labor Cost and assigned it new form number DME 008
06-01-07	5	3-4 6-8 12 -	• Revised "Procurement of Forms" to address new CMS-1500 version and updated vendor information • Added toll-free number for Berkeley, Charleston, and Darlington county offices • Updated phone number for Oconee County • Split forms and exhibits from Section 5 to create separate Forms section
05-01-07	4	36, 56-57, 64, 78-79, 88-89, 121	• Reinserted procedure code E0445 • Added correct pricing for procedure codes K0738, E1232-E1237, E2601-E2605, and E2291-E2294 • Inserted new procedure code K0733 • Removed procedure codes K0090-K0098 • Updated units for procedure code L2750
05-01-07	Appendix 1	-	Updated list of edit codes
04-01-07	2	13 & 14	Changed address for SCDHHS Department of Durable Equipment to 12th floor
04-01-07	4	88 & 89	Corrected modifiers for procedure codes K0108 and K0738
04-01-07	5	8	• Updated phone number for Darlington county office

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
			• Corrected instructions on back of MCMN for Orthotics, Prosthetics, and Diabetic Shoes (DME 004)
04-01-07	Appendix 1	-	Updated list of edit codes
04-01-07	Appendix 2	-	Updated list of carrier codes
04-01-07	Time Restricted Supplement	-	Updated date for mandatory use of revised CMS-1500
03-02-07	4	All	Updated procedure codes and reimbursements in accordance with Medicaid Bulletin dated March 2, 2007.
03-01-07	5	6	Updated Barnwell county office address
03-01-07	Time Restricted Supplement	All	Removed all references to NDC quantity and unit
03-01-07	Appendix 1	-	Updated list of carrier codes
02-01-07	TPL Supplement	31-32	Updated ECF Samples to show third payer line
02-01-07	5	Exhibits	Updated three Medicaid Certificate of Medical Necessity forms (DME 005, 006, and 007).
01-22-07	2	40-50	Updated Power Wheelchair guidelines in accordance with Medicaid Bulletin dated December 18, 2006
01-22-07	4	-	Updated procedure code descriptions, pricing, and requirements in accordance with Medicaid Bulletins dated December 18, 2006 and January 8, 2007.
01-22-07	5	Forms	Updated MCMNs in accordance with Medicaid Bulletin dated December 18, 2006
01-01-07	3	-	Added Time Restricted Supplement

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
01-01-07	5	-	Added line “03” to sample ECF for the third payer declaration
01-01-07	Appendix 1	9, 14	Added Edit Codes 202, 203, 204, 301
01-01-07	Appendix 2	-	Updated list of carrier codes
12-01-06	4	84	Removed procedure code K0800
12-01-06	4	83	Reinserted procedure code K0108
12-01-06	3	32-33	Added descriptions for fields 13 and 14 of ECF
11-01-06	5	-	Updated county office addresses
10-12-06	2, 4, 5	-	Updated policies, procedure codes, and Medicaid Certificates of Medical Necessity in accordance with Medicaid Bulletin dated October 6, 2006.
10-01-06	5	-	Updated county office addresses
10-01-06	Appendix 2	-	Updated list of carrier codes
09-01-06	5	-	Updated county office addresses
09-01-06	Appendix 1	10,11,13 15,17,18 22, 23, 24 26, 27, 28 29, 30, 31 32, 35, 36 39, 40, 41 42, 46, 47 48, 49, 50 52, 58, 60 61, 62, 63 66, 67	• Updated CARCs for edit codes 504, 561, 562, 563, 636, 923, 940, 949 • Updated RARCs for edit codes 207, 208, 227, 234, 239, 263, 317, 369, 377, 421, 501, 504, 505, 507, 508, 515, 541, 545, 553, 564, 570, 672, 674, 709, 714, 719, 721, 722, 748, 749 • Updated resolutions for edit codes 761, 764, 765 768, 769, 771, 772, 773, 774 • Added new edit codes 518, 724 • Deleted edit code 777
08-01-06	4	127, 138-139	Added correct pricing for procedure codes L5856, L5858, L6965, L6970, L6975, and L7180
08-01-06	-	-	Added TPL Supplement
08-01-06	5	-	Updated Reasonable Effort Documentation form

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
07-01-06	Appendix 1	23, 60, 61	Updated resolutions for edit codes 504, 923, 940
07-01-06	Appendix 2	-	Updated list of carrier codes
07-01-06	2	14, 16, 17-20	Updated waiver information
05-08-06	4	89-92	Added Modifier column with “00” to codes L09491 through L0640
05-01-06	Appendix 1	52	Updated resolution for edit code 852
03-22-06	Appendix 1	43	Updated resolution for edit code 735
03-22-06	Appendix 2	-	Updated list of carrier codes
03-22-06	2 3 4	5, 8, 36-9 20 All	Updated in accordance with Medicaid Bulletin dated March 22, 2006.
03-01-06	Appendix 1	60	Changed resolution for edit code 925
02-01-06	Appendix 1	41	Changed resolution for edit code 721
01-01-06	5	-	Updated Authorization Agreement for Electronic Funds Transfer
01-01-06	1	4 & 5	Removed SILVERxCARD sample and program description
01-01-06	Appendix 2	-	Updated list of carrier codes
01-01-06	Appendix 1	67	Added edit code 935
12-01-05	Appendix 1	70	Added edit code 949
11-01-05	1	6, 7	Removed “HIPAA” from names of S.C. Medicaid Provider Outreach and S.C. Medicaid EDI Support Center
11-01-05	3	6	Changed verb tense under Procedural Coding and Diagnostic Codes

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
11-01-05	3	14	Removed requirement for entering whole numbers for day or units in field 24G
11-01-05	3	25, 40	Changed generic reference for the South Carolina Medicaid Web-based Claims Submission Tool from SCMWBCST to Web Tool
11-01-05	3	24	Changed Web site from www.scdhhshipaa.org to www.scmedicaidprovider.org
11-01-05	5	5-14	Updated list of DHHS county offices
10-01-05	2	1-5, 31-34	Revised MCMN requirements to reflect Medicaid Bulletin dated September 30, 2005; added information on wheelchair accessories and options
10-01-05	4	All	Revised code descriptions, pricing, modifiers, etc. to reflect Medicaid Bulletin dated September 30, 2005.
10-01-05	5	5-14	Updated list of DHHS county offices
10-01-05	Appendices	-	Made each appendix a separate file; moved Change Control Record out of appendices to a separate file
09-01-05	Appendix 2	All	Updated lists of carrier codes
09-01-05	Appendix 1	38 & 64	Added edit codes 577 and 900
08-01-05	Appendix 1	A1-62	Added edit code 868
07-01-05	4	-	Made corrections to procedure codes A4216, A4230, E0242, E0940, E2620, E2621, E8000, E8001, E8002, S9537, and X1922
07-01-05	3	2, 10, 11, 25, 36, 37	• Added description of new Web Tool features • Removed instruction to attach EOB to paper claims • Change MIVS zip code to 29211-9804 (from 29201)
07-01-05	Appendix 2	All	Updated lists of carrier codes

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
03-03-05	2, 3, 4 & Appendices	All	Update section(s) of manual to reflect "updated" date 2-14-05 in header and cover of DME manual. New codes were added to Section 4 and new edit codes were added to appendices.
03-01-05	5	-	New versions of forms: Health Insurance Information Referral Form, Confidential Complaint, Reasonable Effort Documentation, and Sample Remittance Advice
03-01-05	5	-	Added DHHS Form 130
03-01-05	5	-	Changed area codes for Saluda and Union county DHHS offices
03-01-05	3	-	Added information about claim-level adjustments process and Form 130
02-11-05	5	4	Updated manual ordering information under Web Address header
01-25-05	5	5, 8	Updated addresses for Allendale and Hampton county offices.
01-05-05	5	17-18	Replaced DME Form 001 (MCMN for Equipment and Supplies) with new version
12-16-04	Appendix 2	All	Added four pages to list of carrier codes.
12-16-04	Appendix 1	71	Deleted the phrase "to your program manager" from criterion #1 of the resolution for edit code 977
12-08-04	5	Exhibits	Replaced Authorization Agreement for Electronic Funds Transfer with 11/04 version.
12-08-04	1	All	Changed "Division of Accountability and Collections" to "Division of Third Party Liability."
12-08-04	1	21	Added TPL phone number.
12-03-04	1	5	Changed SILVERxCARD Benefit Questions phone number to 1-800-834-2680.

CHANGE CONTROL RECORD

Date	Section(s)	Page(s)	Change
12-03-04	5	Exhibits	Updated all four Medicaid Certificate of Medical Necessity forms (DME 001, 004, 005, and 006) to 12/01/04 versions.
12-03-04	5	5-11	Replaced DHHS County Offices contact list.

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GENERAL INFORMATION AND ADMINISTRATION

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SECTION 1

GENERAL INFORMATION AND ADMINISTRATION

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SECTION 1

GENERAL INFORMATION AND ADMINISTRATION

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

PROGRAM DESCRIPTION

The Medicaid program, as established by Title XIX of the Social Security Act, as amended, provides quality health care to low income, disabled, and elderly individuals by utilizing state and federal funds to reimburse providers for approved medical services. This care includes the diagnosis, treatment, and management of illnesses and disabilities.

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency designated to administer the South Carolina Medicaid program in compliance with state and federal laws and regulations and the South Carolina State Plan.

SCDHHS offers two Medicaid Managed Care Programs:

- Medicaid Managed Care Organization (MCO) Program
- Primary Care Case Management/Medical Homes Networks (PCCM or PCCM/MHN)

The Medicaid Managed Care Organization (MCO) program consists of contracted MCOs that, through a developed network of providers, provide, at a minimum, all services outlined in the core benefit package described in the MCO contract, for certain eligibility categories. SCDHHS pays a capitated rate per member per month, according to age, gender, and category of eligibility to MCOs. Payments for core services provided to MCO members are the responsibility of MCOs, not the fee-for-service Medicaid program.

The Medical Homes Network (MHN) Program is a Primary Care Case Management (PCCM) program. An MHN is composed of a Care Coordination Services Organization (CSO) and the primary care providers (PCPs) enrolled in that network. The CSO supports the member physicians by providing care coordination, disease management, and data management. The PCPs manage the health care of their patient members either by directly

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

PROGRAM DESCRIPTION (CONT'D.)

providing medically necessary health care services or authorizing another provider to treat the beneficiary. The Network receives a per-member-per-month (PMPM) care coordination fee. Reimbursement for medical services provided is made on a fee-for-service basis.

Both MHNs and MCOs may elect to provide their members enhanced services beyond what is offered under traditional fee-for-service Medicaid.

ELIGIBILITY DETERMINATION

Applications for Medicaid eligibility may be filed in person or by mail. Applications may be obtained and completed at outstationed locations such as county health departments, some federally qualified health centers, most hospitals, and SCDHHS county eligibility offices. Individuals can also visit the SCDHHS Web site at http://www.scdhhs.gov to download an application for Medicaid.

Individuals who apply for SSI through the Social Security Administration and are determined eligible are automatically eligible for Medicaid.

For certain programs, Medicaid eligibility may be retroactive for a maximum of three months prior to the month of application when the applicant received medical services of the type covered by Medicaid and the applicant would have met all eligibility criteria had the application been filed at the time. A child born to a woman eligible for Medicaid due to pregnancy is automatically entitled to Medicaid benefits for one year provided that the child continues to reside in South Carolina.

Not all Medicaid beneficiaries receive full coverage. Some beneficiaries may qualify under the categories of limited benefits or emergency services only. Questions regarding coverage for these categories should be directed to the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. Providers can also submit an online inquiry at http://scdhhs.gov/contact-us. A provider service representative will then respond to you directly with additional information about these categories.

Providers may verify a beneficiary's eligibility for Medicaid benefits by utilizing a Point of Sale (POS) device, the South Carolina Medicaid Web-based Claims Submission Tool, or an eligibility verification vendor. Additional information on these options is detailed later in this section.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

ELIGIBILITY DETERMINATION (CONT'D.)

If the beneficiary is enrolled in a MCO or MHN/PCCM, certain services will require prior approval and/or coordination through the MCO or MHN/PCCM providers. For questions regarding MCO or MHN/PCCM programs, please visit the SCDHHS Web site at http://scdhhs.gov to view the MCO or MHN Policy and Procedure Guide.

More information about managed care can also be found in the Managed Care Supplement attached to all provider manuals.

ENROLLMENT COUNSELING SERVICES

SCDHHS provides enrollment counseling services to Medicaid beneficiaries through a contract with a private vendor, Maximus, Incorporated. Services are provided under the program name "South Carolina Healthy Connections Choices." The function of the enrollment counselor is to assist Medicaid-eligible members in the selection of the best Medicaid health plan to suit individual/family needs. For additional information, visit http://www.SCchoices.com or contact South Carolina Healthy Connections Choices at (877) 552-4642.

MEDICARE / MEDICAID ELIGIBILITY

Medicaid beneficiaries who are also eligible for Medicare benefits are commonly referred to as "dually eligible." Providers may bill SC Medicaid for Medicare cost sharing for Medicaid-covered services for dually eligible beneficiaries. Some dual eligibles are also Qualified Medicare Beneficiaries (QMB). If the dually eligible beneficiary is also a QMB, providers may bill SC Medicaid for Medicare cost sharing, for services that are covered by Medicare without regard to whether the service is covered by SC Medicaid. Reimbursement for these services will be consistent with the SC State Medicaid Plan.

Please refer to Section 3 of this manual for instructions regarding billing procedures for dually eligible beneficiaries. For instructions on how to access beneficiary information, including QMB status, refer to the Medicaid Web-Based Claims Submission Tool (the Web Tool), explained later in this section.

In the Web Tool, the Eligibility or Beneficiary Information section will indicate "Yes" if the beneficiary is a Qualified Medicare Beneficiary.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

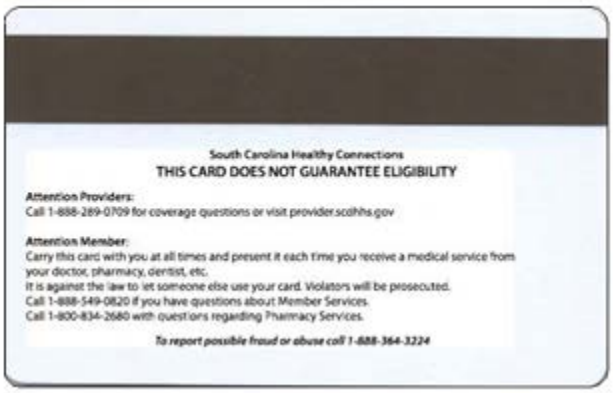
MEDICARE / MEDICAID ELIGIBILITY (CONT'D.)

Note: Pharmacy providers should refer to Section 2 of the Pharmacy Services Provider Manual for more information on coverage for dually eligible beneficiaries.

SOUTH CAROLINA HEALTHY CONNECTIONS MEDICAID CARD

Medicaid beneficiaries are issued a plastic South Carolina Healthy Connections Medicaid card. Only one person's name appears on each card. If more than one family member is eligible for Medicaid, the family receives a card for each eligible member. In addition to the member's name, the front of the card includes the member's date of birth and Medicaid Member Number. Possession of the plastic card does not guarantee Medicaid coverage. Failure to verify eligibility prior to providing a service leaves the provider at risk of providing services to an ineligible individual.

The following is an example of a South Carolina Healthy Connections card:



The back of the Healthy Connections Medicaid card includes:

- A number that providers may call for prior authorization of services outside the normal practice pattern or outside a 25-mile radius of South Carolina
- A magnetic strip that may be used in POS devices to access information regarding Medicaid eligibility, third-party insurance coverage, beneficiary special programs, and service limitations 24 hours a day, seven days a week in a

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

SOUTH CAROLINA HEALTHY CONNECTIONS MEDICAID CARD (CONT'D.)

real time environment. There is a fee to providers for such POS services.

- A toll-free number for the beneficiary if he or she has questions about enrollment or Medicaid-covered services
- A toll-free number for the beneficiary if he or she has questions regarding pharmacy services

Providers are urged to report inappropriate use of a Medicaid card by a beneficiary (such as abuse, card-sharing, etc.) to the Division of Program Integrity's toll-free Fraud and Abuse Hotline at 1-888-364-3224.

Beneficiaries who choose to enroll with a Medicaid Managed Care Organization (MCO) will also be issued an identification card by the MCO. This MCO-issued card contains phone numbers for member services and provider billing issues specific to the managed care plan. Please see the Managed Care Supplement for samples of cards from the various managed care plans.

SC HEALTHY CONNECTIONS HEALTH OPPORTUNITY ACCOUNT

The South Carolina Healthy Connections Health Opportunity Account (HOA) was implemented by SCDHHS in May 2008. It is a Medicaid option that allows beneficiaries to manage their own health care spending and set aside money to be used when they no longer need Medicaid. Routine claims filing procedures apply to HOA participants.

The following is an example of a South Carolina Healthy Connections Health Opportunity Account card:

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SOUTH CAROLINA MEDICAID PROGRAM

SC HEALTHY CONNECTIONS HEALTH OPPORTUNITY ACCOUNT (CONT'D.)

The back of the South Carolina Healthy Connections Health Opportunity Account card includes a toll-free number for questions about enrollment, Medicaid-covered services, or eligibility.

SOUTH CAROLINA MEDICAID WEB-BASED CLAIMS SUBMISSION TOOL

SCDHHS provides a free tool, accessible through an Internet browser, which allows providers to submit claims (UB and CMS-1500), query Medicaid eligibility, check claim status, offers providers electronic access to their remittance packages and the ability to change their own passwords.

Note: Dental claims can no longer be submitted on the Web Tool. Please contact the DentaQuest Call Center at 1-888-307-6553 for billing instructions.

Providers interested in using this tool must complete a SC Medicaid Trading Partner Agreement (TPA) with SCDHHS and return the signed SC Medicaid TPA Enrollment Form. Once received, the provider will be contacted with the Web site address and Web Tool User ID(s). If a provider utilizes a billing agent and elects to have the billing agent access their electronic remittance package, both the provider and the billing agent must have a TPA on file. The provider's TPA must name their billing agent. The billing agent's TPA must include the provider's name and Medicaid number. For more information regarding the TPA, refer to Section 3 of this manual.

To learn more about this tool and how to access it, visit the SC Medicaid e-Learning Web site at: http://medicaidelearning.com/ or contact the SC Medicaid EDI Support Center via the SCDHHS Provider Service Center at 1-888-289-0709. A list of training opportunities is also located on the Web site. For Web Tool training dates, click on "Training Options."

SOUTH CAROLINA MEDICAID BULLETINS AND NEWSLETTERS

SCDHHS Medicaid bulletins and newsletters are distributed electronically through e-mail and are available online at the SCDHHS Web site.

To ensure that you receive important SC Medicaid information, visit the Web site at http://www.scdhhs.gov/ or enroll to receive bulletins and newsletters via e-mail, go to bulletin.scdhhs.gov to subscribe.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

PROVIDER ENROLLMENT

PROVIDER PARTICIPATION

The Medicaid program administered by the South Carolina Department of Health and Human Services (SCDHHS) is considered to be a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

Provider participation in the Medicaid program is voluntary. To participate in the Medicaid program, a provider must meet the following requirements:

- Complete an online provider enrollment application and agreement and submit any necessary supporting documentation. Certain provider types, depending on the type of service provided, are required to sign a contractual agreement in addition to the provider enrollment agreement.

- Accept the terms and conditions of the online application by electronic signature, indicating the provider's agreement to the contents of the participation agreement, the Electronic Funds Transfer Agreement, W-9 and Trading Partner Agreement.

- Be licensed by the appropriate licensing body, certified by the standard-setting agency, and/or other pre-contractual approval processes established by (SCDHHS).

- If eligible, obtain a National Provider Identifier (NPI) and share it with SCDHHS. Refer to https://nppes.cms.hhs.gov for additional information about obtaining an NPI.

- Be enrolled in the South Carolina Medicaid program and receive official notification of enrollment.

- Continuously meet South Carolina licensure and/or certification requirements of their respective professions or boards in order to maintain Medicaid enrollment.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

PROVIDER PARTICIPATION (CONT'D.)

- Comply with all federal and state laws and regulations currently in effect as well as all policies, procedures, and standards required by the Medicaid program.
- Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside the United States

All rendering providers must be enrolled in the Medicaid program. Enrolled providers are prohibited from allowing non-enrolled providers use of their Medicaid ID number/NPI number in order for non-participating providers to be reimbursed for services. Claims for Medicaid reimbursement submitted under a Medicaid ID number or NPI number other than that of the ordering, referring or rendering provider will be considered invalid and may result in a program integrity investigation and/or recoupment of the Medicaid payment. As required by 42 CFR 455.440, all claims submitted for payment for items and services that were ordered or referred must contain the NPI of the physician or other professional who ordered or referred such items or services.

MCO network providers/subcontractors do not have to be Medicaid-enrolled providers. Fee-for-service reimbursement from SCDHHS may only be made to Medicaid-enrolled providers.

A provider must immediately report any change in enrollment or contractual information (*e.g.*, mailing or payment address, physical location, telephone number, specialty information, change in group affiliation, ownership, etc.) to SCDHHS Provider Service Center within 30 days of the change. Failure to report this change of information promptly could result in delay of payment and/or termination of enrollment. Mailing information is located in the Correspondence and Inquiries section.

Extent of Provider Participation

Providers have the right to limit the number of Medicaid patients they are willing to treat within their practice; however, providers may not discriminate in selecting the Medicaid beneficiaries they will treat or services they will render. A provider may not refuse to furnish services covered under Medicaid to an eligible individual because

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

Extent of Provider Participation (Cont'd.)

of a third party's potential liability for the service(s). A provider who is not a part of a Managed Care Organization's network may refuse service to a Medicaid MCO member.

A provider and a beneficiary (or the beneficiary's guardian or representative) should determine before treatment is rendered whether the provider is willing to accept the beneficiary as a Medicaid patient. In an emergency, or if a provider cannot determine that a patient is Medicaid-eligible at the time service is rendered, the provider should meet with the beneficiary (or the beneficiary's legal guardian or representative) at the earliest possible date to determine whether the provider is willing to accept the beneficiary as a Medicaid patient for the previously rendered service. To avoid disputes or misunderstandings, providers are encouraged to document the details of their provider-patient agreement in the patient's record.

In furnishing care to beneficiaries who are participating in a Medicaid managed care option, all providers are required to comply with the benefit requirements specified by the applicable managed care program with respect to issues such as the extent of approvals for referrals, etc. Specific questions may be addressed directly to the managed care provider or the Bureau of Managed Care at (803) 898-4614.

Once a provider has accepted a beneficiary as a Medicaid patient, it is the responsibility of the provider to deliver all Medicaid-covered services throughout the course of treatment. The policy section of this manual may include clarification of specific program policies.

Non-Discrimination

All Medicaid providers are required to comply with the following laws and regulations:

- Title VI of the Civil Rights Act of 1964 that prohibits any discrimination due to race, color, or national origin (45 CFR Part 80)
- Title V, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 that prohibits discrimination on the basis of handicap (45 CFR Part 84)
- The Americans with Disabilities Act of 1990 that prohibits discrimination on the basis of disability (28 CFR Parts 35 & 36)

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

Non-Discrimination (Cont'd.)

- The Age Discrimination Act of 1975 that prohibits discrimination on the basis of age (45 CFR Parts 90 and 91)

Service Delivery

Freedom of Choice

Except as otherwise specified in this manual, a Medicaid beneficiary has the right to choose any provider who is both a participant in the Medicaid program and willing to accept the beneficiary as a patient.

However, once a beneficiary exercises his or her freedom of choice by enrolling in a Medicaid managed care option, the beneficiary is required to follow that plan's requirements (*e.g.*, use of designated primary and specialist providers, precertification of services, etc.) for the time period during which the beneficiary is enrolled in the managed care option.

Medical Necessity

Medicaid will pay for a service when the service is covered under the South Carolina State Plan and is medically necessary. "Medically necessary" means that the service (the provision of which may be limited by specific manual provisions, bulletins, and other directives) is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider's medical records or other appropriate documentation for each beneficiary must substantiate the need for services, must include all findings and information supporting medical necessity and justification for services, and must detail all treatment provided. Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS/ DOCUMENTATION REQUIREMENTS

GENERAL INFORMATION

As a condition of participation in the Medicaid program, providers are required to maintain and provide access to records. These records should fully disclose the medical necessity for treatment and the extent of services provided to Medicaid beneficiaries. Unless program policy otherwise allows, this documentation must be present in the beneficiaries' records before the provider files claims for reimbursement. For the purpose of reviewing and reproducing documents, providers shall grant to staff of SCDHHS, the State Auditor's Office, the South Carolina Attorney General's Office, the Government Accountability Office (GAO), and the U.S. Department of Health and Human Services (USDHHS) and/or any of their designees access to all records concerning Medicaid services and payment. These records may be reviewed during normal business hours, with or without notice.

A provider record or any part thereof will be considered illegible if at least three medical or other professional staff members who regularly perform post-payment reviews are unable to read the records or determine the extent of services provided. If this situation should occur, a written request for a translation may be made. In the event of a negative response or no response, the reimbursed amount will be subject to recoupment.

Assuming that the information is in a reasonably accessible format, the South Carolina Medicaid Program will accept records and clinical service notes in accordance with the Uniform Electronic Transactions Act (S.C. Code Ann. §26-6-10 *et seq.*). Reviewers and auditors will accept electronic documentation as long as they can access them and the integrity of the document is ensured. Furthermore, providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

The minimum retention period for Medicaid records is five years. Exceptions include providers of hospital and nursing home services, who are required to maintain records

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

GENERAL INFORMATION (CONT'D.)

pertaining to Medicaid beneficiaries for a period of six years. Other Medicaid provider agreements/contracts may require differing periods of time for records retention.

Providers should contact the PSC or submit an online inquiry at http://scdhhs.gov/contact-us for specific information regarding the documentation requirements for the services provided. In all cases, records must be retained until any audit, investigation, or litigation is resolved, even if the records must be maintained longer than normally required. Medicaid providers generally maintain on-site all medical and fiscal records pertaining to Medicaid beneficiaries.

Medical and fiscal records pertaining to Medicaid beneficiaries that a provider may maintain at an off-site location/storage facility are subject to the same retention policies, and the records must be made available to SCDHHS within five business days of the request. For reviews by the SCDHHS Division of Program Integrity, requested Medicaid records should be provided within two business days.

Note: These requirements pertain to retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods.

DISCLOSURE OF INFORMATION BY PROVIDER

As of April 14, 2003, for most covered entities, health care providers are required to comply with privacy standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, which includes providing all patients and/or clients with a Notice of Privacy Practices. The Notice should include sufficient information to disclose to each Medicaid patient/client the provider's intent to release any medical information necessary for processing claims, including Medicaid claims. Providers who have not issued their patients/clients a Notice of Privacy Practices should obtain authorization to release such information to SCDHHS. The authorization must be signed and dated by the beneficiary and must be maintained in the patient's/client's record.

Once a Notice of Privacy Practices is acknowledged by the Medicaid beneficiary, or the beneficiary's authorization to release information is obtained, a provider who uses hard-copy claim forms that require the patient's signature is no

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

DISCLOSURE OF INFORMATION BY PROVIDER (CONT'D.)

longer required to have each claim form signed by the beneficiary. Providers who file claims electronically are required under their Trading Partner Agreement (TPA) to ensure ready association of electronic claims with an acknowledged Notice of Privacy Practices or a signed statement from the beneficiary consenting to the release of information necessary to process claims.

Certain medical services may be subject to more stringent rules or regulations governing the disclosure of information than others. However, if a provider is unable to release information necessary for Medicaid claims processing due to the lack of proper Notice or authorization from the beneficiary, payment may be denied and/or previous payments may be recouped. Consequently, providers who are concerned about releasing patient information to SCDHHS are advised to obtain specific written authorization from the Medicaid patient/client.

SAFEGUARDING BENEFICIARY INFORMATION

Federal regulations at 42 CFR Part 431, Subpart F, and South Carolina Regulations at Chapter 126, Article 1, Subarticle 4, require that certain information concerning Medicaid applicants and beneficiaries be protected. As a condition of participation in the Medicaid program, all providers must agree to comply with the federal laws and regulations regarding this protection, by execution of either a contract or a provider enrollment agreement. Questions regarding access to protected information should be referred to the PSC. Provider can also submit an online inquiry at http://scdhhs.gov/contact-us to request additional information.

Beneficiary information that must be protected includes but is not limited to the following:

- Name and address
- Medical services provided
- Social and economic circumstances
- Medical data, including diagnosis and past history of disease or disability
- Any information involving the identification of legally liable third-party resources
- Any information verifying income eligibility and the amount of medical assistance payments

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

SAFEGUARDING BENEFICIARY INFORMATION (CONT'D.)

This information may generally be used or disclosed only for the following purposes:

- Establishing eligibility
- Determining the amount of medical assistance
- Providing services for beneficiaries
- Assisting in a Medicaid-related investigation, prosecution, or civil or criminal proceeding

Regarding the release of beneficiary information to billing/collection agencies, the Centers for Medicare and Medicaid Services (CMS) has instructed the states that the requirements for the release of beneficiary information should parallel the limitations on payments. Agents to whom payments could be made are allowed to obtain relevant beneficiary information, since the sharing of that information is for a purpose directly connected with Medicaid administration. However, if no payment could be made to the agent because the agent's compensation is tied to the amount billed or collected, or is dependent upon the collection of the payment, then Medicaid is not allowed to release beneficiary information to that agent.

Note: The manner in which the Medicaid program deals with the agent is determined primarily by the terms of the agent's compensation, not by the designation attributed to the agent by the provider. Agents or providers who furnish inaccurate, incomplete, or misleading information to SCDHHS regarding agent compensation issues may face sanctions.

Confidentiality of Alcohol and Drug Abuse Case Records

Federal law requires providers to observe more stringent rules when disclosing medical information from the records of alcohol and drug abuse patients than when disclosing information concerning other Medicaid beneficiaries. Federal regulations govern the information that must be protected in such cases and the circumstances under which this information may be disclosed. These regulations may be found at 42 CFR Part 2.

SPECIAL / PRIOR AUTHORIZATION

Certain medical services must be authorized by SCDHHS (or its designee) prior to delivery in order to be reimbursable by Medicaid. Some of the services that are

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

SPECIAL / PRIOR AUTHORIZATION (CONT'D.)

specifically subject to prior authorization and approval are as follows:

- Services provided outside of the South Carolina Medicaid Service Area (SCMSA). The SCMSA is South Carolina and adjacent areas within 25 miles of its borders. Providers should contact the PSC or submit an online inquiry for prior authorization guidelines.
- Services not routinely covered by Medicaid, or other services that require prior approval before payment or before service delivery as a matter of policy. Please refer to the appropriate section of this manual, contact the PSC, or submit an online inquiry for prior authorization guidelines.
- Services for which prepayment review is required.

Refer to program-specific sections of this manual for other services that must be authorized prior to delivery.

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RECORDS / DOCUMENTATION REQUIREMENTS

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

CHARGE LIMITS

Providers may not charge Medicaid any more for services to a beneficiary than they would customarily charge the general public. Providers should bill their usual and customary charges and not the Medicaid reimbursement rate. Retroactive adjustments can only be made up to the billed amount. Medicaid will generally pay the lower of the established Medicaid reimbursement rate, determined by the program, or the provider's charges. The Medicaid program will not pay for services or items that are furnished gratuitously without regard to the beneficiary's ability to pay, or where no payment from any other source is expected, such as free x-rays or immunizations provided by health organizations.

BROKEN, MISSED, OR CANCELLED APPOINTMENTS

CMS prohibits billing Medicaid beneficiaries for broken, missed, or cancelled appointments. Medicaid programs are state-designed and administered with federal policy established by CMS. Federal requirements mandate that providers participating in the Medicaid program must accept the agency's payment as payment in full. Providers cannot bill for scheduling appointments or holding appointment blocks. According to CMS Program Issuance Transmittal Notice MCD-43-94, broken or missed appointments are considered part of the overall cost of doing business.

NATIONAL CORRECT CODING INITIATIVE (NCCI)

The South Carolina Medicaid program utilizes NCCI edits and its related coding policy to control improper coding.

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations or units of service are reported exceeding what is normally considered to be medically necessary. NCCI edits identify procedures/services performed by the same provider for the same beneficiary on the same date of service.

NCCI consist of two types of edits:

1) NCCI Procedure to Procedure (PTP) edits: These edits define pairs of HCPCS/CPT codes that should not be reported together for a variety of reasons.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

NATIONAL CORRECT CODING INITIATIVE (NCCI) (CONT'D.)

These edits consist of a column one code and a column two code. If both codes are reported, the column one code is eligible for payment and the column two code is denied. In some instances an appropriate modifier may be added to one or both codes of an edit pair to make the code combination eligible for payment.

2) Medically Unlikely Edits (MUE): These edits define for each HCPCS/CPT code the number of units of service that is unlikely to be correct. The units of service that exceed what is considered medically necessary will be denied.

It is important to understand, however, that the NCCI does not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.

Services denied based on NCCI code pair edits or MUEs may not be billed to patients.

The CMS web page http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html provides overview information to providers on Medicaid's NCCI edits and links for additional information.

MEDICAID AS PAYMENT IN FULL

Once a provider has accepted a beneficiary as a Medicaid patient, the provider must accept the amount established and paid by the Medicaid program (or paid by a third party, if equal or greater) as payment in full. Neither the beneficiary, beneficiary's family, guardian, or legal representative may be billed for any difference between the Medicaid allowable amount for a covered service and the provider's actual charge, or for any coinsurance or deductible not paid by a third party. In addition to not charging the patient for any coinsurance or deductible amounts, providers may not charge the patient for the primary insurance carrier's copayment. Only applicable Medicaid copayments and services not covered by Medicaid may be billed to the beneficiary.

For beneficiaries enrolled in a Medicaid managed care option, the managed care entity must accept SCDHHS' capitated payment as payment in full for all services

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

MEDICAID AS PAYMENT IN FULL (CONT'D.)

covered by the capitation arrangement. Managed care network providers must accept their reimbursement from the managed care entity as payment in full. Only services not included in the specified benefits package or not otherwise covered by Medicaid may be billed to a beneficiary enrolled in a managed care option.

PAYMENT LIMITATION

Medicaid payments may be made only to a provider, to a provider's employer, or to an authorized billing entity. **There is no option for reimbursement to a beneficiary.** Likewise, seeking or receiving payment from a beneficiary pending receipt of payment from the Medicaid program is not allowed, except where a copayment is applicable. By virtue of submitting a claim to Medicaid, a provider is agreeing to accept Medicaid as the payer.

REASSIGNMENT OF CLAIMS

In general, Medicaid payments are to be made only to the enrolled practitioner. However, in certain circumstances payment may be made to the following:

1. The employer of the practitioner, if the practitioner is required as a condition of employment to turn over fees to the employer
2. The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim
3. A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim
4. A business agent. Regulations found at 42 CFR Part 447, Subpart A, allow Medicaid to make payment for services to a provider's "business agent" such as a billing service or an accounting firm, <u>only</u> if the agent's compensation is:

   a) Related to the cost of processing the billing

   b) <u>Not</u> related on a percentage or other basis to the amount that is billed or collected

   c) <u>Not</u> dependent upon the collection of the payment

   If the agent's compensation is tied to the amount billed or collected or is dependent upon the

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

REASSIGNMENT OF CLAIMS (CONT'D.)

collection of the payment, Medicaid is not allowed to make payment to the agent. Furthermore, providers are urged to seek advice regarding the HIPAA (Public Law 104-191) provisions when entering into such an agreement.

THIRD-PARTY LIABILITY

As a condition of eligibility for Medicaid, federal regulations at 42 CFR Part 433, Subpart D, require individuals to assign any rights to medical support or other third-party payment to the Medicaid agency (SCDHHS) and cooperate with the agency in obtaining such payments. The South Carolina Code §43-7-420 makes this assignment effective automatically upon application for Medicaid.

Medicaid providers may obtain information regarding third-party resources that are known to SCDHHS by utilizing the South Carolina Healthy Connections Medicaid Insurance card with a Point of Sale (POS) device or by using the South Carolina Medicaid Web-based Claims Submission Tool. Third-party resources include but are not limited to health benefits under commercial health insurance plans, indemnity contracts, school insurance, Workers' Compensation, and other casualty plans that may provide health insurance benefits under automobile or homeowner's coverages.

For Medicaid purposes, third-party resources are divided into two general categories: Health Insurance and Casualty Insurance.

Health Insurance

In general, health insurance may include any individual accident and health policy or group policy that provides payment for health care costs. Unless otherwise permitted, a provider who accepts a Medicaid beneficiary as a patient is required to request payment from all available third-party resources prior to billing Medicaid. All third-party claims filed must be assigned to the provider.

Should the third-party carrier deny payment or reduce payment to less than the Medicaid approved amount, the provider may then submit the claim to Medicaid. The claim filed to Medicaid must be properly completed with all applicable third-party information entered in the appropriate fields (see Section 3 or other appropriate materials for billing instructions). Under the federally mandated Cost Avoidance program, 42 CFR §433.139,

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Health Insurance (Cont'd.)

claims for certain services to beneficiaries who have health insurance coverage may automatically reject if the third-party carrier has not been billed first. If a claim is rejected for failure to bill third-party coverage, the resulting Edit Correction Form (ECF) for the rejected claim will contain the carrier code, policy number, and name of the policyholder for each third-party carrier. SCDHHS will not reprocess the claim unless the provider returns a correctly coded ECF that documents payment or denial of payment by the third-party carrier.

While most claims are subject to coordination of benefits to ensure Medicaid is the payer of last resort, federal regulations exempt claims submitted for physicians' services under the Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) program, Maternal Health, Title IV – Child Support Enforcement, and certain Department of Health and Environmental Control (DHEC) services under Title V. While providers are encouraged to file with any liable third party for these claim types, if they choose not to do so, SCDHHS will pay the claims and bill liable third parties directly through the Benefit Recovery program.

Premium Payment Project

Through the Premium Payment Project, SCDHHS is able to pay private health insurance premiums for Medicaid beneficiaries who are subject to losing coverage due to non-payment. SCDHHS will pay these premiums when said payment is determined to be cost effective.

Premium payment is usually cost effective for Medicaid beneficiaries with chronic medical conditions requiring long-term treatment such as cancer, end stage renal disease, chronic heart problems, congenital birth defects, and AIDS. Depending on the amount of the premium, the program may also be appropriate for beneficiaries with short-term costly health needs, such as pregnancy.

Providers of services to participating beneficiaries should consider Medicaid the payer of last resort and bill any liable third-party insurance plan prior to billing Medicaid.

Questions regarding the Premium Payment Project or referrals for beneficiary participation in this project should be directed to the Third Party Liability - Medicaid Insurance Verification Services (MIVS) department by calling (803) 264-6847.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Casualty Insurance

Casualty insurance includes policies that provide payment for treatment related to an accident or injury. This type of coverage is most commonly related to incidents such as auto accidents, and in these cases the injured party is frequently represented by an attorney.

Unlike health insurance claims, claims involving casualty insurance are not subject to review under the Cost Avoidance program. The accident questionnaire is the primary referral source and is generated by the Medicaid claims processing system. At times, it is the provider who identifies a potentially liable third party. If there is casualty insurance coverage, the provider may pursue the claim directly with either the beneficiary's attorney or the casualty insurance carrier, or file a claim with Medicaid (provided that the one-year time limit for submission of claims has not been exceeded).

If the provider files a claim with Medicaid and the claim is paid, then SCDHHS will pursue reimbursement from any liable third party.

Provider Responsibilities – TPL

A provider who has been paid by Medicaid and **subsequently** receives reimbursement from a third party must repay to SCDHHS either the full amount paid by Medicaid or the full amount paid by the third party, whichever is less. Some providers may choose to submit a repayment check accompanied by a completed Form for Medicaid Refunds (DHHS Form 205) identifying the third-party payer. Others providers may decide to submit a Claim Adjustment Form 130, which will allow them to void and/or replace a claim that resulted in under or overpayment. Examples of these forms can be found in the Forms section of this manual. For detailed information regarding both of these adjustment processes, please refer to Section 3 of this manual.

The Medicaid program makes payments to providers on behalf of beneficiaries for medical services rendered, but only to the extent that the beneficiary has a legal obligation to pay. If the beneficiary does not have a legal obligation to pay, then Medicaid will not make a payment. This means that if a beneficiary has third party insurance, including Medicare, SCDHHS's payment will be limited to the patient's responsibility (usually the deductible, co-pay

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Provider Responsibilities – TPL (Cont'd.)

and/or co-insurance.) The Medicaid reimbursement and third party payment cannot exceed the amount the provider has agreed to accept as payment in full from the third party payer. A provider must not bill Medicaid for the difference between the payment received from a third party and the actual charges if the provider's third-party payment was determined under a "preferred provider" agreement. A "preferred provider" agreement is an agreement between the provider and the third party payer that establishes an amount that the provider is agreeing to accept as payment in full on its claims. Where such an agreement exists, Medicaid may only coordinate payment up to the lesser of the Medicaid allowed amount or the amount the provider has agreed to accept as payment in full from the third party payer.

The South Carolina Code §43-7-440(B) requires Medicaid providers to cooperate with SCDHHS in the identification of any third-party resource that may be responsible for payment of all or part of the cost of medical services provided to a Medicaid beneficiary. Upon receiving knowledge of third-party coverage that is not verified via a POS system or SCDHHS Web Tool, a provider is encouraged to notify SCDHHS's Division of Third-Party Liability of said coverage. The Health Insurance Information Referral Form may be used for this purpose. This form can be found in the Forms section of this manual.

The Division of Third-Party Liability must also be notified in writing if copies of claims submitted to Medicaid are released to anyone, including the beneficiary or the beneficiary's attorney. Before being released, the documents must clearly indicate that third-party benefits are assigned to SCDHHS pursuant to state law.

Providers should be aware that in no instance will SCDHHS pay any amount that is the responsibility of a third-party resource. If a provider releases copies of claims submitted to Medicaid and the release of those documents results in third-party payment being made to the beneficiary rather than to the provider, SCDHHS will not reimburse the provider for the amount of the third-party payment made to the beneficiary.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

TIME LIMIT FOR SUBMITTING CLAIMS

SCDHHS requires that only "clean" claims and related ECFs received and entered into the claims processing system within one year from the date of service (or date of discharge for hospital claims) be considered for payment. A "clean" claim is error-free and can be processed without obtaining additional information from the provider or from another third party. This time limit will not be extended on the basis of third-party liability requirements. However, the one-year time limit does not apply to Medicare cost sharing claims or to claims involving retroactive eligibility.

Medicare Cost Sharing Claims

Claims for payment of Medicare cost sharing amounts must be received and entered into the claims processing system within two years from the date of service or date of discharge, or up to six months following the date of Medicare payment, whichever is later.

Retroactive Eligibility

Effective December 1, 2009, claims and related ECFs involving retroactive eligibility must meet both of the following criteria to be considered for payment:

- Be received and entered into the claims processing system within **six months** of the beneficiary's eligibility being added to the Medicaid eligibility system **AND**
- Be received within **three years** from the date of service or date of discharge (for hospital claims). Claims for dates of service that are more than three years old will not be considered for payment.

To document retroactive eligibility, the provider is responsible for submitting one of the following documents with each claim or ECF within the above time frames:

- DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker, or
- The computer-generated Medicaid eligibility approval letter notifying the beneficiary that Medicaid benefits have been approved. This can be furnished by the beneficiary or the eligibility worker. (This is different from the Certificate of Creditable Coverage.)

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Retroactive Eligibility (Cont'd.)

SCDHHS will no longer consider claims that exceed the timely filing limits due to the provider being unaware of the beneficiary's coverage.

Payment Information

SCDHHS establishes reimbursement rates for each Medicaid-covered service. Specific service rates for covered services can be found in the appropriate section of this provider manual. Providers should contact the PSC or submit an online inquiry for additional information.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

The South Carolina Department of Health and Human Services ensures the integrity of the Medicaid Program and seeks to identify and reduce waste, fraud, and abuse in the use of Medicaid funds through the activities carried out by the Division of Program Integrity and the Division of Audits. The purposes of program oversight are to safeguard against unnecessary, inappropriate, and/or fraudulent use of Medicaid services, identify excessive or inaccurate payments to providers, and ensure compliance with the applicable Medicaid laws, regulations, and policies.

PROGRAM INTEGRITY

The Division of Program Integrity conducts post-payment reviews of all health care provider types including but not limited to hospitals (inpatient and outpatient) rural health clinics, Federally-qualified health clinics, pharmacies, ASCs, ESRD clinics, physicians, dentists, other health care professionals, speech, PT and OT therapists, CLTC providers, durable medical equipment providers, transportation providers, and behavioral and mental health care providers. Program Integrity uses several methods to identify areas for review:

- The toll-free Fraud and Abuse Hotline for complaints of provider and beneficiary abuse. The number is 1-888-364-3224.
- Complaints of provider or beneficiary abuse reported using the Fraud and Abuse email address: fraudres@scdhhs.gov. Each complaint received from the hotline or email is reviewed, and if the complaint is determined to involve either a Medicaid beneficiary or provider, a preliminary investigation is conducted to identify any indications of fraud and abuse.
- Referrals from other sources as well as ongoing provider monitoring that identify aberrant or excessive billing practices.
- The automated Surveillance and Utilization Review System (SURS) to create provider profiles and

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

exception reports that identify excessive or aberrant billing practices.

A Program Integrity review can cover several years' worth of paid claims data. (See "Records/Documentation Requirements" in this section for the policy on Medicaid record retention.) The Division conducts payment reviews, analysis of provider payments, and review of provider records, using statistical sampling and overpayment estimation when feasible, to determine the following:

- Medical reasonableness and necessity of the service provided
- Compliance with Medicaid program coverage and payment policies
- Compliance with state and federal Medicaid laws and regulations
- Compliance with accepted medical coding conventions, procedures, and standards
- Whether the amount, scope, and duration of the services billed to Medicaid are fully documented in the provider's records

Most Program Integrity on-site reviews are unannounced. The medical records and all other necessary documents obtained/received from the provider must contain documentation sufficient to disclose the extent of services delivered, medical necessity, appropriateness of treatment, and quality of care. Program Integrity staff thoroughly review all the documentation and notify the provider of the post-payment review results.

If the Program Integrity review finds that excessive, improper, or unnecessary payments have been made to a provider, the provider will be required to refund the overpayment or have it taken from subsequent Medicaid reimbursement. Failure to provide sufficient medical records within the timeframe allowed, or refusal to allow access to records, will also result in denial of the claim(s) involved, and Medicaid reimbursement for these claims must be refunded. Even if a provider terminates his or her agreement with Medicaid, the provider is still liable for any penalties or refunds identified by a Program Integrity review or audit. Failure to repay an identified overpayment may result in termination or exclusion from the Medicaid

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

program and other sanctions, which will be reported to the Federal Office of Inspector General (OIG).

For claims selected for a Program Integrity review, the provider cannot void, replace, or tamper with any claim records and documentation until the review is finalized.

Providers who disagree with the review findings are instructed to follow the process outlined in the certified letter of notification. The process affords providers the opportunity to discuss and/or present evidence to support their Medicaid claims.

RECOVERY AUDIT CONTRACTOR

The South Carolina Department of Health and Human Services, Division of Program Integrity, has contracted with a Recovery Audit Contractor to assist in identifying and collecting improper payments paid to providers as a result of billing errors as referenced in 42 CFR 476.71. Section 6411(a) of the Affordable Care Act, Expansion of the Recovery Audit Contractor (RAC) Program amends section 1902(a) (42) of the Social Security Act and requires States to establish a RAC program to enable the auditing of claims for services furnished by Medicaid providers. Pursuant to the statute, these Medicaid RACs must: (1) identify overpayments; (2) recoup overpayments; and (3) identify underpayments. The Centers for Medicare & Medicaid Services (CMS) published the final rule implementing this provision, with an effective date of January 1, 2012. States are required to contract with Medicaid RACs "in the same manner as the Secretary enters into contracts" with the Medicare Recovery Auditors. For example, the contingency fee paid to the Medicaid RAC may not exceed that of the highest fee paid to a Medicare Recovery Auditor.

Under this rule, State contracts with Medicaid Recovery Audit Contractors must include the following requirements (or the State must obtain an exemption from CMS for the requirement):

- That each Medicaid RAC hires a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy licensed to practice in that State.
- That each Medicaid RAC also hires certified coders (unless the State determines that certified coders are

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

RECOVERY AUDIT CONTRACTOR (CONT'D.)

not required for the effective review of Medicaid claims)

- An education and outreach program for providers, including notification of audit policies and protocols
- Minimum customer service measures such as a toll-free telephone number for providers and mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers' request
- Notifying providers of overpayment findings within 60 calendar days
- A 3 year maximum claims look-back period and
- A State-established limit on the number and frequency of medical records requested by a RAC.

HMS (Health Management Systems, Inc.) is the current Recovery Audit Contractor for the SCDHHS Division of Program Integrity.

BENEFICIARY EXPLANATION OF MEDICAL BENEFITS PROGRAM

The Beneficiary Explanation of Medical Benefits Program allows Medicaid beneficiaries the opportunity to participate in the detection of fraud and abuse. Each month the Division of Program Integrity randomly selects four hundred beneficiaries for whom claims for services were paid. These beneficiaries are provided with an Explanation of Medical Benefits that lists all non-confidential services that were billed as having been delivered to them and which were paid during the previous 45-day period. Beneficiaries are requested to verify that they received the services listed. The Division of Program Integrity investigates any provider when the beneficiary denies having received the services.

BENEFICIARY OVERSIGHT

The Division of Program Integrity identifies beneficiaries who may be misusing or overusing Medicaid services. Claims for services provided to identified persons are analyzed for patterns of possible fraudulent or abusive use of services. Referral to the State Attorney General's Office or other law enforcement agencies for investigation will be made based on the severity of the misuse. When a referral is not warranted, an educational letter may be sent to the beneficiary encouraging them to select a primary care

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

BENEFICIARY OVERSIGHT (CONT'D.)

physician and one pharmacy to ensure they receive quality care from a health care provider of their choice.

Complaints pertaining to beneficiaries' misuse of Medicaid services can be reported using the Fraud and Abuse Hotline (1-888-364-3224) or fraud email at fraudres@scdhhs.gov.

MEDICAID BENEFICIARY LOCK-IN PROGRAM

SCDHHS implemented a Medicaid Beneficiary Lock-In Program in December 2008. The purpose of the Beneficiary Lock-In Program is to address issues such as coordination of care, patient safety, quality of care, improper or excessive utilization of benefits, and potential fraud and abuse associated with the use of multiple pharmacies and prescribers. The policy implements SC Code of Regulations R 126-425. The Division of Program Integrity reviews beneficiary profiles in order to identify patterns of inappropriate, excessive, or duplicative use of pharmacy services, such as using four or more pharmacies in a six-month period. If beneficiaries meet the lock-in criteria established by SCDHHS, they will be placed in the Medicaid Lock-In Program for one year to monitor their drug utilization and to require them to utilize one designated pharmacy. The beneficiary has the opportunity to select a pharmacy and has the right to appeal. The pharmacy provider selected is also notified of the lock-in, so that adequate time is allowed for selection of another provider should the first provider find he or she cannot provide the needed services.

DIVISION OF AUDITS

Medicaid providers, who contract with SCDHHS for services, including state agencies, may be audited by the SCDHHS Division of Audits. The SCDHHS Division of Audits was formed to assist the agency in the management, assessment, and improvement of agency programs, services, and operations. The Division of Audits accomplishes these goals by continuously reviewing and evaluating programs administered by SCDHHS to determine the extent to which fiscal, administrative, and programmatic objectives are met in a cost-effective manner.

In performing its audits, the Division of Audits follows generally accepted auditing standards (GAGAS). The Division of Audits performs different types of audits of Medicaid providers and programs, including:

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

DIVISION OF AUDITS (CONT'D.)

- Performance audits that provide an independent assessment of the program outcomes and the management of resources. These audits address the effectiveness, efficiency, and adequacy of program results.
- Audits of contracts with health care providers and other state agencies to ensure compliance with contract terms and conditions for Medicaid service delivery and administration
- Audits to confirm the accuracy and allowability of costs and other financial information reported to SCDHHS.

PAYMENT ERROR RATE MEASUREMENT

The South Carolina Medicaid program, along with the Medicaid programs in other states, is required to comply with the CMS Payment Error Rate Measurement (PERM) program, which was implemented in federal fiscal year 2007. Each state will be reviewed every three years. PERM requires states to submit a statistically valid sample of paid Medicaid claims to a federal contractor, which will review for compliance with payment rates and state Medicaid policies, and will determine whether medical necessity for the service is adequately documented in the medical record. Providers who are chosen for the sample will be required to submit all applicable medical records for review; however, for most providers only one claim will be chosen for the sample. Providers who fail to send in the requested documentation will face recoupment of the Medicaid payment for the claim in question. In addition, if the CMS PERM contractor determines that a Medicaid claim was paid in error, SCDHHS will be required to recoup the payment for that claim. PERM will combine the errors found in each state in order to establish a national Medicaid error rate.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS / TERMINATIONS

FRAUD

The South Carolina Medicaid program operates under the anti-fraud provisions of 42 US Code §1320a-7b. This federal law relates to both fraud and abuse of the program and identifies illegal acts, penalties for violations, and the individuals and/or entities liable under this section.

The Division of Program Integrity carries out SCDHHS responsibilities concerning suspected Medicaid fraud as required by 42 CFR Part 455, Subpart A. Program Integrity must conduct a preliminary investigation and cooperate with the state and federal authorities in the referral, investigation, and prosecution of suspected fraud in the Medicaid program. SCDHHS refers suspected cases of Medicaid fraud by health care providers to the Medicaid Fraud Control Unit of the State Attorney General's Office for investigation and possible prosecution. SCDHHS also makes referrals to the Bureau of Drug Control for suspected misuse or overprescribing of prescription drugs, especially controlled substances. If a provider suspected of fraud or abuse is also enrolled in a Medicaid Managed Care Organization (MCO), Program Integrity will coordinate the investigation with the MCO(s) involved. Suspected Medicaid fraud on the part of a beneficiary is referred to a Medicaid Recipient Fraud Unit in the State Attorney General's Office for investigation.

PAYMENT SUSPENSION

Medicaid payments to a provider may be withheld upon credible allegation of fraud, in accordance with the requirements in 42 CFR §455.23.

Suspension of Provider Payments for Credible Allegation of Fraud

SCDHHS will suspend payments in cases of a credible allegation of fraud. A "credible allegation of fraud" is an allegation that has been verified by SCDHHS and that comes from any source, including but not limited to the following:

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MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

Suspension of Provider Payments for Credible Allegation of Fraud (Cont'd.)

- Fraud hotline complaints
- Claims data mining
- Patterns identified through provider audits, civil false claims cases, and law enforcement investigations

SCDHHS has flexibility in determining what constitutes a "credible allegation of fraud." Allegations are considered to be credible when they have indications of reliability based upon SCDHHS' review of the allegations, facts, and evidence on a case-by-case basis.

Notice of Suspension

SCDHHS will suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity. Payments may be suspended without first notifying the provider of the intention to suspend payments. SCDHHS will send notice of its suspension of program payments within the following timeframes:

- Within five business days of suspending the payment, unless requested in writing by a law enforcement agency to temporarily withhold such notice
- Within 30 calendar days of suspending the payment, if requested by law enforcement in writing to delay sending such notice

The Notice of Payment Suspension will include all information required to be provided in accordance with 42 CFR §455.23.

All suspension of payment actions will be temporary and will not continue after either of the following:

- SCDHHS or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider
- Legal proceedings related to the provider's alleged fraud are completed

Referrals to the Medicaid Fraud Control Unit

Whenever an investigation leads to the initiation of a payment suspension in whole or part, SCDHHS will make a fraud referral to the South Carolina Medicaid Fraud Control Unit ("MFCU").

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

Good Cause not to Suspend Payments or to Suspend Only in Part

SCDHHS may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed on an individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;
- Other available remedies implemented by SCDHHS will more effectively or quickly protect Medicaid funds;
- SCDHHS determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed;
- SCDHHS determines that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons:
    - An individual or entity is the sole community physician or the sole source of essential specialized services in a community;
    - The individual or entity serves a large number of beneficiary's within a medically underserved area, as designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
- Law enforcement declines to certify that a matter continues to be under investigation;
- SCDHHS determines that payment suspension is not in the best interests of the Medicaid program.

SCDHHS may also find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, on any individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- SCDHHS determines that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons:

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

Good Cause not to Suspend Payments or to Suspend Only in Part (Cont'd.)

- An individual or entity is the sole community physician or the sole source of essential specialized services in a community;
- The individual or entity serves beneficiaries within a medically underserved area, as designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

- SCDHHS determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such suspension should be imposed only in part.
- SCDHHS determines the following:
  - The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and
  - A payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid. If this determination is made by SCDHHS, it will be documented in writing.
- Law enforcement declines to certify that a matter continues to be under investigation.
- SCDHHS determines that payment suspension is not in the best interest of the Medicaid program.

Even if SCDHHS exercises the good cause exceptions set forth above, this does not relieve the agency of its obligation to refer a credible allegation of fraud to the Medicaid Fraud Control Unit.

PROVIDER EXCLUSIONS

Federal regulations that give States the authority to exclude providers for fraud and abuse in the Medicaid program are found at 42 CFR Part 1002, Subparts A and B. Exclusion means that a health care provider, either an individual practitioner or facility, organization, institution, business, or other type of entity, cannot receive Medicaid payment for any health care services rendered. Exclusions from Medicaid, as well as the State Children's Health Insurance Program (SCHIP), may be the result of:

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MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

PROVIDER EXCLUSIONS (CONT'D.)

- Conviction of a criminal offense related to delivery of services in a health care program
- Conviction of health care fraud under either Federal or State laws
- Conviction of the patient neglect or abuse in connection with delivery of health care
- Excessive claims or furnishing of unnecessary or substandard items and services
- Failure to comply with financial responsibilities and obligations
- Adverse action by a licensing board

Exclusions can be initiated by either federal authorities such as the US Department of Health and Human Services, Office of Inspector General (OIG) or by the State Medicaid agency. An excluded individual may be a licensed medical professional, such as a physician, dentist, or nurse, but exclusion is not limited to these types of individuals. The ban on Medicaid funding can extend to any individual or entity providing services that are related to and reimbursed, directly or indirectly, by a Medicaid program.

In addition, the OIG and/or SCDHHS may exclude an entity, including managed care organizations, if someone who is an owner, an officer, an agent, a director, a partner, or a managing employee of the entity has been excluded.

Any medical provider, organization, or entity that accepts Medicaid funding, or that is involved in administering the Medicaid program, should screen all employees and contractors to determine whether any of them have been excluded. Any individual or entity which employs or contracts with an excluded provider cannot claim Medicaid reimbursement for any items or services furnished, authorized, or prescribed by the excluded provider.

Federal regulations further require that any party who is excluded from participation in Medicare under 42 CFR Part 1001 must also be excluded from the Medicaid program. Medicaid payment is not available for services furnished directly by, or under the supervision of, an excluded party.

The OIG maintains the LEIE (List of Excluded Individuals and Entities), a database accessible to the general public that

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

PROVIDER EXCLUSIONS (CONT'D.)

provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. Visit the OIG Web site at http://www.oig.hhs.gov/fraud/exclusions.asp to search and/or download the LEIE.

SCDHHS also maintains its own list of excluded, South Carolina-only Medicaid providers (or those with a South Carolina connection) on our Web site. Visit the Provider Information page at http://provider.scdhhs.gov for the most current list of individuals or entities excluded from South Carolina Medicaid.

PROVIDER TERMINATIONS

"Termination" means that the SCDHHS has taken an action to revoke a provider's Medicaid billing privileges, the provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and there is no expectation on the part of the provider or SCDHHS that the revocation is temporary. Under Federal regulations established by the Affordable Care Act, SCDHHS has established the reasons under which a provider can be terminated from the Medicaid program "for cause"; see SCDHHS PE Policy-03, Terminations.

ADMINISTRATIVE SANCTIONS

State regulations concerning administrative sanctions in the Medicaid program are found in South Carolina Regulations at Chapter 126, Article 4, Subarticle 1. SCDHHS may impose one or more of the following sanctions against a provider who has been determined to have abused the program:

- Educational intervention
- Post payment review
- Prepayment review
- Peer review
- Financial sanctions, including recoupment of overpayment or inappropriate payment
- Termination or exclusion
- Referral to licensing/certifying boards or agencies

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

OTHER FINANCIAL PENALTIES

The State Attorney General's Office may also impose financial penalties and damages against a provider who has been determined to be guilty of fraud or convicted of a crime related to participation in the Medicaid or Medicare programs.

The United States Department of Health and Human Services (USDHHS), Office of Inspector General (OIG), may also impose civil money penalties and assessments under the provisions of 42 CFR Part 1003

FAIR HEARINGS

Proposed South Carolina initiated exclusion or termination from the Medicaid program, as well as recoupment of an overpayment identified by Program Integrity, may be appealed within 30 days of imposition of the sanction. (See "Appeals Procedures" elsewhere in this section.)

Any party who has been excluded or terminated from the Medicaid program as a result of a similar action by Medicare may exercise appeal rights as set forth in the written notice from the USDHHS OIG. Appeals to the OIG shall be processed in accordance with 42 CFR 1001.2007. A party so excluded shall have no right to separate appeal before SCDHHS.

REINSTATEMENT

Re-enrollment in Medicaid by formerly excluded providers is not automatic. The CFR [42 CFR 1002.215(a)] gives states the right to review requests for reinstatement and to grant or deny the requests.

Before a request for re-enrollment in Medicaid will be considered, the provider must have an active, valid license to practice and must not be excluded from Medicaid or Medicare by the federal government (USDHHS OIG). It is the provider's responsibility to satisfy these requirements. If the individual was excluded by the Office of Inspector General (HHS-OIG), then the individual must first apply to HHS-OIG for reinstatement and follow any federal requirements.

SCDHHS may deny reinstatement to the Medicaid program based on, but not limited to, any one or a combination of the following:

1. The likelihood that the events that led to exclusion will re-occur.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

REINSTATEMENT (CONT'D.)

2. If, since the date of the original exclusion, the provider has been convicted of fraud related to the delivery of services in a healthcare program, or has been convicted or had his license suspended or revoked due to failure to follow standards of care and/or patient harm or abuse.
3. If new information is provided that such conduct (as described above) occurred prior to the date of the exclusion but was not known to SCDHHS at the time.
4. If the provider has been excluded or had billing privileges terminated from Medicaid and/or Medicare by any state or by the US DHHS OIG.
5. Any terms or conditions associated with reinstatement by the appropriate licensing board or regulatory agency, or by the HHS-OIG.
6. Whether all fines, overpayments, or any other debts owed to the Medicaid program have been paid or arrangements have been made to fulfill these obligations.

All requests for re-enrollment in Medicaid will be considered by SCDHHS on an individual basis and on their own merit.

Any appeal of a denial of reinstatement will be in accordance with SCDHHS appeals policies and procedures as provided by South Carolina Code of Laws R. 126-150.

A terminated provider will also be required to reapply and be reenrolled with the Medicaid program if they wish billing privileges to be reinstated.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

APPEALS

SCDHHS maintains procedures ensuring that all Medicaid providers will be granted an opportunity for a fair hearing. These procedures may be found in South Carolina Regulations at Chapter 126, Article 1, Subarticle 3. An appeal hearing may be requested by a provider when a request for payment for services is denied or when the amount of such payment is in controversy.

The South Carolina Medicaid appeals process is not a reconsideration or claims review process. It is a formal process that should be considered as an avenue of last resort to be used in attempting to resolve or settle a dispute(s). Providers should contact the PSC or submit an online inquiry for assistance to resolve or settle a dispute(s) before requesting an administrative hearing.

In accordance with regulations of SCDHHS, a provider wishing to file an appeal must send a letter requesting a hearing along with a copy of the notice of adverse action or the remittance advice reflecting the denial in question. Letters requesting an appeal hearing should be sent to the following address:

Division of Appeals and Hearings
Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The request for an appeal hearing must be made within 30 days of the date of receipt of the notice of adverse action or 30 days from receipt of the remittance advice reflecting the denial, whichever is later. Hearings will be held in Columbia unless otherwise arranged. The appellant or appellant's representative must be present at the appeal hearing.

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APPEALS

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SECTION 2

POLICIES AND PROCEDURES

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

DME OVERVIEW

The Department of Durable Medical Equipment (DME) at the South Carolina Department of Health and Human Services (SCDHHS) oversees the provision of medical supplies and equipment to eligible Medicaid beneficiaries. If you have questions about policies and procedures, 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.

As defined by SCDHHS, Durable Medical Equipment is equipment that provides therapeutic benefits or enables beneficiaries to perform certain tasks that they are unable to undertake otherwise due to certain medical conditions and/or illness. **This equipment can withstand repeated use, is primarily and customarily used for medical purposes, and is appropriate and suitable for use in the home.** Durable Medical Equipment includes equipment such as wheelchairs, hospital beds, traction equipment, canes, crutches, walkers, ventilators, oxygen, prosthetic and orthotic devices, and other medically needed items.

Providers should be aware of policy regulating medical necessity for durable medical equipment. The SCDHHS policy below describes DME-covered supplies and equipment.

Medicaid will pay for a service or item when the service or item is covered under the South Carolina State Plan, is medically necessary, and is appropriate for use in an eligible beneficiary's home (Please refer to the Fee Schedule in Section 4 for covered services and items).

"Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. Convenience and prevention items are not covered. A provider's medical records for each beneficiary must substantiate the need for services and must include all findings and information necessary to support medical necessity.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

DME PROVIDER ENROLLMENT

A provider must be in compliance with all applicable federal and state licensure and regulatory requirements. Providers must submit all information requested by enrollment including, but not limited to, the type of services provided including a list of equipment/supplies by purchase procedure code. Define the location(s) to be serviced.

In-State Providers

Providers who render services at a physical facility on an appropriate site in South Carolina or within 25 miles of the South Carolina border may enroll as a straight Medicaid provider. An in-state provider can render services for patients who are eligible under fee-for-service (FFS) Medicaid (with or without private pay insurance) and/or are dually eligible (Medicare and Medicaid).

Out-of-State Providers

Providers who render services at a physical facility on an appropriate site outside of the 25-mile radius of the South Carolina border may enroll in the SC Medicaid program as one of the following provider types:

- Crossover only — For patients with Medicare and Medicaid
- Emergency services only — Equipment provided for Medicaid-eligible patients outside of their normal service area. Prior approval is required. Requests are reviewed on a case-by-case basis.
- Sole source provider — Provide specialized equipment and/or supplies to patients that cannot otherwise be obtained using an in-state provider. Prior approval is required. Requests are reviewed on a case-by-case basis.

The physical facility must contain adequate space for storing business records including the supplier's delivery, maintenance, and beneficiary communication records. For purposes of this policy, a post office box or a commercial mailbox is not considered a physical facility. In the case of a multi-site supplier, records may be maintained at a centralized location.

Please see the Prior Authorization (PA) section for additional information on obtaining prior approval.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Operating Procedures

A provider must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A provider may not contract with any entity that is currently excluded from the Medicare program, any state health care programs, or from any other federal procurement or non-procurement programs.

A provider must notify beneficiaries of warranty coverage and honor all warranties under applicable state law, and repair or replace free of charge Medicaid-covered items that are under warranty.

A provider must agree not to initiate telephone contact with beneficiaries in order to solicit new business.

A provider is responsible for delivery and must instruct beneficiaries on use of Medicaid-covered items, and maintain proof of delivery.

A provider must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.

A provider must maintain and replace at no charge, or repair directly, or through a service contract with another company, Medicaid-covered items it has rented to beneficiaries. If complaints are filed with SCDHHS, the agency may perform an investigation and/or review of the provider. If the results of this investigation and/or review are unfavorable, SCDHHS will assign the appropriate agency to perform an additional investigation and/or review to establish continuing competency of the provider.

A provider must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.

A provider must disclose these provider standards to each beneficiary to whom it supplies a Medicaid-covered item.

A provider must disclose to the government any person having ownership, financial, or control interest in the provider.

A provider must not convey or reassign a provider number: *i.e.*, the provider may not sell or allow another entity to use its Medicaid billing number.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Operating Procedures (Cont'd.)

A provider must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.

Providers must bill their usual and customary charges and not the Medicaid reimbursement rate. Providers may not charge Medicaid any more for services to a beneficiary than they would customarily charge the general public.

Providers must accept the Medicaid payment as payment in full for covered services to patients accepted as Medicaid beneficiaries. (See Section 1, page 17, for additional information.)

Providers must make home visits as necessary on equipment that cannot be brought into the business or regular follow-up on equipment for maintenance when the equipment is under warranty or being rented.

Providers must bill the code that most accurately describes the item or services actually provided.

Providers cannot deny services to any eligible Medicaid member because of the member's inability to pay the copayment amount imposed. (See "Schedule of Copayments" in Appendix 3.)

Providers must not bill for DME items prior to the date of delivery to a member. Keep delivery records including date and signature of delivery person and member or caregiver. (See page 2-15 for additional information on proof of delivery.)

Providers accept responsibility for providing the appropriate equipment/supplies, set-up, or necessary assembly of the equipment in the home and any teaching necessary for correct use of the equipment and/or the supplies according to the manufacturer's directions and SCDHHS's policies and procedures. Providers accept responsibility for any follow-up teaching or monitoring, maintenance, or repair.

For all DME products that are supplied as an ongoing order, the provider must maintain documentation in the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Operating Procedures (Cont'd.)

beneficiary's medical record showing they are not automatically shipping supply orders without confirming the number of units needed with the beneficiary or the beneficiary's caregiver.

Provider Agreements – Most providers sign formal participation agreements with SCDHHS. These agreements contain general requirements for all providers as well as specific requirements for each service type. Each claim constitutes an agreement for services provided under the claim.

All providers are responsible for ensuring that information on file with the Medicaid program for their practice or facility remains up-to-date. Refer to "Reporting Changes in Provider Status" in this section.

Enrollment Procedure

The enrollment process takes approximately two to four weeks. However, the process can take longer if supporting documentation from other entities is required. Enrollment periods vary according to provider types. Some enrollment periods are end-dated and require the provider to initiate the re-enrollment process at a specified time by contacting SCDHHS Provider Enrollment.

A provider must provide complete and accurate information on the DME provider application. Any changes to this information must be reported to SCDHHS Provider Enrollment. A provider has 30 days to report a change. After 60 days the provider's number will be terminated.

An authorized individual (one whose signature is binding) must sign the application for billing privileges.

Providers are assigned a provider number and are notified of their provider status by mail once the enrollment process has been completed. Providers are referred to SCDHHS's Web site at http://www.scdhhs.gov/ Medicaid service information.

Tax Information

To ensure that 1099 MISC forms are issued to providers correctly, proper tax information must be on file for all providers. This will also ensure that the correct tax information is provided to the IRS. The procedure for submitting corrected tax information to the Medicaid program is as follows:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Tax Information (Cont'd.)

All providers must submit completed and signed W-9 forms along with a completed and signed **Medicaid Provider Change Form** to Medicaid at the address listed below:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809

Providers must also report changes of ownership and group practice changes.

Other Rules That Affect Participation

Civil Rights Act

Providers must comply with the Title VI of the Civil Rights Act of 1964, which states, "No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation under any program or activity receiving federal financial assistance."

Rehabilitation and Disabilities Act

Providers must comply with the following requirements in addition to the laws specifically pertaining to Medicaid:

- **Section 504 of the Rehabilitation Acts of 1973,** as amended, which states "No otherwise qualified handicapped individual in the United States shall solely by reason of his handicap, be excluded from the participation in, be denied the benefit of, or be subject to discrimination under any program or activity receiving federal financial assistance."
- **The Age Discrimination Act of 1975,** as amended, which states, "No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving federal financial assistance."
- **The Americans with Disabilities Act of 1990,** which prohibits exclusion from participation in or denial of services because the agency's facilities are not accessible to individuals with a disability.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Disclosure of Medicaid Information

The provider must comply with the requirements of the Social Security Act and federal regulations concerning:

1. Disclosure by providers (other than an individual practitioner or group of practitioners) of ownership and control information; and
2. Disclosure of information on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid or the Title XIX services program. (*Basic Medicaid Billing Guide, August 2005)*

Rules on Self-Referral

Physician Self-Referral

The rules on physician referrals are at 1877 of the Social Security Act (42 USC 1395nn) and in Part 411 of Title 42 of the Code of Federal Regulations. The rules are quite complex, with numerous exceptions.

Other Acts Involving Federal Health Care Programs

The criminal penalties for certain fraudulent acts (including the anti-kickback provisions) involving federal health care programs (including Medicaid) are at §1128B of the Social Security Acts (42 USC §13220a-7b).

Rules of Advance Directives

Section 4751 of the OBRA 1990, otherwise known as the Patient Self-Determination Act, requires certain Medicaid providers to provide written information to all patients 18 years of age and older about their rights under state law to make decisions concerning their medical care, to accept or refuse medical or surgical treatment, and to execute an advance directive (*e.g.,* living will or health care power of attorney). Effective January 1, 1998, a new law entitled "An Act to Establish Advance Instruction for Mental Health Treatment" (NCGS §122C-71-§122C-77) became effective. The law provides a method for an individual to exercise the right to consent to or refuse mental health treatment if the individual later becomes "incapable" (*i.e.,* lacks the capacity or ability to make and communicate mental health treatment decisions). The advance instruction becomes effective when delivered to the individual's physician or mental health treatment provider, who then makes it part of the individual medical record.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Reporting Changes in Provider Status

What Changes Must Be Reported

All providers are required to report all changes in status to Medicaid. This includes changes of ownership (within 30 days), name, address, tax identification number, licensure status, and the addition or deletion of group members.

Failure to report changes in provider status results in incorrect information in the provider's file. This may prevent or delay payments to the provider, or providers may be liable for taxes on income not received by their business.

How to Report a Change

Medicaid Provider Enrollment can be reached via the SCDHHS Provider Service Center at 1-888-289-0709.

Voluntary Termination

All providers must notify Provider Enrollment in writing at the address listed below of their decision to terminate their participation in the SC Medicaid program. Notification must be on the provider's letterhead and signed by the provider, office manager, or administrator.

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809

Termination of Inactive Providers

Medicaid provider numbers that do not reflect any billing activity within the previous 12 months will be terminated. Providers are notified by mail of SCDHHS's intent to terminate their inactive number and will have two weeks to respond if they wish to request that their number not be terminated. These notices are sent to the current mailing address listed in the provider's file. Once terminated, providers are subject to the full re-enrollment process and can experience a period of ineligibility as a Medicaid provider.

Payment Suspension

If RAs and checks cannot be delivered due to an incorrect billing address in the provider's file, all claims for the provider number are suspended and the subsequent RAs and/or checks are no longer printed. Automatic deposits are also discontinued. Once a suspension has been placed on the provider number, the provider has 60 days to submit an address change. After 60 days, if the address has not

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Payment Suspension (Cont'd.)

been corrected, claims in suspension deny and the provider number is terminated.

Licensure Revocation or Suspension

Any provider whose license(s)/certification is revoked or suspended is not eligible for participation in the SC Medicaid program. In the event that a provider who is licensed should have their license/certification revoked or suspended, the provider should notify Provider Enrollment.

Reactivation in the Medicaid program may occur when the license/certification is reinstated by the licensing authority. The provider must re-enroll and provide a copy of the reactivated license/certification. Reactivation is effective no earlier than the date on the reinstated license.

Sanctions

Providers who receive sanction(s) from CMS are ineligible for Medicaid participation and are responsible for refunding any Medicaid payments made to them while under a CMS sanction(s). CMS will notify SCDHHS of providers who are sanctioned. Individual providers who are sanctioned should notify SCDHHS immediately.

MEDICAID CERTIFICATE OF MEDICAL NECESSITY (MCMN)

A treating/ordering physician, nurse practitioner with prescribing authority, or physician assistant with prescribing authority has the authority to order the items needed in connection with his or her patient's plan of treatment and to determine the length of time the equipment or supplies will be needed.

The physician assistant should perform the services he or she is legally authorized to perform in the state in which he or she practices in accordance with state law (or the state regulatory mechanism provided by state law), and meet all training, education, and experience requirements.

In order for a provider to be reimbursed for equipment or supplies, a physician, nurse practitioner, or physician assistant must medically justify the need for the requested medical equipment and/or supplies on a Medicaid Certificate of Medical Necessity (MCMN).

There are six versions of the MCMN:

- Equipment/Supplies (DME 001)
- Power/Manual Wheelchairs and/or Accessories (DME 003)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

MEDICAID CERTIFICATE OF MEDICAL NECESSITY (MCMN) (CONT'D.)

- Orthotics/Prosthetics/Diabetic Shoes (DME 004)
- Enteral Nutrition (DME 005)
- Parenteral Nutrition (DME 006)
- Oxygen (DME 007)

Please refer to the Forms section of this manual for a copy of these forms. Each MCMN has instructions attached.

Medicaid prohibits DME providers from preparing the entire Medicaid Certificate of Medical Necessity (MCMN). DME providers are specifically prohibited from completing Section B of the MCMN.

Note: The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or a service does not, in itself, make such care, goods or services medically necessary or a covered service.

All applicable fields on the MCMN must be completed and legible. MCMNs that are illegible will be returned to the provider. All corrections to the MCMN must be initialed and dated by the individual responsible for the corrections. Changes to Section A can be made only by the DME provider. Changes to Section B can be made only by the treating or ordering physician.

Any change in the beneficiary's condition, products, or quantities requires a new MCMN.

For equipment/supplies that require a prior authorization (PA), only the date of service field on the MCMN may be completed after the approval is obtained. However, it must be filled in once equipment and supplies are delivered.

All supplies and medical equipment must be specifically identified by procedure code on the MCMN. The provider should refer to the Fee Schedule (Section 4) for a list of procedure codes to enter on the form. All procedure codes listed in the Fee Schedule require a MCMN.

An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.

DME providers are encouraged to resolve any questions or

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

MEDICAID CERTIFICATE OF MEDICAL NECESSITY (MCMN) (CONT'D.)

concerns they have about DME coverage before dispensing the item. If any item ordered appears inappropriate or a potential source of problems, a provider should contact the treating/ordering physician, nurse practitioner, or physician assistant before dispensing for clarification.

All medical documentation supporting the provision of items must be kept on file by the provider. These records are subject to review during on-site visits by SCDHHS. Failure to maintain MCMNs and other appropriate records may subject the provider to recoupment of funds.

Capped Rental Equipment

The items listed below are considered to be capped rental equipment. These items cannot initially be purchased. A capped rental item is only considered purchased when it has been rented for a maximum of ten months. Capped rental items will have the "LL" modifier in the fee schedule but will not have "NU" or "UE" options with the units/time span being "10 in 5 years."

E0250 Manual hospital bed with mattress side rails

E0470 Respiratory assist device, bi-level pressure capability without backup rate feature

E0471 Respiratory assist device, noninvasive interface

E0472 Respiratory assist device, invasive interface

E0601 Continuous airway pressure (CPAP) device

E0784 Insulin pump

E0791 Parenteral infusion pump

E0940 Trapeze free stand complete with grab bar

E2000 Gastric suction pump

K0001 Standard manual wheelchair

K0195 Elevating leg rest, pair

The payment categories for codes E0471 and E0472 were revised to move Respiratory Assist Devices from the DME category for frequently serviced items to the DME payment category for capped rental items, effective on August 1, 2006.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Limited Rentals

The following equipment has a limited rental period. Each item will only be rented for four months and must be requested by a Prior Authorization form and accompanied by a Certificate of Medical Necessity. Any pertinent medical records or justification must also accompany this request. Requests for additional months must be resubmitted with a new Prior Authorization, recertified CMN, and progress notes, and will be reviewed on a case-by-case basis. None of these items can be rented over 10 months.

E0372 Powered air overlay mattress

E0277 Power pressure-reducing air mattress

E0193 Powered air floatation bed

E0194 Air fluidized bed

E2402 Negative pressure wound therapy electrical pump (See additional criteria on page 34 of this section)

E0747 Osteogenesis stimulator

These items cannot be approved for the purpose of prevention.

For detailed instructions on completing the MCMN, please refer to Section 3 of this manual.

MEDICAID PRIOR APPROVAL (PA) FROM KEPRO

Keystone Peer Review Organization (KePRO) is the Quality Improvement Organization (QIO) for South Carolina Medicaid. Effective June 1, 2012, all prior authorization (PA) requests for DME codes must be submitted to KePRO. KePRO will use nationally developed clinical rules and best practices for medical necessity determinations such as McKesson's InterQual for Durable Medical Equipment. Providers for these services will continue to submit the Certificate of Medical Necessity, physician's orders, and all pertinent medical documentation. DME services and equipment requiring prior approval are identified in Section 4 of this manual.

DME will reimburse for medically necessary items only. Items billed as convenience or prevention will are not covered. DME Providers are responsible for submitting and billing the correct HCPCS procedure code(s).

Case Managers and Service Coordinators for Community

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

MEDICAID PRIOR APPROVAL (PA) FROM KEPRO (CONT'D.)

Long Term care (CLTC) and the South Carolina Department of Disabilities and Special Needs (SCDDSN) home and community-based waiver programs will continue to authorize services for their waiver participants.

For beneficiaries with private third party insurance, the provider must follow DME's guidelines for prior approval.

For dually eligible beneficiaries, DME will follow Medicare's guidelines for procedure codes that are deemed not medically justified. Providers are prohibited from billing DME for reimbursement under this circumstance.

An approved authorization is not a guarantee that Medicaid will reimburse the service. Both the provider and beneficiary must be eligible on the date of service, the service must not have exceeded any applicable service limits, and a clean claim must be submitted within the time limit for submitting claims. Denied requests are returned to the provider with a letter of explanation. See Section 1 of this manual for information on eligibility verification.

INSTRUCTIONS FOR OBTAINING PRIOR APPROVAL

Requests for prior authorizations for the above services can be submitted to KePRO using one of the following methods:

KePRO Customer Service Phone: 855-326-5219
KePRO Fax: 855-300-0082
For Provider Issues email: atrezzoissues@Kepro.com

Additionally, you can find additional information in regards to prior authorizing this equipment by visiting the KePRO website at http://scdhhs.kepro.com

The QIO reviewer will screen the medical information provided, using appropriate QIO or InterQual criteria for non-physician review. If criteria are met, the DME item will be approved and an authorization number assigned. Notification of the approval and authorization number will be given by written confirmation to the physician. Write this number in block 23 of the CMS-1500 claim form.

If criteria are not met or a case is otherwise questioned, the QIO reviewer will refer the procedure request to a physician reviewer. If the physician reviewer cannot approve the DME item based on the initial information provided, he or she will make a reasonable effort to contact the DME provider for additional supporting documentation

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

INSTRUCTIONS FOR OBTAINING PRIOR APPROVAL CONT'D.)

of the need for the procedure.

The physician reviewer will document any additional information provided, as well as his or her decision regarding the medical necessity and appropriateness of the DME item.

Review personnel will assign an authorization number (if the procedure is approved), and a written copy of the authorization number will be sent to the DME provider.

If the physician reviewer cannot approve the procedure based on the additional information, he or she will document the reasons for the decision. QIO review personnel will attempt to notify the DME provider's office of the denial.

KePRO will accept medical review documentation via facsimile, telephone, or via their website. Providers are responsible for verifying beneficiary eligibility prior to the PA request being submitted and again prior to performing a service. Eligibility and managed care enrollment status may change during the time a request is submitted and approved and the actual date the DME item is ready for delivery.

The DME provider may request a reconsideration of the initial denial decision by submitting a written request outlining the rationale for recommending the DME item. Requests for reconsiderations must be submitted within 30 calendar days of receipt of the denial. The reconsideration request must include a copy of the denial letter and any documentation not previously submitted that supports the medical necessity of the equipment requested. The request should be in writing to KePRO. If the original denial is upheld, providers may exercise their right to an appeal as outlined in Section 1 of this manual.

PROOF OF DELIVERY

DME providers are responsible for delivering and setting up medical equipment, and for educating the beneficiary in how to use it. The provider may deliver directly to the beneficiary or a designee. The relationship of the designee to the beneficiary should be noted on the delivery slip and the signature should be legible. Providers, their employees, and others with a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (*i.e.*, acting as a designee on behalf

PROOF OF DELIVERY

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

(CONT'D.)

of the beneficiary). Delivery to the beneficiary's home via the United States Postal Service, Federal Express, United Parcel Service, etc. is strictly prohibited for medical equipment. Confirmed cases of this type of delivery will have payments recouped.

The DME provider is responsible for maintaining proof of delivery documentation for any DME services (*i.e.*, repairs, equipment and/or medical supplies) rendered in each beneficiary's medical record for five years. For any DME services which do not have proof of delivery, services will be denied and overpayments will be recovered.

Proof of Delivery and Delivery Methods

When providers deliver directly to the beneficiary or his or her designee, they shall maintain delivery slips in the beneficiary's medical record. A delivery slip shall include:

- The beneficiary's name
- The quantity delivered
- A detailed description of the item being delivered, to include identifying the item as new or used (if equipment)
- The brand name
- The serial number

The date on the delivery slip must be the date the item(s) was received by the beneficiary or designee.

In instances where equipment and/or supplies are delivered directly by the provider, the date the beneficiary received the supply shall be the date of service on the claim.

If the provider uses a shipping service or mail order, the provider shall maintain proof of delivery documentation in the beneficiary's medical record that includes:

- The shipping service's package identification number for that package sent to the beneficiary
- The shipping service's tracking slip that references each individual package
- The delivery address
- The corresponding package identification number given by the shipping service

Proof of Delivery and Delivery Methods (Cont'd.)

- A detailed description of the products delivered in

the package, to include brand name, serial number, and quantity for each product

- The date delivered

If a provider uses a shipping service or mail order, providers shall use the shipping date as the date of service on the claim. DME providers are prohibited from delivering any equipment item via mail order or a shipping service.

Providers may also use a return postage-paid delivery invoice from the beneficiary or designee as a form of proof of delivery. The delivery invoice shall include:

- The beneficiary's name
- A detailed description of the products delivered in the package
- Brand name
- Serial number

The quantity for each product delivered in the package.

AUTO-REFILLING

The over-provision of medical supplies by durable medical equipment (DME) and medical supply providers and the stockpiling of medical supplies by beneficiaries is inappropriate and unnecessary. Beneficiaries' individual medical supply needs vary from month to month. Medical supply quantities must not exceed the individual beneficiary's one month's usage. Placing a beneficiary on automatic supplying or replenishment until the prescription or the active Medicaid Certificate of Medical Necessity (MCMN) expires, or the beneficiary voluntarily discontinues services is prohibited.

For products that are supplied as refills to an original order, suppliers must contact the beneficiary prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes or modifications to the order. The provider shall contact the beneficiary or designee regarding refills no sooner than approximately seven days prior to the shipping date. This is regardless of which delivery method is used. The DME provider should deliver refilled supplies no sooner than approximately five days prior to the end of usage for the current product. Documentation showing each request for refill shall be

AUTO-REFILLING

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

(CONT'D.)

maintained in the beneficiary's medical record.

BILLING

The cost of an item or service must not be disproportionate to its therapeutic benefits or more costly than a reasonable alternative. The item must not serve the same purpose as equipment already available to the beneficiary. Providers must bill their usual and customary charges up to the Medicaid allowable as indicated in the Fee Schedule.

Manual Pricing and Not Otherwise Classified (NOC) Codes

DME does not require enrolled providers to submit manufacturer pricing information with prior authorization requests for procedure codes that have an established allowable. However, pricing information must be attached to all requests involving procedure codes that do not have an established Medicaid maximum reimbursement rate. These procedure codes require manual pricing and are identified in the Fee Schedule by the presence of an "M" in the "Price" column. (Please refer to the Fee Schedule in Section 4 of this manual.)

To ensure accurate payment of manually priced and Not Otherwise Classified (NOC) codes, the provider must submit an actual invoice or a manufacturer price quote. If submitting screen prints and web-page printouts, a signature is required certifying the date, quantity, cost, and description of items being billed. Medicaid will reimburse the invoice cost plus 25 percent. Providers should indicate in documentation if pricing is at cost or Manufacturer Suggested Retail Pricing (MSRP). Claims submitted with documents other than an invoice or a signed document as indicated above will be rejected.

Medicaid does not reimburse sales tax.

Medicare Information/ Pricing Updates

As pricing becomes available for manually priced procedure codes, and Medicare prices fluctuate, Medicaid may implement automatic pricing updates, written deletions, and changes without prior notification. Additionally, as Medicare updates codes, Medicaid will implement code updates and corresponding policy changes without prior notification. Providers are encouraged to routinely check the Medicaid Web site at http://www.scdhhs.gov/ for updates.

Medicare Information/ Pricing Updates (Cont'd.)

Note: Consult the PSC, submit an online inquiry, or visit the SCDHHS agency Web site for codes and pricing

updates.

Frequency Limitations

Providers may only bill Medicaid the actual number units of any supply or equipment that is medically necessary for the beneficiary. The provider may be requested to submit documentation secondary to the Medicaid Certificate of Medical Necessity (MCMN) to substantiate reimbursements paid for the maximum number of units allowed in the Fee Schedule. SCDHHS may seek recoupment of payments made to providers when maximum frequencies for supplies and equipment where billed and paid when beneficiary medical records maintained by the provider do not support the medical necessity of the number or units billed. Requests for reimbursement for items exceeding the frequency limitations will not automatically warrant reimbursement. If a physician requires that a beneficiary receive services beyond Medicaid's normal frequency limits, this must be noted on the MCMN and attached to the CMS-1500 claim form that, in turn, will be forwarded to the program area as a request for review. Requests for similar/same equipment previously provided will not be approved under the following circumstances:

1. If previous equipment is operable
2. If the item is repairable (Repair options should be obtained before item is replaced.)
3. If only to obtain a "newer" model
4. If requested as a back-up or for convenience (*i.e.*, because the beneficiary is eligible to receive another one due to the expiration of the time frequency limit of the previous equipment)

In cases where the beneficiary's medical need exceeds the authorized units for supplies or medical equipment as specified in the Fee Schedule (whether Medicaid is primary or secondary to other insurance), the treating/ordering physician, nurse practitioner, or physician assistant must justify the medical need for the specific number of additional units on the MCMN before approval can be sought. This is not an automatic approval process.

Miscellaneous Procedure

Providers can only use miscellaneous procedure codes

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Codes

when there is not a code available that best describes the product or service being billed. Providers cannot use a miscellaneous code to "bypass" an established code because of pricing issues.

The DME department staff should be consulted before entering Not Otherwise Classified (NOC) procedure codes on the prior authorization form. These procedure codes must be listed on the MCMN.

Note: Procedure codes K0108 and E1399 should **not** be used in lieu of established (or similar) codes located in our manual. The use of these codes in lieu of established (or similar) codes located in our manual for greater reimbursement is **not allowed**.

Modifiers

The following modifiers are acceptable for durable medical equipment and must be listed on the Prior Authorization form. Once Medicare has been billed for reimbursement on dually eligible beneficiaries, the modifier must be changed to the appropriate Medicaid modifier and/or the modifier indicated in the Fee Schedule:

NU New Equipment

LL Rental (equipment may be converted to purchase)

RR Rental (equipment that will always remain on a rental basis)

00 Purchase (used for medical supplies)

52 Reduced Rate (Reduced rental payments are made every 6 months beginning on the 16th month of use regardless of the type or life span of the equipment.)

RT Right

LT Left

UE Used Equipment (Equipment that was issued on a rental basis and then returned to the provider by the beneficiary is considered used equipment. If the provider reissues this equipment, this modifier must be used on the MCMN and claim form.)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Modifiers (Cont'd.)

SC Medically necessary service or supply (This modifier is used only with certain home infusion codes when more than one home infusion therapy is being administered.)

National Correct Coding Initiative (NCCI)

The Centers for Medicare and Medicaid Services (CMS) implemented the National Correct Coding Initiative (NCCI) to control improper coding that leads to inappropriate increased payment for health care services. The South Carolina Medicaid program utilizes NCCI edits and its related coding policy to control improper coding and to evaluate billing of CPT codes and Healthcare Common Procedure Coding System (HCPCS) codes by Medicaid providers in post-payment review of providers' records. For assistance in billing, providers may access the NCCI Edit information online at the CMS Web site, http://www.medicaid.gov/Medicaid%CHIP%Program%Information/By%Topics/Data%and%Systems/National%Correct%Coding%Initiative.html

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

SPECIAL PROGRAMS

Medicaid Managed Care

DME services are considered a core benefit with respect to Medicaid Managed Care. As such, if a beneficiary is enrolled in a Managed Care Organization (MCO), the DME services rendered must be authorized by the MCO and provided by an in-network DME provider. Claims for DME services rendered to MCO members are adjudicated by the MCO.

DME services rendered to beneficiaries enrolled in the Medical Homes Network (MHN) program are to be handled the same as DME services rendered to beneficiaries enrolled in traditional fee-for-service (FFS) Medicaid. Claims for DME services provided to MHN members are adjudicated by the Medicaid agency.

For detailed information concerning Medicaid Managed Care, please review the information contained in the Managed Care Supplement, and the MCO and MHN Policy and Procedure Guides. This information is located in the Managed Care section on the SCDHHS Web site: http://www.scdhhs.gov.

Hospice

Hospice services are an additional benefit under the Medicaid State Plan. Hospice services provide palliative care (relief of pain and uncomfortable symptoms) as opposed to curative care for terminally ill individuals. In addition to meeting the patient's medical needs, hospice addresses the physical, psychosocial, and spiritual needs of the patient, as well as the psychosocial needs of the patient's family and caregiver.

Hospice services are available to Medicaid beneficiaries who choose to elect the benefit and who have been certified as terminally ill with a life expectancy of six months or less by their attending physician and/or the Medical Director of the hospice.

Hospice services are provided to the beneficiary according to a plan of care developed by an interdisciplinary staff of the hospice. Medical appliances and supplies, including drugs, which are used for the relief of pain and symptom control related to the terminal illness, are covered services through hospice.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospice (Cont'd.)

A beneficiary who elects the hospice benefit must waive all rights to other Medicaid benefits for services related to treatment of the terminal condition for the duration of hospice care. Specific services that must be waived include:

1. Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice)
2. Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected, or related condition
3. Any services equivalent to hospice care except for services:
   a) Provided (either directly or under arrangement) by the designated hospice
   b) Provided by the individual's attending physician if that physician is not an employee of the designated hospice or is not receiving compensation from the hospice for those services
   c) Provided as room and board by a nursing facility, if the individual is a resident

Services for illnesses or conditions not related to the terminal illness of the patient may be provided and billed by the appropriate service provider. However, prior authorization is required from the hospice provider before delivery of durable medical equipment and supplies to verify that the services being provided are for a condition not related to the terminal illness. Prior authorization must be obtained by calling the hospice provider (as indicated by the Medicaid beneficiary) to receive the authorization number. The authorization number must be entered in field 19 on the CMS-1500 claim form. Claims submitted without the required hospice authorization will be rejected. All services delivered to hospice beneficiaries will be subject to payment review. Providers should contact the PSC at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for additional information related to terminal illness.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

QUALIFIED MEDICARE BENEFICIARY (QMB)

Medicaid beneficiaries who are also eligible for Medicare benefits are commonly referred to as "dually eligible." Providers may bill SC Medicaid for Medicare cost sharing for Medicaid-covered services for dually eligible beneficiaries. Some dual eligibles are also Qualified Medicare Beneficiaries (QMB). If the dually eligible beneficiary is also a QMB, providers may bill SC Medicaid for the Medicare cost sharing for services that are covered by Medicare without regard to whether the service is covered by SC Medicaid. Reimbursement for these services will be consistent with the SC State Medicaid Plan. Please refer to Section 3 of this manual for instructions regarding billing procedures for dually eligible beneficiaries. Please refer to the Medicaid Web-Based Claims Submission Tool, in Section 1, for instructions on how to access beneficiary information, including QMB status.

COVERED SERVICES/ITEMS

Rental Services

The beneficiary's prognosis is a deciding factor in approving equipment rental. In order to continue the rental, the treating/ordering physician, nurse practitioner, or physician assistant must submit a recertified MCMN request before the initial rental period has expired. At that point, a DME program coordinator makes the determination to either continue renting or convert to purchase. If purchase is decided, the approved dollar amount will reflect the allowable purchase price less the amount already paid in rental. **The provider must then bill the approved amount.**

Maintenance of Rented Equipment

Maintenance of rented equipment is not reimbursable by Medicaid. Parts and supplies used in the maintenance of rented equipment are included in the rental payment of the equipment.

Rent to Purchase

For dually eligible and Medicaid-only beneficiaries, Medicaid will rent most equipment for a maximum of ten months and the item is considered purchased thereafter. Medicaid does not reimburse for maintenance fees.

Warranties

The provider is required to honor all manufacturers' warranties for all new equipment, supplies, parts, and

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Warranties (Cont'd.)

accessories that are issued to beneficiaries. This includes rentals that have been paid for ten months and that are therefore considered purchased. Used equipment is issued with an implied 60-day warranty guaranteed by the selling provider. Used parts, supplies, and accessories will have no warranties. Any warranty period will commence with the date of delivery to the beneficiary.

- Warranties pertaining to mobility equipment (*e.g.*, Custom Seating and Powered Mobility) – Providers must stand behind a two-year warranty of the major components for custom wheelchairs
- Manual wheeled mobility base – A wheelchair with a manual wheeled mobility base must have a lifetime warranty on the frame of the wheelchair against defects in material and workmanship.
- Powered mobility base – A unit with a powered mobility base must have a lifetime warranty on the frame against defects in materials and workmanship for the lifetime of the member.

Additional Warranty

- The main electronic controller must have a two-year warranty from the date of delivery.
- Motors, gearboxes, and the remote joystick must have a two-year warranty from the date of delivery.
- Cushions and seating systems must have a two-year warranty or full replacement for manufacturer defects or the surface that does not remain intact due to normal wear.

In the event a provider asks the Medicaid DME program to approve payment for a repair to any new medical equipment within the first year of its use by the beneficiary, the provider must provide a copy of said warranty demonstrating a warranty period of less than one year. DME will reimburse any warranty labor not reimbursed by the manufacturer. The Medicaid Program may reimburse loaner equipment needed by the beneficiary during an extended repair only for the time that would be reasonable for the repair to be completed.

Prior authorization must be obtained if the loaner equipment procedure code requires prior approval.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Replacement

The DME Program covers replacement medical equipment as needed due to wear, theft, or irreparable damage or loss by disasters if the medical equipment is still medically needed by the beneficiary. Documentation must accompany the MCMN for reimbursement in these instances (*i.e.*, police report, fire report). Cases suggesting malicious damage, neglect, or wrongful misuse will be denied. Contact the Fraud and Abuse Hotline at 1-888-364-3224 if you have questions or suspect abuse.

Repairs

Repairs to Medicaid-covered durable medical equipment owned by the beneficiary are reimbursable by Medicaid. Providers who received approval from KePRO for equipment or accessories on or after June 1, 2012, must submit a repair request for those items to KePRO. If the original request was approved by SCDHHS prior to June 1, 2012, providers must continue to submitted repair requests to SCDHHS along with the Certificate of Repair and Labor Cost (CRLC). The Certificate of Repair and Labor Cost (CRLC) is used for labor and/or repairs. These repairs must be pre-authorized by DME staff. Providers must use the Prior Authorization Form (DHHS Form 214) and attach the manufacturer's pricing with the request.

For items with established procedure codes that do not require a PA, attach the CRLC form to the CMS-1500 form when billing.

Note: Replacement or repair of equipment is covered in cases of occurrences (*e.g.,* from fire) or when the member's condition changes. Equipment will NOT be replaced due to the member's negligence and/or abuse (*e.g.,* a wheelchair left outside). Equipment will NOT be replaced before its normal life expectancy has been attained unless supporting medical documentation of a change in the physical condition of the member is submitted for prior approval. In addition, a purchase estimate and supporting documentation must be submitted as to the reason for replacement of purchased equipment (*e.g.,* fire report).

Note: Labor codes listed below must be billed with all repairs on the same form.

- K0739 (replaces E1340 effective for dates of services on and after April 1, 2009)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Repairs (Cont'd.)

- L4205 (orthotics)

Repair requests should not be combined with any other equipment request. If a repair exceeds the limitation on labor, a written justification must be attached to the request. These requests will be reviewed and considered for payment on a case-by-case basis.

Supplies and Medical Equipment

Apnea Monitors

Apnea monitors are reimbursed according to the following criteria:

1. The monitor is a part of a written plan of care ordered and supervised by the treating/ordering physician.
2. Monitor use is instituted after evaluation and treatment of other causes of prolonged sleep apnea to include but not limited to: arterial hypoxemia due to respiratory distress syndrome or aspiration, bacterial or viral pneumonia; sepsis, seizure disorder, intracranial hemorrhage, hypoglycemia, cardiac abnormalities due to congestive heart failure, patent ductus arteriosis, and arrhythmias aspiration reflex; endocrine abnormalities; and child abuse.
3. Monitor use is instituted after pediatric pneumogram and ECG monitoring to determine the frequency and duration of sleep apnea and cardiac rate changes have recorded respirations and heart rate for at least several sleep cycles to confirm prolonged sleep apnea.
4. Monitor use is instituted after parents are provided with training and a plan of support to include use of the infant monitor; theory of operation; review of all controls, wires, leads, and electrodes; recording procedures; securing monitor and lead wires to prevent damage; use of event log; methods of responding to alarms (tactile stimulation and cardio-pulmonary resuscitation);24-hour availability of appropriate personnel for monitoring of child and equipment; and a monitor anxiety and dependency reduction plan to include an explanation that the presence of a monitor does not guarantee there will be no complications.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Apnea Monitors (Cont'd.)

5. A sibling has been diagnosed as having Sudden Infant Death Syndrome.
6. The beneficiary is an infant with neurological conditions that cause central hypoventilation.

Medicaid Managed Care

An augmentative alternative communication (AAC) device is a speech-generating device. The following medical justification is needed and should be attached to the prior authorization and MCMN for medical review:

1. Summary of beneficiary's communication abilities, communication needs, and purpose for an AAC device
2. Speech and language abilities — provide assessment data related to beneficiary's speech production status, oral and non-oral language comprehension abilities, current opportunities for communication interactions, and prior intervention history, including specific information related to patient's prior use of AAC
3. Cognitive status — describe the beneficiary's cognitive abilities related to the use of augmentative communication components for functional purposes, *i.e.*, beneficiary's alertness, attention span, persistence, orientation, learning ability as relevant to his or her meaningful use of AAC
4. Current AAC abilities and specific communication needs — describe the aided low and/or high technology AAC components currently being used in the beneficiary's environment. Also, describe the unaided AAC techniques.
5. Symbol level — complete a symbol assessment, including performance data per mode and symbol assessed
6. Summary of beneficiary's physical status, motor capabilities, and specific access abilities
7. Sensory functioning — provide data regarding the beneficiary's visual and auditory status
8. Delineate features of communication system prescribed and submit medical justification

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Diabetic Supplies

Diabetic Supplies are reimbursed according to the following criteria:

- Eligible Medicaid beneficiaries under the age of 21 can receive up to 300 diabetic strips per month as needed; those ages 21 and over can receive up to 150 diabetic strips per month. If additional diabetic strips are needed, then the treating and/or ordering physician, nurse practitioner, or physician assistant must justify the medical need for the specific number of additional diabetic strips on the MCMN form.
- Effective May 1, 2009, SC Medicaid allows diabetic meters and strips to be billed under the DME POS, the CMS-1500 claim form, or the SC Medicaid Web-based Claims Submission Tool.

External Insulin Infusion Pump

Criteria for External Insulin Pump (E0784) and related supplies

Continuous subcutaneous insulin infusion and related supplies are covered as medically necessary for the treatment of gestational diabetes or for insulin-dependent diabetes mellitus.

To receive an **initial approval** for beneficiaries who are diagnosed with insulin-dependent diabetes mellitus, providers must submit the following information on the MCMN form or attached documentation:

1. The beneficiary has a diagnosis of insulin-dependent diabetes mellitus or gestational diabetes.
2. An endocrinologist, physician, physician assistant, or nurse practitioner experienced in pump therapy orders the insulin pump and monitors the beneficiary's status at least every three months during the period of time that the beneficiary uses the pump.
3. The physician, physician assistant, or nurse practitioner documents a history of poor glycemic control on multiple daily injections of insulin, including a persistently elevated glycosylated hemoglobin level (HbA1C > 7.0%).
4. The physician, physician assistant, or nurse practitioner documents additional history of poor control, such as:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

External Insulin Infusion Pump (Cont'd.)

- Widely fluctuating blood glucose levels before bedtime or mealtime
- History of severe hypoglycemia (<60 mg/dl) or hyperglycemia (>300 mg/dl); or fasting blood glucose levels frequently above 200 mg/dl
- Treatment of secondary diabetic complications requiring tighter blood glucose control

5. The physician, physician assistant, or nurse practitioner documents that the beneficiary and/or caregiver has demonstrated the ability and commitment to comply with the regiment of pump care, frequent self-monitoring of blood glucose, and careful attention to diet and exercise. For pediatric beneficiaries, the documentation should also address that the caregiver and/or parent is motivated and committed to use the insulin pump, test the child's blood glucose, and return for follow-up appointments as ordered. The beneficiary has been receiving at least three subcutaneous insulin injections per day for a minimum of six months prior to initiation of the insulin pump.
6. The beneficiary has been self-monitoring blood glucose averaging four times per day for a minimum of one month prior to initiation of the insulin pump.

Catheter Care Supplies

The supplies used for the maintenance of an intravenous infusion catheter are reimbursable during periods when a drug is not infused, but future therapy is anticipated. The provider must submit a CMS-1500 claim form using procedure codes specified in the Fee Schedule for all supplies required to maintain the intravenous infusion catheter. The provider cannot bill a supply procedure code for any drug therapy supplies during the same dates of service that the catheter care supply procedure code is submitted.

Continuous Positive Airway Pressure (CPAP) and Bi-Level Positive Airway Pressure (BIPAP) Devices

Criteria for the CPAP and BIPAP include obstructive sleep apnea and hypopnea. Criteria for the Bi-Level Positive Airway Pressure Spontaneous/Timed Mode (BIPAPST) device include but are not limited to chronic obstructive pulmonary disease, musculoskeletal disorders, muscular dystrophy, cystic fibrosis, and multiple sclerosis. Documentation sufficient to establish the need for ventilatory

Continuous Positive Airway Pressure (CPAP) and Bi-Level Positive Airway Pressure (BIPAP) Devices (Cont'd.)

support must be present on the MCMN. Related supplies are included in the rental of the BIPAPST (E0471). The provider must maintain in his or her files the interpretation of a sleep study, signed by a physician that documents the beneficiary's medical need and the effectiveness of the device. The sleep study must be within the 60 days prior to the date of service on the MCMN. See "Capped Rental Equipment" in this section for more information.

Diabetic Shoes

Criteria for diabetic shoes are as follows:

1. The patient has diabetes mellitus (ICD-9 diagnosis codes 250.00-250.93).
2. The patient has one or more of the following conditions:
   a) Previous amputation of the other foot, or part of either foot
   b) History of previous foot ulceration of either foot
   c) History of pre-ulcerative calluses of either foot
   d) Peripheral neuropathy with evidence of callus formation of either foot
   e) Foot deformity of either foot
   f) Poor circulation in either foot
3. The certifying physician who is managing the patient's systemic diabetes condition has certified that indications (1) and (2) are met.

Hearing Aids

Eligible beneficiaries under 21 years of age and/or enrolled in the ID/RD waiver program may only obtain hearing aids under an agreement with the Division of Children's Rehabilitative Services, Department of Health and Environmental Control. Medicaid does not cover hearing aids for non-ID/RD Medicaid beneficiaries who are 21 or older.

Home Intravenous Hydration Therapy

Prior authorization is not required for hydration therapy (S9373-S9376); however, an MCMN **is** required.

Home Infusion Therapy

The DME program will reimburse supplies used in the administration of parenteral medications that are given in a home environment. The medication is classified as a pharmaceutical product and its usage must meet the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Home Infusion Therapy (Cont'd.)

guidelines of the Medicaid Pharmacy Services program for reimbursement.

If a provider issues a single use disposable infusion device for the administration of a drug in intravenous therapy, the provider cannot bill separately for a durable infusion pump. Providers are permitted to bill two separate home infusion therapies that are administered at the same time. Modifier "SC" must be used to bill the second therapy. The device must be included as part of the supply kit for the particular therapy being administered. For example, if a provider is supplying antibiotic therapy to a beneficiary and using the manufacturer's disposable infusion device to administer the drug, the provider must bill this device as part of other supplies using the antibiotic therapy supply procedure codes S9494, S9497, and S9500 thru S9504.

Home Uterine Activity Monitoring (HUAM)/Supplies and Subcutaneous Tocolytic Therapy

Reimbursement for HUAM (S9001 or S9349), in conjunction with Subcutaneous Tocolytic Therapy services, is covered through the Department of DME. In order for the provider to be reimbursed, the treating/ordering physician must complete a Justification for Home Uterine Activity Monitoring/Supplies and Subcutaneous Tocolytic Therapy form, which is provided to the physician by the enrolled DME provider. (A copy of this form can be found in the Forms section of this manual). This form must be attached to the CMS-1500 claim form for reimbursement. For auditing purposes, the DME provider must keep on file proof of daily monitoring. The physician should document any request that exceeds the frequency limit. Those requests, along with all justification, should be submitted to the program representative for review and approval before the service is rendered. Such cases will be considered for reimbursement on a case-by-case basis.

Clinical Criteria For HUAM Therapy: The patient must have a gestational age of at least 24 weeks, but not more than 35 weeks, and meet **at least one** of the following criteria which necessitates a home uterine activity monitor and/or subcutaneous tocolytic therapy:

1. Idiopathic pre-term labor that has required or will require hospitalization for IV tocolytic therapy
2. Multiple gestation (three or more fetuses) that has required or will require hospitalization for IV tocolytic therapy

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PROGRAM SERVICES

Home Uterine Activity Monitorin***g (HUAM)/Supplies and Subcutaneous Tocolytic Therapy (Cont'd.)***

3. Uterine anomalies or placenta previa that has required or will require hospitalization for IV tocolytic therapy

Additionally, the patient must meet **all** of the following criteria:

1. The patient has been diagnosed with pre-term labor based on uterine activity and/or cervical changes.
2. The patient has been stabilized by tocolytic medication.
3. There are no contraindications to the continuation of this pregnancy.
4. There is no fetal distress.
5. The patient's membranes are intact.
6. The patient is on homebound status and is agreeable to bed-rest activities.
7. The patient has a telephone and is agreeable to daily phone contact and frequent physician follow-up.
8. The patient would have to be hospitalized for uterine activity monitoring and/or subcutaneous tocolytic therapy if this service were not offered.
9. If the patient is hospitalized, this service will allow her to be discharged.
10. The patient is assigned to a delivering physician who has back-up coverage in his or her absence.

Ongoing Supplies

Ongoing supplies for use in the home, such as ostomy supplies, catheters, and sterile gloves, are reimbursable by DME. The specific code for each supply must be listed on the MCMN. Recertification is required prior to the expiration of the current MCMN.

Orthotic Appliances

Orthotic appliances are those items employed for the correction or prevention of skeletal deformities. These include braces, splints, etc. Braces include rigid and semi-rigid devices that are used for the purpose of supporting weak or deformed extremities.

Providers who make custom equipment should submit quotes on company letterhead.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Oxygen

Guidelines for oxygen therapy are as follows (specify portable or stationary):

1. The diagnosis must indicate a chronic debilitating medical condition.
2. The beneficiary's arterial oxygen partial pressure (PaO_2) must be below 60mm Hg. If a PaO_2 cannot be obtained, arterial oxygen saturation of the beneficiary must be provided. The arterial oxygen saturation must be below 89mm Hg. For nocturnal oxygen, the beneficiary must have at least five minutes of desaturations less than 89mm Hg to qualify for the oxygen. If the PaO_2 is 56-59mm or an arterial blood oxygen saturation of 89 percent at rest (awake), during sleep for at least five minutes, or during exercise, then any one of the following must apply:
    a. Dependent edema suggesting congestive heart failure
    b. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3mm in standard leads II, III, or AVF)
    c. Erythrocythemia with a hematocrit greater than 56 percent

    Exceptions to these PaO_2 and oxygen saturation levels will be based on the age of the beneficiary, diagnosis, and the severity of the disease.
3. The provider must maintain an MCMN in the beneficiary's file for audit purposes.
4. Portable oxygen systems are reimbursed if the physician has ordered an exercise program requiring the patient to be away from his or her stationary oxygen system or when a patient must receive oxygen while en route to a doctor's office, hospital, etc.
5. Associated equipment or supplies such as regulators, oxygen tubing, and cannulas are included in the rental of the system.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Oxygen (Cont'd.)

6. The use of the portable systems should be limited to periods of time in which a beneficiary must be separated from his or her stationary system.
7. The treating/ordering physician must have seen the beneficiary and obtained the arterial blood gas (ABG) and/or the arterial oxygen saturation within 30 days of prescribing oxygen therapy.

DME has established a 36-month (three-year) limit or cap on monthly payments for stationary and portable oxygen equipment. This cap applies to oxygen equipment furnished on or after January 1, 2006.

On the first day after the month for which the 36th monthly payment amount is made, monthly payments can begin to be make for oxygen contents using procedure codes E0441, E0442, E0443 and/or E0444 effective January 1, 2009.

Parenteral and Enteral Nutrition (PEN)

Parenteral nutrition is reimbursed for those beneficiaries who cannot absorb nutrients by the gastrointestinal tract. Enteral nutrition is reimbursed for beneficiaries with conditions that do not permit nutrients to reach a normally functional gastrointestinal tract.

These formulae must provide nutrition that will maintain the beneficiary's body weight and/or provide nutrition for weight gain or healing. A feeding tube must be in place for the provision of the nutrient. Feeding tubes are not included in the procedure code reimbursement and may be billed separately.

Enteral feedings will be reimbursed based on 100-calorie units. The number of units reimbursed per diem may not exceed the quantity prescribed.

When billing for parenteral and enteral nutrition for both dually eligible and straight Medicaid beneficiaries, providers must use the formula listed below. Please note that enteral nutrients should be billed in units (100 calories = 1 unit).

Formula:

Number of calories per day, divided by 100, multiplied by days' usage

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Parenteral and Enteral Nutrition (PEN) (Cont'd.)

Example:

Delivery of 1500 calories per day for 30 days = 450 units

[1500 calories per day, divided by 100 (1 unit) = 15 units

15 units x 30 days = 450 units]

If a pump (B9000-B9002) is ordered, there must be documentation in the patient's medical record to justify its use (*e.g.*, gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload, gastrostomy/jejunostomy tube used for feeding). If the medical necessity of the pump is not documented, the pump will be denied as not medically necessary.

Special nutrient formulas, HCPCS codes B4149, B4153-B4157, B4161, and B4162, are produced to meet unique nutrient needs for specific disease conditions. The patient's medical records must adequately document the specific condition and the need for the special nutrient. This information shall be available to SCDHHS on request.

Supplies

Payment for a catheter/tube anchoring device is considered included in the allowance for enteral feeding supply kits (B4034-B4036). Code A5200 should not be billed separately and is not paid in addition to the supplies for enteral nutrition.

The codes for feeding supply kits (B4034-B4036) include all supplies, other than the feeding tube itself, required for the administration of enteral nutrients to the patient for one day. Supplies include but are not limited to bags, tubing, syringes, irrigation solution, dressings (any type), tape, etc. Individual items may differ from patient to patient and from day to day. Only one unit of service may be billed for any one day. Units of service in excess of one per day will be denied as not separately payable.

Coding Guidelines

When enteral nutrition is covered, dressings used in conjunction with a gastrostomy or enterostomy tube are

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Parenteral and Enteral Nutrition (PEN) (Cont'd.)

included in the supply kit code (B4034-B4036) and should not be billed separately using dressing codes.

Additionally, the following should occur when billing for the gastrostomy button:

1. DME should not be billed for buttons that are implanted at the doctor's office. The reimbursement is included in the surgical price. Additionally, a statement should be added to all future MCMNs to indicate if the button is being implanted in the doctor's office or at home.
2. The button kits are to be billed with the B9998 code. The frequency limitations will be four per year instead of the one per month.
3. The following frequency changes are effective with dates of services beginning July 1, 2009, in accordance with Medicare's frequency limitations:
   - B4081 are limited to 24 per year
   - B4082 are limited to 24 per year
   - B4083 are limited to 24 per year
   - B4087 are limited to 24 per year
   - B4088 are limited to 24 per year

Hospital Beds

Medicaid covers most hospital beds. As is customary, each request is handled on a case-by-case basis. In order for a patient to be eligible to receive a hospital bed, the patient's condition must make such an item medically necessary. A physician's prescription, MCMN and additional prescription, documentation, including medical records and physician's reports, must establish medical need. In appropriately documented cases, Medicaid may determine that a hospital bed is medically necessary and, therefore, covered for the following situations:

- Patients, who require positioning of the body to alleviate pain, promote good body alignment, prevent contractors, avoid respiratory infections, etc., in ways not feasible in an ordinary bed
- Patients with severe arthritis and other injuries to lower extremities, *e.g.*, fractured hip such that the patient requires the variable height feature to assist

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospital Beds (Cont'd.)

him or her to ambulate by enabling the patient to place his or her feet on the floor while sitting on the edge of the bed

- Patients with severe cardiac conditions who are able to leave bed, but who must avoid the strain of "jumping" up or down
- Patients with spinal cord injuries, including quadriplegic and paraplegic patients and multiple limb amputees and for those patients who are able to transfer from bed to a wheelchair, with or without help
- Patients with other severely debilitating diseases and conditions, if the variable height feature is required to assist the patient to ambulate.

If the stated reason for a hospital bed is the patient's positioning, the prescription or other documentation must describe the medical condition and also the severity and the frequency of the symptoms of the condition that necessitate a hospital bed for positioning.

If the stated reason for a hospital bed is that the patient's condition requires special attachments, the prescription must describe the patient's condition and specify the attachments that require a hospital bed. Special attachments will only be considered if they cannot be fixed or used on an ordinary bed. Bedside rails can be covered as an integral part of, or as an accessory to a hospital bed.

Bariatric Beds

Request for bariatric beds for patients who are morbidly obese must include information regarding weight management. A hospital bed will not be approved for morbid obesity alone.

Electrically powered adjustments to lower and raise the head and foot of the bed may be covered when:

1. Medicaid determines that the patient's condition requires a frequent change in body position; and/or
2. There may be an immediate need for a change in body position; and
3. The patient can operate the controls and cause the adjustments. Exceptions may be made in cases of spinal cord injury and brain damaged patients. The documentation must indicate that the patient and/or

Bariatric Beds (Cont'd.)

caregiver can perform these changes in body positioning only by the use of electric controls.

Wheelchairs

To qualify for Medicaid reimbursement for a wheelchair, the physician must prescribe the equipment which is medically necessary for the beneficiary. The attending physician is responsible for ordering the items in connection with his or her plan of treatment. The attending physician must be a licensed, active, South Carolina Medicaid provider. The DME provider is responsible for delivering and setting up the equipment as well as educating the beneficiary and/or caretaker as appropriate in the use of the equipment.

For a South Carolina Medicaid beneficiary to qualify for a manual or power wheelchair, an functional needs assessment must be completed and documented in the beneficiary's file at the DME provider's place of business.

Functional Needs Assessment Criteria

The functional needs assessment is used to assess the presence of a mobility deficit to determine if a wheelchair or power wheelchair is medically necessary for an individual. This assessment should be documented and kept on file and be available upon request.

The beneficiary must meet the following functional needs assessment criteria:

1) The beneficiary has a mobility limitation that significantly impairs his and/or her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home, that would be alleviated by the mobility device. A mobility limitation is one that:
   a) Prevents the beneficiary from accomplishing a MRADL entirely
   b) Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL,
   c) Prevents the beneficiary from completing an MRADL within a reasonable time frame
2) The absence of other conditions that limit the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Wheelchairs (Cont'd.)

beneficiary's ability to perform MRADL at home is considered medically necessary if the other condition prevents completion of tasks even with a wheelchair.

a) Some examples are the significant impairment of cognition or judgment and/or vision.

b) For these beneficiaries, the provision of a wheelchair might not enable them to perform MRADL if the co-morbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with a wheelchair.

3) If other limitations exist, the beneficiary must be ameliorated or compensated sufficiently such that the additional provision of mobility equipment will be reasonably expected to materially improve the individual's ability to perform MRADL in the home.

a) A caretaker, for example a family member, may be compensatory, if consistently available in the beneficiary's home and willing and able to safely operate and transfer him or her to and from the wheelchair and to transport the beneficiary using the wheelchair. The caretaker's need to use a wheelchair to assist the beneficiary in the MRADL is to be considered in this determination.

b) If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for determination that a wheelchair does not meet medical necessity criteria if the non-compliance results in the beneficiary continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of mobility assistive equipment.

4) The beneficiary must demonstrate the capability and the willingness to consistently operate the device safely.

a) Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several

Wheelchairs (Cont'd.)

times during the process as the consideration focuses on a specific device.

b) A history of unsafe behavior in other venues may be considered.

5) The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately-fitted cane or walker.

a) The cane or walker must be appropriately fitted to the beneficiary for this evaluation.

b) The beneficiary's ability to safely use a cane or walker must be assessed.

Manual Wheelchairs

Medicaid considers the rental or purchase of one manual wheelchair (including any medically necessary accessories and attachments) medically necessary when the beneficiary's condition is such that, without the use of a wheelchair, he or she would otherwise be unable to ambulate about the home (*e.g.,* from bedroom to bathroom, bedroom to kitchen, etc.).

The following criteria **must** be met:

1. The beneficiary must meet the functional needs assessment criteria 1 through 5 listed above.
2. The beneficiary's typical environment (home) must support the use of manual wheelchairs.

   a) The beneficiary's environment must support the use of this type of mobility equipment;

   b) Factors such as temperature, physical layout, surfaces, and obstacles must be considered, as these may render mobility equipment unusable in the beneficiary's home; *and*

3. The beneficiary must have sufficient upper extremity function to propel a manual wheelchair in the home through the course of the performance of MRADL during a typical day. The manual wheelchair must be optimally configured (seating options, wheelbase, device weight and other appropriate accessories) for this determination.

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Wheelchairs (Cont'd.)

a) Limitations of strength, endurance, range of motion, coordination and absence or deformity in one or both upper extremities are relevant.

b) An individual with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, *i.e.*, light weight, heavy duty, etc. must be determined based on the beneficiary's physical characteristics and anticipated intensity of use.

c) The beneficiary's home must provide adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.

d) The beneficiary's ability to safely use a manual wheelchair must be assessed.

4. The beneficiary's condition is such that the requirement for a wheelchair is long term (at least three months). The purchase of a wheelchair is considered not medically necessary if the underlying condition is reversible and the length of need is less than three months (*e.g.*, following lower extremity surgery which limits ambulation); and

5. Use of a wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home.

A standard wheelchair must be requested unless documentation supports the need for any variation from the standard wheelchair. An example of this variation is an obese beneficiary who requires the wide heavy-duty wheelchair. Medicaid reimburses DME providers for extra heavy duty wheelchairs. These wheelchairs accommodate weight capacities up to 600 lbs. and greater. Medicaid will require weight, width, and depth specification for these items. (This information must be listed on the Medicaid Certificate of Medical Necessity.) The DME provider must ensure that the wheelchair is adequate to meet the beneficiary's need. For instance, providers must obtain measurements of obese beneficiaries to ascertain body width for issuance of a properly fitted wheelchair.

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Wheelchairs (Cont'd.)

Power Wheelchairs

Medicaid covers most power (motorized) wheelchairs. As is customary, each request will be handled on a case-by-case basis. Medicaid will not provide power chairs for leisure or recreation. In order for a beneficiary to be eligible to receive a power wheelchair, the beneficiary's condition must make such an item medically necessary.

Note: It is important to keep in mind that because of the way that the Social Security Act defines durable medical equipment, a power wheelchair device is covered by Medicaid only if the beneficiary has a mobility limitation that significantly impairs his and/or her ability to perform activities of daily living within the home. Your evaluation must clearly distinguish the beneficiary's mobility needs within the home environment only.

In order for Medicaid to provide reimbursement for a power wheelchair, there are several statutory requirements that must be met:

1) There must be an in-person visit with a physician specifically addressing the patient's mobility needs.
2) There must be a history and physical examination by the physician or other medical professional (see below) focusing on an assessment of the beneficiary's mobility limitation and needs. The results of this evaluation must be recorded in the beneficiary's medical record.
3) A prescription must be written **after** the in-person visit has occurred and the medical evaluation is completed.
4) The prescription and medical records documenting the in-person visit and evaluation must be sent to the equipment supplier within 45 days after the completion of the evaluation.

The beneficiary must be:

1. Non-ambulatory, with severe weakness in the upper extremities due to a neurological or muscular condition
2. Bed- or chair-confined when not using a wheelchair
3. Unable to operate a manual wheelchair

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Wheelchairs (Cont'd.)

4. Able to safely operate the controls of a power wheelchair

Power wheelchair replacement is limited to one per seven years. For dually eligible beneficiaries or beneficiaries with primary insurance coverage, South Carolina Medicaid will follow Medicare or the primary insurance's guidelines for frequency limitations. The provider will need to attach a copy of the primary insurance EOB to the claim as proof that the primary approved and paid for the requested services.

If a wheelchair is stolen or destroyed due to a house fire or natural disaster a replacement is authorized. Providers must submit documentation along with requests such as fire department or police department reports as proof of incident. Normal wear and all items no longer under manufacturer warranty will also be considered. All requests for repair or replacement must be fully documented by the provider and submitted for review.

Within the seven year period, Medicaid will not repair or replace equipment if during the review of the request it is found that patient neglect is the reason behind the need for repair or replacement. Patient neglect such as loss of equipment, selling/loaning of equipment, equipment stolen because left outdoors, damage due to weather, or use outside of the home will not be covered.

Face-To-Face Examination Criteria

The in-person visit and mobility evaluation together are often referred to as the face-to-face examination. The complete history and physical examination typically includes:

- History of the present condition(s) and past medical history that is relevant to the beneficiary's mobility needs in the home
- Symptoms that limit ambulation
- Diagnoses that are responsible for these symptoms
- Medications or other treatment for these symptoms
- Progression of ambulation difficulty over time
- Other diagnoses that may relate to ambulatory problems
- How far the patient can walk without stopping and

Wheelchairs (Cont'd.)

with what assistive device, such as a cane or walker

- Pace of ambulation
- History of falls, including frequency, circumstances leading to falls, and why a walker isn't sufficient
- What ambulatory assistance (cane, walker, wheelchair) is currently used and why it isn't sufficient
- What has changed to now require use of a power wheelchair
- Ability to use a manual wheelchair
- Description of the home setting and the ability to perform activities of daily living in the home
- Physical examination that is relevant to the patient's mobility needs
- Weight and height
- Cardiopulmonary examination
- Musculoskeletal examination
  - Arm and leg strength and range of motion
- Neurological examination
  - Gait
  - Balance and coordination

If the beneficiary is capable of walking, the report must include documented observation of ambulation (with use of a cane or walker, if appropriate)

Examples of vague or subjective descriptions of the beneficiary's mobility limitations include:

- Upper extremity weakness
- Poor endurance
- Gait instability
- Weakness
- Abnormality of gait
- Difficulty walking
- SOB on exertion

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Wheelchairs (Cont'd.)

- Pain
- Fatigue
- Deconditioned

These types of statements are insufficient and do not objectively address the mobility limitation or provide a clear picture of the beneficiary's mobility deficits. Objective measurements must be provided.

The evaluation must be tailored to the beneficiary's conditions. **The history must detail a complete picture of your beneficiary's functional abilities and limitations on a typical day.** It must contain as much objective data as possible.

The physical examination must be focused on the body systems that are responsible for the beneficiary's ambulatory difficulty or impact on the beneficiary's ambulatory ability.

The physician or supplier may elect to refer the beneficiary to another medical professional, such as a physical therapist or occupational therapist, to perform part of the evaluation as long as that beneficiary has no financial relationship with the wheelchair supplier. However, the physician does have to personally see the beneficiary before or after the PT/OT evaluation. The physician must review the report, indicate their agreement in writing on the report, and sign and date the report. If the physician does not see the beneficiary after the PT/OT evaluation, the date that they sign the report is considered to be the date of completion of the face-to-face examination.

Mobility evaluations that contain check-off boxes or space for only brief answers and thus do not provide enough detailed information about the beneficiary's ambulatory abilities and limitations to allow the Medicaid coordinator to determine if a coverage criterion has been met are not allowed. What is required is a thorough narrative description of your beneficiary's current condition, past history, and pertinent physical examination that clearly describes their mobility needs in the home and why a cane, walker, or optimally configured manual wheelchair is not sufficient to meet those needs. Physicians must record the visit and mobility evaluation in their usual medical record-keeping format.

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Wheelchairs (Cont'd.)

The physician must write a prescription for a power wheelchair ONLY after the visit and examination are complete. This prescription must contain the following seven elements:

1. Beneficiary's name
2. Description of the item that is ordered. This may be general (*e.g.,* power wheelchair) device or may be more specific.
3. Date of completion of the face-to-face examination
4. Pertinent diagnoses and/or conditions that relate to the need for the power wheelchair
5. Length of need
6. Physician's signature
7. Date of physician signature

The physician must send back a copy of the face-to-face evaluation (received from the supplier or PT/OT) and seven-element prescription to the supplier within 45 days from the completion of the face-to-face mobility exam. The physician must also include copies of previous notes, consultations with other physicians, and reports of pertinent laboratory, x-ray, or other diagnostic tests if they will help to document the severity of the patient's ambulatory problems.

After the supplier receives this information, they will prepare a detailed product description that describes the item(s) being provided including all options and accessories. After gathering this information the physician must review it and, if they agree with what is being provided, sign, date and return it to the supplier. If the physician does not agree with any part of the detailed product description, they must contact the supplier to clarify what the beneficiary is to receive.

Power Wheelchair Home Assessment

The power wheelchair home assessment must include the following:

1. On-site evaluation of the beneficiary's home
2. Beneficiary's ability to adequately maneuver the equipment in the existing physical space
3. Measure doorway width

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Wheelchairs (Cont'd.)

4. Inspect doorway thresholds and surfaces
5. A copy of the home assessment must be kept on file and be available on request.

Basic Coverage Criteria

In addition to the beneficiary's condition and documentation requirements that must be submitted and kept on file all of the following basic criteria (A-I) must be met for a power wheelchair (K0813-K0898) to be covered.

Additional coverage criteria for specific devices are listed below:

1. The beneficiary has a mobility limitation that significantly impairs his and/or her ability to participate in one or more MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:
   a) Prevents the beneficiary from accomplishing an MRADL entirely, or
   b) Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
   c) **Prevents the beneficiary from completing an MRADL within a reasonable time frame.**
2. The beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.
3. The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.
4. The beneficiary has the mental and physical capabilities to safely operate the power wheelchair provided.
5. If the beneficiary is unable to safely operate the power wheelchair, the beneficiary has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able

Wheelchairs (Cont'd.)

to safely operate the power wheelchair that is provided.

6. The beneficiary's weight is less than or equal to the weight capacity of the power wheelchair that is provided.
7. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is provided.
8. Use of a power wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it in the home. For beneficiaries with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver.
9. The beneficiary has not expressed an unwillingness to use a power wheelchair in the home.
   a) Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
   b) An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories.

Specific Types of Power Wheelchairs

I. A Group 1 power wheelchair or a Group 2 power wheelchair is covered if the beneficiary's condition and documentation requirements are submitted and kept on file, all of the coverage criteria (a)-(i) for a PWC are met, and the wheelchair is appropriate for the patient's weight.

II. A Group 2 Single Power Option power wheelchair is covered if the beneficiary's condition and documentation requirements are submitted and kept on file, all of the coverage criteria (a)-(i) for a power wheelchair are met, and if:

   A. Criterion 1 or 2 is met; and

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Wheelchairs (Cont'd.)

B. Criterion 3 is met.

The criterion is as follows:

1. The beneficiary requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control).
2. The beneficiary meets coverage criteria for a power tilt or a power recline seating system (see Wheelchair Options and Accessories policy for coverage criteria) and the system is being used on the wheelchair.
3. The beneficiary has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features. The PT, OT, or physician may have no financial relationship with the DME provider.

If a Group 2 Single Power Option power wheelchair is provided and if II (A) or II(B) is not met (including but not limited to situations in which it is only provided to accommodate a power seat elevation feature, a power standing feature, or only power elevating legrests) but the coverage criteria for a power wheelchair are met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 power wheelchair.

III. A Group 2 Multiple Power Option power wheelchair is covered if the patient's condition and documentation requirements are submitted and kept on file, all of the coverage criteria (a)-(i) for a power wheelchair are met, and if:

A) Criterion 1 or 2 is met; and

B) Criterion 3 is met.

Wheelchairs (Cont'd.)

The criterion is as follows:

1. The beneficiary meets coverage criteria for a power tilt and recline seating system (see Wheelchair Options and Accessories policy) and the system is being used on the wheelchair.
2. The beneficiary uses a ventilator which is mounted on the wheelchair.
3. The beneficiary has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or physician may have no financial relationship with the supplier.

If a Group 2 Multiple Power Option power wheelchair is provided, the beneficiary condition and documentation requirements are submitted and kept on file, and if III(A) or III(B) is not met but the criteria for another power wheelchair are met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 power wheelchair.

IV. A Group 3 power wheelchair with no power options is covered if:

A) All of the coverage criteria (a)-(c) for a power wheelchair are met;

and

B) The beneficiary's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and

C) The beneficiary has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the

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wheelchair and its special features (see Documentation Requirements section). The PT, OT, or physician may have no financial relationship with the supplier.

If a Group 3 power wheelchair is provided and criterion A is met but either criterion B or C is not met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 power wheelchair.

V. A Group 3 PWC with Single Power Option or with Multiple Power Options is covered if the patient condition and documentation requirements are submitted and kept on file, and if:

A) The Group 3 criteria IV(A) and IV(B) are met; and

B) The Group 2 Single Power Option (criteria II[A] and II[B]) or Multiple Power Options (criteria III[A] and III[B]) (respectively) are met.

If a Group 3 Single Power Option or Multiple Power Options power wheelchair is provided and Criterion IV(A) is met but all of the other coverage criteria are not met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 or Group 3 power wheelchair.

VI. Group 4 power wheelchairs have added capabilities that are not needed for use in the home. Therefore, if these wheelchairs are provided and coverage criteria for a Group 2 or Group 3 power wheelchairs are met, payment will be based on the allowance for the least costly medically appropriate alternative.

VII. A Group 5 (Pediatric) power wheelchair with Single Power Option or with Multiple Power Options is covered if the patient condition and documentation requirements are submitted and kept on file, and if:

A) All the coverage criteria (a)-(i) for a power wheelchair are met;

and

B) The beneficiary is expected to grow in height; and

C) The Group 2 Single Power Option (criteria II[A]

Wheelchairs (Cont'd.)

and II[B]) or Multiple Power Options (criteria III[A] and III[B]) (respectively) are met.

If a Group 5 power wheelchair is provided but all the coverage criteria are not met, payment will be based on the allowance for the least costly medically appropriate alternative.

Least Costly Alternative

Coverage criteria for power wheelchairs are based on a stepwise progression of medical necessity. If coverage criteria for the device that is provided are not met and if there is another device that meets the beneficiary's medical needs (as defined in this policy), payment will be based on the allowance for the least costly medically appropriate alternative.

Determinations of least costly alternative will take into account the beneficiary's weight, seating needs, and needs for other special features (*i.e.,* power seating systems, alternative drive controls, and ventilators).

Miscellaneous

A power wheelchair with Captain's Chair is not appropriate for a patient who needs a separate wheelchair seat and/or back cushion. If a skin protection and/or positioning seat or back cushion that meets coverage criteria is provided with a power wheelchair with Captain's Chair, the power wheelchair will be denied as not medically necessary.

If **a** beneficiary needs a seat and/or back cushion but does not meet coverage criteria for a skin protection and/or positioning cushion, it is appropriate to provide a Captain's Chair seat (if the code exists) rather than a sling/solid seat/back and a separate general use seat and/or back cushion. If a general use seat and/or back cushion is provided with a power wheelchair with a sling/solid seat/back, total payment for those items will be based on the allowance for the least costly medically appropriate alternative – *e.g.,* the code for the comparable power wheelchair with Captain's Chair, if that code exists.

If a beneficiary's weight can be accommodated by a power wheelchair with a lower weight capacity than the wheelchair that is provided, payment will be based on the allowance for the least costly medically appropriate alternative.

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Wheelchairs (Cont'd.)

A seat elevator is a non-covered option on a power wheelchair. Therefore, if a Group 2 Seat Elevator power wheelchair is provided and if all of the criteria (a)-(i) for a power wheelchair are met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 power wheelchair without seat elevator.

An add-on to convert a manual wheelchair to a joystick controlled power wheelchair will be allowed if medical necessity is met.

Backup wheelchairs, either manual or motorized, are not considered as medically necessary and are non-covered.

One month's rental of a power wheelchair is covered if a patient-owned wheelchair is being repaired. Payment is based on the type of replacement device that is provided but will not exceed the rental allowance for the power mobility device that is being repaired.

A power wheelchair will be denied as not medically necessary if the underlying condition is reversible and the length of need is less than three months (*e.g.,* following lower extremity surgery which limits ambulation).

Code K0108 (Wheelchair component or accessory, not otherwise specified) is the only reimbursable miscellaneous code billable to manual and power wheelchairs. Billing miscellaneous wheelchair items with code E1399 is not permissible.

When billing for equipment not given an established code by SADMERC (*e.g.,* K0108) providers must submit an invoice that contains Manufacturer Suggested Retail Pricing (MSRP) for the items billed. If submitting an internet "screen print", a signature is required certifying the date, quantity, cost, and description of items being billed. If billing cost instead of MSRP Medicaid will reimburse cost plus 25 percent. Claims submitted with documents other than an invoice or a signed document as indicated above will be rejected.

A power wheelchair which has not been reviewed by the SADMERC or which has been reviewed by the SADMERC and found not to meet the definition of a specific power wheelchair listed in the Durable Medical Equipment Fee

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Wheelchairs (Cont'd.)

Schedule will be denied as not medically necessary.

Covered Wheelchair Options and Accessories

Medicaid considers certain wheelchair accessories medically necessary if the wheelchair is considered medically necessary and the options or accessories are necessary for the beneficiary to function in the home and perform the activities of daily living.

The following wheelchair options and accessories may be considered medically necessary when the beneficiary meets the medical necessity criteria for a wheelchair.*

- Amputee adapter
- General use back cushion
- General use seat cushion
- Heel loops
- IV rod
- Narrowing device
- Oxygen carrier
- Speech generating device (SGD) table
- Step tube
- Suspension fork
- Ventilator tray
- Wide stance arm bracket

* This list is not all-inclusive.

Non-Covered Wheelchair Accessory/Attachment

Generally a wheelchair accessory/attachment or wheelchair upgrade is considered a convenience item when used to adapt to the outside environment, for work, or to perform leisure or recreational activities.

Upgraded and specialty wheels (*e.g.*, Spinergy) are considered not medically necessary because they are not required for performance of instrumental activities of daily living.

The following wheelchair items are non-covered as they are considered personal convenience items*:

- Articulating (telescoping) elevating leg rests
- Back support systems: Back support systems have a

Non-Covered Wheelchair Accessory/Attachment (Cont'd.)

plastic frame which is padded and covered with cloth or other material; they are designed to be attached to a wheelchair base, but do not completely replace the wheelchair back. These back support systems are considered convenience items, because they are not generally necessary to provide trunk support in members in wheelchairs. An adequate seating system would allow the beneficiary to function appropriately in the wheelchair.

- Power Assist Devices
- Battery charger: A battery charger for a power wheelchair is included in the allowance for a power wheelchair base. A dual mode battery charger for a power wheelchair is considered a convenience item and is non-covered.
- Canopies
- Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flaps for cars)
- Crutch or cane holder
- Flat-free inserts (zero pressure tubes): Flat free inserts have a removable ring of firm material that is placed inside of a pneumatic tire. Flat free inserts are intended to allow the wheelchair to continue to move if the pneumatic tire is punctured.
- Gloves
- Home modifications: Modifications to the structure of the home to accommodate wheelchairs are not considered treatment of disease and are non-covered. Examples of home modifications and installations that are non-covered include wheelchair ramps, wheelchair accessible showers, elevators, and lowered bath or kitchen counters and sinks.
- Identification devices (such as labels, license plates, name plates)
- Lighting systems
- Power add-ons to manual wheelchairs: A power add-on is used to convert a manual wheelchair to a

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Non-Covered Wheelchair Accessory/Attachment (Cont'd.)

motorized wheelchair (*e.g.*, an add-on to convert a manual wheelchair to a joystick-controlled power mobility device or to a tiller-controlled power mobility device).

- Powered seat elevator attachments for electric, powered, or motorized wheelchairs
- Shock absorbers
- Snow tires for wheelchair
- Speed conversion kits
- Transit Options (tie downs)
- Warning devices, such as horns and backup signals
- Wheelchair baskets, bags, or pouches - used to hold personal belongings
- Wheelchair lifts (e.g., Wheel-O-Vator, trunk loader) - devices to assist in lifting wheelchair up stairways, into car trunks, or in vans (see CPB 459 - Seat Lifts and Patient Lifts)
- Wheelchair rack for automobile (auto carrier) - car attachment to carry wheelchair
- Wheelchair ramp - provides access to stairways or vans
- Wheelchair tie downs
- Any type of computer or electronic device to operate electric, powered, or motorized wheelchair while person is not physically sitting in equipment.

*Note: This list is not all inclusive.

Documentation Requirements for Prior Authorization Review

The following documentation must be submitted with power wheelchair requests and a copy kept on file:

1. A completed MCMN, signed and dated by a physician, nurse practitioner, or physician assistant, with a detailed summary of the beneficiary's medical condition. (The MCMN must be legible and include the physician, nurse practitioner, or physician assistant's license information.)
2. A physician's prescription (if faxed, must be legible)

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Documentation Requirements for Prior Authorization Review (Cont'd.)

3. A copy of the delivery slip and manufacturer information to include manufacturer, make, model, etc.
4. Relevant portions of the beneficiary's medical record containing PT or OT evaluations. Physicians can complete the PT/OT evaluation for beneficiaries. Beneficiaries who are attending public school also have the option of getting a PT evaluation from the school's physical therapist. All PT/OT evaluations must include but not be limited to the following information:
    a. Range of motion and semi-quantitative assessment of strength in the extremities
    b. Quantitative limitations to passive range of motion in the extremities

a) The presence or absence of increased muscle tone or spasms

b) Detailed description of patient's condition including related diagnoses and history

c) Describe how the equipment benefits the patient in performing Activities of Daily Living (ADLs)

d) Detailed list, description, and justification of wheelchair base and accessories

e) Detailed description of patient's long-term prognosis

f) Size, weight, and measurements of the patient

g) Patient's medical condition necessitating use of a power chair

h) Progression of the condition and prognosis

i) MAT Exam

j) The extent of the patient's ability to ambulate. If the patient can ambulate, what are the limits to this ambulation and does it require an assistive device? If a device is currently being used, indicate what device is currently being used.

k) Past use of walker, cane, and/or wheelchair that have been tried and the results

l) Previous equipment tried and the results

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Documentation Requirements for Prior Authorization Review (Cont'd.)

5. Attestation statement. There must be a signed and dated attestation by the provider that the PT/OT therapist has no financial relationship with the provider.
6. Manufacturer information to include price, make, models, and serial numbers.
7. Home assessment

Negative Pressure Wound VAC

South Carolina Department of Health and Human Services (SCDHHS) may reimburse for up to a maximum of four months of therapy with the negative pressure wound therapy electrical pump, stationary or portable (E2402) Wound VAC (vacuum assisted closure device) and supplies A6550 and A6551, when medically necessary. In order for SCDHHS to process the initial order for this product and related supplies, the patient must meet the following conditions:

- The patient has a chronic Stage III or IV pressure ulcer, neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology.
- The therapy must be administered in a home setting with the involvement of a home health nurse and the prescribing licensed medical professional.
- For all ulcers or wounds, the following components of a wound therapy program must include a minimum of all the following general measures, which should either be addressed, applied or considered and ruled out prior to the application the Wound VAC:
    1. Have tested and/or rule out all other wound therapies prior to application of Wound VAC therapy.
    2. Describe in detail why more conservative treatment has not been or would not be appropriate for the specific patient who will receive the Wound VAC.
    3. Provide an estimate of the length of time that Wound VAC therapy will be required.
    4. Provide documentation in the patient's medical record of evaluation, care, and wound measurements by a licensed health care professional.

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Negative Pressure Wound VAC (Cont'd.)

The documentation must include, if applicable:

a. Evaluation of and provision for adequate nutritional status.

b. Application of dressings to maintain a moist wound environment.

c. Debridement of necrotic tissue if present

d. Evidence that:

a. The patient has been appropriately turned and positioned

b. The patient has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk.

c. The patient's moisture and incontinence have been appropriately managed.

d. For neuropathic (for example, diabetic ulcers):

- The patient has been on a comprehensive diabetic management program.
- Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.

e. For venous insufficiency ulcers:

- Compression bandages and/or garments have been consistently applied.
- Leg elevation and ambulation have been encouraged.

Exclusions From Coverage

Wound VACs and supplies will be denied at any time as not medically necessary if one or more of the following is present:

- The presence in the wound of necrotic tissue with eschar, if debridement is not attempted
- Untreated osteomyelitis within the vicinity of the wound
- Cancer present in the wound
- The presence of a fistula to an organ or body cavity within the vicinity of the wound

Wound VACs and their supplies that have not been

Negative Pressure Wound VAC (Cont'd.)

specifically designated as qualified for use of HCPCS codes E2402, A6550, and A7000 for billing to Medicaid will be denied as not medically necessary.

Continued Wound VAC Coverage

The attending physician must initiate any requests for continued use of this product and supplies after four months. Requests must include responses from the above listed concerns in addition to the following items listed below. They must be submitted to SCDHHS along with a new Medicaid Certificate of Medical Necessity and Prior Authorization for approval consideration prior to administering:

1. There must be monthly documented evidence that the Wound VAC therapy has decreased the size or improved the condition of the wound or wounds.
2. The anticipated extended use of the Wound VAC therapy would be based on a month-to-month evaluation.
3. The attending physician must explain the anticipated benefit of continued use of the Wound VAC.
4. On a regular basis the attending physician should:
   a. Directly assess the wound(s) being treated with the Wound VAC
   b. Supervise or directly perform the Wound VAC dressing changes
   c. On at least a monthly basis, document changes in the ulcer's dimensions and characteristics

When Wound VAC Coverage Ends

Wound VAC coverage and supplies will be denied as not medically necessary with any of the following, whichever occurs earliest:

1. In the judgment of the treating physician, adequate wound healing has occurred to the degree that Wound VAC therapy may be discontinued.
2. Any measurable degree of wound healing has failed to occur over the prior month. Wound healing is defined as improvement occurring in either surface area (length times width) or depth of the wound.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Negative Pressure Wound VAC (Cont'd.)

3. Four months. Coverage beyond four months will be given individual consideration based upon required additional documentation (See "Continued Wound VAC Coverage")
4. Once equipment or supplies are no longer being used for the patient, whether or not by the physician's order.

Wound VAC Supplies

- Coverage is provided up to a maximum of 15 dressing kits (A6550) per wound per month unless there is documentation that the wound size requires more than one dressing kit for each dressing change.
- Coverage is provided up to a maximum of 15 canister sets (A7000) per month unless there is documentation evidencing a large volume of drainage (greater than 90 ml of exudate per day). For high volume exudative wounds, a stationary pump with the largest capacity canister must be used. Excess utilization of canisters related to equipment failure (as opposed to excessive volume drainage) will be denied as not medically necessary.

The medical necessity for use of a greater quantity of supplies than the amounts listed must be clearly documented in the patient's medical record and requests for such must be approved by Medicaid prior to administration. If this documentation is not present, excess quantities will be denied for lack of medical necessity.

The SCDHHS Medical Director must approve any exceptions to these coverage criteria and exclusions after a written request is received from the treating physician. Please send requests for exceptions to:

SCDHHS
Dept. of Durable Medical Equipment, 12th floor
Post Office Box 8206
Columbia, SC 29202-8206

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Prosthetic Appliances

Prosthetic appliances replace all or part of the function of a permanently inoperative or malfunctioning body organ. Related supplies are covered when the appliances are essential to the effective use of the artificial limb.

Coverage of prosthetic appliances includes repair or replacement of Medicaid-covered prosthetic devices (other than dental and eyeglasses).

Providers who make custom equipment should submit quotes on company letterhead.

Cranial Remolding Orthotic Devices

Coverage for Cranial Remolding Orthotic Devices are only considered as an adjunct to surgical therapy for craniosynostosis and not for treating positional or non-synostotic plagiocephaly or brachycephaly.

Approval of a cranial remolding orthotic device is only considered when requested by a Pediatric Neurosurgeon, Pediatric Neurologist, Pediatric Ear Nose and Throat (ENT) Physician, or a Cranial Facial Surgeon.

Requests for prior authorization for this equipment is obtained through KePRO and it may be submitted using one of the following methods:

KePRO Customer Service Phone: 855-326-5219
KePRO Fax: 855-300-0082
For Provider Issues email: atrezzoissues@Kepro.com

Reduced Pump Rental for Parenteral, Enteral, and Intravenous Drug Nutrition

Not all parenteral and enteral pumps are considered purchased for the beneficiary after the tenth month of rental. Providers will continue to use the standard procedure codes for pump rentals. These procedure codes are:

B9000 Enteral nutrition infusion pump without alarm

B9002 Enteral nutrition infusion pump with alarm

B9004 Parenteral nutrition infusion pump, portable

B9006 Parenteral nutrition infusion pump, stationary

E0781 Ambulatory infusion pump

E0791 Parenteral infusion pump, stationary

Reduced rental payments will be made every six months starting on the 16th month of use, regardless of the type or life span of the particular pump. Providers will continue to use the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Reduced Pump Rental for Parenteral, Enteral, and Intravenous Drug Nutrition (Cont'd.)

same procedure code but will use the "52" (reduced rental rate) modifier. Medical documentation must be sufficient to support the continued need by the beneficiary when using these reduced rental pump procedure codes.

The provider retains ownership of the pump and is responsible for its maintenance. Medicaid reimbursement is not available for the cost of maintenance.

Supplies

Supplies are those items that are necessary as prescribed by a licensed doctor of medicine.

NON-COVERED ITEMS

Bath Items

Medicaid will no longer cover bath items for the adult population (ages 21 and above).

Deluxe or Luxury Models

Although an item may be classified as durable medical equipment, its provision is not necessarily covered in every instance. Coverage is determined on a case-by-case basis and is subject to the requirement that the equipment is reasonable and necessary for treatment of an illness or injury. DME will deny payment for "deluxe" or "luxury" models if a standard model is adequate.

Medications

Medications used in connection with supplies and medical equipment are not covered for payment by the Department of DME, but may be covered by Medicaid as a pharmaceutical service.

Nursing Home Use

Medicaid will not make direct reimbursement to a DME provider for supplies and medical equipment rendered to a patient residing in a nursing home. Medicaid will reimburse the coinsurance and deductible up to the Medicaid allowed amount for the dually eligible Medicare/Medicaid beneficiary in a Skilled Nursing Facility.

Stand-By Oxygen and Contents

Medicaid does not cover oxygen systems that function only as stand-by or precautionary devices and portable oxygen systems prescribed for patients who do not otherwise qualify for home oxygen therapy.

Oxygen contents are not reimbursable by Medicaid.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Wheelchair Accessories

Medicaid does not cover the following wheelchair accessories:

- Auto carrier
- Transport tie-down
- Baskets, bags, and pouches
- Gloves
- Wheelchair ramps
- Car trunk lifts/individual lifts
- Lowered seat elevator attachments for powered or motorized wheelchairs

SECTION 3
BILLING PROCEDURES

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BILLING PROCEDURES

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SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

The South Carolina Department of Health and Human Services (SCDHHS) strives to make billing as simple for providers as possible. This section is a "how-to" manual on billing procedures with information on how to file a claim, what to do with a rejected claim, etc. Also included is information concerning administrative procedures such as adjustments and refunds. This section will help with these issues, but may not answer all of your questions. You should direct any questions to the Provider Service Center (PSC) at 1-888-289-0709. Providers can also submit an online inquiry at http://www.scdhhs.gov/contact-us and a provider service representative will then respond to you directly.

USUAL AND CUSTOMARY RATES

Providers are required to bill their usual and customary rate when filing Medicaid claims. Charges to Medicaid cannot exceed charges to private patients, whether they are self-pay or covered by another carrier. Billing of covered procedures prior to the date of service is prohibited.

CLAIM FILING TIMELINESS

Medicaid policy requires that only "clean" claims and related Edit Correction Forms (ECFs) received and entered into the claims processing system within one year from the date of service be considered for payment. A "clean" claim is free of errors and can be processed without obtaining additional information from the provider or another third party. Claims with an edit code of 509 or 510 on remittances, or CARC 29 on an electronic Remittance Advice, have not met these criteria. It is the provider's responsibility to follow up on claims in a timely manner to ensure that all claims and ECFs are filed and corrected within Medicaid policy limits.

DUAL ELIGIBILITY

When a beneficiary has both Medicare and Medicaid, Medicare is considered to be the primary payer. Services rendered to persons who are certified dually eligible for Medicare/Medicaid must be billed to Medicare first.

Effective January 1, 2003, the cost for DME supplies, etc. has been removed from the Nursing Home rates for the dually eligible beneficiary. DHHS will pay the Medicare/

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

DUAL ELIGIBILITY (CONT'D.)

Medicaid crossover claims up to Medicaid's usual and customary fee for the inpatient in a Skilled Nursing Facility.

MEDICARE CROSSOVER CLAIMS FOR COINSURANCE AND DEDUCTIBLE

All claims not paid in full by Medicare must be filed directly to Medicaid as claims no longer cross over for automatic payment review.

MEDICARE PRIMARY CLAIM

Claims for payment when Medicare is primary must be received and entered into the claims processing system within two years from the date of service or discharge, or within six months following the date of Medicare payment, whichever is later.

RETROACTIVE ELIGIBILITY

Effective December 1, 2009, claims and related ECFs involving retroactive eligibility must meet both of the following criteria to be considered for payment:

- Be received and entered into the claims processing system within **six months** of the beneficiary's eligibility being added to the Medicaid eligibility system **AND**
- Be received within **three years** from the date of service or date of discharge (for hospital claims). Claims for dates of service that are more than three years old will not be considered for payment.

To document retroactive eligibility, the provider is responsible for submitting one of the following documents with each claim or ECF within the above time frames:

- DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker, or
- The computer-generated Medicaid eligibility approval letter notifying the beneficiary that Medicaid benefits have been approved. This can be furnished by the beneficiary or the eligibility worker. (This is different from the Certificate of Creditable Coverage.)

Claims and related ECFs involving retroactive eligibility that are received more than three years from the date of service will be rejected with edit code 533 (date of service

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

RETROACTIVE ELIGIBILITY (CONT'D.)

more than three years old) and CARC 29 (the time limit for filing has expired).

SCDHHS will no longer consider claims that exceed the timely filing limits due to the provider being unaware of the beneficiary's coverage.

BENEFICIARY COPAYMENTS

Section 1902(a)(14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of Medicaid by imposing copayments upon them. A copayment is the amount of money the beneficiary is expected to pay to the provider at the time services are received.

SC Medicaid has required a copayment from beneficiaries toward the cost of their care since March 2004. The copayment amounts for Medicaid services can be found in Appendix 3 of this manual and on the SCDHHS Web site.

Medicaid beneficiaries may not be denied services if they are unable to pay the copayment at the time the service is rendered; however, this does not relieve the beneficiary of the responsibility for the copayment.

It is the provider's responsibility to collect the copayment from the beneficiary to receive full reimbursement for a service. The amount of the copayment will be deducted from the Medicaid payment for all claims involving copayments.

When a beneficiary has Medicare or private insurance, the Medicaid copayment still applies per the policies outlined in this section. However, if the sum of the copayment and the Medicare/third party payment would exceed the Medicaid-allowed amount, the copayment should be adjusted or eliminated. In other words, though a provider may receive a primary insurance payment higher than what Medicaid would pay, the beneficiary's copayment should not contribute to the excess revenue.

Effective, July 2011, persons ages 19 and older who are enrolled in a Medical Homes Network or participate in waiver programs through Community Long Term Care or the SC Department of Disabilities and Special Needs must make a copayment for their State Plan services according to established policy.

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

Claim Filing Information

The collection of copayment should not be entered in the Amount from Other Sources field on the CMS-1500 claim form; this would result in an additional reduction in payment.

Copayment Exclusions

Pursuant to federal regulations, the following beneficiaries are excluded from copayment requirements: children under the age of 19, pregnant women, institutionalized individuals (such as persons in a nursing facility or ICF-IID), members of a Federally Recognized Indian Tribe (for services rendered by the Catawbas Service Unit in Rock Hill, SC and when referred to a specialist or other medical provider by the Catawbas Service Unit) and members of the Health Opportunity Account (HOA) program. **Additionally, the following services are not subject to a copayment:** Medical equipment and supplies provided by DHEC; Orthodontic services provided by DHEC; Family Planning services, End Stage Renal Disease (ESRD) services, Infusion Center services, Emergency services in the hospital emergency room, Hospice benefits and Waiver services**.**

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Providers may choose one or more of the following options for filing claims:

- Paper Claims
- Electronic Claims
  - SC Medicaid Web-based Claims Submission Tool
  - Tapes, Diskettes, CDs, and Zip Files
  - File Transfer Protocol (FTP)

PAPER CLAIMS SUBMISSIONS

Paper claims are mailed to Medicaid Claims Receipt at the following address:

Medicaid Claims Receipt
Post Office Box 1412
Columbia, SC 29202-1412

CMS-1500 Claim Form

Professional Medicaid claims must be filed on the CMS-1500 claim form (08/05 version). Alternate forms are not acceptable. “Super Bills” and Continuous Claims are not acceptable and will be returned to the provider for correction. Use only black or blue ink on the CMS-1500.

Each CMS-1500 submitted to SC Medicaid must show charges totaled. ONLY six lines can be processed on a hard copy CMS-1500 claim form. If more than six lines are submitted, only the first six lines will be processed for payment or the claim may be returned for corrective action.

SCDHHS does not supply the CMS-1500 (08/05 version) to providers. Providers should purchase the form in its approved format from the private vendor of their choice. A list of vendors who supply the form can be found in Section 5 of this manual. Examples of the CMS-1500 claim form can be found in the Forms section of this manual.

Providers using computer-generated forms are not exempt from Medicaid claims filing requirements. The SCDHHS data processing personnel should review your proposed format before it is finalized to ensure that it can be processed.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Procedural Coding

SC Medicaid requires that claims be submitted using codes from the current editions of the Healthcare Common Procedure Coding System (HCPCS) and the Current Procedural Terminology (CPT). Providers may also use supplemental codes as outlined in the various sections of this manual.

The Centers for Medicare and Medicaid Services revises the nomenclature within the HCPCS/CPT each quarter. When a HCPCS/CPT code is deleted, the SC Medicaid program discontinues coverage of the deleted code. SC Medicaid will not accept billing of discontinued codes for dates of service after the date on which the code is discontinued. When new codes are added, SCDHHS reviews the new codes to determine if the SC Medicaid program will cover them. Until the results of the review are published, SCDHHS does not guarantee coverage of the new codes.

Providers must adopt the new codes in their billing processes effective January 1 of each year and begin using them for services rendered on or after that time to assure prompt and accurate payment of claims.

The current editions of HCPCS/CPT may be ordered from:

Order Department
American Medical Association
Post Office Box 930876
Atlanta, GA 31193-0876

You may order online at
http://www.amabookstore.com/ or call toll free 1-800-621-8335.

Code Limitations

Certain procedures within the HCPCS/CPT may not be covered or may require additional documentation to establish their medical necessity or meet federal guidelines.

Diagnostic Codes

SC Medicaid will not accept billing of discontinued codes for dates of service after the date on which the code is discontinued. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Providers must adopt the new codes for billing processes effective October 1 of each year and use for services rendered on or after that time to assure prompt and accurate payment of claims.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Diagnostic Codes (Cont'd.)

Effective for dates of service on or after October 1, 2004, no further 90-day grace periods apply for the annual ICD-9-CM updates. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Medicaid no longer accepts discontinued codes for dates of service after the date on which the code is discontinued. The new codes must be adopted for billing effective October 1 of each year and used for services rendered on or after that time to assure prompt and accurate payment of claims.

Medicaid requires the addition of a fourth or fifth digit, if applicable, to an ICD-9 code. Valid diagnosis coding can only be obtained from the most current edition of ICD-9-CM, Volume I. "E" codes are sub-classification codes of external causes of injury and poisoning and are not valid as diagnosis codes.

A current edition of the ICD-9-CM may be ordered from:

Practice Management Information Corporation
4727 Wilshire Boulevard, Suite 300
Los Angeles, CA 90010

You may order online at http://www.pmiconline.com/ or call toll free 1-800-MED-SHOP.

Modifiers

Certain circumstances must be identified by the use of a two-character modifier that follows the procedure code. Failure to use these modifiers according to policy will slow turnaround time and may result in a rejected claim.

Only the first modifier entered is used to process the claim. Failure to use modifiers in the correct combination with the procedure code, or invalid use of modifiers, will result in a rejected claim.

The following modifiers may be used:

Modifier	Description
52	Reduced Services
NU	New Equipment (purchased)
UE	Used Equipment (purchased)
LL	Rental (equipment may be converted to purchase)

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Modifiers (Cont'd.)

Modifier	Description
RR	Rental (equipment will always remain on a rental basis)
00	Purchase
RT	Right
LT	Left
SC	Medically necessary service or supply (used only with certain home infusion codes when more than one home infusion is being administered)

Place of Service Key

Place of Service Codes

Code	Description
11	Office
12	Home
31	Skilled Nursing Facility dual eligibility Medicaid/Medicare only (Crossover Coinsurance and Deductible Claims)

National Provider Identifier and Medicaid Provider Number

Providers who are covered entities under HIPAA are required to obtain a National Provider Identifier (NPI). These "typical" providers must apply for an NPI and share it with SC Medicaid. to obtain an NPI and taxonomy code, please visit http://www1.scdhhs.gov/openpublic/service providers/npi%info.asp for more information on the application process.

When submitting claims to SC Medicaid, typical providers must use the NPI of the ordering/referring provider and the NPI and taxonomy code for each rendering, pay-to, and billing provider.

Atypical providers (non-covered entities under HIPAA) identify themselves on claims submitted to SC Medicaid by using their six-character legacy Medicaid provider number.

CMS-1500 Form Completion Instructions

All claims, regardless of the date of service, must be submitted on the 08/05 version of the CMS-1500 (see sample claims in the Forms section of this manual). Use only black or blue ink on this claim form.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

1 Health Insurance Coverage

Show all types of coverage applicable to this claim by checking the appropriate box(es). If Group Health Plan is checked and the patient has only one primary health insurance policy, complete either block 9 (fields 9a, 9c, and 9d) **or** block 11 (fields 11, 11b, and 11c). If the beneficiary has two policies, complete both blocks, one for each policy.

IMPORTANT: Check the **"MEDICAID"** field at the top of the form.

1a* Insured's ID Number

Enter the patient's Medicaid ID number, exactly as it appears on the South Carolina Healthy Connections Medicaid card (10 digits, no letters).

2 Patient's Name

Enter the patient's first name, middle initial, and last name.

3 Patient's Birth Date

Enter the date of birth of the patient written as month, day, and year. *Optional*

Sex

Check "M" for male or "F" for female. *Optional*

4 Insured's Name

Not applicable

5 Patient's Address

Enter the full address and telephone number of the patient. *Optional*

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

6 Patient Relationship to Insured

Not applicable

7 Insured's Address

Not applicable

8 Patient Status

Check the appropriate box for patient's marital status and whether employed or a student.

9 Other Insured's Name

When applicable, enter the name of the insured.

9a Other Insured's Policy or Group Number**

When applicable, enter the policy number.

9b Other Insured's Date of Birth

When applicable, enter the date of birth of the insured.

9c Employer's Name or School Name**

If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.

9d Insurance Plan Name or Program Name**

When applicable, enter the three-digit carrier code. A list of the carrier codes alphabetized by name of insurance company can be found in Appendix 2.

10a Is Patient's Condition Related to Employment?

Check "YES" or "NO."

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

10b Is Patient's Condition Related to an Auto Accident?

Check "YES" or "NO." If "YES," enter the two-character state postal code in the State/Place field (*e.g.,* "SC").

10c Is Patient's Condition Related to an Other Accident?

Check "YES" or "NO."

10d Reserved for Local Use**

When applicable, enter the appropriate TPL indicator for this claim. Valid indicators are as follows:

Code	Description
1	Insurance denied
6	Crime victim
8	Uncooperative beneficiary

11 Insured's Policy Group or FECA Number**

If the beneficiary is covered by health insurance, enter the insured's policy number.

11a Insured's Date of Birth

When applicable, enter the insured's date of birth.

11b Employer's Name or School Name**

If payment has been made by the patient's health insurance, indicate the payment in this field. If the health insurance has denied payment, enter "0.00" in this field.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

11c Insurance Plan Name or Program Name**

When applicable, enter the three-digit carrier code. An alphabetical list of the carrier codes for insurance companies can be found in Appendix 2.

11d Is There Another Health Plan?

Check "YES" or "NO" to indicate whether or not there is another health insurance policy. If "YES," items 9a, 9c, and 9d **or** 11, 11b, and 11c must be completed (If there are two policies, complete both).

12 Patient's or Authorized Person's Signature

"Signature on File" or patient's signature is required.

13 Insured's or Authorized Person's Signature

Not applicable

14 Date of Current Illness, Injury, or Pregnancy

Not applicable

15 If Patient Has Had Same or Similar Illness

Not applicable

16 Dates Patient Unable to Work in Current Occupation

Not applicable

17 Name of Referring Provider or Other Source

Enter the name of Referring or Ordering Provider.

17a ID Number of Referring Physician

If applicable, enter the license number of the referring physician.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

17b NPI

Enter the NPI of Referring or Ordering Provider.

18 Hospitalization Dates Related to Current Services

Complete this field when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

19 Reserved for Local Use**

For beneficiaries participating in special programs (*i.e.*, Medical Homes, Hospice, etc.), enter the primary care provider's referral number.

20 Outside Lab

Not applicable

21* Diagnosis or Nature of Illness or Injury

Enter the diagnosis code of the patient indicated in the current edition of the ICD-9-CM, Volume I. SC Medicaid requires the fourth or fifth digit, if applicable, of the ICD-9 diagnosis code. Enter up to two diagnosis codes in priority order (primary, then secondary condition). Only one diagnosis is necessary to process the claim.

22 Medicaid Resubmission Code

Not applicable

23 Prior Authorization Number**

If applicable, enter the prior authorization number for this claim.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

Fields 24A through 24J pertain to line item information. There are six billable lines on this claim. Each of the six lines contains a shaded and unshaded portion. The shaded portion of the line is used to report supplemental information.

24A Shaded**

NDC Qualifier/NDC Number

If applicable, enter the NDC qualifier of N4, followed by an 11-digit NDC. Do not enter a space between the qualifier and the NDC.

24A Unshaded*

Date(s) of Service

Enter the month, day, and year for each procedure, service, or supply.

24B Unshaded*

Place of Service

Enter the appropriate two-character place of service code. See "Place of Service Key" earlier in this section for a listing of place of service codes.

24C Unshaded**

EMG

Not applicable

24D Unshaded*

Procedures, Services, or Supplies

Enter the procedure code and, if applicable, the two-character modifier in the appropriate field. If two modifiers are entered, the first modifier entered will be used to process the claim. For unusual circumstances and for unlisted procedures, an attachment with a description of each procedure must be included with the claim.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field Description

* Required for claim to process

** Required if applicable (based upon the specific program area requirements)

When more than one service of the same kind is rendered to the **same** patient by the **same** provider on the **same** day, the second service must be billed with the 76 modifier (repeat procedure – same day provider). No more than two services for the same provider and date of service may be billed. Documentation to support billing of repeat procedures to the same patient by the same provider on the same day must be contained in the record.

24E Diagnosis Code

Not applicable

24F Unshaded*

Charges

Enter the charge for each listed service. Do not use dollar signs or commas when reporting dollar amounts. Enter "00" in the cents area if the amount is a whole number.

24G Unshaded**

Days or Units

If applicable, enter the days or units provided for each procedure listed.

24H Unshaded**

EPSDT/Family Planning

Not applicable

24I Shaded*

ID Qualifier

Typical Providers:

Enter ZZ for the taxonomy qualifier.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field	Description
*	Required for claim to process
**	Required if applicable (based upon the specific program area requirements)

Atypical Providers:

Enter 1D for the Medicaid qualifier.

24J Shaded**

Rendering Provider ID #

Enter the six-character legacy Medicaid provider number or taxonomy code of the rendering provider/individual who performed the service(s)

Typical Providers:

Enter the provider's taxonomy code.

Atypical Providers:

Enter the six-character legacy Medicaid provider number.

24J Unshaded**

Rendering Provider ID #

Typical Providers:

Enter the NPI of the rendering individual provider. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI may be entered.

Atypical Providers:

Not applicable

25 Federal Tax ID Number

Enter the provider's federal tax ID number (Employer Identification Number) or Social Security Number.

26 Patient's Account Number

Enter the patient's account number as assigned by the provider. Only the first nine characters will be keyed. The account number is helpful in tracking the claim in case the beneficiary's Medicaid ID

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field **Description**

* Required for claim to process

** Required if applicable (based upon the specific program area requirements)

number is invalid. The patient's account number will be listed as the "Own Reference Number" on the Remittance Advice.

27 Accept Assignment

Complete this field to indicate that the provider accepts assignment of Medicaid benefits. Submitting a claim to SC Medicaid automatically indicates the provider accepts assignment.

28* Total Charge

Enter the total charge for the services.

29 Amount Paid**

If applicable, enter the total amount paid from all insurance sources on the submitted charges in item 28. This amount is the sum of 9c and 11b.

30* Balance Due

Enter the balance due.

When a beneficiary has third party coverage, including Medicare, this is where the patient responsibility amount is entered. The third party payment plus the patient responsibility cannot exceed the amount the provider has agreed to accept as payment in full from the third party payer, including Medicare.

31 Signature of Physician or Supplier

Not applicable

32 Service Facility Location Information**

Note: Use field 32 only if the address is different from the address in field 33.

If applicable, enter the name, address and ZIP+4 code of the facility if the services were rendered in

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field **Description**

* Required for claim to process

** Required if applicable (based upon the specific program area requirements)

a facility other than the patient's home or provider's office.

32a Service Facility Location Information**

Typical Providers:

Enter the NPI of the service facility.

Atypical Providers:

Not applicable

32b ** Service Facility Location Information

Typical Providers:

Enter the two-byte qualifier ZZ followed by the taxonomy code (no spaces).

Atypical Providers:

Enter the two-byte qualifier 1D followed by the six-character legacy Medicaid provider number (no spaces).

33* Billing Provider Info & PH #

Enter the provider of service/supplier's billing name, address, ZIP+4 code, and telephone number.

Note: Do not use commas, periods, or other punctuation in the address. When entering a nine-digit zip code (ZIP+4), include the hyphen. Do not use a hyphen or space as a separator within the telephone number. Claims will be paid to the provider number submitted in field 33 of the CMS-1500 form. This pay-to-provider number is indicated on the Remittance Advice and check.

33a* Billing Provider Info

Typical Providers:

Enter the NPI of the billing provider or group. If the provider rendering the services is a member of a group, the 10-character NPI group/organization number must be entered. If not billing as a member

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field Description

* Required for claim to process

** Required if applicable (based upon the specific program area requirements)

of a group, enter the 10-character individual NPI in the field.

Atypical Providers:

Not applicable

33b* Billing Provider Info

Typical Providers:

Enter the two-byte qualifier ZZ followed by the taxonomy code (no spaces).

Atypical Providers:

Enter the two-byte qualifier 1D followed by the six-character legacy Medicaid provider number (no spaces).

Prior Authorization (DHHS Form 214)

A Prior Authorization (DHHS Form 214) must be completed for items that require prior approval. Services requiring prior authorization are noted on the Fee Schedule (Section 4). The Prior Authorization form can be found in Section 5.

Approved items must be provided prior to the expiration date and billed within one year from the date of service.

Prior Authorization Form Completion Instructions

Provider Information

Field Description

1 Claim Control Number

Do not write in this space.

2 Provider's Name

Self-explanatory

3 Provider's ID Number

Enter your Medicaid Identification Number.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Prior Authorization Form Completion Instructions (Cont'd.)

Field	Description
4	**Own Reference Number** Not applicable for DME
5	**Date Submitted** Self-explanatory
6	**Street Address** Self-explanatory
7	**City/State/ZIP** Self-explanatory
8	**Name and City of Medical Provider** Enter branch location.
9	**Prior Authorization Number** The DME program coordinator will assign this number. The number will consist of seven digits and must be entered on all claim forms, adjustment requests, etc. generated as a result of this Authorization.
10	**Recipient Name** Self-explanatory
11	**Recipient ID Number** Enter the beneficiary's 10-digit Medicaid number. **Note:** The validity of an approved prior authorization is contingent upon Medicaid eligibility. Therefore, the provider should verify eligibility for the date of service.
12	**Sex** Enter "M" for male or "F" for female.
13	**Birth Date** Enter beneficiary's date of birth using two digits each for the month, day, and year (i.e., 021086).

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Prior Authorization Form Completion Instructions (Cont'd.)

Field	Description
14	**Service Indicator** Always enter the letter "S."
15	**Service Code** Enter the appropriate procedure code. If Not Otherwise Classified (NOC) codes are submitted when appropriate procedure codes are available, the request will be corrected and the appropriate procedure code entered.
16	**Modifier** Enter the appropriate modifier. Acceptable modifiers are as follows: NU Not used (new) LL Rental (equipment may be converted to purchase) RR Rental (equipment which will remain on a rental basis) UE Used Equipment LT Left RT Right SC Medically necessary service or supply
17	**Type of Sale** Enter the appropriate code: 1 Purchase 2 Rental 3 Repair **Note:** When a provider is unable to determine rental or purchase, complete one line for purchase and a second for rental. The DME program coordinator will make the final decision. In some cases, the DME program coordinator will make a decision to alter a provider's choice of rental or purchase. For instance, if the support documents indicate a long-term or permanent need for an item

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Prior Authorization Form Completion Instructions (Cont'd.)

Field	Description
	and the provider requests rental, it may be more cost effective for Medicaid to choose purchase. The DME program coordinator reserves the right to make these decisions.
18	**Requested Number of Billings** Authorization may be requested for multiple billings but not to exceed 12-month billings based on the MCMN (field 13). Some equipment is rented for ten months and then considered purchased. Authorization is valid only for the period specified.
19	**EPSDT Referral** Not applicable for DME
20	**Proposed Charge** Enter your proposed purchase or rental price. DHHS will not authorize a separate service/delivery charge. These charges are integral parts of a provider's cost of doing business and should normally be incorporated into the equipment cost. Providers must bill their usual/customary charge for NOC codes. Medicaid will reimburse in one of the following ways: • Wholesale plus 25% (25% includes sitting/fitting fees, freight/delivery charges, etc.) • 20% of retail price. (Sales tax is not reimbursable by SC Medicaid.)
21	**Authorized** The DME program coordinator will complete this field. The appropriate code from the list below will be entered.

Code	Description
1	Approved purchase or repair
2	Approved rental
3	Denied

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Prior Authorization Form Completion Instructions (Cont'd.)

Field	Description
22	**Allowed Number Billings** This field is completed by the DME program coordinator.
23	**Delete** The provider may enter an "X" in this space if an error was made on that line, or the DME program coordinator may enter an "X," if applicable.
24	**Service Name** Enter the description of the item.
25	**Tooth Number** Not applicable for DME
26	**Tooth Surfaces** Not applicable for DME
27	**Authorized Charge** The DME program coordinator will enter an approved amount only if the procedure code does not have an allowable established. Allowables are furnished for your information in Section 4. If there is an allowable established, the DME program coordinator will not enter that amount in field 27.
28	**Expiration Date** The DME program coordinator will enter a date to indicate that the supplies/equipment must be provided prior to that date.
LINES 2-5	Same as Line 1
89	**Documentation Attached** Self-explanatory

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Prior Authorization Form Completion Instructions (Cont'd.)

Field	Description
90	**Total Lines Entered** Note the total line items, excluding deleted lines
91	**Total Proposed Charges** Self-explanatory
92	This information is entered by the DME program coordinator.
93	This information is entered by the DME program coordinator.
94	**Provider's Signature** The form must be signed by the provider.

Medicaid Certificate Of Medical Necessity (MCMN)

To be reimbursed for equipment or supplies, a provider must medically justify the need by submitting a Medicaid Certificate of Medical Necessity (MCMN). An example of this form can be found in Section 5.

Certification Type/Date: If this is an initial certification for the beneficiary, indicate this by placing initial date needed in the space marked "INITIAL"; if this is a "revised" MCMN, indicate the revision date in the space indicated. Likewise, if the MCMN is for recertification, follow the above instructions. Remember to always furnish the initial date when requesting "revised or recertification."

MCMN Form Completion Instructions

Section A: LINES 1 THRU 10 TO BE COMPLETED BY ENROLLED DME PROVIDER:

Line 1	Enter beneficiary's full name, height, and weight.
Line 2	Enter beneficiary's Medicaid 10-digit number, sex, and date of birth.
Line 3	Enter the date of telephone/written/fax order and date of service.
Line 4	Print provider's name and provider's DME number/NPI.
Line 5	Enter provider's signature and date.
Line 6	Enter provider's street address and city.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

MCMN Form Completion Instructions (Cont'd.)

Line 7 Enter provider's state, zip code, and telephone number.

Line 8 Enter diagnosis code(s) and description.

Line 9 Print treating/ordering physician's name and license number.

Line 10 List all procedure codes.

Section B: LINES 11 THRU 14 TO BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

Line 11 This medical information is used to determine medical necessity.

Line 12 Enter date the beneficiary was last seen or evaluated by treating/ordering physician.

Line 13 Enter duration of need.

Line 14 Treating/ordering physician must sign and date the MCMN.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

ELECTRONIC CLAIMS SUBMISSIONS

Trading Partner Agreement

SCDHHS encourages electronic claims submissions. All Medicaid providers who elect to submit or receive electronic transactions are required to complete a SC Medicaid Trading Partner Agreement (TPA) with SCDHHS. The TPA outlines the basic requirements for receiving and sending electronic transactions with SCDHHS. For specifications and instructions on electronic claims submission or to obtain a TPA, visit http://www1.scdhhs.gov/openpublic/hipaa/Trading%20Partner%20Enrollment.asp or contact the EDI Support Center via the SCDHHS Medicaid Provider Service Center at 1-888-289-0709.

Providers should return the completed and signed SC Medicaid TPA Enrollment Form by mail or fax to:

SC Medicaid TPA
Post Office Box 17
Columbia, SC 29202
Fax: (803) 870-9021

If a provider utilizes a billing agent and elects to have the billing agent access their electronic remittance package, both the provider and the billing agent must have a TPA on file.

Note: SCDHHS only distributes remittance advices and associated ECFs electronically through the Web Tool. **All providers must complete a TPA in order to receive these transactions electronically.** Providers that currently use the Web Tool do not need to complete another TPA. Providers who have previously completed a TPA, but are not current users of the Web Tool, must register for a Web Tool User ID by contacting the EDI Support Center via the SCDHHS Medicaid Provider Service Center at 1-888-289-0709.

Companion Guides

Providers submitting electronic transactions must comply with all federal guidelines as contained in the HIPAA-required ANSI X-12 Implementation Guide, and with SCDHHS guidelines as contained in the SC Medicaid Companion Guides. The Companion Guides explain the situational and optional data required by SC Medicaid. Please visit the SC Medicaid Companion Guides webpage at

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Companion Guides (Cont'd.)

http://www.scdhhs.gov/resource/sc-medicaid-companion-guides to download the Companion Guides. Information regarding placement of NPIs, taxonomy codes, and six-character legacy Medicaid provider numbers on electronic claims can also be found here.

Companion Guides are available for the following transactions:

- 837P Professional Health Care Claim
- 837I Institutional Health Care Claim
- 835 Claim Payment/Advice
- 276/277 Claim Status Inquiry/Response
- 270/271 Eligibility Verification Request/Response
- 278 Prior Authorization

Transmission Methods

An Electronic Data Interchange (EDI) transaction is the movement of data between two entities. EDI software enables providers to submit claims directly to SC Medicaid.

The following options may be used to submit claims electronically:

Tapes, Diskettes, CDs, and Zip Files

A biller using this option records transactions on the specified media and mails them to:

SC Medicaid Claims Control System
Post Office Box 2765
Columbia, SC 29202-2765

File Transfer Protocol

A biller using this option exchanges electronic transactions with SC Medicaid over the Internet.

SC Medicaid Web-based Claims Submission Tool

The SC Medicaid Web-based Claims Submission Tool is a free, online Web-based application for submitting HIPAA-compliant professional claims, institutional claims, and associated adjustments to SC Medicaid. The Web Tool offers the following features:

- Providers can submit online CMS-1500 and UB claims.
- List Management allows users to develop their own list of frequently used information (*e.g.*, beneficiaries, procedure codes, diagnosis codes,

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

SC Medicaid Web-based Claims Submission Tool (Cont'd.)

etc.). During claims entry the user has the ability to select information from lists rather than repetitively keying, thus saving valuable time and increasing accuracy.

- Providers can check claims status using either of two options. Claims Status displays status for claims regardless of the submission method. Web Submitted Claims displays status for claims submitted via the Web Tool.
- No additional software is required to use this application.
- Data is automatically archived.
- Providers can verify beneficiary eligibility online by entering Medicaid ID, Social Security Number, or a combination of name and date of birth.
- Providers can view, save and print their own remittance advices and associated ECFs.
- Providers can change their own passwords.

The minimum requirements necessary for using the Web Tool are:

- Signed SC Medicaid Trading Partner Agreement (TPA) Enrollment Form
- Microsoft Internet Explorer (version 6.0 or greater)
- Internet Service Provider (ISP)
- Pentium series processor (recommended)
- Minimum of 32 megabytes of memory
- Minimum of 20 megabytes of hard drive storage

Note: In order to access the Web Tool, all users must have individual login IDs and passwords.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

REMITTANCE PACKAGE

Each week, SCDHHS generates electronic remittance packages for all providers who have had claims processed during the previous week. This package contains any or all of the following:

- A Remittance Advice which lists all claims processed during that week and the status of each claim. (See "Remittance Advice" information on the following page.)
- For every claim with status R (rejected), an edit correction form (ECF) will be included in the remittance package.

  Note: Claims with line item rejects resulting in partially paid claims will not generate an ECF. To be considered for payment, the rejected lines must be filed back to Medicaid.
- Unless an adjustment has been made, a reimbursement payment equaling the sum total of all claims on the Remittance Advice with status P (paid) will be deposited by electronic funds transfer (EFT) into the provider's account. (See "Electronic Funds Transfer (EFT)" later in this section.

Providers must access their remittance packages electronically through the SC Medicaid Web-Based Claims Submission Tool (Web Tool). Providers can view, save, and print their remittance advice(s), but not a Remittance Advice belonging to another provider. Electronic remittance packages are available on Friday for claims processed during the previous week. Remittance advices and associated ECFs for the most recent 25 weeks will be accessible.

SCDHHS only distributes remittance advices and associated ECFs electronically through the Web Tool.

Duplicate Remittance Package

Effective December 2010, SCDHHS will charge for requests of duplicate Remittance Advice(s) including ECFs. Providers must use the Remittance Advice Request Form located in the Forms Section of this provider manual. Providers will have the option of requesting the

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Duplicate Remittance Package (Cont'd.)

complete remittance package, the remittance pages only, or the ECF pages only. The charges associated with the request will be deducted from a future Remittance Advice and will appear as a debit adjustment.

Remittance Advice

The Remittance Advice is an explanation of payments and action taken on all processed claim forms and adjustments. The information on the Remittance Advice is drawn from the original claim submitted by the provider. (See the Forms section of this manual for a sample Remittance Advice.) If a claim is rejected or suspended, the Remittance Advice will display the claim without payment. For a claim that is rejected, edit codes will be listed on the Remittance Advice (under "Recipient Name") and an Edit Correction Form (ECF) will be attached. If some lines on the claim have paid and others are rejected, an ECF will not be generated for the rejected lines. ***Evaluate the reason for the rejection and refile the rejected lines only, if appropriate. Corrections cannot be processed from the Remittance Advice.***

Processed claims and/or lines are assigned one of four statuses in field 10 on the Remittance Advice:

- **Status "P"** – Paid claims or lines
- **Status "S"** – Claims in process that require medical or technical review and are suspended pending further action. Status "S" will be resolved by SCDHHS. Provider response is not required for resolution unless it is requested by SCDHHS. If the claim is not resolved within 30 days, check it for errors and refile.
- **Status "R"** – Rejected claims or lines
- **Status "E"** – Encounter data (line contains service provided by the PCP). No action required.

EDI Remittance Advice – 835 Transaction

Providers who file electronically using EDI Software can elect to receive their Remittance Advice via the ASC X12 835 (005010X221A1) transaction set or a subsequent version. These electronic 835 EDI Remittance Advices contain Claim Adjustment Reason Codes (CARCs), broad definitions of why claims did not pay as billed, and Remittance Advice Remark Codes (RARCs), more detailed reasons for why claims did not pay as billed. (See

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

EDI Remittance Advice – 835 Transaction (Cont'd.)

Appendix 1 for a listing of CARCs and RARCs.) The electronic 835 EDI Remittance Advice will only report items that are returned with P (paid) or R (rejected) statuses.

Providers interested in utilizing this electronic transaction should contact the EDI Support Center via the SCDHHS Medicaid Provider Service Center at 1-888-289-0709.

Reimbursement Payment

SCDHHS no longer issues paper checks for Medicaid payments. Providers receive reimbursement from SC Medicaid via electronic funds transfer.

The reimbursement payment is the sum total of all claims on the Remittance Advice with status P. If an adjustment request has been completed, it will appear on the Remittance Advice. (See "Claim Adjustments" later in this section.)

Note: Newly enrolled providers will receive a hard copy check until the Electronic Funds Transfer (EFT) process is successfully completed.

Electronic Funds Transfer (EFT)

Upon enrollment, SC Medicaid providers must register for Electronic Funds Transfer (EFT) in order to receive reimbursement. SCDHHS will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside the United States.

Prior to revoking or revising the EFT authorization agreement, the provider must provide 30 days written notice to:

Medicaid Provider Enrollment
PO Box 8809
Columbia, SC 29202-8809

The provider is required to submit a completed and signed EFT Authorization Agreement Form to confirm new and/or updated banking information. Refer to the Forms section for a copy of the EFT Authorization form.

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 SC Medicaid direct deposits are made.

During the pre-certification period, the provider will receive reimbursement via hard copy checks.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Electronic Funds Transfer (EFT) (Cont'd.)

If the bank account cannot be verified during the pre-certification period, the provider will be notified and will be required to submit an EFT form and bank account verification from their financial institution.

Upon completion of the pre-certification period, reimbursement payment will be deposited directly into the provider's bank account.

Providers may view their Remittance Advice (RA) on the Web Tool for payment information. The last four digits of the bank account are reflected on the RA.

When SCDHHS is notified that the provider's bank account is closed or the routing and/or bank account number is no longer valid, the provider will be notified and will be required to submit an EFT form and bank account verification from their financial institution.

Each time banking information changes, the 15-day pre-certification period will occur and the provider will receive reimbursement via copy checks.

Uncashed Medicaid Checks

SCDHHS may, under special circumstances, issue a paper reimbursement check. In instances where Medicaid checks to providers remain outstanding 180 days or longer from the date of check issue, SCDHHS is required by federal regulations to refund to the federal government the federal share of those Medicaid checks. Therefore, SCDHHS will have the bank return (or not honor) Medicaid checks presented for payment that are 180 days old or older.

Edit Correction Form (ECF)

When an entire claim rejects (status "R") the Remittance Advice will be accompanied by an Edit Correction Form (ECF). (See the Forms section of this manual for a sample ECF.)

The ECF is generated for the purpose of making corrections to the original claim. Except for possible data entry error, information on the ECF reflects the information submitted on the claim form.

Rejected claims may be resolved in either of two ways. An entirely new corrected CMS-1500 claim form may be submitted, or the appropriate corrections may be made to a hard copy of the ECF. Corrections must be made using **RED** ink and resubmitted for payment. **Do not circle any item.**

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Edit Correction Form (ECF) (Cont'd.)

It is possible for some lines on a claim to be paid while other lines on the same claim are rejected. Due to the fact that some payment was made on the claim, an ECF will not be provided in these cases. When part of a claim is paid and part is rejected, the unpaid line items must be corrected and resubmitted on a new claim form.

Note: Medicaid will pay claims that are up to one year old. If the date of service is greater than one year old, Medicaid will not make payment. The one-year time limit does not apply to **retroactive eligibility** for beneficiaries. Refer to "Retroactive Eligibility" earlier in this section for more information. Timeliness standards for the submission and resubmission of claims are also found in Section 1 of this manual.

Edit Identification

The upper right section of the ECF contains a field entitled EDITS; this is the edit identification section. Underneath that title, one or more three-digit edit codes will be listed to indicate all edits detected by the MMIS claims processing system. Except for possible data entry errors, all information on the ECF is taken from the claim form. A list of edit codes, along with CARCs, RARCs, and resolutions, can be found in Appendix 1.

Edit Types

Insurance Edits

These edit codes apply to third-party carrier coverage. They can stand alone or be prefaced by a number (00, 01, etc.). Always review these insurance edit codes first.

Claim Edits

These edit codes apply to the body of the claim (not the line items) and have rejected the entire claim from payment. Such edits either stand alone or are prefaced by "00."

Line Edits

These edit codes are line specific and are always prefaced by a number ("01," "02," etc.). They apply to only the line indicated by the number.

Description of Fields

Claim Control

A 16-digit number followed by an alpha suffix is assigned to each original invoice (upper right corner of ECF). This is the Claim Control Number (CCN).

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Description of Fields (Cont'd.)

Doc Ind

The Document Indicator field will indicate "Y" when documentation was attached to the hard copy claim and "N" when documentation was not attached. Documentation is anything attached to the claim when originally received for processing (*i.e.*, medical records, insurance explanation of benefits, copy of a Medicaid card, letter, etc.).

EMC

The Electronic Media Content field will indicate "Y" when the claim was electronically transmitted and "N" when the claim was filed hard copy.

Rejections for Duplicate Billing

The original claim payment information is provided when a claim is rejected for duplicate billing. This eliminates the need for contacting SCDHHS program staff for the original reimbursement date.

When a claim is rejected for duplicate billing, the payment date of the original claim appears beside the duplicate edit code within a block named Claims/Line Payment Information. This block is located on the ECF on the upper right side above all other edit information.

Section 1: Provider/ Beneficiary Information

The following numbered items represent field numbers on the ECF:

Field	Description
1	**Prov/Xwalk ID** Six-character legacy Medicaid provider (pay-to Medicaid) number and/or ten-character National Provider Identifier (NPI)
2	**Recipient ID** Beneficiary's ten-digit Medicaid identification number
3	**P Auth Number (Prior Authorization Number)** Prior authorization number furnished by provider on the claim. Seven-digit number assigned by DME staff to provider on MCMN/AF.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Description of Fields (Cont'd.)

Field	Description

4 TPL (Third-Party Liability Indicator)

TPL indicator entered by the provider on the claim. Valid indicators for this field are:

1 Insurance denied

6 Crime victim

8 Uncooperative beneficiary

5 Injury Code (Injury [Accident] Code Indicator)

An indicator in this field prompts follow-up by the Division of Third-Party Liability for possible casualty coverage. Valid indicators are:

2 Work

4 Auto

6 Other

6 Emerg (Emergency Indicator)

Not applicable

7 PC Coord (Primary Care Coordinator)

Not applicable

8 Primary Diagnosis

The foremost reason for medical attention should be indicated with an ICD-9 code. To find the correct diagnosis code, always use Volume I of the current year's edition for final coding. A fourth and fifth digit are required when applicable.

9 Secondary Diagnosis

The secondary diagnosis is a secondary reason medical attention is needed, but is of a lesser importance than the primary diagnosis. It is indicated by an ICD-9 code. A fourth and fifth digit are required when applicable. Use the current year's edition of ICD-9-CM.

10 Recipient Name

First name, middle initial, and last name based on

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Description of Fields (Cont'd.)

Field	Description
	the Recipient ID Number in field 2. This field is not keyed.
11	**Date of Birth**
	Beneficiary's date of birth based on the Recipient ID Number in field 2. This field is not keyed and is the information on the beneficiary record at the time of processing.
12	**Sex**
	Beneficiary's sex based on the Recipient ID Number in field 2. This field is not keyed and is the information on the beneficiary record at the time of processing.
	Section II: Line Item Information
13	**Res**
	Agency use only. Do not write in this field.
14	**Allowed**
	Agency use only. Do not write in this field.
15	**Date of Service**
	The date on which each service was rendered. This is entered from field 24A (unshaded), the "To" field, on the CMS-1500 claim form.
16	**Place**
	This is the code for where the service was rendered – the place of service.
17	**Proc Code (Procedure Code)**
	This is the procedure code which reflects the service that was rendered.
18	**Mod (Modifier)**
	Two-character code used to modify the procedure.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Description of Fields (Cont'd.)

Field	Description
19	**Individual Provider** This is the provider's six-character legacy Medicaid provider number or ten-character NPI, or rendering physician's six-character legacy Medicaid provider number and/or NPI if practicing within a group.
20	**Charges** The amount billed per procedure code
21	**Pay Ind** This indicator is only printed on the Remittance Advice. Refer to Medicaid Remittance Package.
22	**Units** Number of days/units/minutes, as applicable
23	**NDC** Not applicable
Section III: Third Party	
24	**Ins Carr Number (Insurance Carrier Number)** Three-digit insurance carrier code(s)
25	**Policy Number** Policy number with third-party payer(s)
26	**Ins Carr Paid (Insurance Carrier Paid)** Amount paid by third-party payer(s)
27	**Total Charge** Sum of all line item gross charges billed. (Indicate actual charges for your program.)
28	**Amt Rec'd Ins (Amount Received Insurance)** Total amount paid on this claim by insurance company(s)

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Description of Fields (Cont'd.)

Field Description

29 Balance Due

Enter the balance due.

When a beneficiary has third party coverage, including Medicare, this is the patient responsibility amount. The third party payment plus the patient responsibility cannot exceed the amount the provider has agreed to accept as payment in full from the third party payer, including Medicare.

30 Own Ref # (Own Reference Number)

Number assigned to a given claim by providers as their patient account number. (It will appear on the Remittance Advice. No edits are performed on this number.)

Additional Fields on the ECF

Return To

Return ECFs to the address shown.

Provider

Your computer-printed name and address

Insurance Policy Information

Carrier code, policy number, and name of insurance policyholder on file with SC Medicaid at the time the claim was processed.

Resolution Instructions

Each edit code has associated instructions to assist the providers in resolving their claims. **See Appendix 1 for a list of edit codes and their resolutions.**

Follow these instructions for resolving each edit on an ECF:

1. Match and compare the ECF with a copy of the original claim.

   Note: Ensure the claim control number on the ECF is legible and complete. To correct an incomplete CCN, please log into the Web Tool for assistance.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Resolution Instructions (Cont'd.)

2. Review the Edit Code section to determine the error(s).
3. Review the edit code description and resolution.
4. Make the appropriate corrections for each edit using RED ink by striking a line through the incorrect data and entering the correct data directly above or as close as possible to the data being corrected. If the field is blank, enter the missing data using RED ink.
5. Place a RED check mark over each corrected edit in the edit identification section. **DO NOT MAKE ANY OTHER MARKS OR NOTES ON THE ECF.**
6. If necessary, staple applicable attachments to the ECF.
7. Resubmit the ECF to the return address shown on the lower portion of the ECF.

Note: All corrections and additions to the ECF must be made in RED. Do not circle any item. In addition, ECFs must be resolved before resubmitting. Writing a note and/or signing an ECF and submitting to Medicaid Claims Receipt will not resolve the ECF. Any ECF returned to Medicaid Claims Receipt with no corrective action taken or critical information from the printed ECF is missing, illegible or incomplete will be returned to the provider and not processed. If you are unable to resolve an ECF, contact the PSC or submit an online inquiry at http://scdhhs.gov/contact-us for assistance before resubmitting your claim. Except for possible data entry error, information on the ECF reflects the information submitted on the claim form.

THIRD-PARTY LIABILITY (TPL)

The SCDHHS Health Insurance Information Referral Form is used to document third-party insurance coverage, policy changes, beneficiary coverage changes, carrier changes, and policy lapse information. A copy of this form is included in the Forms section of this manual. Completed forms should be mailed or faxed directly to Medicaid Insurance Verification Services at the following address:

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

THIRD-PARTY LIABILITY (TPL) (CONT'D.)

South Carolina Healthy Connections
Post Office Box 101110
Columbia, SC 29211-9804
Fax: (803) 252-0870

Cost Avoidance

Under the cost avoidance program, claims billed primary to Medicaid for many providers will automatically be rejected for those beneficiaries who have other resources available for payment that are responsible as the primary payer.

Providers should not submit claims to Medicaid until payment or notice of denial has been received from any liable third party. However, the time limit for filing claims cannot be extended on the basis of third-party liability requirements.

If a claim is rejected for primary payer(s), the Edit Correction Form will supply all information necessary for the provider to file with the third-party payer. This information is listed to the right of the Medicaid claims receipt address on the ECF under the heading "INSURANCE POLICY INFORMATION" and includes the insurance carrier code, the policy number, and the name of the policyholder. Information about the carrier address and telephone number may be found in Appendix 2 of this manual. Providers can also view carrier codes on the Provider Information page at http://provider.scdhhs.gov. More specific policy information such as the group number can be provided by your program representative..

Reporting Third-Party Insurance On a CMS-1500 Claim Form

After the claim has been submitted to the third-party payer, and the third-party payer denies payment or the third-party payment is less than the Medicaid allowed amount, the provider may submit the claim to Medicaid. To indicate that a claim has been submitted to a third-party insurance carrier, include the carrier code, the policy number, and the amount paid. Instructions are provided earlier in this section on coding the CMS-1500 claim for third-party insurance information.

If the third party denies payment, the TPL indicator for "insurance denied" should be entered in the appropriate field on the CMS-1500 claim form. For the CMS-1500 (version 08/05) the appropriate field for TPL coding is field 10d. The TPL indicators accepted are:

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Reporting Third-Party Insurance On a CMS-1500 Claim Form (Cont'd.)

Code	Description
1	Insurance denied
6	Crime victim
8	Uncooperative beneficiary

If the third-party payment is equal to or greater than the SC Medicaid established rate, Medicaid will not reimburse the balance. The Medicaid beneficiary **is not liable** for the balance.

Third-Party Liability Exceptions

Providers may occasionally encounter difficulties in obtaining documentation and payment from third parties and beneficiaries. For example, the third-party insurer may refuse to send a written denial or explanation of benefits, or a beneficiary may be missing or uncooperative. In such cases it is the provider's responsibility to seek a solution to the problem.

Providers have many resources available to them for pursuing third party payments. Program areas will work with providers to explore these options.

As a final measure, providers may submit a reasonable effort document along with a claim filed as a denial. This form can be found in the Forms section of this manual. The reasonable effort document must demonstrate sustained efforts of claim submission and/or adequate follow-up to obtain the needed action from the insurance company or beneficiary. This document should be used only as a last resort, when all other attempts at contact and payment collection have failed.

The reasonable effort documentation process does not exempt providers from timely filing requirements for claims. Please refer to "Time Limit for Submitting Claims" in Section 1.

If the provider received an ECF or is filing a hard copy claim, the reasonable effort document should be attached to the claim form or ECF and returned to Medicaid Claims Receipt.

Dually Eligible Beneficiaries

When a dually eligible beneficiary also has a commercial payer, the provider should file to all payers before filing to Medicaid. If the provider chooses to submit a CMS-1500 claim form for consideration of payment, he or she must

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Dually Eligible Beneficiaries (Cont'd.)

declare all payments and denials. If the combined payments of Medicare and the other payer add up to less than Medicaid's allowable, Medicaid will make an additional payment up to that allowable not to exceed the remaining patient responsibility. If the sum of Medicare and other payers is greater than Medicaid's allowable, the claim will reject with the 690 edit (payment from other sources is more than Medicaid allowable).

TPL Refunds

When reimbursed by both Medicaid and third-party insurance, the provider must refund the lesser of either the amount paid by Medicaid or the full amount paid by the insurance company. See "Claim Adjustments" and "Refunds" later in this section.

Medicaid Recovery Initiatives

Retro-Health Insurance

Where SCDHHS discovers a primary payer for a claim Medicaid has already paid, SCDHHS will pursue recovery. Once an insurance policy is added to the TPL policy file, claims that have services in the current and prior calendar years are invoiced directly to the third party.

Retro-Medicare

Every quarter, providers are notified by letter of claims Medicaid paid primary for beneficiaries with Medicare coverage. The letter provides the beneficiary's Medicare number to file the claim with Medicare. The Medicaid payments will be recouped within 30 days of the date of the letter. Please retain the letter for accurate accounting of the recoupment. Questions about this letter may be referred to Medicaid Insurance Verification Services (MIVS) at 1-888-289-0709 option 5.

Where claims have been pulled into retro Medicare and retro health for institutional providers, the provider should not attempt to refund the claim with a void or void/replacement claim. Should they do so, they will incur edits 561, 562, and 563.

Carrier Codes

All third-party payers are assigned a three-digit code referred to as a carrier code. The appropriate carrier code must be entered on the CMS-1500 form when reporting third-party liability.

The list of carrier codes (Appendix 2) contained in this

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Carrier Codes (Cont'd.)

manual is categorized both alphabetically by the names of the insurance companies and numerically by the carrier code assigned to each company. These codes are current at the time of publication of this manual; however, they are subject to change.

If a particular carrier or carrier code cannot be found in this manual, providers should visit the Provider Information page on the SCDHHS Web site at http://provider.scdhhs.gov to view and/or download the most current carrier codes. Carrier codes are updated each quarter on the Web site.

If a particular carrier code is neither listed in the manual nor on the SCDHHS Web site, providers may use the generic carrier code 199 for billing purposes. Contact the PSC or submit an online inquiry for assistance should an ECF list a numerical code that cannot be located in the carrier codes either in this manual or online.

CLAIM ADJUSTMENTS

Adjustments can be made to paid claims only. A request may be initiated by the provider or SCDHHS. SCDHHS-initiated adjustments are used when the agency determines that an overpayment or underpayment has been made to a provider; SCDHHS will notify the provider when this occurs. Questions regarding an adjustment should be directed to the PSC or submit an online inquiry for assistance. It is important to note that discontinuation of participation in Medicaid will **NOT** eliminate an existing overpayment debt.

A **claim-level adjustment** is a **detail-level** Void (debit) or Void/Replacement that is used to correct both the payment history **and** the actual claim record. It is limited to one claim per adjustment request. A Void claim will always result in an account debit for the total amount of the original claim. A Void/Replacement claim will generate an account debit for the original claim and re-file the claim with the corrected information.

A **gross-level adjustment** is defined as a **provider-level** adjustment that is a debit or credit that will affect the financial account history for the provider; however, the patient claim history in the Medicaid Management Information System (MMIS) will not be altered, and the Remittance Advice will not be able to provide claim-specific information.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Claim-Level Adjustments

All Medicaid providers are able to initiate claim-level adjustments. Please note: gross-level adjustments may still be used as discussed in "Gross-Level Adjustments." The process for claim-level adjustments gives providers the option of initiating their own corrections to individual claim records. This process allows providers to submit adjustments directly to SC Medicaid. Claim-level adjustments should only be submitted for claims that have been paid (status "P").

Claim-level adjustments should be initiated when:

- The provider has identified the need for a **Void/Replacement** of an original claim. This process should be used when the information reported on the original claim needs to be amended. **The original claim must have a date of service that is less than 12 months old.** (See "Claim Filing Timeliness" in this section for more information.)
- The provider has identified the need for a **Void Only** of a claim that was paid within the last 18 months. This process should be used when the provider wishes to withdraw the original claim entirely.

Claim-level adjustments can be submitted in several ways:

- Providers who submit claims using a HIPAA-compliant electronic claims submission format must use the void or replacement option provided by their system. (See "Void and Replacement Claims for HIPAA-Compliant Electronic Submissions" below.)
- Providers who submit claims on paper using CMS-1500, or Transportation forms can use the Claim Adjustment Form 130 (DHHS Form 130, revised 03-13-2007). They can also use the Web Tool to initiate claim-level adjustments in a HIPAA-compliant electronic format, even if they continue using paper forms for regular billing. See "Electronic Claims Submissions" in this section for more information about the Web Tool.

Providers who use an electronic format that is not compliant with HIPAA standards to submit CMS-1500 or

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Claim-Level Adjustments (Cont'd.)

Transportation claims can use DHHS Form 130; they may also use the Web Tool to submit adjustments.

Void and Replacement Claims (HIPAA-Compliant Electronic Submissions)

Providers may use a HIPAA-compliant electronic format to void a claim that has been filed in error, processed, and for which payment has been received. Submitting a **Void claim** with the original Claim Control Number will alert SCDHHS that claim payment has been made in error. The amount paid for the original claim will be deducted from the next Remittance Advice**.**

Alternatively, these providers may submit a **Replacement claim** to change information on a claim that has been filed, processed, and for which payment has been received. Submitting a Replacement claim automatically voids the original claim and processes the Replacement claim. The Void and Replacement claims must have the same beneficiary and provider numbers.

Void Only and Void/Replacement Claims

Providers who file claims on paper or who submit electronic claims that are not in a HIPAA-compliant electronic format may use DHHS Form 130 to submit claim-level adjustments. (A sample DHHS Form 130 can be found in the Forms section of this manual.) Once a provider has determined that a claim-level adjustment is warranted, there are two options:

- Submitting a **Void Only** claim will generate an account debit for the amount that was reimbursed. A Void Only claim should be used to retract a claim that was paid in error. To initiate a Void Only claim, complete DHHS Form 130 and attach a copy of the original Remittance Advice.
- Submitting a **Void/Replacement** claim will generate an account debit for the original claim and re-file the claim with the corrected information. A Void/Replacement claim should be used to:
  - Correct a keying or billing error on a paid claim
  - Add new or additional information to a claim
  - Add information about a third party insurer or payment

To initiate a Void/Replacement claim, complete DHHS Form 130 and attach a copy of the original Remittance

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Void Only and Void/Replacement Claims (Cont'd.)

Advice, as well as the new Replacement claim. Also attach any documentation relevant to the claim.

Form 130 Instructions

The completed DHHS Form 130 and any other documents specified above should be sent directly to SC Medicaid at the same address used for regular claims submission. All fields are required with the exception of field 13, "Comments."

1 Provider Name

Enter the provider's name.

2 Provider Address

Enter the provider's address.

3 Provider City, State, Zip

Enter the provider's city, state, and zip code.

4 Total amount paid on the original claim

Enter the total amount that was paid on the original claim that is to be voided or replaced.

5 Original CCN

Enter the Claim Control Number of the original claim you wish to Void or Void/Replace. The CCN is 17 characters long; the first 16 characters are numeric, and the 17th is alpha, indicating the claim type.

6 Provider ID/NPI

Enter the six-character Medicaid legacy provider number and/or NPI of the provider reimbursed on the original claim.

7 Recipient ID

Enter the beneficiary's Medicaid ID as submitted on the original claim.

8 Adjustment Type

Fill in the appropriate bubble to indicate Void or Void/Replace.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Form 130 Instructions (Cont'd.)

9 Originator

Fill in the "Provider" bubble.

10 Reason for Adjustment

Select only **one** reason for the adjustment and fill in the appropriate bubble.

11 Analyst ID

This field is for agency use only.

12 For Agency Use Only

These adjustment reasons are for agency use only.

13 Comments

Include any relevant comments in this field. Comments are not required.

14 Signature

The person completing the form must sign on this line.

15 Date

Enter the date the form was completed.

16 Phone

Enter the contact phone number of the person completing the form.

Visit Counts

Because visit counts are stored on the claim record for beneficiaries, the claim-level adjustment process can affect the visit count for services that have a limitation on the number of visits allowed within a specific timeframe (typically the state fiscal year). Those services include Ambulatory, Home Health, and Chiropractic visits.

In the case of a **Void Only** adjustment, the visit count for a beneficiary will be restored by the same number and type of visits on the original claim. Once the Void Only adjustment has been processed, those allowed visits are returned to the beneficiary's record and are available for use.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Visit Counts (Cont'd.)

In the case of a **Void/Replacement** adjustment, a new visit count will be applied to the beneficiary record after the replacement claim has completed processing.

There are two factors to note here:

- If the recalculated visit count exceeds that beneficiary's limits, reimbursement for the excess visits on the Replacement claim will be denied.
- There may be cases when a Void/Replacement adjustment is submitted, the Void of the old claim is processed, and the Replacement claim is suspended. In such cases, the allowable visits on the original claim are "held" until the suspension is resolved. If the resolution results in "Paid" status for the Replacement claim, the allowable visits are applied to it. However, if the Replacement claim is denied ("R" status), then those allowable visits again become active in the beneficiary's record and can be applied to other visits.

Gross-Level Adjustments

Gross-level adjustments will be initiated when:

- A claim is no longer in Medicaid's active history file (the claim payment date is more than 18 months old.)
- The adjustment request is not "claim-specific" (cost settlements, disproportionate share, etc.). SCDHHS will initiate this type of gross adjustment.
- A claim in TPL Recovery will not be taken back in full.

Provider requests for credit adjustments (where the provider can substantiate that additional reimbursement is appropriate) or debit adjustments (where the provider wishes to make a voluntary refund of an overpayment) should be directed to the Medicaid program manager within 90 days of receipt of payment. Requests for gross-level **credit** adjustments for dates of service that are more than one year old typically cannot be processed by SCDHHS without documentation justifying an exception. Providers may send TPL-related adjustments directly to Medicaid Insurance Verification Services (MIVS) at the following address:

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Gross-Level Adjustments (Cont'd.)

South Carolina Healthy Connections
Post Office Box 101110
Columbia, SC 29211-9804

Fax: (803) 462-2582
Phone: 1-888-289-0709 option 5

In the event of a debit adjustment, the provider should not send a check. Appropriate deductions will be made from the provider's account, if necessary. Providers may inquire directly to Medicaid Insurance Verification Services about debit or credit adjustments resulting from private health insurance or retroactive Medicare coverage.

To request a gross-level adjustment, the provider should submit a letter on letterhead stationery to the Medicaid program manager providing a brief description of the problem, the action that the provider wishes SCDHHS to take on the claim, and the amount of the adjustment, if known. If the problem involves an individual claim, the letter should also provide the beneficiary's name and Medicaid number, the date of service involved, and the procedure code for the service to be adjusted. The provider's authorized representative must sign the letter. For problems involving individual claims, copies of the pertinent Medicaid Remittance Advices with the beneficiary's name and Medicaid number, date of service, procedure code, and payment amount **highlighted** should also be included.

The provider will be notified of the adjustment via a letter or a copy of an Adjustment/Alternate Claim Form (DHHS Form 115). After it is processed by SCDHHS, the gross-level adjustment will appear on the last page of the provider's next Remittance Advice. Each adjustment will be assigned a unique identification number ("Own Reference Number" on the adjustment form), which will appear in the first column of the Remittance Advice. The identification number will be up to nine alphanumeric characters in length. A sample Remittance Advice can be found in the Forms section of this manual. Gross-level adjustments are shown on page 3 of the sample.

Adjustments on the Remittance Advice

If a Void claim and its Replacement process in the same payment cycle, they are reported together on the Remittance Advice along with other paid claims. The

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Adjustments on the Remittance Advice (Cont'd.)

original Claim Control Number (CCN) and other claim details will appear on both the Void and the Replacement lines.

Void Only claim adjustments are reported on a separate page of the Remittance Advice; they will also show the original CCN and other claim details. If the Replacement claim for a Void/Replacement processes in a subsequent payment cycle, it will appear with other paid claims.

Gross-level adjustments are reported on the last page of the Remittance Advice, and show only a reference number and debit/credit information.

A sample Remittance Advice that shows Void Only, Void/Replacement, and gross-level adjustments can be found in the Forms section of this manual.

Refund Checks

Providers who are instructed to send a refund check should complete the Form for Medicaid Refunds (DHHS Form 205) and send it along with the check to the following address:

South Carolina Healthy Connections
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

All refund checks should be made payable to the SC Department of Health and Human Services. A sample of the Form for Medicaid Refunds, along with instructions for its completion, can be found in the Forms section of this manual. SCDHHS must be able to identify the reason for the refund, the beneficiary's name and Medicaid number, the provider's number, and the date of service in order to post the refund correctly.

If you submit a refund to SCDHHS and subsequently discover that it was in error, SCDHHS must receive your credit adjustment request within 90 days of the refund.

SECTION 4
DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

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PROCEDURE CODE AND MODIFIER

The most current DME fee schedule is maintained on the SCDHHS website at www.scdhhs.gov. Provider should visit the website frequently for changes to the fee schedule.

CODES REQUIRING A MEDICAID CERTIFICATE OF MEDICAL NECESSITY (MCMN)

The following list of codes requires a Medicaid Certificate of Medical Necessity (MCMN) to be attached to the CMS-1500 claim form. The MCMN must be kept in the beneficiary's file at the provider's place of business.

HCPCS Code	Description	Modifier
A4352	INTERM. CATH URINARY EACH	00
A4353	INTERM URINARY CATH EACH	00
A4420	OST PCH CLSD;FOR BARR W LOCKNG FLANGE,EA	00
A4427	OST POU DRAINABLE(USE ON BARR W/LOC FLAN	00
A4604	TUBING W/HEAT ELEM/POS AIRWAY PRES DEVC	NU
A4930	GLOVES, STERILE, PER PAIR	00
A5500	DIAB ONLY FIT/PREP/SUPP DEPTH-INLAY SHOE	00
A5501	DIAB ONLY FIT/PREP/SUPP CUSTOM MOLD SHOE	00
A5503	DIAB ONLY MOD OF ROLLER/RIGID BOTTOM SHO	00
A5504	DIAB ONLY MOD DEPTH-INLAY/CUST MOLD SHOE	00
A5505	DIAB ONLY MOD DEPTH-INLAY/METATAR BAR SH	00
A5506	DIAB ONLY MOD DEPTH-INLAY/OFF-SET HEELS	00
A5507	DIAB ONLY NOS MOD DEPTH-INLAY/CUST MOLDE	00
A5510	DIABETICS,DIRECT FORM,COMP MOLD,PER SHOE	00
A5513	DIAB,MULTI DEN INSERT,CUSTOM FOOT FORM	00
A6205	COMPOSTE DRSG,PAD>48IN,W/ADHSVE BORDR EA	00
A6411	EYE PAD, NON-STERILE, EACH	00
A6412	EYE PATCH, OCCLUSIVE, EACH	00
A6441	PADDED BANDAGE W>=3" <5"/PER YARD	00
A6445	CONFORM BANDAGE STERILE <3"WIDE, PER YD	00
A6452	HIGH COMPRES BAND, WIDTH >= 3" & <5",YD	00
A6453	SELF-ADHERENT BAND, < 3" , PER YARD	00
A6454	SELF-ADHERENT BAND,W >=3"& <5", PER YD	00
A6501	COMPRESSION BURN GARMENT	00

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING A MEDICAID CERTIFICATE OF MEDICAL NECESSITY (MCMN)

A6502	COMPRESSION BURN GARMENT	00
A6503	COMPRESSION BURN GARMENT	00
A6504	COMPRESSION BURN GARMENT	00
A6505	COMPRESSION BURN GARMENT	00
A6506	COMPRESSION BURN GARMENT	00
A6507	COMPRESSION BURN GARMENT	00
A6508	COMPRESSION BURN GARMENT	00
A6509	COMPRESSION BURN GARMENT	00
A6510	COMPRESSION BURN GARMENT	00
A6511	COMPRESSION BURN GARMENT, LOWER TRUNK IN	00
A6512	COMPRESSION BURN GARMENT	00
A8000	HELMET,PROTECT,SOFT,PREFAB,COMPONENT&ACC	NU
A8001	HELMET,PROTECT,HARD,PREFAB,COMPONENT&ACC	NU
A8002	HELMET,PROTECT,SOFT,CUSTOM FAB,COMP&ACC	NU
A8003	HELMET,PROTECTIVE,HARD,CUSTOM FAB,COMP&A	NU
A8004	SOFT INTERFACE REPLACEMENT FOR HELMET	NU
B4104	ADDITIVE FOR ETERAL FORMULA (E.G. FIBER)	00
E0130	WALKER RIGID (PICKUP) ADJUST OR FIXED HT	LL
E0130	WALKER RIGID (PICKUP) ADJUST OR FIXED HT	NU
E0130	WALKER RIGID (PICKUP) ADJUST OR FIXED HT	UE
E0135	WALKER FOLDING (PICKUP) ADJUST OR FIX HT	LL
E0135	WALKER FOLDING (PICKUP) ADJUST OR FIX HT	NU
E0135	WALKER FOLDING (PICKUP) ADJUST OR FIX HT	UE
E0140	WALKER, WITH TRUNK SUPPORT, ANY TYPE	LL
E0140	WALKER, WITH TRUNK SUPPORT, ANY TYPE	NU
E0140	WALKER, WITH TRUNK SUPPORT, ANY TYPE	UE
E0141	RIGID WALKER, WHEELED, WITHOUT SEAT	LL
E0141	RIGID WALKER, WHEELED, WITHOUT SEAT	NU
E0141	RIGID WALKER, WHEELED, WITHOUT SEAT	UE
E0143	WALKER, FOLDING, WHEELED, WITHOUT SEAT	LL
E0143	WALKER, FOLDING, WHEELED, WITHOUT SEAT	NU
E0143	WALKER, FOLDING, WHEELED, WITHOUT SEAT	UE
E0144	ENCLOSED FRAMED FLD WALKER WHEELED W/SEA	LL
E0144	ENCLOSED FRAMED FLD WALKER WHEELED W/SEA	NU

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING A MEDICAID CERTIFICATE OF MEDICAL NECESSITY (MCMN)

E0144	ENCLOSED FRAMED FLD WALKER WHEELED W/SEA	UE
E0147	HD MULT BRK SRS VR WHEEL RESIST WALKER	LL
E0147	HD MULT BRK SRS VR WHEEL RESIST WALKER	NU
E0147	HD MULT BRK SRS VR WHEEL RESIST WALKER	UE
E0148	WALKER,HEAVY DUTY,NO WHEELS, ANY TYPE,EA	LL
E0148	WALKER,HEAVY DUTY,NO WHEELS, ANY TYPE,EA	NU
E0148	WALKER,HEAVY DUTY,NO WHEELS, ANY TYPE,EA	UE
E0149	WALKER,HEAVY DUTY,WHEELED,ANY TYPE,EACH	LL
E0149	WALKER,HEAVY DUTY,WHEELED,ANY TYPE,EACH	NU
E0149	WALKER,HEAVY DUTY,WHEELED,ANY TYPE,EACH	UE
E0153	PLATFORM ATTACH, FOREARM CRUT, EACH	LL
E0153	PLATFORM ATTACH, FOREARM CRUT, EACH	NU
E0153	PLATFORM ATTACH, FOREARM CRUT, EACH	UE
E0154	PLATFORM ATTACH, WALKER, EACH	LL
E0154	PLATFORM ATTACH, WALKER, EACH	NU
E0154	PLATFORM ATTACH, WALKER, EACH	UE
E0155	WHEEL ATTACH,RIGID PICK-UP WALKER, PAIR	LL
E0155	WHEEL ATTACH,RIGID PICK-UP WALKER, PAIR	NU
E0155	WHEEL ATTACH,RIGID PICK-UP WALKER, PAIR	UE
E0168	COMMODE CHAIR,EX.WIDE/HVY.DTY,ANYTYPE,EA	LL
E0168	COMMODE CHAIR,EX.WIDE/HVY.DTY,ANYTYPE,EA	NU
E0168	COMMODE CHAIR,EX.WIDE/HVY.DTY,ANYTYPE,EA	UE
E0190	POSITIONING CUSHION/PILLOW/WEDGE	LL
E0190	POSITIONING CUSHION/PILLOW/WEDGE	NU
E0190	POSITIONING CUSHION/PILLOW/WEDGE	UE
E0248	TRANSFER BENCH,HVY DUTY,FOR TUB/TOILET	NU
E0271	MATTRESS, INNERSPRING	LL
E0271	MATTRESS, INNERSPRING	NU
E0271	MATTRESS, INNERSPRING	UE
E0274	OVER BED TABLE	LL
E0274	OVER BED TABLE	NU
E0472	RAD, W/ BACK-UP INVASIVE INTERFACE	LL
E0562	HUMIDIFIER, HEATED, USED W/ PAP DEVICE	LL
E0562	HUMIDIFIER, HEATED, USED W/ PAP DEVICE	NU

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING A MEDICAID CERTIFICATE OF MEDICAL NECESSITY (MCMN)

E0562	HUMIDIFIER, HEATED, USED W/ PAP DEVICE	UE
E0585	NEBULIZER W/COMPRESSOR AND HEATER	LL
E0585	NEBULIZER W/COMPRESSOR AND HEATER	NU
E0585	NEBULIZER W/COMPRESSOR AND HEATER	UE
E0621	SLING OR SEAT, PATIENT LIFT, CANVAS/NYLO	LL
E0621	SLING OR SEAT, PATIENT LIFT, CANVAS/NYLO	NU
E0621	SLING OR SEAT, PATIENT LIFT, CANVAS/NYLO	UE
E0784	EXTERNAL AMBULATORY INFUSION PUMP, INSU	LL
E0911	TRAPEZE BAR,HVY DUTY,WT >250 LB,ATCH BED	LL
E0911	TRAPEZE BAR,HVY DUTY,WT >250 LB,ATCH BED	NU
E0911	TRAPEZE BAR,HVY DUTY,WT >250 LB,ATCH BED	UE
E0912	TRAPEZE BAR,HVY DUTY,WT > 250,FREE STNDG	LL
E0912	TRAPEZE BAR,HVY DUTY,WT > 250,FREE STNDG	NU
E0912	TRAPEZE BAR,HVY DUTY,WT > 250,FREE STNDG	UE
E0935	PASSIVE MOTION DEVICE, KNEE USE ONLY	RR
E0956	LAT TRK OK HIP SUP PREFAB IWCL MNTNG HDU	LL
E0956	LAT TRK OK HIP SUP PREFAB IWCL MNTNG HDU	NU
E0956	LAT TRK OK HIP SUP PREFAB IWCL MNTNG HDU	UE
E1015	SHOCK ABSORBER FOR MANUAL WHEELCHAIR,EA.	LL
E1015	SHOCK ABSORBER FOR MANUAL WHEELCHAIR,EA.	NU
E1015	SHOCK ABSORBER FOR MANUAL WHEELCHAIR,EA.	UE
E1020	RESIDUAL LIMB SUPPORT SYSTEM FOR W/W	NU
E1028	WHEELCHAIR ACCES, MANUAL SWINGAWAY	LL
E1028	WHEELCHAIR ACCES, MANUAL SWINGAWAY	NU
E1028	WHEELCHAIR ACCES, MANUAL SWINGAWAY	UE
E1029	WHEELCHAIR ACCES, VENTILATOR TRAY, FIXED	LL
E1029	WHEELCHAIR ACCES, VENTILATOR TRAY, FIXED	NU
E1029	WHEELCHAIR ACCES, VENTILATOR TRAY, FIXED	UE
E1038	TRANSPORT CHAIR, ADULT SIZE, <301	LL
E1038	TRANSPORT CHAIR, ADULT SIZE, <301	NU
E1038	TRANSPORT CHAIR, ADULT SIZE, <301	UE
E1039	TRANSPORT CHAIR,ADULT,HVY DTY,>= 250 LBS	LL
E1039	TRANSPORT CHAIR,ADULT,HVY DTY,>= 250 LBS	NU
E1039	TRANSPORT CHAIR,ADULT,HVY DTY,>= 250 LBS	UE

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING A MEDICAID CERTIFICATE OF MEDICAL NECESSITY (MCMN)

E1225	WHEELCHAIR, SEMIRECLINE BACK CUST CHAIR	LL
E1225	WHEELCHAIR, SEMIRECLINE BACK CUST CHAIR	NU
E1225	WHEELCHAIR, SEMIRECLINE BACK CUST CHAIR	UE
E1226	WHEELCHAIR, FULL RECLIN BACK CUST CHAIR	LL
E1226	WHEELCHAIR, FULL RECLIN BACK CUST CHAIR	NU
E1226	WHEELCHAIR, FULL RECLIN BACK CUST CHAIR	UE
E2201	MAN W/C ACES,NONSTAN SEAT FR,W>=20"&<24"	LL
E2201	MAN W/C ACES,NONSTAN SEAT FR,W>=20"&<24"	NU
E2201	MAN W/C ACES,NONSTAN SEAT FR,W>=20"&<24"	UE
E2202	MAN W/CHR ACCES,NONSTAN SEAT FR,W 24-27"	LL
E2202	MAN W/CHR ACCES,NONSTAN SEAT FR,W 24-27"	NU
E2202	MAN W/CHR ACCES,NONSTAN SEAT FR,W 24-27"	UE
E2203	MAN W/CHR ACCES,NONSTAN SEAT FR,DEP< 22"	LL
E2203	MAN W/CHR ACCES,NONSTAN SEAT FR,DEP< 22"	NU
E2203	MAN W/CHR ACCES,NONSTAN SEAT FR,DEP< 22"	UE
E2204	FRAME DEPTH 22 TO 25 IN	LL
E2204	FRAME DEPTH 22 TO 25 IN	NU
E2204	FRAME DEPTH 22 TO 25 IN	UE
E2218	MAN W-CHR ACC,FOAM PROPULATION TIRE,EACH	NU
E2222	MAN W-CHR ACC,SOLID CASTER INTEGRATD WHL	LL
E2222	MAN W-CHR ACC,SOLID CASTER INTEGRATD WHL	NU
E2222	MAN W-CHR ACC,SOLID CASTER INTEGRATD WHL	UE
E2226	MAN W-CHR ACC,CASTER FORK,REPL ONLY,EACH	LL
E2226	MAN W-CHR ACC,CASTER FORK,REPL ONLY,EACH	NU
E2226	MAN W-CHR ACC,CASTER FORK,REPL ONLY,EACH	UE
E2295	MAN WHLCHR ACCES,PED SIZE,DYNAMC SEAT FR	NU
E2295	MAN WHLCHR ACCES,PED SIZE,DYNAMC SEAT FR	RR
E2295	MAN WHLCHR ACCES,PED SIZE,DYNAMC SEAT FR	UE
E2369	POWER W/CHR COMPONENT,GEAR BOX,REPL ONLY	LL
E2369	POWER W/CHR COMPONENT,GEAR BOX,REPL ONLY	NU
E2369	POWER W/CHR COMPONENT,GEAR BOX,REPL ONLY	UE
E2370	POWER W/CHAIR,MOTOR & GEAR BOX,REPL ONLY	LL
E2370	POWER W/CHAIR,MOTOR & GEAR BOX,REPL ONLY	NU
E2370	POWER W/CHAIR,MOTOR & GEAR BOX,REPL ONLY	UE

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING A MEDICAID CERTIFICATE OF MEDICAL NECESSITY (MCMN)

E2371	PWR W-CHR ACC,GR27 SEALD LEAD ACID BATTE	LL
E2371	PWR W-CHR ACC,GR27 SEALD LEAD ACID BATTE	NU
E2371	PWR W-CHR ACC,GR27 SEALD LEAD ACID BATTE	UE
E2372	PWR W-CHR ACC,GR27 NON-SEALED LD ACD BAT	NU
E2392	PWC ACC,SOLID CASTER TIRE,INTEGRATED WHL	LL
E2392	PWC ACC,SOLID CASTER TIRE,INTEGRATED WHL	NU
E2392	PWC ACC,SOLID CASTER TIRE,INTEGRATED WHL	UE
E2394	PWC ACC,DRIVE WHEEL EXCL TIRE,REPL,EA	LL
E2394	PWC ACC,DRIVE WHEEL EXCL TIRE,REPL,EA	NU
E2394	PWC ACC,DRIVE WHEEL EXCL TIRE,REPL,EA	UE
E2395	PWC ACC,CASTER WHEEL EXCLUDES TIRE,EA	LL
E2622	SKIN PROTECTION W-CHAIR SEAT CUSHION<22"	NU
E2622	SKIN PROTECTION W-CHAIR SEAT CUSHION<22"	RR
E2622	SKIN PROTECTION W-CHAIR SEAT CUSHION<22"	UE
K0195	ELEV LEG RESTS PR USE W/CAPPED RENT WHCH	LL
K0269	DIAB ONLY MULT DEN INS CUSTOM MOLDED	00
L0113	CRANIAL CERV ORTH,TORTIC,INCL FIT&ADJUST	00
L0482	TLSO RIGID PLASTIC SHELL LINED, CUSTOM	00
L0484	TLSO RIGID PLASTIC SHELL, CUSTOM FAB	00
L0486	TLSO RIGID LINED CUST FAB TWO-PIECE	00
L0700	CERV-THOR-LUMB-SAS-ORTHO ANT/POST(MINER	00
L0810	HALO PROCEDURES CERV INCORP TO/SPIN/THOR	00
L0820	HALO PROCEDURES CERV TO/PLASTER BODY JAC	00
L0830	HALO PROCEDURES CERV TO/MILWAUKEE TYPE O	00
L1000	CTLSO-MIL INC OF FURN IN I ORTH INC MODE	00
L1200	TLSO INCLUSIVE OF FURNISHINGS INITI ONLY	00
L1300	OTHER SCOLIO PROC BODY JACKET MOLDED TO	00
L1310	OTHER SCOLIO PROCED POST-OPER BODY JACKE	00
L1685	HO ABDUCT CONT HIP JOINTS POSTOP HIP ABD	00
L1690	COBIN, BILAT,LUMBO-SACRAL,HIP,FEMUR ORTH	00
L1720	LEGG PERTH ORTHO TRILAT(TACHDIJAN)CUSTOM	00
L1755	LEGG PERTHES ORTHO PATTEN BOTTOM CUSTOM	00
L2005	KAFO,ANY MAT'L,SNGL OR DBL,ANY TYPE,CUST	00
L2034	KNEE-ANK-FT ORTH,PLASTIC,UPRIGHT,CUSTOM	00

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING A MEDICAID CERTIFICATE OF MEDICAL NECESSITY (MCMN)

L2036	KAFO FULL PLASTIC DBL UPRT FREE KNE CUST	00
L2037	KAFO FL PLAS S-UP FREE KNEE CUSTOM FABRI	00
L3455	HEEL-NEW LEATHER, STANDARD	00
L3900	WHFO,DYNAMIC FLEXOR HINGE WRIST/FING DR	00
L3901	WHFO,DYNAMIC FLEXOR HINGE CABLE DRIVEN	00
L3904	WHFO,EXTERNAL POWER ELECTRIC CUSTOM-FABR	00
L3961	SH-EL-WR-HND ORTH,CAP DESIGN,W/O JNT,CUS	00
L3967	SH-EL-WR-HND ORTH,AIRPLNE DES,W/O JNT,CU	00
L3971	SH-EL-WR-HND ORTH,CAP DESIGN,W/JNTS,CUST	00
L3975	SH-EL-WR-HN-FGR ORT,CAP DESGN,W/O JNT,CU	00
L3976	SH-EL-WR-HND-FGR ORT,AIRPLANE,W/O JNT,CU	00
L3977	SH-EL-WR-HND-FGR ORT,CAP DESGN,W/JNTS,CU	00
L5020	PARTIAL FOOT MOLDED SOCI TIBI TUBER HEIG	00
L5050	ANKLE (SYME) MOLDED SOCKET< SACH FOOT	00
L5100	BELOW KNEE,MOLDED SOCKET,SHIN, SACH FT	00
L5150	KNEE DISART,MOLD SOCK,EXTER KNE JT-S-SE	00
L5160	KNEE DISART MOLD KNE SOC BENT KNEE CONFI	00
L5210	ABOVE KNEE, SHORT PROSTH,NO KNE-AN JT EA	00
L5250	HIP DISART,CANADIAN TYPE SINGLE AXIS	00
L5301	BELOW KNEE,MOLDED SOCKT,ENDOSKELETAL SYS	00
L5321	ABOVE KNEE,MOLDED SOCKT,ENDOSK,AXIS KNEE	00
L5341	HEMIPELVECTMY,END OSK,HIP JNT,SNG AXIS	00
L5420	IMMED POST SURG/EAR FIT ONE CAST CH/KN-A	00
L5505	INT AK/DISAR SOC USMC SACFT PLSOC DIRFOR	00
L5520	PREP BK SOC USMC SACFT THERMPLAS DIRFORM	00
L5530	PREP BK SOC USMC SACFT THERMPLA MPLD MOD	00
L5535	PREP BK PTB SOCK PYLON SF PRE ADJ OPEN S	00
L5540	PREP BK SOC USMC SACFT LAM SOC MOLD MOD	00
L5560	PREP AK/DIS SOC USMC SACFT PLS SOC MLDMO	00
L5580	PREP AK/DISAR USMC SACFT THERPL MLD MOD	00
L5595	PREP HIP DISART-HEMI PYL SF THERMOPLASTI	00
L5600	PREP HIP DISART-HEMI PYL SF LAMIN SOCKET	00
L5610	ADDITIONS TO LOWER EXTREM AB KNE HYDRACA	00
L5611	ADD TO L/EXT, ABOVE KNEE-DISART 4B LINK	00

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING A MEDICAID CERTIFICATE OF MEDICAL NECESSITY (MCMN)

L5613	ADD L/EXT, AB KNEE-DISART, 4B LNK, W/HYD	00
L5649	ADD TO LWR EXT CAT-CAM SOCKET	00
L5700	REPL, SOCKET BELOW KNEE, MOLD TO PAT MOD	00
L5701	REPL SKT AK/K DISARTIN/ATCH PL MOL PT MO	00
L5703	ANKLE, SYMES, W/O SACH FOOT,REPLACE ONLY	00
L5724	AD EXO K-SHIN SYS S AX FL SW PHASE CONT	00
L5726	AD EX KSHIN SYS S AX EXT JT FL SW PH CON	00
L5814	AD,ENSKLTL K-S SYS POLY HYD SW PH C,MSPC	00
L5822	AD ENSKLTL K-S SYS SGL AX PN SW F-S PH C	00
L5824	AD ENSKLTL K-S SYS SGL AX FL SW PHAS CON	00
L5828	AD ENSKLTL K-S SGL AX FL SW ST PH CO	00
L5830	AD ENSKLTL K-S SYS SGL AX PN/HYD SW PH C	00
L5840	ADD ENDOSKLTL K-S SYS MLT AX PN/SWG PH C	00
L5979	ALL LOW EXT PROS MULTIAXIAL ANK/FT DY RE	00
L5980	ALL LOWER EXT PROSTHESES,FLEX FT SYSTEM	00
L5981	ALL LOW EXT PROS FLEX-WALK SYS OR EQUAL	00
L6010	PARTIAL HAND, ROBIN AID LIT/OR RI FI RE	00
L6050	WRIST DISARTICULATION, MOLDED SOCKET TRI	00
L6055	WRST DISART MS W/EXP INTRF FLX EL HG TRP	00
L6120	BELOW ELBOW, MOLDED DOUBL WAL SOC STEP H	00
L6130	BELOW ELBOW, MOLDED WAL STUMP ACT LOC H	00
L6200	ELBOW DISARTICULATION MOLD SOCK OUTS LOC	00
L6205	ELB DISART MS W/EXP INTER OUT LKG HG FAR	00
L6300	SHOULDER DISARTICULATION, MOLD SOCK SHOU	00
L6310	SHOULDER DISARTICULATION COMPLET PROSTHE	00
L6320	SHOULDER DISARTICULATION PASSI SHOUL CAP	00
L6350	INTERSCAPULAR THORACIC MOLDE SOC INT LOC	00
L6360	INTERSCAPULAR THORACIC PASS REST COMP PR	00
L6370	INTERSCAPULAR THORACIC, SHOULDER CAP ONL	00
L6382	IM AP DSG INC FTG ALGN SUS ELB DART A/EL	00
L6384	IM AP DSG INC FTG ALGN SUS SH DART/INTER	00
L6450	ELBOW DISARTICULATION,MOLDED SOCK ENDO	00
L6550	SHOU DISAR MLD SOC END SY PRO TIS SHA	00
L6570	INTERSCAPULAR THORACIS, MOLDED SOCK ENDO	00

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING A MEDICAID CERTIFICATE OF MEDICAL NECESSITY (MCMN)

L6580	PRP WR DSRT SGL WL PSTC SOC MOLD TO PT	00
L6582	PRP WR DSRT SGL WL PLSTC SOCKET DIR FRM	00
L6584	PREP ELB DISART SGL WALL PLSTC SOCK ECT	00
L6586	PREP ELB DISART SGL WALL SKT FRC WRS ECT	00
L6588	PREP SHOU DISAR S WAL LPAS SOC MOLD MOD	00
L6590	PREP SHOLD DISAR S WAL SOC DIRECT FORMED	00
L6621	UP EX PROS ADD,FLEX/EX WRIST W/WO FRICTN	00
L6646	UP EXTR MULTIPOSITN LOCKING SHOULDER JNT	00
L6648	UP EXTRM SHOULDER LOCK,EXTERNAL ACTUATOR	00
L6697	ADD/UP EXTR,ABV/BEL EL,NOT ATYP AMPUT,IN	00
L6883	REPLACEMNT SOCKT,BEL ELB-WRIST DISARTICU	00
L6884	REPLC SOCKET,ABOVE ELBOW DISARTICULATION	00
L6885	REPLC SOCKT,SHOULDR DISARTICULATN/INTERS	00
L6900	HAND RESTORATION, PART HAND ONE FING REM	00
L6905	WRIST DISART PWR SELF-SUSP INNER ECT	00
L6910	HAND RESTORATION, GLOVE, NO FINGER REMAI	00
L7900	VACUUM ERECTION SYSTEM	00
L8035	CUSTOM BREAST PROS,PST MAST,MOLD TO PATI	00
S8189	TRACHEOSTOMY, SUPPLY, NOS	00
S9001	HOME UTERINE MONITOR W/WO NURSING SERV	LL
S9349	TOCOLYTIC INFUSION THERAPY, PER DIEM	LL
S9357	HOME INF,ENZ REPL IV THER,SUPPLIES&EQUIP	00
V2623	PROSTHETIC EYE PLASTIC CUSTOM	00
V2624	OCULAR PROSTHESIS-POLISHING/RESURFACING	00
V2625	OCCULAR PROSTHESIS ENLARGEMENT	00
V2626	OSCULAR PROSTHESIS REDUCTION	00
V2627	SCLERAL COVER SHELL	00
V2628	OCULAR CONFORMER/FABRICATION AND FITTING	00

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING PRIOR AUTHORIZATION FROM KEPRO

Effective June 1, 2012, KePRO, the QIO for SCDHHS, is responsible for prior authorization (PA) of services for wheelchairs (manual and power), wheelchair accessories, and cranial molding orthotic devices. Effective August 1, 2012, all DME codes that require prior authorization will be authorized by KePRO.

Requests for prior authorizations for the above services can be submitted to KePRO using one of the following methods:

KePRO Customer Service Phone: 855-326-5219
KePRO Fax: 855-300-0082
For Provider Issues email:
atrezzoissues@Kepro.com

Additionally, you can find additional information in regards to prior authorizing this equipment by visiting the KePRO website at http://scdhhs.kepro.com

Note: Procedure codes K0108 and E1399 should **not** be used in lieu of established (or similar) codes located in our manual. The use of these codes in lieu of established (or similar) codes located in our manual for greater reimbursement is **not allowed**.

HCPCS Code	Description	Modifier
B9998	NOT OTHERWISE CLASSIFIED ENTERAL SUPPLIE	0
A4280	ADHES SKIN SUPP ATCH W/EXT BREAST PRO,EA	0
A9999	MISC DME SUPPLY OR ACCESSORY, NOC	0
B4103	ENTERAL,PEDS,FLUID/ELECTR,500 ML=1 UNIT	0
B4157	NUTR COMPL,SPEC METABOLIC NEED,100CAL=1U	0
B4162	ENTR,PEDS,SPC METABOLIC NEEDS,100CAL=1UN	0
B9999	NOC FOR PARENTERAL SUPPLIES	0
E0193	POWERED AIR FLOTATION BED	NU
E0193	POWERED AIR FLOTATION BED	RR
E0194	AIR FLUIDIZED BED	RR
E0255	HOSPITAL BED SIDE RAILS VAR HT, MATTRESS	LL
E0255	HOSPITAL BED SIDE RAILS VAR HT, MATTRESS	NU
E0255	HOSPITAL BED SIDE RAILS VAR HT, MATTRESS	UE
E0260	HOSP BED SEMIELEC, SIDE RAILS MATTRESS	LL
E0260	HOSP BED SEMIELEC, SIDE RAILS MATTRESS	NU
E0260	HOSP BED SEMIELEC, SIDE RAILS MATTRESS	UE
E0261	HOSP BED SEMI-ELEC W/SIDERAILS W/O MTRS	LL
E0261	HOSP BED SEMI-ELEC W/SIDERAILS W/O MTRS	NU

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING PRIOR AUTHORIZATION FROM KEPRO

E0261	HOSP BED SEMI-ELEC W/SIDERAILS W/O MTRS	UE
E0277	POWER PRESSURE-REDUCING AIR MATTRESS	RR
E0291	HOSP BED FX HT W/O SIDE RAIOS W/O MATRSS	LL
E0291	HOSP BED FX HT W/O SIDE RAIOS W/O MATRSS	NU
E0291	HOSP BED FX HT W/O SIDE RAIOS W/O MATRSS	UE
E0294	HOSP BED SEMI-ELEC W/O SIDERAILS W MTRSS	LL
E0294	HOSP BED SEMI-ELEC W/O SIDERAILS W MTRSS	NU
E0295	HOSP BED SEMI-ELEC W/O SIDRAIL W/O MATDR	LL
E0295	HOSP BED SEMI-ELEC W/O SIDRAIL W/O MATDR	NU
E0295	HOSP BED SEMI-ELEC W/O SIDRAIL W/O MATDR	UE
E0301	HOSP BED, DUTY,X-WIDE,WT 350-600 LB	LL
E0301	HOSP BED, DUTY,X-WIDE,WT 350-600 LB	NU
E0301	HOSP BED, DUTY,X-WIDE,WT 350-600 LB	UE
E0302	HOSP BED, X-HVY DUTY,X-WIDE,WT > 600 LBS	LL
E0302	HOSP BED, X-HVY DUTY,X-WIDE,WT > 600 LBS	NU
E0302	HOSP BED, X-HVY DUTY,X-WIDE,WT > 600 LBS	UE
E0303	HOSP BED,HEAVY DUTY,X-WIDE,WT 350-600 LB	LL
E0303	HOSP BED,HEAVY DUTY,X-WIDE,WT 350-600 LB	NU
E0303	HOSP BED,HEAVY DUTY,X-WIDE,WT 350-600 LB	UE
E0304	HOSP BED, X-HVY DUTY,X-WIDE,WT > 600 LBS	LL
E0304	HOSP BED, X-HVY DUTY,X-WIDE,WT > 600 LBS	NU
E0304	HOSP BED, X-HVY DUTY,X-WIDE,WT > 600 LBS	UE
E0372	POWERED AIR OVERLAY MATTRESS,STND L & W	RR
E0446	TOPICAL OXYGEN DELIVERY SYSTEM, NOS	0
E0482	COUGH STIML DEV,ALTERN POS&NG AIRWY PRES	RR
E0483	HIGH FREQUENCY CHEST WALL OSCILLATION AI	LL
E0483	HIGH FREQUENCY CHEST WALL OSCILLATION AI	NU
E0483	HIGH FREQUENCY CHEST WALL OSCILLATION AI	UE
E0565	COMPRESS AIR POWER FOR EQUIP NOT CONTAIN	LL
E0565	COMPRESS AIR POWER FOR EQUIP NOT CONTAIN	NU
E0565	COMPRESS AIR POWER FOR EQUIP NOT CONTAIN	UE
E0575	NEBULIZER, ULTRASONIC, LARGE VOLUME	LL
E0575	NEBULIZER, ULTRASONIC, LARGE VOLUME	NU

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING PRIOR AUTHORIZATION FROM KEPRO

E0575	NEBULIZER, ULTRASONIC, LARGE VOLUME	UE
E0625	PATIENT LIFT, BATH/TOILET	LL
E0625	PATIENT LIFT, BATH/TOILET	NU
E0625	PATIENT LIFT, BATH/TOILET	UE
E0630	PATIENT LIFT HYDRAULIC W/SEAT OR SLING	LL
E0630	PATIENT LIFT HYDRAULIC W/SEAT OR SLING	NU
E0630	PATIENT LIFT HYDRAULIC W/SEAT OR SLING	UE
E0635	PATIENT LIFT ELECTRIC W/SEAT OR SLING	LL
E0635	PATIENT LIFT ELECTRIC W/SEAT OR SLING	NU
E0635	PATIENT LIFT ELECTRIC W/SEAT OR SLING	UE
E0638	STANDING FRAME SYSTEM, ANY SIZE	LL
E0638	STANDING FRAME SYSTEM, ANY SIZE	NU
E0638	STANDING FRAME SYSTEM, ANY SIZE	UE
E0640	PATIENT LIFT,FIXED SYSTEM W/COMPONENT&AC	LL
E0640	PATIENT LIFT,FIXED SYSTEM W/COMPONENT&AC	NU
E0640	PATIENT LIFT,FIXED SYSTEM W/COMPONENT&AC	UE
E0641	STANDING FRAME SYSTEM, MULTI-POSITION	LL
E0641	STANDING FRAME SYSTEM, MULTI-POSITION	NU
E0641	STANDING FRAME SYSTEM, MULTI-POSITION	RR
E0641	STANDING FRAME SYSTEM, MULTI-POSITION	UE
E0655	NON-SEG PNEUM APPL USE W/PN COM HALF ARM	LL
E0655	NON-SEG PNEUM APPL USE W/PN COM HALF ARM	NU
E0655	NON-SEG PNEUM APPL USE W/PN COM HALF ARM	UE
E0656	SEGMENTL PNEUMATIC APP/USE COMPRES TRUNK	NU
E0656	SEGMENTL PNEUMATIC APP/USE COMPRES TRUNK	RR
E0656	SEGMENTL PNEUMATIC APP/USE COMPRES TRUNK	UE
E0657	SEGMENTL PNEUMATIC APP/USE COMPRES CHEST	NU
E0657	SEGMENTL PNEUMATIC APP/USE COMPRES CHEST	RR
E0657	SEGMENTL PNEUMATIC APP/USE COMPRES CHEST	UE
E0660	NON-SEG PNEUM APPL USE W/PN COM FULL LEG	LL
E0660	NON-SEG PNEUM APPL USE W/PN COM FULL LEG	NU
E0660	NON-SEG PNEUM APPL USE W/PN COM FULL LEG	UE
E0675	PNEUMATIC COMPRESSION DEVICE	LL

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING PRIOR AUTHORIZATION FROM KEPRO

E0675	PNEUMATIC COMPRESSION DEVICE	NU
E0675	PNEUMATIC COMPRESSION DEVICE	UE
E0744	NEUROMUSCULAR STIMULATOR FOR SCOLIOSIS	LL
E0744	NEUROMUSCULAR STIMULATOR FOR SCOLIOSIS	NU
E1002	W/CHR ACCES,POWER SEATING SYS, TILT ONLY	LL
E1002	W/CHR ACCES,POWER SEATING SYS, TILT ONLY	NU
E1002	W/CHR ACCES,POWER SEATING SYS, TILT ONLY	UE
E1005	W/CHR ACCES,PWR SEAT,RECLINE ONLY,POWER	LL
E1005	W/CHR ACCES,PWR SEAT,RECLINE ONLY,POWER	NU
E1005	W/CHR ACCES,PWR SEAT,RECLINE ONLY,POWER	UE
E1007	W/CHR ACCES,PWR SEAT,COMBO,W/SHEAR REDUC	LL
E1007	W/CHR ACCES,PWR SEAT,COMBO,W/SHEAR REDUC	NU
E1007	W/CHR ACCES,PWR SEAT,COMBO,W/SHEAR REDUC	UE
E1008	W/CHR ACCES,PWR SEAT,COMBO,W/POWER SHEAR	LL
E1008	W/CHR ACCES,PWR SEAT,COMBO,W/POWER SHEAR	NU
E1008	W/CHR ACCES,PWR SEAT,COMBO,W/POWER SHEAR	UE
E1010	W/CHR ACCES,ADD POWER LEG ELEVATION SYST	LL
E1010	W/CHR ACCES,ADD POWER LEG ELEVATION SYST	NU
E1010	W/CHR ACCES,ADD POWER LEG ELEVATION SYST	UE
E1011	MODIFICATION TO PEDIATRIC WHEELCHAIR	NU
E1011	MODIFICATION TO PEDIATRIC WHEELCHAIR	RR
E1011	MODIFICATION TO PEDIATRIC WHEELCHAIR	UE
E1014	RECLINING BACK, ADDITION TO PEDIATRIC WH	LL
E1014	RECLINING BACK, ADDITION TO PEDIATRIC WH	NU
E1014	RECLINING BACK, ADDITION TO PEDIATRIC WH	UE
E1031	ROLLABOUT CHAIR, ANY TYPE	LL
E1031	ROLLABOUT CHAIR, ANY TYPE	NU
E1031	ROLLABOUT CHAIR, ANY TYPE	UE
E1037	TRANSPORT CHAIR, PEDIATRIC SIZE	LL
E1037	TRANSPORT CHAIR, PEDIATRIC SIZE	NU
E1037	TRANSPORT CHAIR, PEDIATRIC SIZE	UE
E1050	WHEELCHAIR, FULL RECLINE, FFA, SADELR	LL
E1050	WHEELCHAIR, FULL RECLINE, FFA, SADELR	NU

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING PRIOR AUTHORIZATION FROM KEPRO

E1050	WHEELCHAIR, FULL RECLINE, FFA, SADELR	UE
E1060	WHEELCHAIR, FULL RECLINE DA SA	LL
E1060	WHEELCHAIR, FULL RECLINE DA SA	NU
E1060	WHEELCHAIR, FULL RECLINE DA SA	UE
E1065	WHEELCHAIR, POWER ATTACHMENT CONERT	LL
E1065	WHEELCHAIR, POWER ATTACHMENT CONERT	NU
E1065	WHEELCHAIR, POWER ATTACHMENT CONERT	UE
E1070	FULLY-RECLIN WHEELCH DE ARM SW AW D FT R	LL
E1070	FULLY-RECLIN WHEELCH DE ARM SW AW D FT R	NU
E1070	FULLY-RECLIN WHEELCH DE ARM SW AW D FT R	UE
E1161	MANUAL ADULT SZ WHEELCH,INC TILT IN SPAC	LL
E1161	MANUAL ADULT SZ WHEELCH,INC TILT IN SPAC	NU
E1161	MANUAL ADULT SZ WHEELCH,INC TILT IN SPAC	UE
E1229	WHEELCHAIR, PEDIATRIC SIZE, NOS	LL
E1229	WHEELCHAIR, PEDIATRIC SIZE, NOS	NU
E1229	WHEELCHAIR, PEDIATRIC SIZE, NOS	UE
E1231	WHEELCHAIR, PED SIZE	LL
E1231	WHEELCHAIR, PED SIZE	NU
E1231	WHEELCHAIR, PED SIZE	UE
E1232	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPA	LL
E1232	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPA	NU
E1232	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPA	UE
E1233	WHEELCHAIR, PED SIZE	LL
E1233	WHEELCHAIR, PED SIZE	NU
E1233	WHEELCHAIR, PED SIZE	UE
E1234	WHEELCHAIR, PED SIZE	LL
E1234	WHEELCHAIR, PED SIZE	NU
E1234	WHEELCHAIR, PED SIZE	UE
E1235	WHEELCHAIR, PED SIZE	LL
E1235	WHEELCHAIR, PED SIZE	NU
E1235	WHEELCHAIR, PED SIZE	UE
E1236	WHEELCHAIR, PED SIZE	LL
E1236	WHEELCHAIR, PED SIZE	NU

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING PRIOR AUTHORIZATION FROM KEPRO

E1236	WHEELCHAIR, PED SIZE	UE
E1237	WHEELCHAIR, PED SIZE	LL
E1237	WHEELCHAIR, PED SIZE	NU
E1237	WHEELCHAIR, PED SIZE	UE
E1238	WHEELCHAIR, RECLINING, PEDIATRIC	LL
E1238	WHEELCHAIR, RECLINING, PEDIATRIC	NU
E1238	WHEELCHAIR, RECLINING, PEDIATRIC	UE
E1310	WHIRLPOOL NON-PORTABLE (BUILT-IN TYPE)	LL
E1310	WHIRLPOOL NON-PORTABLE (BUILT-IN TYPE)	NU
E1310	WHIRLPOOL NON-PORTABLE (BUILT-IN TYPE)	UE
E1399	DURABLE MEDICAL EQUIPMENT, MISC	NU
E1841	MULTI-DIRECT STATIC PROGR SHOULDR DEVICE	RR
E2291	BACK,PLANAR,FOR PED W/CHR W/FIXED HARDWA	NU
E2292	SEAT,PLANAR,PED SIZE W/CHR W/FIX HARDWAR	NU
E2293	BACK,CONTOUR,PED SIZE W/CHR W/FIX HARDWA	NU
E2294	SEAT,CONTOUR,FOR PED W/CHR W/FIX HARDWAR	NU
E2310	PWR W/C AC,ELECTRON CONECT BETWN CONTRLR	LL
E2310	PWR W/C AC,ELECTRON CONECT BETWN CONTRLR	NU
E2310	PWR W/C AC,ELECTRON CONECT BETWN CONTRLR	UE
E2311	PWR W/C AC,ELEC CONECT CONTR BETW 2>SYST	LL
E2311	PWR W/C AC,ELEC CONECT CONTR BETW 2>SYST	NU
E2311	PWR W/C AC,ELEC CONECT CONTR BETW 2>SYST	UE
E2321	PWR W/CHR AC,HAND INTERFACE,REMOTE JOYST	LL
E2321	PWR W/CHR AC,HAND INTERFACE,REMOTE JOYST	NU
E2321	PWR W/CHR AC,HAND INTERFACE,REMOTE JOYST	RR
E2321	PWR W/CHR AC,HAND INTERFACE,REMOTE JOYST	UE
E2322	PWR W/C,HAND CONTRL, MULTI MECH SWITCHES	LL
E2322	PWR W/C,HAND CONTRL, MULTI MECH SWITCHES	NU
E2322	PWR W/C,HAND CONTRL, MULTI MECH SWITCHES	UE
E2323	PWR W/CHAIR, SPECIALTY JOYSTICK HANDLE	LL
E2323	PWR W/CHAIR, SPECIALTY JOYSTICK HANDLE	NU
E2323	PWR W/CHAIR, SPECIALTY JOYSTICK HANDLE	UE
E2324	PWR W/C AC,CHIN CUP FOR CONTRL INTERFACE	NU

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING PRIOR AUTHORIZATION FROM KEPRO

E2324	PWR W/C AC,CHIN CUP FOR CONTRL INTERFACE	UE
E2325	PWR W/C,SIP&PUFF INTERFACE,NONPROPORTION	LL
E2325	PWR W/C,SIP&PUFF INTERFACE,NONPROPORTION	NU
E2325	PWR W/C,SIP&PUFF INTERFACE,NONPROPORTION	UE
E2326	PWR W/C,BREATH TUBE KIT FOR SIP&PUFF INT	LL
E2326	PWR W/C,BREATH TUBE KIT FOR SIP&PUFF INT	NU
E2326	PWR W/C,BREATH TUBE KIT FOR SIP&PUFF INT	UE
E2330	PWR W/C,HEAD CONTRL,PROXIMITY SWITCH MEC	LL
E2330	PWR W/C,HEAD CONTRL,PROXIMITY SWITCH MEC	NU
E2330	PWR W/C,HEAD CONTRL,PROXIMITY SWITCH MEC	UE
E2331	PWR W/C, ATTENDANT CONTROL, PROPORTIONAL	LL
E2331	PWR W/C, ATTENDANT CONTROL, PROPORTIONAL	NU
E2340	PWR W/C,NONSTANDARD SEAT FRAME WI 20-23"	LL
E2340	PWR W/C,NONSTANDARD SEAT FRAME WI 20-23"	NU
E2340	PWR W/C,NONSTANDARD SEAT FRAME WI 20-23"	UE
E2341	PWR W/C,NONSTANDARD SEAT FRAME WI 24-27"	LL
E2341	PWR W/C,NONSTANDARD SEAT FRAME WI 24-27"	NU
E2341	PWR W/C,NONSTANDARD SEAT FRAME WI 24-27"	UE
E2342	PWR W/C,NONSTANDARD SEAT FRME DEP,20-21"	LL
E2342	PWR W/C,NONSTANDARD SEAT FRME DEP,20-21"	NU
E2342	PWR W/C,NONSTANDARD SEAT FRME DEP,20-21"	UE
E2343	PWR W/C,NONSTANDARD SEAT FRME DEP,22-25"	LL
E2343	PWR W/C,NONSTANDARD SEAT FRME DEP,22-25"	NU
E2343	PWR W/C,NONSTANDARD SEAT FRME DEP,22-25"	UE
E2373	PWC ACC,HAND/CHIN CONTROL SPEC JOYSTICK	LL
E2373	PWC ACC,HAND/CHIN CONTROL SPEC JOYSTICK	NU
E2373	PWC ACC,HAND/CHIN CONTROL SPEC JOYSTICK	UE
E2374	PWC ACC,HAND/CHIN CTRL STANDARD JOYSTICK	LL
E2374	PWC ACC,HAND/CHIN CTRL STANDARD JOYSTICK	NU
E2374	PWC ACC,HAND/CHIN CTRL STANDARD JOYSTICK	UE
E2376	PWC ACC,EXPANDABLE CONTROLLER,REPL ONLY	LL
E2376	PWC ACC,EXPANDABLE CONTROLLER,REPL ONLY	NU
E2376	PWC ACC,EXPANDABLE CONTROLLER,REPL ONLY	UE

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING PRIOR AUTHORIZATION FROM KEPRO

E2377	PWC ACC,EXPANDABLE CONTROLLER,INITIAL IS	LL
E2377	PWC ACC,EXPANDABLE CONTROLLER,INITIAL IS	NU
E2377	PWC ACC,EXPANDABLE CONTROLLER,INITIAL IS	UE
E2402	NEGATIVE PRESUR WOUND THER ELECTRIC PUMP	RR
E2500	SPEECH GENERAT DEV,DIGIT PRE-REC <=8 MIN	LL
E2500	SPEECH GENERAT DEV,DIGIT PRE-REC <=8 MIN	NU
E2500	SPEECH GENERAT DEV,DIGIT PRE-REC <=8 MIN	UE
E2502	SPCH GENERAT DEV,DIG PRE-REC >8 <=20 MIN	LL
E2502	SPCH GENERAT DEV,DIG PRE-REC >8 <=20 MIN	NU
E2502	SPCH GENERAT DEV,DIG PRE-REC >8 <=20 MIN	UE
E2504	SPCH GEN DEV,DIG PRE-REC MSG,>20MIN,<=40	LL
E2504	SPCH GEN DEV,DIG PRE-REC MSG,>20MIN,<=40	NU
E2504	SPCH GEN DEV,DIG PRE-REC MSG,>20MIN,<=40	UE
E2510	SPCH GEN DEV,SYN SPCH,MULTI METH MSG/ACC	LL
E2510	SPCH GEN DEV,SYN SPCH,MULTI METH MSG/ACC	NU
E2510	SPCH GEN DEV,SYN SPCH,MULTI METH MSG/ACC	UE
E2512	ASS. FOR SPEECH GEN. DEVICE MOUNTING SYS	NU
E2599	SPEECH GENERATING DEVICE ACCESSORY, NOC	NU
E2609	CUSTM FABRICATE W/CHR SEAT CUSH,ANY SIZE	NU
E2617	CUSTM FABRICATE W/CHR BACK CUSH,ANY SIZE	NU
K0002	STANDARD HEMI (LOW SEAT) WHEELCHAIR	LL
K0002	STANDARD HEMI (LOW SEAT) WHEELCHAIR	NU
K0003	LIGHTWEIGHT WHEELCHAIR	LL
K0003	LIGHTWEIGHT WHEELCHAIR	NU
K0004	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR	LL
K0004	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR	NU
K0005	ULTRALIGHTWEIGHT WHEELCHAIR	LL
K0005	ULTRALIGHTWEIGHT WHEELCHAIR	NU
K0006	HEAVY DUTY WHEELCHAIR	LL
K0006	HEAVY DUTY WHEELCHAIR	NU
K0007	EXTRA HEAVY DUTY WHEELCHAIR	LL
K0007	EXTRA HEAVY DUTY WHEELCHAIR	NU
K0011	STRD WG FRAME MTRIZED/PWR CHAIR PROG CON	LL

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING PRIOR AUTHORIZATION FROM KEPRO

K0011	STRD WG FRAME MTRIZED/PWR CHAIR PROG CON	NU
K0011	STRD WG FRAME MTRIZED/PWR CHAIR PROG CON	UE
K0014	OTHER MOTORIZED/POWER WHEELCHAIR BASE	NU
K0108	WHEEL CHAIR COMPONENT OR ACCESSORY, NOS	LL
K0108	WHEEL CHAIR COMPONENT OR ACCESSORY, NOS	NU
K0108	WHEEL CHAIR COMPONENT OR ACCESSORY, NOS	UE
K0269	DIAB ONLY MULT DEN INS CUSTOM MOLDED	0
K0606	AUTO EXTERNAL DEFIBRILLATOR W/INTES-GARM	RR
K0669	SEAT/BACK CUS NO DMEPDAC VER	LL
K0669	SEAT/BACK CUS NO DMEPDAC VER	NU
K0669	SEAT/BACK CUS NO DMEPDAC VER	UE
K0733	PWR W/C 12-24AMP HR SEALD LEAD ACID BATT	LL
K0733	PWR W/C 12-24AMP HR SEALD LEAD ACID BATT	NU
K0733	PWR W/C 12-24AMP HR SEALD LEAD ACID BATT	UE
K0813	PWC, GRP 1 STND,PORTABLE,SEAT/BACK, <300	LL
K0813	PWC, GRP 1 STND,PORTABLE,SEAT/BACK, <300	NU
K0813	PWC, GRP 1 STND,PORTABLE,SEAT/BACK, <300	UE
K0814	PWC, GRP 1 STNRD,PORTABL,CAP CHR,<300 LB	LL
K0814	PWC, GRP 1 STNRD,PORTABL,CAP CHR,<300 LB	NU
K0814	PWC, GRP 1 STNRD,PORTABL,CAP CHR,<300 LB	UE
K0815	PWC, GRP 1 C107STANDRD,SEAT/BACK, <300 L	LL
K0815	PWC, GRP 1 C107STANDRD,SEAT/BACK, <300 L	NU
K0815	PWC, GRP 1 C107STANDRD,SEAT/BACK, <300 L	UE
K0816	PWC, GRP 1 STANDARD,CAP CHAIR, <300 LBS	LL
K0816	PWC, GRP 1 STANDARD,CAP CHAIR, <300 LBS	NU
K0816	PWC, GRP 1 STANDARD,CAP CHAIR, <300 LBS	UE
K0820	PWC, GRP 2 STND,PORTABLE,SEAT/BACK, <300	LL
K0820	PWC, GRP 2 STND,PORTABLE,SEAT/BACK, <300	NU
K0820	PWC, GRP 2 STND,PORTABLE,SEAT/BACK, <300	UE
K0821	PWC, GRP 2 STNRD,PORTABL,CAP CHR,<300 LB	LL
K0821	PWC, GRP 2 STNRD,PORTABL,CAP CHR,<300 LB	NU
K0821	PWC, GRP 2 STNRD,PORTABL,CAP CHR,<300 LB	UE
K0822	PWR W-CHR, GRP 2 STANRRD,SEAT/BACK, <300	LL

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING PRIOR AUTHORIZATION FROM KEPRO

K0822	PWR W-CHR, GRP 2 STANRRD,SEAT/BACK, <300	NU
K0822	PWR W-CHR, GRP 2 STANRRD,SEAT/BACK, <300	UE
K0823	PWR W-CHAIR, GRP 2 STNRD,CAP CHR,<300 LB	LL
K0823	PWR W-CHAIR, GRP 2 STNRD,CAP CHR,<300 LB	NU
K0823	PWR W-CHAIR, GRP 2 STNRD,CAP CHR,<300 LB	UE
K0824	PWC, GRP 2 HVY DUTY,SEAT/BACK, 301-450LB	LL
K0824	PWC, GRP 2 HVY DUTY,SEAT/BACK, 301-450LB	NU
K0824	PWC, GRP 2 HVY DUTY,SEAT/BACK, 301-450LB	UE
K0825	PWC, GRP 2 HVY DUTY,CAP CHR, 301-450 LBS	LL
K0825	PWC, GRP 2 HVY DUTY,CAP CHR, 301-450 LBS	NU
K0825	PWC, GRP 2 HVY DUTY,CAP CHR, 301-450 LBS	UE
K0827	PWC,G-2 VERY HVY DTY,CAP CHR,451-600 LBS	LL
K0827	PWC,G-2 VERY HVY DTY,CAP CHR,451-600 LBS	NU
K0827	PWC,G-2 VERY HVY DTY,CAP CHR,451-600 LBS	UE
K0828	PWC,GRP-2 EX-HVY DTY,SEAT/BACK,>=601 LBS	LL
K0828	PWC,GRP-2 EX-HVY DTY,SEAT/BACK,>=601 LBS	NU
K0828	PWC,GRP-2 EX-HVY DTY,SEAT/BACK,>=601 LBS	UE
K0829	PWC,GRP-2 EX-HVY DTY,CAP CHR, >=601 LBS	LL
K0829	PWC,GRP-2 EX-HVY DTY,CAP CHR, >=601 LBS	NU
K0829	PWC,GRP-2 EX-HVY DTY,CAP CHR, >=601 LBS	UE
K0835	PWC,GRP 2 STD,SNG PWR OPT,ST/BK,TO 300LB	LL
K0835	PWC,GRP 2 STD,SNG PWR OPT,ST/BK,TO 300LB	NU
K0835	PWC,GRP 2 STD,SNG PWR OPT,ST/BK,TO 300LB	UE
K0836	PWC,GRP 2 STD,SNG PWR,CAP CHR,TO 300 LBS	LL
K0836	PWC,GRP 2 STD,SNG PWR,CAP CHR,TO 300 LBS	NU
K0836	PWC,GRP 2 STD,SNG PWR,CAP CHR,TO 300 LBS	UE
K0837	PWC,GRP 2 HD,SNG PWR ,ST/BK,301-450 LBS	LL
K0837	PWC,GRP 2 HD,SNG PWR ,ST/BK,301-450 LBS	NU
K0837	PWC,GRP 2 HD,SNG PWR ,ST/BK,301-450 LBS	UE
K0841	PWC,GP2 STD,MULTI-PWR,SEAT/BK,TO 300 LBS	LL
K0841	PWC,GP2 STD,MULTI-PWR,SEAT/BK,TO 300 LBS	NU
K0841	PWC,GP2 STD,MULTI-PWR,SEAT/BK,TO 300 LBS	UE
K0842	PWC,GP2 STD,MULTI-PWR,CAP CHR,TO 300 LBS	LL

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING PRIOR AUTHORIZATION FROM KEPRO

K0842	PWC,GP2 STD,MULTI-PWR,CAP CHR,TO 300 LBS	NU
K0842	PWC,GP2 STD,MULTI-PWR,CAP CHR,TO 300 LBS	UE
K0843	PWC,GP2 HD,MULTI-PWR,SEAT/BK,301-400 LBS	LL
K0843	PWC,GP2 HD,MULTI-PWR,SEAT/BK,301-400 LBS	NU
K0843	PWC,GP2 HD,MULTI-PWR,SEAT/BK,301-400 LBS	UE
K0848	PWC, GRP 3 STANDARD,SEAT/BACK, <300 LBS	LL
K0848	PWC, GRP 3 STANDARD,SEAT/BACK, <300 LBS	NU
K0848	PWC, GRP 3 STANDARD,SEAT/BACK, <300 LBS	UE
K0849	PWC, GRP 3 STANARD,CAP CHAIR, <300 LBS	LL
K0849	PWC, GRP 3 STANARD,CAP CHAIR, <300 LBS	NU
K0849	PWC, GRP 3 STANARD,CAP CHAIR, <300 LBS	UE
K0850	PWC, GRP 3 HVY DUTY,SEAT/BACK, 301-450LB	LL
K0850	PWC, GRP 3 HVY DUTY,SEAT/BACK, 301-450LB	NU
K0850	PWC, GRP 3 HVY DUTY,SEAT/BACK, 301-450LB	UE
K0851	PWC, GRP 3 HVY DUTY,CAP CHR, 301-450 LBS	LL
K0851	PWC, GRP 3 HVY DUTY,CAP CHR, 301-450 LBS	NU
K0851	PWC, GRP 3 HVY DUTY,CAP CHR, 301-450 LBS	UE
K0852	PWC,G-3 VERY HVY DTY,SEAT/BK, 451-600LBS	LL
K0852	PWC,G-3 VERY HVY DTY,SEAT/BK, 451-600LBS	NU
K0852	PWC,G-3 VERY HVY DTY,SEAT/BK, 451-600LBS	UE
K0853	PWC,G-3 VERY HVY DTY,CAP CHR,451-600 LBS	LL
K0853	PWC,G-3 VERY HVY DTY,CAP CHR,451-600 LBS	NU
K0853	PWC,G-3 VERY HVY DTY,CAP CHR,451-600 LBS	UE
K0856	PWC,GRP 3 STD,SNG PWR OPT,ST/BK,TO 300LB	LL
K0856	PWC,GRP 3 STD,SNG PWR OPT,ST/BK,TO 300LB	NU
K0856	PWC,GRP 3 STD,SNG PWR OPT,ST/BK,TO 300LB	UE
K0857	PWC,GRP 3 STD,SNG PWR,CAP CHR,TO 300 LBS	LL
K0857	PWC,GRP 3 STD,SNG PWR,CAP CHR,TO 300 LBS	NU
K0857	PWC,GRP 3 STD,SNG PWR,CAP CHR,TO 300 LBS	UE
K0858	PWC,GRP 3 HD,SNG PWR ,ST/BK,301-450 LBS	LL
K0858	PWC,GRP 3 HD,SNG PWR ,ST/BK,301-450 LBS	NU
K0858	PWC,GRP 3 HD,SNG PWR ,ST/BK,301-450 LBS	UE
K0859	PWC,GRP 3 HD,SNG PWR ,CAP CHR, 301-450LB	LL

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING PRIOR AUTHORIZATION FROM KEPRO

K0859	PWC,GRP 3 HD,SNG PWR ,CAP CHR, 301-450LB	NU
K0859	PWC,GRP 3 HD,SNG PWR ,CAP CHR, 301-450LB	UE
K0860	PWC,GP3 VERY HD,SNG PWR ,ST/BK,451-600LB	LL
K0860	PWC,GP3 VERY HD,SNG PWR ,ST/BK,451-600LB	NU
K0860	PWC,GP3 VERY HD,SNG PWR ,ST/BK,451-600LB	UE
K0861	PWC,GP3 STD,MULTI-PWR,SEAT/BK,TO 300 LBS	LL
K0861	PWC,GP3 STD,MULTI-PWR,SEAT/BK,TO 300 LBS	NU
K0861	PWC,GP3 STD,MULTI-PWR,SEAT/BK,TO 300 LBS	UE
K0862	PWC,GP3 STD,MULTI-PWR,CAP CHR,301-450 LB	LL
K0862	PWC,GP3 STD,MULTI-PWR,CAP CHR,301-450 LB	NU
K0862	PWC,GP3 STD,MULTI-PWR,CAP CHR,301-450 LB	UE
K0863	PWC,G3 VERY HD,MULTI-PWR,ST/BK,451-600LB	LL
K0863	PWC,G3 VERY HD,MULTI-PWR,ST/BK,451-600LB	NU
K0863	PWC,G3 VERY HD,MULTI-PWR,ST/BK,451-600LB	UE
K0864	PWC,GP3 EX HD,MULTI=PWR,ST/BK, >=601 LBS	LL
K0864	PWC,GP3 EX HD,MULTI=PWR,ST/BK, >=601 LBS	NU
K0864	PWC,GP3 EX HD,MULTI=PWR,ST/BK, >=601 LBS	UE
K0868	PWC, GRP 4 STANDARD,SEAT/BACK, <300 LBS	LL
K0868	PWC, GRP 4 STANDARD,SEAT/BACK, <300 LBS	NU
K0868	PWC, GRP 4 STANDARD,SEAT/BACK, <300 LBS	UE
K0869	PWC, GRP 4 STANDARD,CAP CHR, <300 LBS	LL
K0869	PWC, GRP 4 STANDARD,CAP CHR, <300 LBS	NU
K0869	PWC, GRP 4 STANDARD,CAP CHR, <300 LBS	UE
K0870	PWC, GRP 4 HVY DUTY,SEAT/BACK, 301-450LB	LL
K0870	PWC, GRP 4 HVY DUTY,SEAT/BACK, 301-450LB	NU
K0870	PWC, GRP 4 HVY DUTY,SEAT/BACK, 301-450LB	UE
K0871	PWC,G4 VERY HD,MULTI-PWR,ST/BK,451-600LB	LL
K0871	PWC,G4 VERY HD,MULTI-PWR,ST/BK,451-600LB	NU
K0871	PWC,G4 VERY HD,MULTI-PWR,ST/BK,451-600LB	UE
K0877	PWC,GRP 4STD,SNG PWR OPT,ST/BK,TP 300LB	LL
K0877	PWC,GRP 4STD,SNG PWR OPT,ST/BK,TP 300LB	NU
K0877	PWC,GRP 4STD,SNG PWR OPT,ST/BK,TP 300LB	UE
K0878	PWC,GRP 4 STD,SNG PWR,CAP CHR,TO 300 LBS	LL

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING PRIOR AUTHORIZATION FROM KEPRO

K0878	PWC,GRP 4 STD,SNG PWR,CAP CHR,TO 300 LBS	NU
K0878	PWC,GRP 4 STD,SNG PWR,CAP CHR,TO 300 LBS	UE
K0879	PWC,GRP 4 HD,SNG PWR ,ST/BK,301-450 LBS	LL
K0879	PWC,GRP 4 HD,SNG PWR ,ST/BK,301-450 LBS	NU
K0879	PWC,GRP 4 HD,SNG PWR ,ST/BK,301-450 LBS	UE
K0880	PWC,GP4 VERY HD,SNG PWR ,ST/BK,451-600LB	LL
K0880	PWC,GP4 VERY HD,SNG PWR ,ST/BK,451-600LB	NU
K0880	PWC,GP4 VERY HD,SNG PWR ,ST/BK,451-600LB	UE
K0884	PWC,GP4 STD,MULTI-PWR,SEAT/BK,TO 300 LBS	LL
K0884	PWC,GP4 STD,MULTI-PWR,SEAT/BK,TO 300 LBS	NU
K0884	PWC,GP4 STD,MULTI-PWR,SEAT/BK,TO 300 LBS	UE
K0885	PWC,GP4 STD,MULTI-PWR,CAP CHR,TO 300 LBS	LL
K0885	PWC,GP4 STD,MULTI-PWR,CAP CHR,TO 300 LBS	NU
K0885	PWC,GP4 STD,MULTI-PWR,CAP CHR,TO 300 LBS	UE
K0886	PWC,GP4 HD,MULTI-PWR,SEAT/BK,301-400 LBS	LL
K0886	PWC,GP4 HD,MULTI-PWR,SEAT/BK,301-400 LBS	NU
K0886	PWC,GP4 HD,MULTI-PWR,SEAT/BK,301-400 LBS	UE
K0890	PWC,G 5 PEDIATRIC,SNG PWR,ST/BK,TO 125LB	LL
K0890	PWC,G 5 PEDIATRIC,SNG PWR,ST/BK,TO 125LB	NU
K0890	PWC,G 5 PEDIATRIC,SNG PWR,ST/BK,TO 125LB	UE
K0898	POWER WHEELCHAIR, NOC	LL
K0898	POWER WHEELCHAIR, NOC	NU
K0898	POWER WHEELCHAIR, NOC	UE
L0624	SACROLIAC ORTH,PELVIC-SACRAL SUP,,CUSTOM	0
L0629	LUMBAR-SAC ORTH,FLEX,POSTERIOR,CUSTOM FA	0
L0632	LUMBAR-SAC ORTH,RIGID ANTER/POST,CUSTOM	0
L0634	LUMBAR-SAC ORTH,SAGITTAL-CORON,CUSTO	0
L1005	TENSION BASE SCOLIOS ORTHOSIS&ACCESS PAD	0
L1499	SPINAL ORTHOSIS, NOT OTHERWISE SPECIFIED	0
L2999	LOWER EXTREMITY ORTHOSES, NOS	0
L3913	HAND-FINGER ORTH,W/O JNTS,CUST FAB,FIT &	0
L3978	SH-EL-WR-HN-FGR ORT,AIRPLANE,W/JNT(S),CU	0
L3999	UPPER LIMB ORTHOSIS,NOT OTHERWISE SPECIF	0

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING PRIOR AUTHORIZATION FROM KEPRO

L4002	REPLACE STRAP,ANY ORTHOSIS,ALL COMPONENT	0
L4999	UNLISTED PROCEDURE FOR ORTHOTIC DEVICE	0
L8499	UNLISTED PROCEDURES FOR MISC PROSTHE SER	0
L8609	ARTIFICIAL CORNEA	0
S1040	CRANIAL REMOLDING ORTHOSIS	NU
T2101	HUMAN BREAST MILK PROC/STORAGE/DISTRIBTN	0
T5001	VEHICLE POSITN SEAT/SPECL ORTHOPED NEEDS	NU
V2629	PROSTHETIC EYE OTHER TYPE NOC	0

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

CODES REQUIRING PRIOR AUTHORIZATION FROM KEPRO

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SECTION 5

ADMINISTRATIVE SERVICES

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SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

ADMINISTRATION

The Department of Health and Human Services (DHHS) administers the South Carolina Medicaid Program. This section outlines the available resources for Medicaid providers, with telephone numbers and addresses for county DHHS offices.

CORRESPONDENCE AND INQUIRIES

All correspondence to South Carolina Medicaid should be directed to the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. In addition, provider may submit an online inquiry at http://www.scdhhs.gov/contact-us. Inquiries concerning specific claims should also be directed to the PSC, but only after corrections have been made on rejected claims and all claims filing requirements have been met. Medicaid Provider Inquiry (DHHS Form 140) may be used to check the status on outstanding claims. (See the blank form in the Forms section.) Always include the provider's Medicaid number, the resident's Medicaid number, and the date of service when requesting the status of outstanding claims. **Allow 45 days from the submission date before requesting the status of the claim.**

Questions concerning beneficiary eligibility or identification numbers should be directed to the SCDHHS county office in the beneficiary's county of residence. Beneficiaries who have questions regarding specific coverage issues should be referred to the appropriate staff of their county SCDHHS office for assistance. To verify eligibility status, please use the South Carolina Medicaid Web-based Claims Submission Tool (Web Tool). For information on the Web Tool, please contact the PSC at 1-888-289-0709.

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SECTION 5 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

The Department of Health and Human Services will not supply the CMS-1500 claim form (08/05 version) to providers. Providers should purchase the form in its approved format from the private vendor of their choice. Examples of vendors who supply the form are listed below. This list should not be viewed as an endorsement of these vendors by SCDHHS.

REPRODUCIBLE NEGATIVES

Government Printing Office
Room C-836
Building Three
Washington, DC 20401
(202) 275-1189

SOFTWARE

Attn: Orders Department
American Medical Association
Post Office Box 10946
Chicago, IL 60610

HARD COPY CLAIM FORMS

Government Printing Office
Superintendent of Documents
Post Office Box 371954
Pittsburgh, PA 15250-7954
(202) 512-1800
Fax: (202) 512-2250
Web site orders: http://bookstore.gpo.gov

PRIVATE VENDORS

Moore Wallace
1210 Key Road
Columbia, SC 29201
(803) 576-1302

Physicians' Record Company
3000 S. Ridgeland Ave.
Berwyn, IL 60402-0724
(800) 323-9268 (toll free)
Fax: (708) 749-0171

SECTION 5 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

PRIVATE VENDORS (CONT'D.)

Standard Register Company
140 Stoneridge Drive, Suite 380
Columbia, SC 29210
(803) 256-0004
Fax: (803) 256-1602

SCDHHS FORMS

Providers may order SCDHHS forms via email at forms@scdhhs.gov. Copies of forms, including program-specific forms, are also available in the Forms section of this manual.

WEB ADDRESS

Providers should visit the Provider Information page on the SCDHHS Web site at http://provider.scdhhs.gov for the most current version of this manual.

To order a paper or CD version of this manual, please contact the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. From the Main Menu, select the Provider Enrollment and Education option. Charges for printed manuals are based on actual costs of printing and mailing.

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
1. Abbeville County	(864) 366-5638	Medicaid Eligibility Abbeville County DHHS Human Services Building 903 W. Greenwood St. Abbeville, SC 29620-5678 Post Office Box 130 Abbeville, SC 29620-0130
2. Aiken County	(803) 643-1938 Toll Free: 1-888-866-8852	Medicaid Eligibility Aiken County DHHS 1410 Park Ave. S.E. Aiken, SC 29801-4776 Post Office Box 2748 Aiken, SC 29802 -2748
3. Allendale County	(803) 584-8137	Medicaid Eligibility Allendale County DHHS 521 Barnwell Highway Allendale, SC 29810 Post Office Box 326 Allendale, SC 29810
4. Anderson County	(864) 260-4541	Medicaid Eligibility Anderson County DHHS 224 McGee Rd. Anderson, SC 29625 Post Office Box 160 Anderson, SC 29622-0160

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

	County	Telephone No.	Address
5.	Bamberg County	(803) 245-3932	Medicaid Eligibility Bamberg County DHHS 374 Log Branch Rd. Bamberg, SC 29003 Post Office Box 544 Bamberg, SC 29003
6.	Barnwell County	(803) 541-3825	Medicaid Eligibility Barnwell County DHHS 10913 Ellenton Street Barnwell, SC 29812 Post Office Box 648 Barnwell, SC 29812
7.	Beaufort County	(843) 255-6095	Medicaid Eligibility Beaufort County DHHS 1905 Duke St. Beaufort, SC 29902-4403 Post Office Box 1255 Beaufort, SC 29901-1255
8.	Berkeley County	(843) 719-1170 Toll Free: 1-800-249-8751	Medicaid Eligibility Berkeley County DSS 2 Belt Dr. Moncks Corner, SC 29461-2801 Post Office Box 13748 Charleston, SC 29422-3748
9.	Calhoun County	(803) 874-3384	Medicaid Eligibility Calhoun County DHHS 2831 Old Belleville Rd. St. Matthews, SC 29135 Post Office Box 378 St. Matthews, SC 29135

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
10. Charleston County	(843) 740-5900	Medicaid Eligibility Charleston County DHHS 326 Calhoun St. Charleston, SC 29401-1124
	Toll Free: 1-800-249-8751	Post Office Box 13748 Charleston, SC 29422-3748
11. Cherokee County	(864) 487-2521	Medicaid Eligibility Cherokee County DHHS 1434 N. Limestone St. Gaffney, SC 29340-4734
		Post Office Box 89 Gaffney, SC 29342
12. Chester County	(803) 377-8135	Medicaid Eligibility Chester County DHHS 115 Reedy St. Chester, SC 29706-1881
13. Chesterfield County	(843) 623-5226	Medicaid Eligibility Chesterfield County DHHS 201 N. Page St. Chesterfield, SC 29709 -1201
		Post Office Box 855 Chesterfield, SC 29709 - 0855
14. Clarendon County	(803) 435-4305	Medicaid Eligibility Clarendon County DSS 3 S. Church St. Manning, SC 29102
		Post Office Box 788 Manning, SC 29102

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
15. Colleton County	(843) 549-1894	Medicaid Eligibility Colleton County DHHS Bernard Warshaw Building 215 S. Lemacks St. Walterboro, SC 29488 Post Office Box 110 Walterboro, SC 29488
16. Darlington County	(843) 398-4427	Medicaid Eligibility Darlington County DHHS 300 Russell St., Room 145 Darlington, SC 29532 -3340 Post Office Box 2077 Darlington, SC 29540 -2077
	(843) 332-2289	404 S. Fourth St., Suite 300 Hartsville, SC 29550 - 5718
17. Dillon County	(843) 774-2713	Medicaid Eligibility Dillon County DHHS 1213 Highway 34 W. Dillon, SC 29536 - 8141 Post Office Box 351 Dillon, SC 29536 - 0351
18. Dorchester County	(843) 821-0444 Toll Free: 1-800-249-8751	Medicaid Eligibility Dorchester County DSS 216 Orangeburg Rd Summerville, SC 29483-8945 Post Office Box 13748 Charleston, SC 29422-3748

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
19. Edgefield County	(803) 637-4040	Medicaid Eligibility Edgefield County DHHS 120 W. A. Reel Dr. Edgefield, SC 29824-1607 Post Office Box 386 Edgefield, SC 29824 - 0386
20. Fairfield County	(803) 589-8035	Medicaid Eligibility Fairfield County DHHS 1136 Kincaid Bridge Rd. Winnsboro, SC 29180-7116 Post Office Box 1139 Winnsboro, SC 29180-5139
21. Florence County	(843) 673-1761	Medicaid Eligibility Florence County DHHS 2685 S. Irby St., Box I Florence, SC 29505 - 3440
	(843) 394-8575	345 S. Ron McNair Blvd Lake City, SC 29560 -3434
22. Georgetown County	(843) 546-5134	Medicaid Eligibility Georgetown County DSS 330 Dozier St. Georgetown, SC 29440-3219 Post Office Box 371 Georgetown, SC 29442
23. Greenville County	(864) 467-7800	Medicaid Eligibility Greenville County DSS 301 University Ridge, Suite 6700 Greenville, SC 29601 Post Office Box 100101 Columbia, SC 29202-3101

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
24. Greenwood County	(864) 229-5258	Medicaid Eligibility Greenwood County DHHS 1118 Phoenix St. Greenwood, SC 29646-3918 Post Office Box 1016 Greenwood, SC 29648-1016
25. Hampton County	(803) 914-0053	Medicaid Eligibility Hampton County DHHS 102 Ginn Altman Ave., Suite B Hampton, SC 29924 Post Office Box 693 Hampton, SC 29924
26. Horry County	(843) 381-8260	Medicaid Eligibility Horry County DHHS 1601 11th Ave., 1st Floor Conway, SC 29526 Post Office Box 290 Conway, SC 29528
27. Jasper County	(843) 726-7747	Medicaid Eligibility Jasper County DHHS 10908 N. Jacob Smart Blvd. Ridgeland, SC 29936
28. Kershaw County	(803) 432-3164	Medicaid Eligibility Kershaw County DHHS 110 E. DeKalb St. Camden, SC 29020-4432 Post Office Box 220 Camden, SC 29021-0220

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
29. Lancaster County	(803) 286-8208	Medicaid Eligibility Lancaster County DHHS 1599 Pageland Highway Lancaster, SC 29720-2409
30. Laurens County	(864) 833-6109	Medicaid Eligibility Laurens County DHHS 93 Human Services Rd. Clinton, SC 29325-7546 Post Office Box 388 Laurens, SC 29360-0388
31. Lee County	(803) 484-5376	Medicaid Eligibility Lee County DHHS 820 Brown St. Bishopville, SC 29010 -4207 Post Office Box 406 Bishopville, SC 29010 -0406
32. Lexington County	(803) 785-2991 (803) 785-5050	Medicaid Eligibility Lexington County DHHS 605 West Main St. Lexington, SC 29072-2550
33. McCormick County	(864) 465-5221	Medicaid Eligibility McCormick County DHHS 215 N. Mine St. McCormick, SC 29835-8363
34. Marion County	(843) 423-5417	Medicaid Eligibility Marion County DHHS 137 Airport Ct., Suite J Mullins, SC 29574

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
35. Marlboro County	(843) 479-4389	Medicaid Eligibility Marlboro County DHHS County Complex 1 Ag St. Bennettsville, SC 29512 - 4424 Post Office Box 1074 Bennettsville, SC 29512-1074
36. Newberry County	(803) 321-2159	Medicaid Eligibility Newberry County DHHS County Human Services Center 2107 Wilson Rd. Newberry, SC 29108-1603 PO Box 1225 Newberry, SC 29108 - 1225
37. Oconee County	(864) 638-4420	Medicaid Eligibility Oconee DHHS 223 B Kenneth St. Walhalla, SC 29691
38. Orangeburg County	(803) 515-1793	Medicaid Eligibility Orangeburg County DHHS 2570 Old St. Matthews Rd., N.E. Orangeburg, SC 29118 Post Office Box 1407 Orangeburg, SC 29116-1407
39. Pickens County	(864) 898-5815	Medicaid Eligibility Pickens County DHHS 212 McDaniel Ave. Pickens, SC 29671 Post Office Box 160 Pickens, SC 29671-0160

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
40. Richland County	(803) 714-7562 (803) 714-7549	Medicaid Eligibility Richland County DHHS 3220 Two Notch Rd. Columbia, SC 29204-2826
41. Saluda County	(864) 445-2139 Toll Free: 1-800-551-1909	Medicaid Eligibility Saluda County DHHS 613 Newberry Highway Saluda, SC 29138-8903 Post Office Box 245 Saluda, SC 29138 - 0245
42. Spartanburg County	(864) 596-2714	Medicaid Eligibility Spartanburg County DHHS Pinewood Shopping Center 1000 N. Pine St., Suite 23 Spartanburg, SC 29303
43. Sumter County	(803) 774-3447	Medicaid Eligibility Sumter County DHHS 105 N. Magnolia St., 3rd Floor Sumter, SC 29150-4941 Post Office Box 2547 Sumter, SC 29151 - 2547
44. Union County	(864) 424-0227	Medicaid Eligibility Union County DHHS 200 S. Mountain St. Union, SC 29379 Post Office Box 1068 Union, SC 29379

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
45. Williamsburg County	(843) 355-5411	Medicaid Eligibility Williamsburg County DSS 831 Eastland Ave. Kingstree, SC 29556 Post Office Box 767 Kingstree, SC 29556
46. York County	(803) 366-1900	Medicaid Eligibility York County DHHS 1890 Neelys Creek Road Rock Hill, SC 29730 Post Office Box 710 Rock Hill, SC 29731-6710

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 Medicaid and Medicare with NPI	08/2005
CMS-1500	Sample Claim Showing Medicaid Only with NPI	08/2005
CMS-1500	Sample Claim Showing Medicaid and Private Pay with NPI and Medicaid Provider ID	08/2005
CMS-1500	Sample Claim Showing Medicare, Medicaid, Private Pay with NPI and Medicaid Provider ID	08/2005
	Sample Edit Correction Form	10/2008
	Sample Remittance Advice	06/2007
DME 001	Medicaid Certificate of Medical Necessity Equipment/Supplies	04/2010
DME 003	Medicaid Certificate of Medical Necessity Power/Manual Wheelchairs and/or Accessories	04/2010
DME 004	Medicaid Certificate of Medical Necessity Orthotics, Prosthetics, and Diabetic Shoes	04/2010
DME 005	Medicaid Certificate of Medical Necessity Enteral Nutrition	04/2010
DME 006	Medicaid Certificate of Medical Necessity Parenteral Nutrition	04/2010
DME 007	Medicaid Certificate of Medical Necessity Oxygen	04/2010
DME 008	Certificate of Repair and Labor Cost	02/2010
	Justification for Home Uterine Activity Monitor/Supplies (HUAM) for Subcutaneous Tocolytic Therapy	02/2013

FORMS

Number	Name	Revision Date
HASCI-12-F	SC Dept of Disabilities and Special Needs Head and Spinal Cord Injury Waiver Authorization for PERS Services	02/2004
HASCI 12-I	SC Dept of Disabilities and Special Needs Head and Spinal Cord Injury Waiver Authorization for Specialized Supplies and Adaptations	02/2004
DHHS 214	Prior Authorization	04/1997

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:

Provider ID:

NPI:

Recipient ID:

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:

- ◯ 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.

Revised 05/2007

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**

SCDHHS (Revised 10/2012)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Durable Medical Equipment
Sample Claim Showing Medicaid and Medicare
With NPI

PICA

PICA

1. MEDICARE [x] (Medicare #) MEDICAID [x] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

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 01 DD 01 YY 1947 SEX M [x] F [ ]

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 [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: SC

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

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:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 123456789999

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [x] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [x] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: 0.00

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [x] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: 620

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 1

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 846.0

2.

3.

4.

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	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	20	07	01	20	07	12		A4253	00					90 00	2		ZZ	1212121212
																		NPI	1234567890
2																		NPI	
3																		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 SSN [ ] EIN [x]

26. PATIENT'S ACCOUNT NO.: DOE1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [x] YES [ ] NO

28. TOTAL CHARGE $ 90 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 90 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

ABC Medical Supply
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Durable Medical Equipment
Sample Claim Showing Medicaid Only
With NPI

PICA

1. MEDICARE (Medicare #) | MEDICAID [x] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

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 01 DD 01 YY 1947 SEX M [x] F

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 | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown | STATE: SC

8. PATIENT STATUS: Single | Married | Other | Employed | Full-Time Student | Part-Time Student

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:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES | [x] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M | F

b. AUTO ACCIDENT? YES | [x] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | [x] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 846 . 0
2.
3.
4.

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	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1																	ZZ	1212121212
01	20	07	01	20	07	12		A4253	00					90 00	2		NPI	1234567890
2																	NPI	
3																	NPI	
4																	NPI	
5																	NPI	
6																	NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 SSN | EIN [x]

26. PATIENT'S ACCOUNT NO.: DOE1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [x] YES | NO

28. TOTAL CHARGE $ 90 00

29. AMOUNT PAID $

30. BALANCE DUE $ 90 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
ABC Medical Supply
111 Main Street
Anytown, SC 22222-2222
a. 1234567890
b. ZZ1212121212

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Durable Medical Equipment
Sample Claim Showing Medicaid and Private Pay
With NPI and Medicaid Provider ID

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [x] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [x] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

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 01 DD 01 YY 1947 SEX M [x] F [ ]

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 [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: SC

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

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:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 01200000A

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [x]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [x] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: 22.00

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [x]

c. INSURANCE PLAN NAME OR PROGRAM NAME: 401

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [x] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 846.0
2.
3.
4.

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	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
																		1D	ABC123
1	01	20	07	01	20	07	12		A4253	00					90 00	2		NPI	1234567890
2																		NPI	
3																		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 SSN [ ] EIN [x]

26. PATIENT'S ACCOUNT NO.: DOE1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [x] NO [ ]

28. TOTAL CHARGE $ 90 00

29. AMOUNT PAID $ 22 00

30. BALANCE DUE $ 68 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

ABC Medical Supply
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. 1DABC123

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Durable Medical Equipment
Sample Claim Showing Medicare, Medicaid, and Private Pay
With NPI and Medicaid Provider ID

PICA

1. MEDICARE [x] (Medicare #) MEDICAID [x] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [x] (SSN or ID) FECA BLKLUNG [ ] (SSN) OTHER [ ] (ID)

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 01 DD 01 YY 1999 SEX M [x] F [ ]

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 [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: SC

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

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:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 01200000A

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 012345678

a. EMPLOYMENT? (Current or Previous): [ ] YES [x] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [x] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: 0.00

c. EMPLOYER'S NAME OR SCHOOL NAME: 50.00

c. OTHER ACCIDENT? [ ] YES [x] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: 400

d. INSURANCE PLAN NAME OR PROGRAM NAME: 620

10d. RESERVED FOR LOCAL USE: 1

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [x] YES [ ] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 846.0

2.

3.

4.

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	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1																	1D	ABC123
01	20	07	01	20	07	12		A4253	00					90 00	2		NPI	1234567890
2																	NPI	
3																	NPI	
4																	NPI	
5																	NPI	
6																	NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 SSN [ ] EIN [x]

26. PATIENT'S ACCOUNT NO.: DOE1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [x] YES [ ] NO

28. TOTAL CHARGE $ 90 00

29. AMOUNT PAID $ 50 00

30. BALANCE DUE $ 40 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
ABC Medical Supply
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. 1DABC123

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Only

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 - 76 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
PROV/XWALK ID	RECIPIENT ID	P AUTH NUMBER	TPL	INJURY CODE	EMERG	PC COORD	---- DIAGNOSIS ---- PRIMARY	SECONDARY
ABC123	1111111111						871.3	.

NPI: 1234567890

EDITS
INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 714

10 RECIPIENT NAME - DOE, JANE 11 DATE OF BIRTH 01/25/1992 12 SEX F

13 RES	14 ALLOWED	15 LN NO	16 DATE OF SERVICE	17 PLACE	18 PROC CODE	19 MOD	20 INDIVIDUAL PROVIDER	21 CHARGE IND	22 PAY	23 UNITS
	.00	1	02/01/00	12	V2624	OLT	DME000	65.00		001

NDC

NPI: 1234567890 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

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

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

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID
01		
02		
03		

27 TOTAL CHARGE 1765.00
28 AMT REC'D INS
29 BALANCE DUE 1765.00
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:
ACME DME SUPPLIERS
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 DME SUPPLIES                                    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|      CLAIM      |      |SERVICE RENDERED|  AMOUNT|TITLE 19|S|RECIPIENT |RECIPIENT NAME     |M  |TLE. 18| COPAY | TITLE |
| OWN REF.|   REFERENCE     |      | DATE(S) |      |  BILLED| PAYMENT|T|    ID.   |F M                | O |ALLOWED|   AMT | 18    |
|  NUMBER |      NUMBER     |PY IND|MMDDYY   | PROC.|        |MEDICAID|S|  NUMBER  |I I LAST NAME      |  D|CHARGES|       |PAYMENT|
+---------+-----------------+------+---------+------+--------+--------+-+----------+-------------------+---+-------+-------+-------+
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|ABB222222|0406001089000400A|      |         |      | 1192.00|  243.71|P|1112233333|M   CLARK          |   |       |   0.00|       |
|         |              01 |      |021507   |V2624 |  800.00|  117.71|P|          |                   |0HH|       |       |   0.00|
|         |              02 |      |021507   |V2623 |  392.00|  126.00|P|          |                   |0HH|       |       |   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-| |          |                   |0HH|       |       |       |
|         |              02 |      |012107   |V2623 | 300.00-| 130.00-| |          |                   |0HH|       |       |       |
|         |                 |                |      |        |        | |          |                   |   |       |       |       |
|         |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|          |                   |0HH|       |       |   0.00|
|         |              02 |      |012107   |V2623 |  859.00|    0.00|R|          |                   |0HH|       |       |   0.00|
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|         |           TOTALS|      |        2|      | 2193.50|  286.46| |          |                   |   |       |   0.00|   0.00|
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
+---------+-----------------+------+---------+------+--------+--------+-+-+--------+-------------------+---+-------+-------+-------+
                                              |            |   |     $286.46|
                                              +------------+   +------------+    STATUS CODES:       PROVIDER NAME AND ADDRESS
FOR AN EXPLANATION OF THE                      CERT. PG TOT    MEDICAID PG TOT                      +-----------------------------------+
ERROR CODES LISTED ON THIS                   +-------------+  +-------------+    P = PAYMENT MADE  |ACME DME SUPPLIES                  |
FORM REFER TO:  "MEDICAID                    |       $0.00 |  |      $286.46|    R = REJECTED      |                                   |
PROVIDER MANUAL".                            +-------------+  +-------------+    S = IN PROCESS    |PO BOX 000000                      |
                                               CERTIFIED AMT   MEDICAID TOTAL    E = ENCOUNTER      |FLORENCE       SC 00000-0000       |
IF YOU STILL HAVE QUESTIONS+-------------+ +-------------+  +-------------+    +---------+        |                                   |
PHONE THE D.H.H.S. NUMBER  |       $0.00 | |       $0.00 |  |         0.00|    |         |        +-----------------------------------+
SPECIFIED FOR INQUIRY OF   +-------------+ +-------------+  +-------------+    +---------+
CLAIMS IN THAT MANUAL.      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.	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	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	M O D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	0406001089000400U				513.00-	197.71-		1112233333	CLARK		M		022807	0404711253670430A
	01		012107	V2624	453.00	160.71-	P					0HH		
	02		012107	V2623	60.00	33.00-	P					OHH		
	TOTALS		1		513.00-	193.71-								

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		
	$193.71-			
YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER		
0.00	$50.00	4197304		

PROVIDER NAME AND ADDRESS

ACME DME SUPPLIES
PO BOX 000000
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. AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE 03/26/2007

PAGE 3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME F M 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

YOUR CURRENT DEBIT BALANCE	ADJUSTMENTS	MAXIMUS AMT
5293.45	0.00	0.00

CHECK TOTAL	CHECK NUMBER
0.00	

PROVIDER NAME AND ADDRESS

ACME DME SUPPLIES
PO BOX 000000
FLORENCE SC 00000-0000

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR EQUIPMENT/SUPPLIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: _____ Medicaid # (10 digits): _____

(2) DOB: ___/___/_____: Sex: ___ HT: _____ (in); WT: _____ Date of Service: _____/_____/_____

(3) Provider's name: _____ Provider's DME # _____NPI#_____

(4) Street address: _____ City: _____ State: ____ Zip: _____Local telephone #: _____

(5) Provider's signature: _____Date: _____

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT/SUPPLIES:
_____
_____

NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD-9) _____ Description(s):_____

_____ _____

_____ _____

(8) Indicate patient's ambulatory status while performing activities of daily living: ___Non-ambulatory ___Ambulatory, without assistance

___Ambulatory with the aid of a walker or cane, ____Ambulatory, with other assistance as described
_____
_____

Does the patient have decubitus ulcers? ___ Yes ___ No. If yes, circle stage(s): I, II, III, or IV. Indicate the wound size(s): _____

Please describe how this equipment / supply is medically necessary, the benefits to the recipient and how long will it take for the benefit to be evident:
_____
_____
_____

(9) For supplies, please indicate the dressing change required per day, week, month, etc.
_____
_____

Is additional information attached on separate sheet? _____Yes _____No (If "yes," enter recipient's name & I.D. Medicaid number on attachment

(10) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____

(11) Please indicate the prescription date: _____

(12) Duration of need (maximum of 12 months): _____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(13) PHYSICIAN'S NAME :_____ PHYSICIAN'S NPI # :_____

PHYSICIAN'S SIGNATURE _____DATE___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR EQUIPMENT/SUPPLIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #:	**Indicate the patient's name and his/her Medicaid # (10 digits).**
PATIENT DOB, SEX, HEIGHT, WEIGHT:	**Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.**
DATE OF SERVICE:	**Indicate the date of service (DOS). The date of service must be the same as the delivery date.**
PROVIDER'S NAME, DME # AND NPI#:	**Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.**
PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:	**Indicate the provider's physical address (provider's location) and telephone number.**
PROVIDER SIGNATURE AND DATE:	**Signature of DME provider representative and date.**
HCPCS CODES:	**List all HCPCS procedure codes for items ordered by the treating/ordering physician.** **Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.**

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES:	**In the first field, list the ICD-9 diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD-9 diagnosis code(s).**
QUESTION SECTION:	**These fields are used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.**
DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:	**Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 60 days before prescribing equipment and/or supplies.**
PRESCRIPTION DATE:	**Indicate the prescription date. The prescription date must be within 60 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame will be returned (if submitted with a PA) or rejected (if attached to a claim) and the MCMN will be deemed invalid.**
EST. LENGTH OF NEED:	**Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.**
PHYSICIAN ATTESTATION:	**The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.**
PHYSICIAN SIGNATURE AND DATE:	**After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR POWER/MANUAL WHEELCHAIRS AND/OR ACCESSORIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: _____Medicaid # (10 digits) _____

(2) DOB ____/____/____; Sex: ___ HT: _____(in); WT: _____Date of Service: _____

(3) Provider's name: _____Provider's DME # _____ NPI#: _____

(4) Street address: _____City: _____ State: _____ Zip: _____Local telephone #:_____

(5) Provider's signature: _____Date: _____

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN ON: _____

_____

_____

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

I ATTEST THAT THE PT/OT THERAPIST AND/OR THE TREATING /ORDERING PHYSICIAN HAS NO FINANCIAL RELATIONSHIP WITH MY COMPANY.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD-9): _____ Diagnosis(s): _____

_____ _____

(8) Indicate the patient's mobility limitation & explain how it interferes with the performance of activities of daily living (ADLs):
_____

_____

- **Explain why a cane or walker is not sufficient to meet the patient's mobility needs in the home:**
_____
- **Explain why a manual wheelchair is not sufficient to meet the patient's mobility needs in the home:**
_____
- **How long has the condition been present and what is the patient's clinical progression:**
_____

_____
- **Indicate any related diagnosis and all other interventions tried and the results:**
_____

_____
- **Has the patient ever used a walker, manual or power wheelchair and what were the results?**
_____

_____

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____
(10) Prescription Date: _____

(11) Duration of need (Maximum of 12 months): _____

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) PRINT PHYSICIAN'S NAME: _____ NPI # _____

PHYSICIAN'S SIGNATURE: _____ DATE _____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

DME 003 – Dated 01/01/11

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR POWER/MANUAL WHEELCHAIRS AND/OR ACCESSORIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #:	**Indicate the patient's name and his/her Medicaid # (10 digits).**
PATIENT DOB, SEX, HEIGHT, WEIGHT:	**Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.**
DATE OF SERVICE:	**Indicate the date of service (DOS). The date of service must be the same as the delivery date.**
PROVIDER'S NAME, DME # AND NPI#:	**Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.**
PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:	**Indicate the provider's physical address (provider's location) and telephone number.**
PROVIDER SIGNATURE AND DATE:	**Signature of DME provider representative and date.**
HCPCS CODES:	**List all HCPCS procedure codes for items ordered by the treating/ordering physician.** **Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.**

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES:	**In the first field, list the ICD-9 diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD-9 diagnosis code(s).**
QUESTION SECTION:	**This information is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.**
DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:	**Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 60 days before prescribing equipment and/or supplies.**
PRESCRIPTION DATE:	**Indicate the prescription date. The prescription date must be within 60 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame will be returned (if submitted with a PA) or rejected (if attached to a claim) and the MCMN will be deemed invalid.**
EST. LENGTH OF NEED:	**Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.**
PHYSICIAN ATTESTATION:	**The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.**
PHYSICIAN SIGNATURE AND DATE:	**After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM FOR ORTHOTICS, PROSTHETICS AND DIABETIC SHOES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: _____ Medicaid # (10 digits): _____

(2) DOB: _____/____/____; Sex: __ HT: _____ (in); WT: _____ Date of Service: _____

(3) Provider's name: _____Provider's DME # _____NPI# _____

(4) Street address: _____ City: _____State: _____ Zip: _____ Local telephone #: _____

(5) Provider's signature: _____Date: _____

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR ORTHOTICS, PROSTHETICS, AND/OR DIABETIC SHOES. _____

_____

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD-9): _____ Diagnosis (s): _____

_____ _____

_____ _____

(8) Give a detailed description of the severity of the recipient's condition(s) as related to orthotics, prosthetics, and/or diabetic shoes.

Orthotics and/or Prosthetics:

_____

_____

_____

Diabetic Shoes: Does the patient have one or more of the following conditions? Check all that apply:

____History of previous foot ulcerations ____Peripheral neuropathy with evidence of callus formation _____Foot deformity

____Poor circulation ____History of partial or complete amputation of the foot _____History of pre-ulcerative callus

Is additional information attached on a separate sheet? _____Yes _____No (If "yes," enter recipient's name and Medicaid I.D. number on attachment)

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____

(10) Prescription Date: _____

(11) Duration of need (Maximum of 12 months): _____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) PHYSICIAN'S NAME: _____ NPI # _____

PHYSICIAN'S SIGNATURE: _____ DATE _____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

DME 004 – Dated 01/01/11

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR ORTHOTICS, PROSTHETICS AND DIABETIC SHOES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #:	**Indicate the patient's name and his/her Medicaid # (10 digits).**
PATIENT DOB, SEX, HEIGHT, WEIGHT:	**Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.**
DATE OF SERVICE:	**Indicate the date of service (DOS). The date of service must be the same as the delivery date.**
PROVIDER'S NAME, DME # AND NPI#:	**Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.**
PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:	**Indicate the provider's physical address (provider's location) and telephone number.**
PROVIDER SIGNATURE AND DATE:	**Signature of DME provider representative and date.**
HCPCS CODES:	**List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.**

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES:	**In the first field, list the ICD-9 diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD-9 diagnosis code(s).**
QUESTION SECTION:	**This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.**
DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:	**Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 60 days before prescribing equipment and/or supplies.**
PRESCRIPTION DATE:	**Indicate the prescription date. The prescription date must be within 60 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame will be returned (if submitted with a PA) or rejected (if attached to a claim) and the MCMN will be deemed invalid.**
EST. LENGTH OF NEED:	**Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.**
PHYSICIAN ATTESTATION:	**The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.**
PHYSICIAN SIGNATURE AND DATE:	**After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR ENTERAL NUTRITION

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: _____ Medicaid # (10 digits): _____

(2) DOB: _____/____/____; Sex: __ HT: _____ (in); WT: _____ Date of Service: _____

(3) Provider's name: _____Provider's DME # _____NPI# _____

(4) Street address: _____ City: _____State: _____ Zip: _____ Local telephone #: _____

(5) Provider's signature: _____Date: _____

(6) LIST ALL PROCEDURE CODES ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR ENTERAL NUTRITION.

_____

_____

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: IF FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD-9): _____ Diagnosis (s): _____

_____ _____

_____ _____

(8) Does the patient have permanent non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel? Yes _____ No _____.

Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's over all health status? Yes _____ No _____.

Product name (s): _____

Total calories Per Day: _____

The method of administration: Syringe _____ Gravity _____ Pump _____Does not apply _____.

Does the patient have a documented allergy or intolerance to semi-synthetic nutrients? Yes _____ No ____.

Is additional information attached on separate sheet? ___Yes ___No (If "yes," enter recipient's name & Medicaid I.D. number on attachment)

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____

(10) Enter the prescription date: _____

(11) Duration of need (Maximum of 12 months): _____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify the requested equipment/supplies are appropriate for the patient.

(12) PHYSICIAN'S NAME: _____ NPI# _____

PHYSICIAN'S SIGNATURE _____DATE_____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

DME 005 – Dated 01/01/11

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR ENTERAL NUTRITION

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #:	**Indicate the patient's name and his/her Medicaid # (10 digits).**
PATIENT DOB, SEX, HEIGHT, WEIGHT:	**Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.**
DATE OF SERVICE:	**Indicate the date of service (DOS). The date of service must be the same as the delivery date.**
PROVIDER'S NAME, DME # AND NPI#:	**Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.**
PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:	**Indicate the provider's physical address (provider's location) and telephone number.**
PROVIDER SIGNATURE AND DATE:	**Signature of DME provider representative and date.**
HCPCS CODES:	**List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.**

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES:	**In the first field, list the ICD-9 diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD-9 diagnosis code(s).**
QUESTION SECTION:	**This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.**
DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:	**Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 60 days before prescribing equipment and/or supplies.**
PRESCRIPTION DATE:	**Indicate the prescription date. The prescription date must be within 60 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame will be returned (if submitted with a PA) or rejected (if attached to a claim) and the MCMN will be deemed invalid.**
EST. LENGTH OF NEED:	**Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.**
PHYSICIAN ATTESTATION:	**The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.**
PHYSICIAN SIGNATURE AND DATE:	**After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR PARENTERAL NUTRITION

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: _____ Medicaid # (10 digits): _____

(2) DOB: _____/____/____; Sex: __ HT: _____ (in); WT: _____ Date of Service: _____

(3) Provider's name: _____Provider's DME # _____NPI# _____

(4) Street address: _____ City: _____State: _____ Zip: _____ Local telephone #: _____

(5) Provider's signature: _____Date: _____

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR PARENTERAL NUTRITION:
_____
_____

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD-9): _____ Diagnosis (s): _____
_____ _____
_____ _____

(8) Does the patient have severe permanent disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength commensurate with the patient's overall health status? Yes _____ No _____.

Formula components:

Amino Acid. _____ (ml/day) _____concentration% _____gms protein/day

Dextrose. _____ (ml/day) _____concentration%

Lipids. _____ (ml/day) _____days/weeks _____concentration%.

Check the method of administration: Central line _____Hemodialysis access line _____ Peripherally inserted catheter (PIC) ____

Is additional information attached on separate sheet? ___Yes ___No (If "yes", enter recipient's name & Medicaid I.D. number on attachment)

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____

(10) Enter the prescription date: _____

(11) Duration of need (Maximum of 12 months): _____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) PHYSICIAN'S NAME: _____ NPI # _____

PHYSICIAN'S SIGNATURE _____DATE_____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN SECTION 2 OF THE DME MEDICAID PROVIDER MANUAL.

DME 006 – Dated 01/01/11

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR PARENTERAL NUTRITION

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #:	**Indicate the patient's name and his/her Medicaid # (10 digits).**
PATIENT DOB, SEX, HEIGHT, WEIGHT:	**Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.**
DATE OF SERVICES:	**Indicate the date of service (DOS). The date of service must be the same as the delivery date.**
PROVIDER 'S NAME, DME # AND NPI#:	**Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.**
PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:	**Indicate the provider's physical address (provider's location) and telephone number.**
PROVIDER SIGNATURE AND DATE:	**Signature of DME provider representative and date.**
HCPCS CODES:	**List all HCPCS procedure codes for items ordered by the treating/ordering physician.** **Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.**

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES:	**In the first field, list the ICD-9 diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD-9 diagnosis code(s).**
QUESTION SECTION:	**This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.**
DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:	**Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 60 days before prescribing equipment and/or supplies.**
PRESCRIPTION DATE:	**Indicate the prescription date. The prescription date must be within 60 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame will be returned (if submitted with a PA) or rejected (if attached to a claim) and the MCMN will be deemed invalid.**
EST. LENGTH OF NEED:	**Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.**
PHYSICIAN ATTESTATION:	**The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.**
PHYSICIAN SIGNATURE AND DATE:	**After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR OXYGEN

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: _____ Medicaid # (10 digits): _____

(2) DOB ____/___/___; Sex: ___ HT: _____(in); WT_____ Date of service: _____/____/_____

(3) Provider's name: _____ Provider's DME # _____NPI #_____

(4) Street address: _____City: _____State:____ Zip: _____Local telephone # _____

(5) Provider's signature: _____Date: _____

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT:
_____
_____

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD-9) _____ (Descriptions): _____
_____ _____
_____ _____

(8) ANSWERS	**ANSWER QUESTIONS 1-9. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted)**
a) _____mm Hg b) _____% c) ____/____/____	1. Enter the result of most recent test taken **on or before** the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test, Enter date of test (c)
Y N	2. Was the test in Question 1 performed **EITHER** with the patient in a chronic stable state as an outpatient **OR** within two days prior to discharge from an inpatient facility to home?
1 2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
XXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXXXXX	4. Physician/provider performing test in Question 1 (and, if applicable, Question 7) Print/type name and address below NAME: ADDRESS:
Y N D	5. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D
_____LPM	6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a **"X"**

IF PO2 = 56-60 OR OXYGEN SATURATION = < 89%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.

Y N 7	7. Does the patient have dependent edema due to congestive heart failure?
Y N D	8. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?
Y N D	9. Does the patient have a hematocrit greater than 56%?

NAME OF PERSON ANSWERING SECTION C QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print:
NAME: _____ TITLE: _____ EMPLOYER: _____

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____

(10) Please indicate the Prescription date: _____

(11) Duration of need (maximum of 12 months): _____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) PHYSICIAN'S NAME _____NPI# _____

PHYSICIAN'S SIGNATURE _____DATE___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

DME 007 – Dated 01/01/11

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR OXYGEN

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #:	**Indicate the patient's name and his/her Medicaid # (10 digits).**
PATIENT DOB, SEX, HEIGHT, WEIGHT:	**Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.**
DATE OF SERVICE:	**Indicate the date of service (DOS). The date of service must be the same as the delivery date.**
PROVIDER'S NAME, DME # AND NPI#:	**Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.**
PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:	**Indicate the provider's physical address (provider's location) and telephone number.**
PROVIDER SIGNATURE AND DATE:	**Signature of DME provider representative and date.**
HCPCS CODES:	**List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.**

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES:	**In the first field, list the ICD-9 diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD-9 diagnosis code(s).**
QUESTION SECTION:	**This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, circling "Y for yes, "N" for no, or "D" for does not apply.**
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	**If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the question of Section B, he/she must print his/her name, give his/her professional title and name of his/her employer where indicated. If the physician is answering the question, this space may be left blank.**
DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:	**Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 60 days before prescribing equipment and/or supplies.**
PRESCRIPTION DATE:	**Indicate the prescription date. The prescription date must be within 60 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame will be returned (if submitted with a PA) or rejected (if attached to a claim) and the MCMN will be deemed invalid.**
EST. LENGTH OF NEED:	**Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.**
PHYSICIAN ATTESTATION:	**The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.**
PHYSICIAN SIGNATURE AND DATE:	**After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF DURABLE MEDICAL EQUIPMENT

CERTIFICATE OF REPAIR AND LABOR COST

TO BE COMPLETED BY ENROLLED DME PROVIDER										
(1) RECIPIENT'S NAME:										
(2) RECIPIENT'S MEDICAID # (10 DIGITS):										
(3) BRAND NAME OF EQUIPMENT:			(4) DATE OF REPAIR AND/OR LABOR:							
(5) SPECIFICALLY IDENTIFY EQUIPMENT TO BE REPAIRED:										
(6) ESTIMATED COST OF REPAIR:										
(7) GIVE A DETAILED DESCRIPTION OF THE TYPE OF REPAIR AND/OR LABOR TO BE PERFORMED ON EQUIPMENT:										
(8) PROVIDER'S NAME:			PROVIDER ID and/or NPI:							
(9) STREET ADDRESS:			CITY:							

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF REPAIR AND LABOR COST

LINE 1	**RECIPIENT'S NAME**	**Enter recipient's full name.**
LINE 2	**RECIPIENT'S MEDICAID #**	**Enter recipient's 10-digit Medicaid number.**
LINE 3	**BRAND OF EQUIPMENT**	**Enter the brand name of the equipment you are repairing.**
LINE 4	**DATE OF REPAIR AND/OR LABOR**	**Enter the date the repair and/or labor was performed.**
LINE 5	**SPECIFICALLY IDENTIFY EQUIPMENT TO BE REPAIRED**	**Specify equipment being repaired.**
LINE 6	**ESTIMATED COST OF REPAIRED**	**Enter estimated cost of repair. This cost must be itemized if you are repairing more than one item. Please use the additional space at the bottom of this form if needed.**
LINE 7	**GIVE A DETAILED DESCRIPTION OF THE TYPE OF REPAIR AND/OR LABOR TO BE PERFORMED ON EQUIPMENT**	**Give a detailed description of what type of repair was performed.**
LINE 8	**PROVIDER'S NAME & PROVIDER ID AND/OR NPI**	**Enter provider's name and Medicaid DME number and/or National Provider Identifier.**
LINE 9	**STREET ADDRESS AND CITY**	**Enter provider's street address and city.**

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

JUSTIFICATION FOR HOME UTERINE ACTIVITY MONITOR/SUPPLIES (HUAM) FOR SUBCUTANEOUS TOCOLYTIC THERAPY

PART I – (ALL INFORMATION MUST BE PRINTED)

Patient's Name	Medicaid #:

Date Telephone Order/Written Order Given:

Patient's Expected Date of Delivery:

Provider's NPI or Medicaid ID:

PART II

The patient must have a gestational age of at least 24 weeks, but not more than 35 weeks AND meet AT LEAST ONE of the following criteria which necessitates a home uterine activity monitor/supplies and/or subcutaneous tocolytic therapy:

(AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE CHECKED)

- _____ Has experienced idiopathic pre-term labor that has required or will require hospitalization for IV tocolytic therapy.
- _____ Multiple gestation, three (3) or more fetuses, that has required or will require hospitalization for IV tocolytic therapy.
- _____ Patient has uterine anomalies or placenta previa that has required or will require hospitalization for IV tocolytic therapy.

PART III

Additionally, the patient must also meet ALL of the following criteria:

1) The patient has been diagnosed with pre-term labor based on uterine activity and/or cervical changes.
2) The patient has been stabilized by tocolytic medication.
3) There are no contraindications to the continuation of this pregnancy.
4) There is no fetal distress.
5) The patient's membranes are intact.
6) The patient is on homebound status and is agreeable to bed rest activities.
7) The patient has a telephone and is agreeable to daily phone contact and frequent physician follow-up.
8) The patient would have to be hospitalized for uterine activity monitoring and/or subcutaneous tocolytic therapy, if this service were not offered.
9) If the patient is hospitalized, this service will allow her to be discharged.
10) The patient is assigned to a delivering physician who has back up coverage in his/her absence.

PART IV

Physician Certification

I, _____, (Ordering/Treating Physician's Name) certify that _____ (Patient's Name), qualifies for Home Uterine Activity Monitoring/Supplies for Subcutaneous Tocolytic Therapy based on medical necessity and that the patient meets the above criteria.

Ordering/Treating Physician's Signature:	Date:
Physician UPIN/License #:	Phone #:

This form MUST be signed within 60 days of ordering service.

(Revised 02/13)

South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for PERS Services

Medicaid #: _____
1 2 3 4 5 6 7 8 9 10

Referred To: _____

_____

_____

Individuals Name	**Address**
Date of Birth	**City/State/Zip**

Prior Authorization Number: _____
1 2 3 4 5 6 7

Billing should be submitted to: ☐ DHHS ☐ DSN Board

You are hereby authorized to provide:

☐ **PERS Services**

☐ **PERS Installation (S516Ø)** **Start Date:** _____

☐ **PERS Monitoring (S5161)** **Start Date:** _____

Only the number of units rendered may be billed.
Please note: This nullifies any previous authorization to this provider for PERS Services.

PLEASE PRINT

DSN Board Name: _____ **Svc. Coord.:** _____

Address: _____

Phone: ( ) - ext. _____

Signature: _____ Date: _____

South Carolina Department of Disabilities and Special Needs
Head and Spinal Cord Injury Waiver
Authorization for Specialized Supplies and Adaptations

Medicaid #: _____ (1 2 3 4 5 6 7 8 9 10)

Referred To: _____

_____

_____

Individuals Name	**Address**
Date of Birth	**City/State/Zip**

Prior Authorization Number: _____ (1 2 3 4 5 6 7) Billing should be submitted to: ☐ DHHS ☐ DSN Board

You are hereby authorized to provide:

☐ **Specialized Supplies & Adaptations (X1922)** **Start Date:** _____

Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____
Item: _____ Cost: _____ Frequency: _____

☐ **HASCI Waiver Diapers** _____ **number of *individual* diapers needed** **Start Date:** _____

☐ Child - small/medium size (A4529) ☐ Child - large size (A4530) **Frequency:** _____
☐ Youth (A4533)
☐ Adult - small size (A4521) ☐ Adult - medium size (A4522) ☐ Adult - large size (A4523) ☐ Adult - extra large size (A4524)

☐ **HASCI Waiver Underpads (A4554)** **Start Date:** _____

Amount: ☐ 1 case ☐ 2 cases ☐ 3 cases **Frequency:** _____

☐ **Environmental Modification (S5165) (Home Modification)** **Start Date:** _____

Description: _____ Cost: _____

Only the number of units rendered may be billed.
Please note: This nullifies any previous authorization to this provider for Waiver Services.

PLEASE PRINT

DSN Board Name: _____ Svc. Coord.: _____

Address: _____

Phone: ( ) - ext. _____

Signature: _____ Date: _____

MAIL TO: DEPT. OF HEALTH AND HUMAN SERVICES, P. O. BOX 8206, COLUMBIA, S. C. 29202-8206

PRIOR AUTHORIZATION

1 CLAIM CONTROL NUMBER (DO NOT WRITE IN THIS SPACE)

TYPEWRITER ALIGNMENT
USE CAPITAL LETTERS ONLY

PROVIDER INFORMATION

2 PROVIDERS NAME

3 PROVIDER ID NUMBER

4 OWN REFERANCE #

5 DATE SUBMITTED

6 STREET ADRESS

7 CITY/ STATE/ZIP

8 NAME AND CITY OF MEDICAL PROVIDER

9 PRIOR AUTHORIZATION #

RECIPIENT INFORMATION

10 RECIPIENT NAME (FIRST, MIDDLE INITIAL, LAST)

11 RECIPIENT ID NUMBER

12 SEX

13 BIRTH DATE

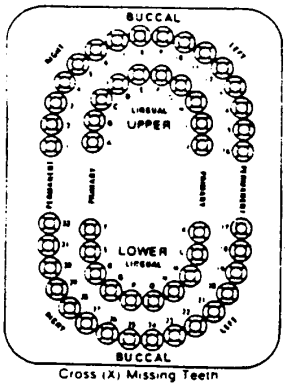
1	14 SERVICE INDICATOR	15 SERVICE CODE	16 MODIFIER	17 TYPE OF SALE	18 REQUESTED # BILLINGS	19 EPSDT REFERRAL	20 PROPOSED CHARGE	21 AUTHORIZED	22 ALLOWED # BILLINGS	23 DELETE	24 SERVICE NAME	25 TOOTH #	26 TOOTH SURFACES	27 AUTHORIZED CHARGE	28 EXPIRATION DATE
2	29 SERVICE INDICATOR	30 SERVICE CODE	31 MODIFIER	32 TYPE OF SALE	33 REQUESTED # BILLINGS	34 EPSDT REFERRAL	35 PROPOSED CHARGE	36 AUTHORIZED	37 ALLOWED # BILLINGS	38 DELETE	39 SERVICE NAME	40 TOOTH #	41 TOOTH SURFACES	42 AUTHORIZED CHARGE	43 EXPIRATION DATE
3	44 SERVICE INDICATOR	45 SERVICE CODE	46 MODIFIER	47 TYPE OF SALE	48 REQUESTED # BILLINGS	49 EPSDT REFERRAL	50 PROPOSED CHARGE	51 AUTHORIZED	52 ALLOWED # BILLINGS	53 DELETE	54 SERVICE NAME	55 TOOTH #	56 TOOTH SURFACES	57 AUTHORIZED CHARGE	58 EXPIRATION DATE
4	59 SERVICE INDICATOR	60 SERVICE CODE	61 MODIFIER	62 TYPE OF SALE	63 REQUESTED # BILLINGS	64 EPSDT REFERRAL	65 PROPOSED CHARGE	66 AUTHORIZED	67 ALLOWED # BILLINGS	68 DELETE	69 SERVICE NAME	70 TOOTH #	71 TOOTH SURFACES	72 AUTHORIZED CHARGE	73 EXPIRATION DATE
5	74 SERVICE INDICATOR	75 SERVICE CODE	76 MODIFIER	77 TYPE OF SALE	78 REQUESTED # BILLINGS	79 EPSDT REFERRAL	80 PROPOSED CHARGE	81 AUTHORIZED	82 ALLOWED # BILLINGS	83 DELETE	84 SERVICE NAME	85 TOOTH #	86 TOOTH SURFACES	87 AUTHORIZED CHARGE	88 EXPIRATION DATE

89 DOCUMENTATION ATTACHED

90 TOTAL LINES ENTERED

91 TOTAL PROPOSED CHARGES

92 TOTAL AUTHORIZED CHARGES



Cross (X) Missing Teeth

EXPLAIN MEDICAL NECESSITY FOR EACH PROCEDURE BELOW

X

93 REVIEWED BY (FOR DEPARTMENT USE ONLY)

X

94 PROVIDERS SIGNATURE

DHHS FORM 214 (4/97) Replaces DSS Form 3204 (1-79) which may be used until exhausted.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

PLEASE NOTE: Edit Correction Forms (ECFs) returned with "NO CORRECTIVE ACTION" will be disregarded. Corrected ECFs should be returned to the Medicaid Claims Receipt address which is located at the bottom of the ECF. If the ECF does not require corrections, but needs to be reprocessed because information in the system has been updated, submit a new claim for processing.

Edit Code	Description	CARC	RARC	Resolution
007	PAT DAILY INCOME RATE MORE THAN HOME RATE	45 – Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement.		Patient's daily recurring income is greater than the nursing facility's daily rate. Verify that you have provided the correct information.
050	DATE OF BIRTH/ DATE OF SERV. INCONSISTENT	14 – The date of birth follows the date of service.	M52 – Incomplete/invalid "from" date(s) of service.	**CMS-1500 CLAIM:** Verify that the Medicaid ID# in field 2, date of birth in field 11, and date of service in field 15 were billed correctly. If incorrect, make the appropriate correction. If the date of birth in field 11 is correct according to your records, contact the local county Medicaid office to update the system. After the system has been updated, submit a new claim. **UB CLAIM:** Verify that the Medicaid ID# in field 60, date of birth in field 10, and date of service in field 6 were billed correctly. If incorrect, make the appropriate correction. If the date of birth in field 10 is correct according to your records, contact the local county Medicaid office to update the system. After the system has been updated, submit a new claim.
051	DATE OF DEATH/ DATE OF SERV INCONSISTENT	13 – The date of death precedes the date of service.	M59 – Incomplete/ invalid "to" date(s) of service.	**CMS-1500 CLAIM:** Verify that the correct Medicaid ID# in field 2 and date of service in field 15 were billed. If incorrect, make the appropriate correction. If correct, contact the local county Medicaid office to see if there is an error with the patient's date of death. After the system has been updated, submit a new claim. **UB CLAIM:** Verify that the correct Medicaid ID# in field 60 and date of service in field 6 were billed. If incorrect, make the appropriate correction. If correct, contact the local county Medicaid office to see if there is an error with the patient's date of death. After the system has been updated, submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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Edit Code	Description	CARC	RARC	Resolution
052	ID/RD WAIVER CLM FOR NON ID/RD WAIVER RECIP	A1 – Claim/service denied.	N30 – Recipient ineligible for this service.	The claim was submitted with a ID/RD waiver-specific procedure code, but the recipient was not a participant in the ID/RD waiver. Check for error in using the incorrect procedure code. If the procedure code is incorrect, strike through the incorrect code and write the correct code above it. Check for correct recipient Medicaid number If the recipient's Medicaid number is incorrect, strike through the incorrect number and enter the correct Medicaid number above it, attach the ID/RD waiver referral form to the ECF and resubmit. If the recipient Medicaid number is correct, the procedure code is correct, and a ID/RD waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form. After the system has been updated, submit a new claim.
053	NON ID/RD WAIVER CLM FOR ID/RD WAIVER RECIP	A1 – Claim/service denied.	N34 – Incorrect claim for this service.	Verify that you have billed the correct Medicaid number, procedure code, and that this client is in the ID/RD waiver. If you have not billed either the correct Medicaid number or procedure code, or the client is not in the ID/RD waiver, re-bill the claim with the correct information.
055	MEDICARE B ONLY SUFFIX WITH A COVERAGE	16 – Claim/service lacks information which is needed for adjudication.	MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	Submit a claim to Medicare Part A.
056	MEDICARE B ONLY SUFFIX/NO A COV/NO 620	16 – Claim/service lacks information which is needed for adjudication.	M56 – Incomplete/invalid provider payer identification.	Enter Medicare carrier code 620, Part A - Mutual of Omaha carrier code 635, or Part B - Mutual of Omaha carrier code 636 in field 50 A through C line. Enter the Medicare Part B payment in field 54 A through C. Enter the Medicare ID number in field 60 A through C. The carrier code, payment, and ID number should be entered on the same lettered line, A, B, or C.
057	MEDICARE B ONLY SUFFIX/NO A COV/NO $	107 – Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.		Enter Medicare carrier code 620, Part A - Mutual of Omaha carrier code 635, or Part B - Mutual of Omaha carrier code 636 in field 54 A through C line which corresponds with the line on which you entered the Medicare carrier code field 50 A through C.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

PLEASE NOTE: Edit Correction Forms (ECFs) returned with "NO CORRECTIVE ACTION" will be disregarded. Corrected ECFs should be returned to the Medicaid Claims Receipt address which is located at the bottom of the ECF. If the ECF does not require corrections, but needs to be reprocessed because information in the system has been updated, submit a new claim for processing.

Edit Code	Description	CARC	RARC	Resolution
058	RECIP NOT ELIG FOR MED. COMPLEX CHILDREN'S WAIVER SVCS	A1 – Claim/service denied.	N30 – Recipient ineligible for this service.	The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System. Discard the ECF.
059	MED. COMPLEX CHILDREN'S WAIVER RECIP SVCS REQUIRE PA	15- The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62 – Incomplete/invalid treatment authorization code.	The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System. Contact recipient's PCP to obtain authorization for this service. Discard the ECF.
060	MED.COMPLEX CHILDREN'S WAIVER, CLAIM TYPE NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim for this service.	The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System. Discard the ECF.
061	INMATE RECIP ELIG FOR EMER INST SVC ONLY	A1 – Claim/service denied.	N30 – Recipient ineligible for this service.	Check DOS on ECF. If DOS is prior to 07/01/04 and service was not directly related to emergency institutional services, service is non-covered. **UB CLAIM:** Only inpatient claims will be reimbursed.
062	HEALTHY CONNECTIONS KIDS (HCK) - RECIPIENT in HMO Plan/ Service Covered by HMO	24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		This recipient is in the Healthy Connections Kids (HCK) Program and enrolled with an HMO. These services are covered by the HMO. Bill the HMO and discard the edit correction form.
065	PHYSICIAN ASST SRVC/RECIPIENT NOT QMB/CLAIM NOT CROSSOVER	185 – Rendering provider is not eligible to perform the service billed.	N30 – Recipient ineligible for this service	The service is non-covered for the rendering provider and/or recipient and will not be considered for payment.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

PLEASE NOTE: Edit Correction Forms (ECFs) returned with "NO CORRECTIVE ACTION" will be disregarded. Corrected ECFs should be returned to the Medicaid Claims Receipt address which is located at the bottom of the ECF. If the ECF does not require corrections, but needs to be reprocessed because information in the system has been updated, submit a new claim for processing.

Edit Code	Description	CARC	RARC	Resolution
079	PRIVATE REHAB UNITS EXCEEDED	B5 – Coverage/program guidelines were not met or were exceeded.		If the number of units is incorrect, mark through the existing number and enter the correct number. If the number of units is correct, check the procedure code to be sure it is correct. Change the procedure code if it is incorrect. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. Refer to the Prior Authorization letter from the QIO to determine the number of units authorized.
080	SERVICES NON-COVERED FOR RECIPIENTS OVER 21 YEARS OF AGE	6 – The procedure/ revenue code is inconsistent with the patient's age.	N129 – Not eligible due to the patient's age.	These services are non-covered for South Carolina Medicaid Eligible recipients over the age of 21.
101	INTERIM BILL	135 – Claim denied. Interim bills cannot be processed.		Verify the bill type in field 4 and the discharge status in field 17. Medicaid does not process interim bills. Please do not file a claim until the recipient is discharged from acute care.
102	INVALID DIAGNOSIS/ PROCEDURE CODE	16 – Claim/service lacks information which is needed for adjudication.	M67 – Incomplete/invalid other procedure code(s) and/or date(s).	Check the most current edition of the ICD for the correct code. This could be either a diagnosis or a surgical procedure code. If the code on your ECF is incorrect, mark through the code, write in the correct code, and resubmit.
103	SEX/DIAGNOSIS/ PROCEDURE INCONSISTENT	7 – The procedure/ revenue code is inconsistent with the patient's gender.		Verify the recipient's Medicaid ID number. Make the appropriate correction if applicable. Compare the sex on your records with the sex listed on the first line of the body of your ECF. If there is a discrepancy, contact the county Medicaid office and ask them to correct sex on file for this recipient and update the system. After the county Medicaid office has made the correction and updated the system, submit a new claim. If the sex is the same on your file and the ECF, check the current ICD for codes which are sex-specific. Verify that this is the correct code.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

PLEASE NOTE: Edit Correction Forms (ECFs) returned with "NO CORRECTIVE ACTION" will be disregarded. Corrected ECFs should be returned to the Medicaid Claims Receipt address which is located at the bottom of the ECF. If the ECF does not require corrections, but needs to be reprocessed because information in the system has been updated, submit a new claim for processing.

Edit Code	Description	CARC	RARC	Resolution
104	AGE/DIAGNOSIS/ PROCEDURE INCONSISTENT	6 – The procedure/ revenue code is inconsistent with patient's age.		Verify the recipient's Medicaid ID number. Make the appropriate correction, if applicable. Compare the date of birth on your records with the date of birth listed on the first line of the body of your ECF. If there is a discrepancy, contact the county Medicaid office and ask them to correct the date of birth on file for this recipient and update the system. After the county Medicaid office has made the correction and updated the system, submit a new claim. If the date of birth is the same on your file and the ECF, check the current ICD for codes that are age-specific. Verify that this is the correct code.
105	PRINCIPAL DIAG NOT JUSTIFICATION FOR ADM	A8 – Claim denied; ungroupable DRG.		Check diagnosis codes in the most current edition of the ICD for codes marked with a Q (Questionable Admission). Verify that the diagnosis codes are listed in the correct order, and that all codes have been used. If the code listed is one marked with a Q, Medicaid does not allow this code as a principal diagnosis. Mark through the code and write the correct code on the ECF and resubmit.
106	MANIFESTATION CODE UNACCEPT AS PRIN DIAG	A8 – Claim denied; ungroupable DRG.		Manifestation codes describe the manifestation of an underlying disease, not the disease itself, and should not be used as a principal diagnosis. If a manifestation code is listed as the principal diagnosis, mark through the code and write the correct code on the ECF and resubmit.
107	CROSSWALK TO DETECT MULTIPLE DRG'S	A1 – Claim/service denied.	N208 – Missing/incomplete/ invalid DRG code	Check the drug code (DRG) to make sure it is correct. If the DRG code is not correct, make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
108	E-CODE NOT ACCEPTABLE AS PRINCIPAL DIAG	A8 – Claim denied; ungroupable DRG.		E-codes describe the circumstance that caused an injury, not the nature of the injury, and should not be used as a principal diagnosis. If an E-code is listed as the principal diagnosis, mark through the code and write the correct code on the ECF and resubmit. E-codes should be used in the designated E-code field (field 72)

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Edit Code	Description	CARC	RARC	Resolution
109	DIAG/PROC HAS INVALID 4TH OR 5TH DIGIT	146 – Payment denied because the diagnosis was invalid for the date(s) of service reported.	MA66 – Incomplete/invalid principal procedure code and/or date.	Medicaid requires a complete diagnosis or procedure code as specified in the current edition of ICD 9. Mark through the existing diagnosis or procedure code and write in the entire correct code on the ECF and resubmit. ICD updates are edited effective with the date of discharge.
112	MEDICAID NON-COVER PROC-37.5, 50.51, 50.59	96 – Non-covered charge(s).	N431 – Service is not covered with this procedure.	Provider is not authorized to bill for these procedures, as Medicaid does not cover them.
113	SELECTED V-CODE NOT ACCEPT AS PRIN DIAG	96 – Non-covered charge(s).	MA63 – Incomplete/invalid principal diagnosis code.	Not all V-Codes can be used as the principal diagnosis in field 67. Check the most current edition of the ICD for an acceptable code. Mark through the existing diagnosis code and write in the correct code on the ECF and resubmit.
114	INVALID AGE - NOT BETWEEN 0 AND 124	6 – The procedure/ revenue code is inconsistent with the patient's age.		Contact your county Medicaid Eligibility office to correct the date of birth on the recipient's file. After the county Medicaid Eligibility office has made the correction to update the system, submit a new claim.
115	INVALID SEX - MUST BE MALE OR FEMALE	16 – Claim/service lacks information which is needed for adjudication.	MA39 – Incomplete/invalid patient's sex.	Contact your county Medicaid Eligibility office to correct the sex on the recipient's file. After the county Medicaid Eligibility office has made the correction to update the system, submit a new claim.
116	INVALID PAT STATUS-MUST BE 01-07, 20, 30	16 – Claim/service lacks information which is needed for adjudication.	MA43 – Incomplete/invalid patient status.	Check the most current edition of the NUBC manual for a list and descriptions of valid discharge status codes for field 17. If the discharge status code on your ECF is not valid for Medicaid billing, mark through the code and write in the correct code and resubmit.
117	DRG 469 - PRIN DIAG NOT EXACT ENOUGH	16 – Claim/service lacks information which is needed for adjudication.	M81 – Patient's diagnosis in a narrative form is not provided on an attachment or diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity.	This is a non-covered DRG. Verify the diagnoses and procedure codes on your claim are correct. If not, mark through the incorrect codes and write in the correct code and resubmit.
118	DRG 470 - PRINCIPAL DIAGNOSIS INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Incomplete/invalid principal diagnosis code.	Resolution is the same as for edit code 117.

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Edit Code	Description	CARC	RARC	Resolution
119	INVALID PRINCIPAL DIAGNOSIS	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Incomplete/invalid principal diagnosis code.	Verify the diagnosis in the current ICD-9 manual. Make corrections to the ECF and resubmit.
120	CLM DATA INADEQUATE CRITERIA FOR ANY DRG	A8 – Claim Denied ungroupable DRG.		Verify data with the medical records department. Make corrections to the ECF and resubmit.
121	INVALID AGE	6 – Procedure/revenue code inconsistent with age.		Contact your county Medicaid Eligibility office to correct the date of birth on the recipient's file. After the county Medicaid Eligibility office has made the correction and updated the system, submit a new claim.
122	INVALID SEX	16 – Claim/service lacks information which is needed for adjudication.	MA39 – Incomplete/invalid patient's sex.	Contact your county Medicaid Eligibility office to correct the sex on the recipient's file. After the county Medicaid Eligibility office has made the correction and updated the system, submit a new claim.
123	INVALID DISCHARGE STATUS	16 – Claim/service lacks information which is needed for adjudication.	N50 – Discharge information missing/incomplete/incorrect/ invalid.	Check the most current edition of the NUBC manual for a list and descriptions of valid discharge status codes for field 17. If the discharge status code on your ECF is not valid for Medicaid billing, mark through the code and write in the correct code on the ECF and resubmit.
125	PPS PROVIDER RECORD NOT ON FILE	CARC B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		The provider is not enrolled with Medicaid and will not be considered for payment.
127	PPS STATEWIDE RECORD NOT ON FILE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		The provider is not enrolled with Medicaid and will not be considered for payment.
128	DRG PRICING RECORD NOT ON FILE	A8 – Claim denied ungroupable DRG.		This DRG is not currently priced by Medicaid. Verify the diagnoses and procedure codes on your claim are correct. If not, mark through the incorrect codes and write in the correct code and resubmit

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Edit Code	Description	CARC	RARC	Resolution
150	TPL COVER VERIFIED/FILING NOT IND ON CLM	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92 – Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	Please see INSURANCE POLICY INFORMATION on the ECF (to the right of the Medicaid Claims Receipt Address) for the three-digit carrier code that identifies the insurance company, as well as the policy number and the policyholder's name. Identify the insurance company by referencing the numeric carrier code list in this manual. File the claim(s) with the primary insurance before re-filing to Medicaid. If the insurance company that has been billed is the one that appears on the ECF, enter the carrier code in field 24 (must exactly match the carrier code(s) under INSURANCE POLICY INFORMATION). Enter the policy number in field 25 (must exactly match the policy number(s) under INSURANCE POLICY INFORMATION). If payment is made, enter the total amount(s) paid in fields 26 and 28. Adjust the balance due in field 29. If payment is denied (i.e., applied to the deductible, policy lapsed, etc.) by the other insurance company, put a "1" (denial indicator) in field 4. Enter the appropriate corrections to the ECF and resubmit. If the carrier that has been billed is not the insurance for which the claim received edit 150, the provider must file with the insurance carrier that is indicated in MMIS. **UB CLAIM:** Enter the carrier code in field 50. Enter the policy number in field 60. If payment is made, enter the amount paid in field 54. If payment is denied, enter 0.00 in field 54 and also enter code 24 and the date of denial in the Occurrence Code fields 31-34 A and B.
151	MULTIPLE INS POL/NOT ALL FILED-CALL TPL	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA64 – Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	Eliminate any duplicate primary insurance policy entries on the CMS-1500, ensuring that blocks 9 and 11 contain unique information, one carrier per block. Medicaid coverage should not be entered in either primary block. If there is no duplicate information, refer to the INSURANCE POLICY INFORMATION section on the ECF, and file the claim(s) with each insurance company listed before re-filing to Medicaid. Enter all insurance results on the ECF. Documentation must show that each policy has been billed, and that proper coordination of benefits has been followed, *e.g.*, bill primary carrier first, then bill second carrier for the difference. If there are three or more separate third-party payers, the claim must be processed by the Third-Party Liability, attach the documentation to the ECF and resubmit.

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Edit Code	Description	CARC	RARC	Resolution
155	POSS NOT POSITIVE INS MATCH/OTHER ERRORS	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92 – Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	Bill the primary insurer(s) according to the resolution instructions for edit code 150.
156	TPL VERIFIED/FILING NOT INDICATED ON CLM	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA08 – You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan or you do not participate in Medicare.	File a claim with the insurance company listed under INSURANCE POLICY INFORMATION on the ECF. (Refer to the carrier code list in the provider manual.) If the insurance company denies payment or makes a partial payment, attach a copy of the explanation of benefits and resubmit. If the insurance carrier pays the claim in full, discard the ECF.
165	TPL BALANCE DUE/ PATIENT RESPONSIBILITY MUST BE PRESENT/ NUMERIC	16-Claim/service lacks information which is needed for adjudication.	MA92 – Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	When there is a third party payer on the claim that is primary to Medicaid, the "patient responsibility", entered in the "balance due" and the co-pay, coinsurance and deductible for the third party payer, cannot be blank or nonnumeric. Make the appropriate corrections to the ECF and resubmit.
170	LAB PROC BILLED/NO CLIA # ON FILE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Attach a copy of your CLIA certification to the ECF and resubmit.
171	NON-WAIVER PROC/PROV HAS CERT OF WAIVER	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Our records indicate that your CLIA certificate of waiver allows Medicaid reimbursement for waivered procedures only. Lab services billed are not waivered procedures. If your CLIA certification has changed, attach a copy of your updated CLIA certificate from CMS to your ECF and resubmit.
172	D.O.S. NONCOVERED ON CLIA CERT DATE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Medicaid will not reimburse for services outside CLIA certification dates. If your CLIA certification has been renewed, attach a copy of your updated CLIA certificate from CMS to your ECF and resubmit. Contact your lab director or CMS for current CLIA certificate information.

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Edit Code	Description	CARC	RARC	Resolution
174	NON-PPMP PROC/PROV HAS PPMP CERT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Our records indicate that your CLIA certificate of PPMP allows Medicaid reimbursement for PPMP procedures only. Lab services billed are not PPMP procedures. If your CLIA certification has changed, attach a copy of your updated CLIA certificate from CMS to your ECF and resubmit.
201	MISSING RECIPIENT ID NO	31 – Claim denied, as patient cannot be identified as our insured.		**CMS-1500 CLAIM:** Enter the patient's 10-digit Medicaid ID# in field 2 on the ECF and resubmit. **UB CLAIM:** Enter the patient's 10-digit Medicaid ID# in field 60 on the ECF and resubmit.
202	MISSING NATIONAL DRUG CODE (NDC)	16 – Claim/service lacks information which is needed for adjudication.	M119- Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	**CMS-1500 CLAIM:** Discard ECF. This edit cannot be manually corrected. Submit a new claim. **UB CLAIM:** Enter the missing NDC in the appropriate field on the ECF and resubmit.
206	MISSING DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M59 – Incomplete/invalid "to" date(s) of service.	**CMS-1500 CLAIM:** Enter the missing date of service in field 15 on the ECF and resubmit. **UB CLAIM:** Enter the missing date of service in field 45 on the ECF and resubmit.
207	MISSING SERVICE CODE	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid procedure codes (s).	**CMS-1500 CLAIM:** Enter the missing procedure code in field 17 on the ECF and resubmit.
208	NO LINES ON CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N517 – Resubmit a new claim with the requested information.	This ECF cannot be manually corrected. Discard the ECF and submit a new claim with the billable services.
209	MISSING LINE ITEM SUBMITTED CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79 – Did not complete or enter the appropriate charge for each listed service.	**CMS-1500 CLAIM:** Enter missing charges in field 20 on the ECF and resubmit. **UB CLAIM:** Enter missing charges in field 47 on the ECF and resubmit.
210	MISSING TAXONOMY CODE	16 – Claim/service lacks information which is needed for adjudication.	N94 – Claim/service denied because a more specific taxonomy code is required for adjudication.	Enter the taxonomy code on the ECF and resubmit. Taxonomy codes are required when an NPI is shared by multiple legacy provider numbers.

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Edit Code	Description	CARC	RARC	Resolution
213	LINE ITEM MILES OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M22 – Claim lacks the number of miles traveled.	Enter the number of miles in field 22 on the ECF and resubmit.
219	PRESENT ON ADMISSION (POA) INDICATOR IS MISSING, DIAGNOSIS IS NOT EXEMPT	A1 – Claim/service denied.	N434 – Missing/Incomplete/invalid Present on Admission indicator.	The POA indicator will distinguish conditions and diagnoses that are present at the time of the admission. Make the appropriate correction to the ECF by entering the POA indicator and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
225	FUND CODE NOT ASSIGNED	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identifier.	Unable to crosswalk to an assigned fund code. Verify the correct procedure code, modifier, NPI and/or legacy number was submitted. If the claim/service information is incorrect, make the appropriate change(s) to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. **Note:** Fund codes may identify specific procedure codes, modifiers, and provider type/provider specialties. If these are submitted in the wrong combination or entered incorrectly, the system searches but cannot find the appropriate fund code and is unable to process the claim.
227	MISSING LEVEL OF CARE	16 – Claim/service lacks information which is needed for adjudication.	N188 – The approved level of care does not match the procedure code submitted.	Make the appropriate corrections to the ECF by entering the level of care, attach any applicable DHHS forms and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information and applicable forms.
233	PRIMARY DIAGNOSIS CODE IS MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Incomplete/invalid principal diagnosis code.	Enter the primary diagnosis code in field 8 on the ECF from the current edition of the ICD-9, Volume I and resubmit.
234	PLACE OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M77-Missing/incomplete/invalid place of service	**CMS-1500 CLAIM:** Enter the place of service in field 16 on the ECF and resubmit.
239	MISSING LINE NET CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79-Missing/incomplete/invalid charge.	Make the appropriate correction by entering the missing net charge(s) to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.

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Edit Code	Description	CARC	RARC	Resolution
243	ADMISSION DATE/START OF CARE MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA40 – Incomplete/invalid admission date.	Enter the admission/start of care date in field 12 on the ECF and resubmit.
244	PRINCIPAL DIAGNOSIS CODE MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Incomplete/invalid principal diagnosis code.	Enter the principal diagnosis code in field 67 on the ECF and resubmit.
245	TYPE OF BILL MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Incomplete/invalid type of bill.	Refer to the most current edition of the NUBC manual for valid type of bill. Enter a valid Medicaid bill type code in field 4 on the ECF and resubmit.
246	FIRST DATE OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M52 – Incomplete/invalid "from" date(s) of service.	**UB CLAIM**: Enter the first date of service in field 6 on the ECF and resubmit.
247	MISSING LAST DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M59 – Incomplete/invalid "to" date(s) of service.	Enter the last date of service in field 6 on the ECF and resubmit.
248	TYPE OF ADMISSION MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA41 – Incomplete/invalid type of admission.	Refer to the most current edition of the NUBC manual for valid types of admissions. Enter a valid Medicaid type of admission code in field 14 on the ECF and resubmit.
249	TOTAL CLAIM CHARGE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M54 – Did not complete or enter the correct total charges for services rendered.	Enter revenue code 001 on the total charges line in field 42 on the ECF and resubmit. This revenue code must be listed as the last field.
252	PATIENT STATUS MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA43 – Incomplete/invalid patient status.	Refer to the most current edition of the NUBC manual for patient status. Enter the valid Medicaid patient status code in field 17 on the ECF and resubmit.
253	SOURCE OF ADMISSION MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA42 – Incomplete/invalid source of admission.	Refer to the most current edition of the NUBC Manual for source of admission. Enter a valid Medicaid source of admission code in field 15 on the ECF and resubmit.
263	MISSING TOTAL DAYS	16 – Claim/service lacks information which is needed for adjudication.	M53 – Missing/incomplete/invalid days or units of service.	Make the appropriate correction to the ECF by entering or correcting the total number of days and resubmit. If the ECF cannot be corrected, submit a new claim with new or corrected information.

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Edit Code	Description	CARC	RARC	Resolution
281	PROCEDURE CODE MODIFIER MISSING	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.		Enter modifier in field 18 of the line that received the edit code on the ECF and resubmit.
300	UB82 FORM NO LONGER ACCEPTED	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim for this service.	Resubmit claim on appropriate claim form.
301	INVALID NATIONAL DRUG CODE (NDC)	16 – Claim/service lacks information which is needed for adjudication.	M119 – Missing / incomplete /invalid/ deactivated/withdrawn National Drug Code (NDC).	Make the appropriate correction to the ECF by entering a valid 11-digit NDC number and resubmit. If the NDC is valid, attach a copy of the prescription label to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information and appropriate documentation (copy of the prescription label).
304	TOTAL CLAIM CHARGE NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M54 – Did not complete or enter the correct total charges for services rendered.	**CMS-1500 CLAIM:** Enter the correct numeric amount in field 27 on the ECF and resubmit.
305	INVALID TAXONOMY CODE	16 – Claim/service lacks information that is needed for adjudication.	N94 – Claim/service denied because a more specific taxonomy code is required for adjudication.	Taxonomy code must be valid. Either update the taxonomy code on the ECF to the one that the provider registered with SCDHHS or contact Provider Enrollment to add the taxonomy code that is being used on the claim. After Provider Enrollment has updated the system, submit a new claim. Please visit http://www.wpc-edi.com/codes/taxonomy for valid taxonomy codes.
308	INVALID PROCEDURE CODE MODIFIER	4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.	N13 – Payment based on professional/technical component modifier(s).	Enter correct modifier in field 18 on the ECF and resubmit.
309	INVALID LINE ITEM MILES OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M22 – Claim lacks the number of miles traveled.	Enter the correct number of miles in field 22 on the ECF and resubmit.

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Edit Code	Description	CARC	RARC	Resolution
310	INVALID PLACE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M77 – Incomplete/invalid place of service(s).	**CMS-1500 CLAIM:** Medicaid requires the numeric coding for place of service. Enter the appropriate place of service code in field 16 on the ECF and resubmit.
311	INVALID LINE ITEM SUBMITTED CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79 – Did not complete or enter the appropriate charge for each listed service.	**CMS-1500 CLAIM:** Enter the correct charge in field 20 on the ECF and resubmit. **UB CLAIM:** Enter the correct charge in field 47 on the ECF and resubmit.
312	MODIFIER NON-COVERED BY MEDICAID	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.		A modifier not accepted by Medicaid has been filed and entered in field 18 on the ECF. Enter the correct modifier in field 18 and resubmit.
316	THIRD PARTY CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA92 – Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	**CMS-1500 CLAIM:** Incorrect third party code was used in field 4 on the ECF. Correct coding would be "1" for denial or "6" for crime victim. Enter the correct code in field 4 on the ECF and resubmit. If a third party payer is not involved with this claim, mark through the character in field 4 on the ECF and resubmit.
317	INVALID INJURY CODE	16 – Claim/service lacks information which is needed for adjudication.	N517 – Resubmit a new claim with the requested information.	Incorrect injury code was used. Correct coding would be "2" for work related accident, "4" for automobile accident, or "6" for other accident. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
318	INVALID EMERGENCY INDICATOR / EPSDT REFERRAL CODE	16 – Claim/service lacks information that is needed for adjudication.	N517 – Resubmit a new claim with the requested information.	Verify that the emergency indicator/EPSDT referral code on the ECF was billed correctly. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
322	INVALID AMT RECEIVED FROM OTHER RESOURCE	16 – Claim/service lacks information which is needed for adjudication.	M49 – Incomplete/invalid value code(s) and/or amount(s).	Enter a valid number amount in "amount other sources" on the ECF and resubmit.

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Edit Code	Description	CARC	RARC	Resolution
323	INVALID LINE ITEM UNITS OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M53 – Did not complete or enter the appropriate number (one or more) of days or unit(s) of service.	**CMS-1500 CLAIM:** Enter the correct numeric units in field 22 on the ECF and resubmit. **UB CLAIM:** Enter the correct numeric units in field 46 on the ECF and resubmit.
330	INVALID LINE ITEM DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M52 – Incomplete/invalid "from" date(s) of service.	**CMS-1500 CLAIM:** Enter the correct date of service in field 15 on the ECF and resubmit. Make sure that the correct number of days is being billed for the billing month.
334	ERRONEOUS SURGERY – DO NOT PAY	233 – Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		Services/Treatment is related to a hospital acquired condition and no payment is due. Discard the ECF.
339	PRESENT ON ADMISSION (POA) INDICATOR IS INVALID	A1- Claim/Service denied.	N434 – Missing/incomplete/ invalid Present on Admission indicator.	The POA indicator distinguishes conditions and diagnoses that are present at the time of the admission. Enter the appropriate POA indicator on the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
349	INVALID LEVEL OF CARE	150 – Payer deems the information submitted does not support this level of service.		Check the ECF to make sure the correct level of care has been entered. If incorrect, make the appropriate correction to the ECF and resubmit. If the information is correct, attach appropriate clinical documentation (i.e., level of care forms, etc.,) from the applicable policy manual to substantiate the service being billed and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
354	TOOTH NUMBER NOT VALID LETTER OR NUMBER	16 – Claim/service lacks information which is needed for adjudication.	N39 – Procedure code is not compatible with tooth number/letter.	Enter the valid tooth number or letter in field 15 on the ECF on the ECF and resubmit. Verify tooth number or letter with procedure code.
355	TOOTH SURFACE CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N75 – Missing or invalid tooth surface information.	Enter the correct tooth surface code in field 16 on the ECF on the ECF and resubmit.
356	IMMUNIZATION AND ADMINISTRATION CODES MUST BE INCLUDED ON CLAIM	B5 – Coverage/program guidelines were not met or were exceeded.	N349 – The administration method and drug must be reported to adjudicate this service.	Medicaid requires that immunization and administration codes must be on the claim. Enter the appropriate codes on the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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Edit Code	Description	CARC	RARC	Resolution
357	MAXIMUM OF THREE ADMINISTRATION UNITS CAN BE BILLED PER DATE OF SERVICE	B5 – Coverage/program guidelines were not met or were exceeded.	N362 – The number of days or units of service exceeds our acceptable maximum.	Claim exceeds administration units. If there are unit errors, make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. If there are no unit errors, the claim will not be considered for payment. Discard the ECF.
358	SECONDARY ADMINISTRATION CPT CODE NOT ALLOWED PRIOR TO PRIMARY CODE	B15 – This service/ procedure requires that a qualifying service/ procedure be received and covered. The qualifying other service/ procedure has not been received/adjudicated.	N349 – The administration method and drug must be reported to adjudicate this service.	If the qualifying "primary" service/procedure has been rendered, complete or enter accurately the required information. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
361	SECONDARY PROC CODE NOT ALLOWED PRIOR TO PRIMARY PROC CODE	B15 – This service/ procedure requires that a qualifying service/ procedure be received and covered. The qualifying other service/ procedure has not been received/adjudicated.		If the qualifying "primary" service/procedure has been rendered, complete or enter accurately the required information. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
367	ADMISSION DATE/START OF CARE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA40 – Incomplete/invalid admission date.	Draw a line through the admission/start of care date in field 12, and write the correct date on the ECF and resubmit. Date must be six digits and numeric.
368	TYPE OF ADMISSION NOT VALID	16 – Claim/service lacks information which is needed for adjudication.	MA41 – Incomplete/invalid type of admission.	Refer to the most current edition of the NUBC manual for valid type of admission. Enter a valid Medicaid type of admission code in field 14 on the ECF and resubmit.
369	MONTHLY INCURRED EXPENSES MUST BE VALID	16 – Claim/service lacks information which is needed for adjudication.	N446 – Incomplete/invalid document for actual cost or paid amount.	Make the appropriate correction to the ECF by entering the valid monthly expenses and attach any applicable Medicaid forms from the appropriate policy manual and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. If correct, attach any applicable Medicaid forms from appropriate policy manual to substantiate the monthly expenses for review and consideration for payment and resubmit.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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Edit Code	Description	CARC	RARC	Resolution
370	SOURCE OF ADMISSION INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA42 – Incomplete/invalid source of admission.	Refer to the most current edition of the NUBC manual for valid source of admission. Enter a valid Medicaid source of admission code in field 15 on the ECF and resubmit.
373	PRINCIPAL SURG PROCEDURE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA66 – Incomplete/invalid principal procedure code and/ or date.	Draw a line through the invalid date in field 74 and enter correct date on the ECF and resubmit. Date must be six digits and numeric.
375	OTHER SURGICAL PROCEDURE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M67 – Incomplete/invalid other procedure code(s) and/ or date(s).	Draw a line through the invalid date in field 74, A - E, and enter correct date on the ECF and resubmit. Date must be six digits and numeric.
376	TYPE OF BILL NOT VALID FOR MEDICAID	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Incomplete/invalid type of bill.	Refer to the most current edition of the NUBC manual for valid type of bill. Enter a valid Medicaid type of bill in field 4 on the ECF and resubmit.
377	FIRST DATE OF SERVICE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM:** Enter the correct date of service in field 6 on the ECF and resubmit.
378	LAST DATE OF SERVICE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M59 – Incomplete/invalid "to" date(s) of service.	Draw a line through the invalid date in field 6, and enter the correct "to" date on the ECF and resubmit. Date must be six digits and numeric.
379	VALUE CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M49 – Incomplete/invalid value code(s) and/or amount(s).	Refer to the most current edition of the NUBC manual for valid value codes. Draw a line through the invalid code in fields 39 - 41 A - D, and enter the correct code on the ECF and resubmit.
380	VALUE AMOUNT INVALID	16 – Claim/service lacks information which is needed for adjudication.	M49 – Incomplete/invalid value code(s) and/or amount(s).	Draw a line through the amount in fields 39 - 41 A - D, and enter the correct numeric amount on the ECF and resubmit.
381	OCCURRENCE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M45 – Incomplete/invalid occurrence codes and dates.	Draw a line through the incorrect date in fields 31 - 34 A - B, and enter the correct date on the ECF and resubmit. Dates must be six digits and numeric.
382	PATIENT STATUS NOT VALID FOR MEDICAID	16 – Claim/service lacks information which is needed for adjudication.	MA43 – Incomplete/invalid patient status.	Refer to the most current edition of the NUBC manual for valid status codes on the ECF and resubmit. Enter a valid Medicaid patient status code in field 17.

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Edit Code	Description	CARC	RARC	Resolution
383	OCCURR.CODE, INCL. SPAN CODES, INVALID	16 – Claim/service lacks information which is needed for adjudication.	M45 – Incomplete/invalid occurrence codes and dates.	Refer to the most current edition of the NUBC manual for valid occurrence codes. Enter a valid Medicaid occurrence code in fields 31 – 34, A – B and in fields 35-36, A - B on the ECF and resubmit.
384	CONDITION CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M44 – Incomplete/invalid condition code.	Refer to the most current edition of the NUBC manual for valid condition codes. Enter a valid Medicaid condition code in fields 18 – 28 on the ECF and resubmit.
385	TOTAL CHARGE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M54 – Did not complete or enter the correct total charges for services rendered.	Total charge must be numeric. Draw a line through the invalid total, and enter the correct numeric total charge on the ECF and resubmit.
387	NON COVERED CHARGE INVALID	96 – Non-covered charge(s).	M54 – Did not complete or enter the correct total charges for services rendered.	Charges must be numeric. Draw a line through the invalid charge in field 48, and enter the correct numeric charge on the ECF and resubmit.
390	TPL PAYMENT AMT NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M49 – Incomplete/invalid value code(s) and/or amount(s).	Enter numeric payment from all primary insurance companies in field 26 or enter 0.00 if no payment was received. If the claim was denied by the other insurance company, put a "1" (denial indicator) in field 4. If no third party insurance was involved, delete information entered in field 26 by drawing a red line through it on the ECF and resubmit.
391	PATIENT PRIOR PAYMENT AMT NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M49 – Incomplete/invalid value code(s) and/or amount(s).	Verify the payment amount and enter the correct numeric amount on the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
394	OCCURRENCE SPAN CODES"FROM"DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M46 – Incomplete/invalid occurrence span codes and dates.	Dates must be six digits and numeric. Draw a line through the invalid date in field 35 – 36 A - B, and enter the correct date on the ECF and resubmit.
395	OCCURRENCE SPAN CODES"THRU"DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M46 – Incomplete/invalid occurrence span codes and dates.	Date must be six digits and numeric. Draw a line through the invalid date in field 35 - 36 A - B and enter the correct date on the ECF and resubmit.
400	TPL CARR and POLICY # MUST BOTH BE PRESENT	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92 – Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	Enter a valid carrier code in field 24 and a valid policy number in field 25 and resubmit the ECF. Make sure to indicate whether the primary insurance denied or paid the claim as noted in the 150 resolution. **UB CLAIM:** Enter a valid carrier code in field 50 and a valid policy number in field 60 and resubmit the ECF.

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Edit Code	Description	CARC	RARC	Resolution
401	AMT IN OTHER SOURCES/NO TPL CARRIER CODE	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92 – Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	**CMS-1500 CLAIM:** Complete fields 24, 25, and 26 (carrier code, policy number, amount paid). If the insurance company denied payment, put the denial indicator "1" in field 4 of the ECF and resubmit. **Notes:** If there is no third party involved, be sure all third party fields (4, 24, 25, 26, 28) are deleted of information by marking through in red. If there are more than two other insurance companies that have paid, enter the total combined amounts paid by all insurance companies in field 28 of the ECF and resubmit. The total combined amounts should be equal to field 26.
402	DEDUCTIBLE EXCEEDS CALENDAR YEAR LIMIT	16 – Claim/Service lacks information which is needed for adjustment.	N246 – State regulated patient payment limitations apply to this service.	Refer to the EOMB for the deductible amount (including blood deductible). If the amount entered is incorrect, change the amount on the ECF and resubmit. If it matches, attach the EOMB/Medicare electronic printout to the ECF and resubmit for review and consideration of payment. Do not add professional fees in the deductible amount. Professional fees should be filed separately on a CMS-1500 form under the hospital-based physician provider number. If the ECF cannot be corrected, submit a new claim with the corrected information.
403	INCURRED EXPENSES NOT ALLOWED	45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		Verify the requested charge amount. If the charge amount is incorrect, make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
411	ANESTHESIA PROC REQUIRES ANES. MODIFIER	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.		Refer to the current list of anesthesia modifiers found in section 2 of your provider manual and enter the correct modifier in field 18 on the ECF and resubmit.

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Edit Code	Description	CARC	RARC	Resolution
412	SURG PROC NOT VALID W/ANES. MODIFIER	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.		Enter the appropriate anesthesia procedure when an anesthesiologist administers anesthesia during a surgical procedure on the ECF and resubmit.
460	PROCEDURE CODE / INVOICE TYPE INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete/ invalid type of bill.	Oral & Maxillofacial Surgeons must file CPT procedure codes on the CMS-1500 and CDT procedure codes on the ADA Claim Form.
463	INVALID TOTAL DAYS	16 – Claim/service lacks information which is needed for adjudication.	M59 – Incomplete/invalid "to" date(s) service.	Make the appropriate correction to the ECF by entering the valid total days and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
468	CARRIER CODE 619 (MEDICAID) LISTED TWICE	16 – Claim/service lacks information which is needed for adjudication.	M56 – Incomplete/invalid payer identification.	Draw a line through the carrier code 619 which appears on either the first or second "other payer" line in field 50 on your ECF and resubmit. Do not draw a line through the 619 after "Medicaid Carrier ID."
469	INVALID LINE NET CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M49 – Incomplete/invalid value code(s) and/or amount(s).	Make the appropriate correction to the ECF by entering a valid net charge and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
501	INVALID DATE ON REVENUE LINE	16 – Claim/service lacks information which is needed for adjudication.	N301 – Missing/ incomplete /invalid procedure date(s).	Enter the correct date in field 45 on the ECF and resubmit.
502	DOS AFTER THE ENTRY DATE/ JULIAN DATE	110 – Billing date predates service date.		**CMS-1500 CLAIM:** Verify the date of service in field 15 on ECF. Make the appropriate corrections to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. A claim cannot be submitted prior to the date of service.
503	INCORRECT DIAGNOSIS (REASON) CODE	16 – Claim/service lacks information which is needed for adjudication.	M76 – Incomplete/invalid patient's diagnosis(es) and condition(s).	Verify diagnosis code in the ICD coding manual. Make the appropriate correction to the ECF and resubmit.
504	PROVIDER TYPE AND INVOICE INCONSISTENT	170 – Payment is denied when performed/billed by this type of provider.	N34-Incorrect claim form/format for this service.	Provider has filed the wrong claim form. Please refer to your provider manual for information on claims filing.

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Edit Code	Description	CARC	RARC	Resolution
505	MISSING DATE ON REVENUE LINE	16 – Claim/service lacks information which is needed for adjudication.	N301 – Missing/ incomplete /invalid procedure date(s).	Enter the date in field 45 on the ECF and resubmit.
506	PANEL CODE and REVENUE CODE BILLED	16 – Claim/service lacks information which is needed for adjudication.	M15 – Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is now allowed.	**UB CLAIM:** Individual panel code and procedure codes included in the panel cannot be billed in combination on the claim for the same dates of service. If the ECF cannot be corrected, submit a new claim with the corrected information.
507	MANUAL PRICING REQUIRED	16 – Claim/service lacks information which is needed for adjudication.	N45-Payment based on authorized amount.	Attach appropriate clinical documentation (i.e., EOB, QIO prior authorization, manufacture pricing, invoices, etc.) to the ECF and resubmit. Please refer to the appropriate section in your provider manual.
508	NO LINE ITEM RECORD	16 – Claim/service lacks information which is needed for adjudication.	N517 – Resubmit a new claim with the requested information.	**CMS-1500 CLAIM:** Complete fields 15 – 22 on the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. **UB CLAIM:** Resubmit the claim or enter information on the line(s) indicated and resubmit the ECF.
509	DOS OVER 2 YRS XOVER/ EXT CARE CLM ONLY	29 – The time limit for filing has expired.		Claims for payment of Medicare cost sharing amounts must be received and entered into the claims processing system within two years from the date of service or date of discharge, or up to six months following the date of Medicare payment, whichever is later. Attach appropriate documentation (Medicare EOMB) to each ECF and resubmit. **NURSING HOME PROVIDERS:** Resubmit ECF and appropriate documentation to : MCCS Nursing Facility Claims Post Office Box 100112 Columbia, SC 29202. Refer to the timely filing guidelines in the appropriate section of your provider manual.

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Edit Code	Description	CARC	RARC	Resolution
510	DOS IS MORE THAN 1 YEAR OLD	29 – The time limit for filing has expired.		Claims/ECFs for retroactive eligibility must be received and entered into the claims processing system within six months of the recipient's eligibility being added to the Medicaid eligibility system AND be received within three years from the date of service or date of discharge (for hospital claims). If the above time frames are met, attach one of the following documents listed below with each claim or ECF and resubmit. 1) DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker, or 2) The computer generated Medicaid eligibility approval letter notifying the recipient that Medicaid benefits have been approved. This can be furnished by the recipient or the eligibility worker. (This is different from the Certificate of Creditable Coverage.) **For NURSING HOME PROVIDERS:** Resubmit ECF and appropriate documentation to: MCCS Nursing Facility Claims Post Office Box 100112 Columbia, SC 29202. Refer to the timely filing guidelines in the appropriate section of your provider manual.
513	INCONSISTENT MEDICARE CARRIER CODE	16 – Claim/service lacks information which is needed for adjudication.	M56 – Incomplete/invalid payer identification.	Enter the correct Medicare Part A or Part B carrier code and resubmit.
514	PROC RATE/MILE X MILES NOT=SUBMIT CHRG	16 – Claim/service lacks information which is needed for adjudication.	M79 – Did not complete or enter the appropriate charge for each listed service.	Check the calculations for the rates, miles and submitted changes. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
515	AMBUL/ITP TRANS. MILEAGE LIMITATION	16 – Claim/service lacks information which is needed for adjudication.	M22-Missing/incomplete/invalid number of miles traveled.	Make the appropriate correction to the ECF and resubmit. For review and consideration of payment, attach clinical documentation to substantiate the mileage being billed and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.

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Edit Code	Description	CARC	RARC	Resolution
517	WAIVER SERVICE BILLED. RECIPIENT NOT IN A WAIVER.	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	The claim was submitted for a waiver-specific procedure code, but the recipient was not a participant in a Medicaid waiver. Check for error in using incorrect procedure code. If the procedure code is incorrect, strike through the incorrect code and write in the correct code on the ECF and resubmit. Check for correct recipient Medicaid number. If the recipient Medicaid number is incorrect, strike through the incorrect number and write in the correct Medicaid number on the ECF and resubmit.
518	PROCEDURE CODE COMBINATION NON-COVERED OR INVALID	16 – Claim/service lacks information which is needed for adjudication.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	For further assistance contact DentaQuest at 1-888-307-6553.
519	CMS REBATE TERM DATE HAS EXPIRED/ENDED	29 – The time limit for filing has expired.	N304 – Missing/incomplete /invalid dispensed date.	If the National Drug Code (NDC) end date has not expired for that particular date of service, make the appropriate correction to the ECF and attach a copy of drug label indicating the NDC number billed, as well as the expiration date of the drug administered and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information and attach a copy of the drug label indicating the NDC number billed as well as the expiration date of the drug administered.
528	PRTF WAIVER RECIPIENT BUT NOT WAIVER SERVICE	A1 – Claim/Service denied.	N379 – Claim level information does not match line level information.	The claim was submitted with a procedure code/service that is not in the PRTF service array. Enter the correct procedure code on the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
529	REVENUE CODE BEING BILLED OVER 15 TIMES PER CLAIM	A1 – Claim/Service denied.	N517 – Resubmit a new claim with the requested information.	Discard the ECF. This edit code cannot be manually corrected. A new claim must be submitted.
533	DOS IS MORE THAN 3 YEARS OLD	29 – The time limit for filing has expired.		Claim exceeds timely filing limits and will not be considered for payment. Refer to the timely filing guidelines in the appropriate section of your provider manual.

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Edit Code	Description	CARC	RARC	Resolution
534	PROVIDER/CCN DO NOT MATCH FOR ADJUSTMENT	16 – Claim/service lacks information which is needed for adjudication.	M47 –Incomplete/invalid internal or document control number.	Review the original claim and verify the provider number from that claim. Make sure that the correct original provider number is entered on the adjustment claim and resubmit the adjustment claim.
536	PROCEDURE-MODIFIER NOT COVERED ON DOS	A1 – Claim/Service denied.	N519 – Invalid combination of HCPCS modifiers.	Verify that the correct procedure code and modifier combination was entered in field 17 and 18 on ECF for the date of service. Make the appropriate correction to the procedure code in field 17 and/or the modifier in field 18 and resubmit the ECF.
537	PROC-MOD COMBINATION NON-COVERED/INVALID	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.		Verify that the correct procedure code and modifier combination was entered in fields 17 and 18 on ECF for the date of service. Make the appropriate correction to the procedure code in field 17 and/or modifier in field 18 and resubmit the ECF.
538	PATIENT PAYMENT EXCEEDS MED NON-COVERED	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Check the ECF to make sure the prior payment and the total non-covered amounts were entered correctly. A Medicaid recipient is not liable for charges unless they are non-covered services. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
539	MEDICAID NOT LISTED AS PAYER	31 – Claim denied as patient cannot be identified as our insured.		Enter Medicaid payer code 619 in field 50 A through C line which corresponds with the line on which you entered the Medicaid ID number field 60 A through C and resubmit the ECF.
540	ACCOM REVENUE CODE/OP CLAIM INCONSIST	16 – Claim/service lacks information which is needed for adjudication.	M56 – Incomplete/invalid payer identification.	Room accommodation revenue codes cannot be used on an outpatient claim. If the room accommodation revenue codes are correct, check the bill type (field 4) and the Health Plan ID (field 51). Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
541	MISSING LINE ITEM/REVENUE CODE	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/invalid revenue code (s).	The two digits before the edit code tell you on which line in field 42 the revenue code is missing. Enter the correct revenue code for that line and resubmit.

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Edit Code	Description	CARC	RARC	Resolution
542	BOTH OCCUR CODE and DATE NEC INC SPAN CODE	16 – Claim/service lacks information which is needed for adjudication.	M46 – Incomplete/invalid occurrence span codes and dates.	If you have entered an occurrence code in fields 31 through 36 A and B, an occurrence date must be entered. If you have entered an occurrence date in any of these fields, an occurrence code must also be entered. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
543	VALUE CODE/AMOUNT MUST BOTH BE PRESENT	16 – Claim/service lacks information which is needed for adjudication.	M49 – Incomplete/invalid value code(s) and/or amount(s).	If you have entered a value code in fields 39 through 41 A - D, a value amount must also be entered. If you have entered a value amount in these fields, a value code must also be entered. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
544	NURSING HOME CLAIMS SUBMITTED VIA 837	16 – Claim/service lacks information which is needed for adjudication.	N34- Incorrect claim form/format for this service.	For further assistance contact South Carolina Medicaid EDI Support Center at 1-888-289-0709.
545	NO PROCESSABLE LINES ON CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N142-The original claim was denied. Resubmit a new claim, not a replacement claim.	All lines on ECF have been rejected or deleted. This edit cannot be manually corrected. Discard the ECF and resubmit a new claim.
546	SURGICAL PROCEDURE MUST BE REPORTED AT THE REVENUE CODE LINE LEVEL	16 – Claim/service lacks information which is needed for adjudication.	M20 – Missing/incomplete/invalid HCPCS.	Enter surgical procedure code(s) on claim line(s) and resubmit claim.
547	PRINCIPAL SURG PROC AND DTE REQUIRED	16 – Claim/service lacks information which is needed for adjudication.	MA66 – Incomplete/invalid principal procedure code and/ or date.	Enter the surgical procedure code and date in field 74 on ECF and resubmit.
548	OTHER SURG PROC AND DATE MUST BE PRESENT	16 – Claim/service lacks information which is needed for adjudication.	M67 – Incomplete/invalid other procedure code(s) and/ or date(s).	Enter the surgical procedure codes and dates in fields 74 A - E and resubmit.
550	REPLACE/VOID BILL/ORIGINAL CCN MISSING	16 – Claim/service lacks information which is needed for adjudication.	M47 – Incomplete/invalid internal or document control number.	Check the remittance advice for the paid claim you are trying to replace or cancel to find the CCN. Enter the CCN in field 64 and resubmit.

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Edit Code	Description	CARC	RARC	Resolution
551	TYPE ADMISSION/SOURCE CODE INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA41 – Incomplete/invalid type of admission.	Check the most current edition of the NUBC manual for source of admission. Enter the valid Medicaid source of admission code in field 15 and resubmit.
552	MEDICARE INDICATED/NO MEDICAID LIABILITY	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		**CMS-1500 CLAIM:** Medicare coverage was indicated on claim form. Make sure fields 24, 25, and 26 on ECF are correct and resubmit. **UB CLAIM:** Medicare coverage was indicated on claim form. Make sure fields 50, 54, and 60 on ECF are correct and resubmit.
553	ALLOW AMT=ZERO/UNABLE TO DETERMINE PYMT	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	Information is incorrect or missing which is necessary to allow the Medicaid system to calculate the payment for the claim. Check for errors in the following fields: revenue codes, CPT codes, ICD 9 surgical codes, diagnosis codes, condition codes, value codes as applicable. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim. If this edit code appears with other edit codes, it may be resolved by correcting the other edit codes.
554	VALUE CODE/3RD PARTY PAYMENT INCONSIST	16 – Claim/service lacks information which is needed for adjudication.	MA92 – Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	If you have entered value code 14 in fields 39 through 41 A - D, you must also enter a prior payment in field 54. Make the appropriate corrections to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
555	TPL PAYMENT > PAYMENT DUE FROM MEDICAID	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Verify that the payment amount you have entered in field 54 is correct. If not correct, enter the correct amount and resubmit the ECF. If the amount is correct, no payment from Medicaid is due. Do not resubmit claim or ECF.
557	CARR PYMTS MUST = OTHER SOURCES PYMTS	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92 – Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	If any amount appears in field 28, you must indicate a third party payment. If there is no third party insurance involved, delete information entered in field 26 and/or field 28 by drawing a red line through it and resubmit the ECF.
558	REVENUE CHGS NOT WITHIN +- $1 OF TOTAL	16 – Claim/service lacks information which is needed for adjudication.	M54 – Did not complete or enter the correct total charges for services rendered.	Recalculate your revenue charges. Also check the resolution column on the ECF. If there is a "D" on any line, that line has been deleted by you on a previous cycle. Charges on these lines should no longer be added into the total charges.

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Edit Code	Description	CARC	RARC	Resolution
559	MEDICAID PRIOR PAYMENT NOT ALLOWED	B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.		Prior payment from Medicaid (field 54 A - C) should never be indicated on a claim or ECF. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
560	REVENUE CODES INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	M50 – Incomplete/invalid revenue codes.	Revenue code 100 is an all-inclusive revenue code and cannot be used with any other revenue code except 001, which is the total charges revenue code.
561	CLAIM ALREADY DEBITED (RETRO-MEDICARE), CANNOT ADJUST	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.	N185 – Do not resubmit this claim/service.	Retroactive Medicare claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.
562	CLAIM ALREADY DEBITED (HEALTH CLAIM), CANNOT ADJUST	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.	N185 – Do not resubmit this claim/service.	Retroactive Healthcare claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.
563	CLAIM ALREADY DEBITED (PAY & CHASE CLAIM), CANNOT ADJUST	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.	N185 – Do not resubmit this claim/service.	Medicaid Pay & Chase claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.
564	OP REV 450,459,510,511 COMB NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	N61 – Re-bill services on separate claims.	These revenue codes should never appear in combination on the same claim. If a recipient was seen in the emergency room, clinic, and treatment room on the same date of service for the same or related condition, charges for both visits should be combined under either revenue code 450, 510, or 761. If the recipient was seen in the ER and clinic on the same date of service for unrelated conditions, both visits should be billed on separate claims using the correct revenue code. If the recipient is a PEP member, and was triaged in the ER, the submitted claim should be filed with only revenue code 459. No other revenue codes should be filed with revenue code 459. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.

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Edit Code	Description	CARC	RARC	Resolution
565	THIRD PARTY PAYMENT/NO 3RD PARTY ID	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92 – Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	If a prior payment is entered in field 54, information in all other TPL-related fields (50 and 60) must also be entered. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
566	EMERG OP SERV/PRIN DIAG DOES NOT JUSTIFY	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Incomplete/invalid principal diagnosis code.	Check to make sure that the correct diagnosis code was billed. If not, enter the correct diagnosis code and resubmit the ECF.
567	NONCOV CHARGES > OR = TOTAL CHARGES	16 – Claim/service lacks information which is needed for adjudication.	M54 – Did not complete or enter the correct total charges for services rendered.	Check the total of non-covered charges in field 48 and total charges in field 47 to see if they were entered correctly. If they are correct, no payment from Medicaid is due. If incorrect, make the appropriate correction to the ECF and resubmit.
568	CORRESPONDING ADJUSTMENT (VOID) IS SUSPENDED OR DENIED	107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	N142 – The original claim was denied. Resubmit a new claim, not a replacement claim.	Review the edit code assigned to the void adjustment claim to determine if it can be corrected. If the void adjustment claim can be corrected, make the necessary changes and resubmit the adjustment claim. Resubmit the replacement claim along with the corrected void adjustment claim.
569	ORIGINAL CCN IS INVALID OR ADJUSTMENT CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N185 – Do not resubmit this claim/service.	Check the original CCN on the Form 130 as it is either invalid or a CCN for an adjustment claim. If the CCN is invalid, enter the correct CCN and resubmit. If the CCN is for an adjustment claim, it cannot be voided or replaced.
570	OP REV 760 762, 769 COMB NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	N61 – Re-bill services on separate claims.	These revenue codes cannot be used in combination for the same day; bill either revenue code 762 or 769 on an outpatient claim. Verify the correct revenue code for the claim, and make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.

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Edit Code	Description	CARC	RARC	Resolution
575	REPLACE/VOID CLM/CCN INDICATED NOT FOUND	16 – Claim/service lacks information which is needed for adjudication.	M47 – Incomplete/invalid internal or document control number.	Review the original claim and verify the claim control number (CCN) and recipient ID number from that claim. Make sure that the correct original CCN and recipient ID number are entered on the adjustment claim and resubmit the adjustment claim. **UB CLAIM:** Check the CCN you have entered in field 64 A - C with the CCN on the remittance advice of the paid claim you want to replace or cancel. Only paid claims can be replaced or cancelled. If the CCN is incorrect, write the correct CCN on the ECF. If this edit appears with other edits, it may be corrected by correcting the other edit codes. If edit code 575 and 863 are the only edits on the replacement claim, the replacement claim criteria have not been met (see Section 3 on replacement claims).
576	TYPE OF BILL AND PROVIDER TYPE INCONSIST	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Incomplete invalid type of bill.	If the bill type you have entered in field 4 is 131 or 141, you must use your outpatient number in field 51. If the bill type is 111, you must use your inpatient number. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
577	FP MOD. USED – PATIENT UNDER 10 OR OVER 55	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N30 – Recipient ineligible for this service.	Verify that the procedure code and modifier are correct. If incorrect, make the appropriate corrections to the ECF by entering the correct procedure code/modifier and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. For review and consideration for payment, attach appropriate clinical documentation to support the procedure code and modifier combination being billed and resubmit the ECF.
584	NATIVE AMERICAN HEALTH SERVICE PROCEDURE-MODIFIER COMBINATION NON-COV/INVALID	4- The procedure code is inconsistent with the modifier used or a required modifier is missing.		Make the appropriate correction to the ECF by entering the correct procedure code/modifier and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
587	1ST DATE OF SERV SUBSEQUENT TO LAST DOS	16 – Claim/service lacks information which is needed for adjudication.	M59 – Incomplete/invalid "to" date(s) of service.	Check the "from" and "through" dates in field 6. "From" date must be before "through" date. Be sure you check the year closely. Enter the correct dates and resubmit the ECF.

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Edit Code	Description	CARC	RARC	Resolution
588	1ST DOS SUBSEQUENT TO ENTRY DATE	16 – Claim/service lacks information which is needed for adjudication.	M52 – Incomplete/invalid "from" date(s) of service.	Check the "from" date of service in field 6. Be sure to check the year closely. Enter the correct dates and resubmit the ECF.
589	LAST DOS SUBSEQUENT TO DATE OF RECEIPT	16 – Claim/service lacks information which is needed for adjudication.	M59 – Incomplete/invalid "to" date(s) of service.	Check the "through" date of service in field 6. Enter the correct dates and resubmit the ECF.
590	NO DISCHARGE DATE ON FINAL BILL	16 – Claim/service lacks information which is needed for adjudication.	N50 – Discharge information missing/incomplete/incorrect/ invalid.	Check the ECF for errors with the date entered. If the date is incorrect, enter the correct date and resubmit the ECF. If the field was not completed, enter the date and resubmit the ECF. If the ECF cannot be corrected, submit a new claim with the corrected information.
591	NCCI – PROCEDURE CODE COMBINATION NOT ALLOWED	236- This procedure or procedure/modifier combination is not compatible with another procedure or procedure/ modifier combination provided on the same day according to the National Correct Coding Initiative.	N431 – Not covered with this procedure.	This procedure code combination is not allowed on the same date of service. Therefore, only one procedure code was paid. **Note**: The National Correct Coding Initiative (NCCI) does not allow the rendering or payment of certain procedure codes on the same date of service. For NCCI guidelines and specific code combinations; please refer to Medicaid bulletins about NCCI edits or the CMS website.
594	FINAL BILL/DISCHRG DTE BEFORE LAST DOS	16 – Claim/service lacks information which is needed for adjudication.	N50 – Discharge information missing/incomplete/incorrect/ invalid.	Check the occurrence code 42 and date in fields 31 through 34 A and B, and the "through" date in field 6. These dates must be the same. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
597	ACCOMODATION UNITS/STMT PERIOD INCONSIST	16 – Claim/service lacks information which is needed for adjudication.	M52 – Incomplete/invalid "from" date(s) of service.	Check the dates entered in field 6; the covered days calculated in field 7 on the ECF; the discharge date in fields 31 through 34 A - B and the units entered for accommodation revenue codes in field 42 (the discharge date and "through" date must be the same). If the dates in field 6 are correct, the system calculated the correct number of days, so the units for accommodation revenue codes should be changed. If the dates are incorrect, correcting the dates will correct the edit. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.

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Edit Code	Description	CARC	RARC	Resolution
598	QIO INDICATOR 3/APPROVAL DATES REQUIRED	16 – Claim/service lacks information which is needed for adjudication.	M52 – Incomplete/invalid "from" date(s) of service.	If condition code C3 is entered in fields 31 through 34 A - B, the approved dates must be entered in occurrence span, field 35-36 A or B. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
599	QIO DATES/OCCUR SPAN DATES N/SEQUENCED	16 – Claim/service lacks information which is needed for adjudication.	M52 – Incomplete/invalid "from" date(s) of service.	The dates which have been entered in field 35 - 36 A or B (occurrence span), do not coincide with any date in the statement covers dates in field 6. There must be at least one date in common in these two fields. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
600	QIO DATE/STATEMENT COVERS DATES DON'T OVERLAP	16 – Claim/service lacks information which is needed for adjudication.	M52 – Incomplete/invalid "from" date(s) of service.	The date(s) of service do not coincide with statement covers dates in field 6. Verify the approved date(s) received from the QIO are correct. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
603	REVENUE/CONDITION/VALUE CODES INCONSIST	16 – Claim/service lacks information which is needed for adjudication.	M49 – Incomplete/invalid value code(s) and/or amount(s).	Medicaid only sponsors a semi-private room. When a private room revenue code is used, condition code 39 or value codes 01 or 02 and value amounts must be on the claim. See current NUBC manual for definition of codes. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
605	NCCI - UNITS OF SERVICE EXCEED LIMIT	B5 – Coverage/program guidelines were not met or were exceeded.	N362 – The number of Days or Units of Service exceeds our acceptable maximum.	The number of units billed on the specified line exceeds the allowable limit based on NCCI guidelines. **Note:** For NCCI guidelines, please refer to Medicaid bulletins about NCCI edits or the CMS website.
636	COPAYMENT AMOUNT EXCEEDS ALLOWED AMOUNT	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		The Medicaid recipient is responsible for a Medicaid copayment for this service/date of service. The allowed payment amount is less than the recipient's copayment amount; therefore no payment is due from Medicaid. Please collect the copayment from the Medicaid recipient.

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Edit Code	Description	CARC	RARC	Resolution
637	COINS AMT GREATER THAN PAY AMT	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Verify that the coinsurance amount is correct. If not, correct and resubmit. If the coinsurance amount is correct, attach a copy of the Medicare remittance to the ECF and resubmit.
642	MEDICARE COST SHARING REQ COINS/DEDUCTIB	16 – Claim/Service lacks information which is needed for adjustment.	N479 – Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	For Medicaid to consider payment of the claim, the Medicare coinsurance and deductible must be present. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
672	NET CHRG/TOTAL DAYS X DAILY RATE UNEQUAL	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	Make the appropriate correction(s) to calculations on the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
673	REJECT LOC 6 - EXCLUDES SWING BEDS	96 – Non-covered charge(s).	N517 – Resubmit a new claim with the requested information.	Make the appropriate correction to the ECF and resubmit. For review and consideration for payment, attach appropriate clinical documentation (i.e., Form 181) to substantiate reimbursement and resubmit the ECF. If the ECF cannot be corrected, submit a new claim with the corrected information.
674	NH RATE - PAT DAY INC NOT = PAT DAY RATE	16 – Claim/service lacks information which is needed for adjudication.	N153 – Missing/incomplete/invalid room and board rate.	Make the appropriate corrections to the rate amounts on the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
690	OTHER SOURCES AMT MORE THAN MEDICAID AMT	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		**CMS-1500 CLAIM:** Verify the dollar amount in amount received insurance (field 28) and the amount paid (field 26). If not correct, enter the correct amount and resubmit the ECF. If the amounts are correct, no payment is due from Medicaid — Discard the ECF.
693	MENTAL HEALTH VISIT LIMIT EXCEEDED	B5 – Coverage/program guidelines were not met or were exceeded.	M86 – Service denied because payment already made for same/similar procedure within set time frame.	Additional services require Prior Authorization from the QIO. If the authorization number is incorrect, make the appropriate correction to the ECF and resubmit. Contact the QIO for review and consideration of authorization for additional visits.

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Edit Code	Description	CARC	RARC	Resolution
700	PRIMARY/PRINCIPAL DIAG CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Incomplete/invalid principal diagnosis code.	**CMS-1500 CLAIM:** Medicaid requires the complete diagnosis code as specified in the current edition of Volume I of the ICD-9-CM manual, (including fifth digit sub-classification when listed). Check the diagnosis code in field 8 with Volume I of the ICD-9 manual. Mark through the existing code and write in the correct code on the ECF and resubmit. **UB CLAIM:** Medicaid requires the complete diagnosis code as specified in the current edition of the ICD-9-CM manual, (including fifth digit sub-classification when listed). Check the diagnosis code in field 67 with the ICD-9 manual. Mark through the existing code and write in the correct code on the ECF and resubmit.
701	SECONDARY/ OTHER DIAG CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M64 – Incomplete/invalid other diagnosis code.	**CMS-1500 CLAIM:** Follow the resolution for edit code 700 and resubmit. The secondary diagnosis code appears in field 9. **UB CLAIM:** Follow the resolution for edit code 700 and resubmit. The secondary diagnosis code appears in field 67 A-Q.
703	RECIP AGE/PRIM/PRINCIPAL DIAG INCONSIST	9 – The diagnosis is inconsistent with the patient's age.	MA63 – Incomplete/invalid principal diagnosis code.	**CMS-1500 CLAIM:** Check the patient's Medicaid number in field 2. A common error is entering another family member's number. Make sure the number matches the patient served. Check the diagnosis code in field 8 to be sure it is correct. Make the appropriate correction to the patient Medicaid number in field 2 or the diagnosis code in field 8 and resubmit the ECF. Field 11 indicates the date of birth in our system as of the claim run date. Contact your county Medicaid office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. **UB CLAIM:** Check the patient's Medicaid number in field 60. A common error is entering another family member's number. Make sure the number matches the patient served. Check the diagnosis code in field 67 to be sure it is correct. Make the appropriate correction to the patient Medicaid number in field 60 or the diagnosis code in field 67 and resubmit the ECF. Field 10 indicates the date of birth in our system as of the claim run date. Contact your county Medicaid office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim.

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Edit Code	Description	CARC	RARC	Resolution
704	RECIP AGE/SECONDARY/OTHER DIAG INCONSIST	9 – The diagnosis is inconsistent with the patient's age.	M64 – Incomplete/invalid other diagnosis code.	**CMS-1500 CLAIM:** Check the patient's Medicaid number in field 2. A common error is entering another family member's number. Make sure the number matches the patient served. Check the secondary diagnosis code in field 9 to be sure it is correct. Make the appropriate correction to the patient Medicaid number in field 2 or the secondary diagnosis code in field 9 and resubmit the ECF. Field 11 indicates the date of birth in our system as of the claim run date. Contact your county Medicaid office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. **UB CLAIM:** Check the patient's Medicaid number in field 60. A common error is entering another family member's number. Make sure the number matches the patient served. Check the secondary diagnosis code(s) in fields 67 A-Q to be sure it is correct. Make the appropriate correction to the patient Medicaid number in field 60 or the secondary diagnosis code(s) in fields 67 A-Q and resubmit the ECF. Field 10 indicates the date of birth in our system as of the claim run date. Contact your county Medicaid office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim.
705	RECIP SEX/PRIM/PRINCIPAL DIAG INCONSIST	10 – The diagnosis is inconsistent with the patient's gender.	MA63 – Incomplete/invalid principal diagnosis code.	**CMS-1500 CLAIM:** Check the patient's Medicaid number in field 2. A common error is entering another family member's number. Make sure the number matches the patient served. Check the diagnosis code in field 8 to be sure it is correct. Make the appropriate correction to the patient Medicaid number in field 2 or the diagnosis code in field 8 and resubmit the ECF. Contact your county Medicaid office if your records indicate a different sex. After the county Medicaid Eligibility office has updated the system, submit a new claim. **UB CLAIM:** Check the patient's Medicaid number in field 60. A common error is entering another family member's number. Make sure the number matches the patient served. Check the diagnosis code in field 67 to be sure it is correct. Make the appropriate correction to the patient Medicaid number in field 60 or the diagnosis code in field 67 and resubmit the ECF. Contact your county Medicaid office if your records indicate a different sex. After the county Medicaid Eligibility office has updated the system, submit a new claim.

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Edit Code	Description	CARC	RARC	Resolution
706	RECIP SEX/SECONDARY/OTHER DIAG INCONSIST	10 – The diagnosis is inconsistent with the patient's gender.	M64 – Incomplete/invalid other diagnosis code.	**CMS-1500 CLAIM:** Check the patient's Medicaid number in field 2. A common error is entering another family member's number. Make sure the number matches the patient served. Check the secondary diagnosis code in field 9 to be sure it is correct. Make the appropriate correction to the patient Medicaid number in field 2 or the secondary diagnosis code in field 9 and resubmit the ECF. Contact your county Medicaid office if your records indicate a different sex. After the county Medicaid Eligibility office has updated the system, submit a new claim. **UB CLAIM:** Check the patient's Medicaid number in field 60. A common error is entering another family member's number. Make sure the number matches the patient served. Check the secondary diagnosis code(s) in fields 67 A-Q to be sure it is correct. Make the appropriate correction to the patient Medicaid number in field 60 or the secondary diagnosis code(s) in fields 67 A-Q and resubmit the ECF. Contact your county Medicaid office if your records indicate a different sex. After the county Medicaid Eligibility office has updated the system, submit a new claim.
707	PRIN.DIAG. NOW REQUIRES 4TH OR 5TH DIGIT	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Incomplete/invalid principal diagnosis code.	**CMS-1500 CLAIM:** Medicaid requires a complete diagnosis code as specified in the current edition of the ICD-9 manual. The diagnosis code in field 8 requires a fourth or fifth digit. Mark through the existing diagnosis code and write in the entire correct code and resubmit the ECF or submit a new claim. **UB CLAIM:** Medicaid requires a complete diagnosis code as specified in the current edition of the ICD-9 manual. The diagnosis code in field 67 requires a fourth or fifth digit. Mark through the existing diagnosis code and write in the entire correct code and resubmit the ECF or submit a new claim.

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Edit Code	Description	CARC	RARC	Resolution
708	SEC. DIAG. NOW REQUIRES 4TH OR 5TH DIGIT	16 – Claim/service lacks information which is needed for adjudication.	M64 – Incomplete/invalid other diagnosis code.	**CMS-1500 CLAIM:** Medicaid requires a complete diagnosis code as specified in the current edition of the ICD-9 manual. The diagnosis code in field 9 requires a fourth or fifth digit. Mark through the existing diagnosis code and write in the entire correct code and resubmit the ECF or submit a new claim. **UB CLAIM:** Medicaid requires a complete diagnosis code as specified in the current edition of the ICD-9 manual. The diagnosis code(s) in fields 67 A-Q requires a fourth or fifth digit. Mark through the existing diagnosis code and write in the entire correct code and resubmit the ECF or submit a new claim.
709	SERV/PROC CODE NOT ON REFERENCE FILE	96 – Non-covered charge(s).	M51 – Missing/incomplete/invalid procedure code.	Check the most current manual. If the procedure code on your ECF is incorrect, mark through the code and write in the correct code and resubmit the ECF. If the code is correct, attach appropriate documentation for review and consideration for payment and resubmit the ECF.
710	SERV/PROC/DRUG REQUIRES PA-NO NUM ON CLM	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.		**CMS-1500 CLAIM:** Please enter prior authorization number in field 3 and resubmit the ECF. **UB CLAIM:** Please enter prior authorization number in field 63 and resubmit the ECF. If the prior authorization number was not obtained prior to rendering the service, you will not be considered for payment.
711	RECIP SEX - SERV/PROC/DRUG INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA39 – Incomplete/invalid patient's sex.	**CMS 1500 CLAIM:** Verify the patient's Medicaid number in field 2 and the procedure code in field 17. A common error is entering another family member's Medicaid number. Make sure the number matches the patient served. Make the appropriate correction, if applicable, and resubmit the ECF. Field 12 shows the patient's sex indicated in our system. If there is a discrepancy, contact your county Medicaid Eligibility office to correct the sex on the patient's file. After the county Medicaid Eligibility office has updated the system, submit a new claim. **UB CLAIM:** Verify the recipient's Medicaid number in field 60 and the procedure code in field 44 and resubmit the ECF.

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Edit Code	Description	CARC	RARC	Resolution
712	RECIP AGE-PROC INCONSIST/NOT ID/RD RECIP	6 – The procedure/ revenue code is inconsistent with the patient's age.		**CMS-1500 CLAIM:** Follow the resolution for edit code 711. Field 11 shows the patient's date of birth indicated in our system. Make the appropriate correction, if applicable, and resubmit the ECF. Notify the county Medicaid Eligibility office of discrepancies. After the county Medicaid Eligibility office has updated the system, submit a new claim. **UB CLAIM:** Follow the resolution for edit code 711. The top of the ECF indicates the date of birth in our system as of the claim run date. Make the appropriate correction, if applicable, and resubmit the ECF.
713	NUM OF BILLINGS FOR SERV EXCEEDS LIMIT	151 – Payment adjusted because the payer deems the information submitted does not support this many services.		**CMS-1500 CLAIM:** Check the number of units in field 22 on the specified line to be sure the correct number of units has been entered on the ECF. If the number of units is incorrect, mark through the existing number and enter the correct number and resubmit the ECF. If the number of units is correct, check the procedure code to be sure it is correct. For review and consideration for payment of additional units, attach appropriate clinical documentation to substantiate the services being billed and resubmit the ECF. **UB CLAIM:** The system has already paid for the procedure entered in field 44. Verify the procedure is correct. Make appropriate corrections to the ECF, if applicable, and resubmit. If this is a replacement claim, attach appropriate clinical documentation to justify the services being billed and resubmit the ECF for consideration for payment.
714	SERV/PROC/DRUG REQUIRES DOC-MAN REVIEW	16 – Claim/service lacks information which is needed for adjudication.	N102 – This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	Attach appropriate clinical documentation (i.e., Sterilization Consent Form 1723, medical records, etc.) to the ECF and resubmit for manual review. Please refer to the applicable provider policy manual for the specific documentation requirements.
715	PLACE OF SERVICE/PROC CODE INCONSISTENT	5 – The procedure code/bill type is inconsistent with the place of service.		**CMS-1500 CLAIM:** Check the procedure code in field 17 and the place of service code in field 16 to be sure that they are correct. If incorrect, make the appropriate correction on the indicated line and resubmit the ECF. For review and consideration for payment, attach appropriate clinical documentation to the ECF verifying where the procedure/service was provided and resubmit.

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Edit Code	Description	CARC	RARC	Resolution
716	PROV TYPE INCONSISTENT WITH PROC CODE	8 – The procedure code is inconsistent with the provider type/ specialty (taxonomy).		**CMS-1500 CLAIM:** The type of provider rendering this service/procedure code is not authorized. Verify that the information in fields 17 and 19 are correct. If incorrect, make the appropriate corrections to the ECF and resubmit. If correct, attach appropriate clinical documentation to the ECF for review and consideration for payment and resubmit.
717	SERV/PROC/DRUG NOT COVERED ON DOS	A1 – Claim/service denied.		**CMS-1500 CLAIM:** Check the procedure code in field 17 and the date of service in field 15 on the indicated line to be sure both are correct. Make the appropriate corrections to the ECF and resubmit. The procedure code may have been deleted from the program or changed to another procedure code.
718	PROC REQUIRES TOOTH NUMBER/SURFACE INFO	16 – Claim/service lacks information which is needed for adjudication.	N37 – Tooth number/letter required.	The procedure requires either a tooth number and/or surface information in fields 15 and 16 on the ECF. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
719	SERV/PROC/DRUG ON PREPAYMENT REVIEW	133 – The disposition of this claim/service is pending further review.	M87-Claim/service subjected to CFO-CAP prepayment in review.	Verify that the information on the prior approval letter matches the information on the ECF. Check the prior authorization number, procedure code(s) and modifier(s) and make the appropriate corrections to the ECF and resubmit. Attach appropriate documentation to the ECF, if applicable, and resubmit for review and consideration for payment.
720	MODIFIER 22 REQUIRES ADD'L DOCUMENT	16 – Claim/service lacks information which is needed for adjudication.	M69 – Paid at the regular rate, as you did not submit documentation to justify modifier 22.	For review and consideration for payment, attach appropriate clinical documentation (i.e., increased intensity indications, difficulty of procedure, severity of patient's condition, etc.) to the ECF to justify the unusual procedural services and resubmit for review and consideration for payment.

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Edit Code	Description	CARC	RARC	Resolution
721	CROSSOVER PRICING RECORD NOT FOUND	A1 – Claim/service denied.	N8-Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data to adjudication.	Pricing record not found for the specific procedure code and modifier being billed. Please verify that the correct procedure code and modifier were submitted. Make the appropriate correction to the ECF and resubmit or submit a new claim with the corrected information. If the provider has knowledge that the specific procedure code and modifier being billed is valid and a covered service by Medicaid, resubmit the ECF, and attach the appropriate clinical documentation (i.e., medical records, radiology reports, operative notes, etc.) to have the procedure code/modifier considered for payment and added to the system. If the procedure code/modifier is not valid and non-covered by Medicaid, the claim will not be considered for payment.
722	PROC MODIFIER and SPEC PRICING NOT ON FILE	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N65 – Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	Verify that the correct procedure code and modifier were submitted. If incorrect, make the appropriate change to the ECF and resubmit or submit a new claim with the corrected information. If the provider has knowledge that the specific procedure code and modifier being billed is valid and a covered service by Medicaid, resubmit the ECF, and attach the appropriate clinical documentation (i.e., medical records, radiology reports, operative notes, etc.) to have the procedure code/modifier considered for payment and added to the system. If the code/modifier is not valid and non-covered by Medicaid, the claim will not be considered for payment. **Note:** The Medicaid pricing system is programmed specifically for procedure codes, modifiers, and provider specialties. If these are submitted in the wrong combination, the system searches but cannot "find" a price, and the line will automatically reject with edit code 722. Attaching documentation for review and consideration for payment or system updates is not applicable to all provider types. Please refer to the appropriate policy manual for procedure codes and modifiers that are applicable to your provider type/specialty to ensure that you are using the correct procedure code and modifier. A common error is entering the incorrect modifier or entering no modifier.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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Edit Code	Description	CARC	RARC	Resolution
724	PROCEDURE CODE REQUIRES BILLING IN WHOLE UNITS	16 – Claim/service lacks information which is needed for adjudication.	M53 –Missing/incomplete/invalid days or units of service.	Make the appropriate correction the units entered on the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information or call for assistance.
727	DELETED PROCEDURE CODE/CK CPT MANUAL	16 – Claim/service lacks information which is needed for adjudication.	M51 – Incomplete/invalid, procedure code(s) and/or rates, including "not otherwise classified" or "unlisted" procedure codes submitted without a narrative description or the description is insufficient. (Add to message by Medicare carriers only: "Refer to the HCPCS Directory. If an appropriate procedure code(s) does not exist, refer to Item 19 on the HCFA-1500 instructions.")	**CMS-1500 CLAIM:** Check the procedure code in field 17 and the date of service in field 15 to verify their accuracy and resubmit the ECF. **UB CLAIM:** Check the procedure code in field 44 and the date of service in field 45 to verify their accuracy and resubmit the ECF.
732	PAYER ID NUMBER NOT ON FILE	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	M56 – Incomplete/invalid provider payer identification.	**CMS-1500 CLAIM:** Refer to the codes listed under the INSURANCE POLICY INFORMATION on the ECF. Enter the correct carrier code in field 24 and resubmit the ECF. To view a complete listing of carrier codes, visit the Provider Information webpage on the DHHS website http://provider.scdhhs.gov. The carrier code listing is also included in the provider manuals. **UB CLAIM:** Refer to the codes listed under INSURANCE POLICY INFORMATION on the ECF. Enter the correct carrier code in field 50 on the ECF and resubmit the ECF. To view a complete listing of carrier codes, visit the Provider Information webpage on the DHHS website http://provider.scdhhs.gov. The carrier code listing is also included in the provider manuals.

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Edit Code	Description	CARC	RARC	Resolution
733	INS INFO CODED, PYMT OR DENIAL MISSING	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92 – Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	**CMS-1500 CLAIM:** If any third-party insurer has not made a payment, there should be a TPL denial indicator in field 4. If all carriers have made payments, there should be no TPL denial indicator. If payment is denied (*i.e.,* applied to the deductible, policy lapsed, etc.) by either primary insurance carrier, put a "1" (denial indicator) in field 4 and 0.00 in field 26. If payment is made, remove the "1" from field 4 and enter the amount(s) paid in fields 26 and 28. Adjust the net charge in field 29. If no third party insurance was involved, delete information entered in fields 24 and 25 by drawing a red line through it. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim. **UB CLAIM:** If any third-party insurer has not made a payment, there should be a TPL occurrence code and date in fields 31-34. If payment is denied show 0.00 in field 54. If payment is made enter the amount in field 54. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
734	REVENUE CODE REQUIRES UNITS	16 – Claim/service lacks information which is needed for adjudication.	M53 – Did not complete or enter the appropriate number (one or more) of days or unit(s) of service.	The revenue code listed in field 42 requires units of service in field 46. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
735	REVENUE CODE REQUIRES AN ICD-9 SURGICAL PROCEDURE OR DELIVERY DIAGNOSIS CODE	16 – Claim/service lacks information which is needed for adjudication.	M76 – Incomplete/invalid patient's diagnosis(es) and condition(s).	On inpatient claims w/ revenue codes 360 OR, 361 OR-Minor, or 369 OR-Other, an ICD-9 surgical code is required in fields 74 A-E. On inpatient claims w/ revenue codes 370 Anesthesia, 710 Recovery Room, 719 Other Recovery Room or 722 Delivery Room, a delivery diagnosis code is required in fields 67 A-Q or an ICD-9 surgical code is required in fields 74 A-E. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
736	PRINCIPAL SURGICAL PROCEDURE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA66 – Incomplete/invalid principal procedure code and/ or date.	Verify the correct procedure code was submitted. If incorrect, make the appropriate change and resubmit the ECF.
737	OTHER SURGICAL PROCEDURE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M67 – Incomplete/invalid other procedure code(s) and/ or date(s).	Follow the resolution for edit code 736. The two digits in front of the edit code identify which surgical procedure code is not on file.

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Edit Code	Description	CARC	RARC	Resolution
738	PRINCIPAL SURG PROC REQUIRES PA/NO PA #	15 – Payment adjusted because the submitted authorization number is missing, invalid or does not apply to billed services or provider.		Check for errors and make the appropriate correction to the ECF and resubmit. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment.
739	OTHER SURG PROC REQUIRES PA/NO PA NUMBER	15 – Payment adjusted because the submitted authorization number is missing, invalid or does not apply to billed services or provider.		Check for errors and make the appropriate correction to the ECF and resubmit. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment.
740	RECIP SEX/PRINCIPAL SURG PROC INCONSIST	7 – The procedure/ revenue code is inconsistent with the patient's gender.		Verify the recipient's Medicaid number (field 60) and the procedure code in field 74. A common error is entering another family member's Medicaid number. Make sure the number matches the recipient served. Make the appropriate correction, if applicable, and resubmit ECF. Check the recipient's sex listed on the ECF. If there is a discrepancy, contact your county Medicaid Eligibility office to correct the sex on the recipient's file. After county Medicaid Eligibility office has made the correction and updated the system, submit a new claim.
741	RECIP SEX/OTHER SURG PROC INCONSISTENT	7 – The procedure/ revenue code is inconsistent with the patient's gender.		Follow resolution for edit code 740. The two digits in front of the edit code identify which other surgical procedure code in field 74 A - E is inconsistent with the recipient's sex.
742	RECIP AGE/PRINCIPAL SURG PROC INCONSIST	6 – The procedure/ revenue code is inconsistent with the patient's age.		Verify the recipient's Medicaid ID number (field 60) and the procedure code in field 74. A common error is entering another family member's Medicaid number. Make sure the number matches the recipient served. Make the appropriate correction, if applicable, and resubmit ECFs. Check the recipient's date of birth listed on the ECF. If there is a discrepancy, contact your county Medicaid Eligibility office to correct the date of birth on the recipient's file. After county Medicaid Eligibility office has made the correction and updated the system, submit a new claim.

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Edit Code	Description	CARC	RARC	Resolution
743	RECIPIENT AGE/OTHER SURG PROC INCONSIST	6 – The procedure/ revenue code is inconsistent with the patient's age.		Follow the resolution for edit code 742. The two digits in front of the edit code identify which other surgical procedure code in field 74 A - E is inconsistent with the recipient's age.
746	PRINCIPAL SURG PROC EXCEEDS FREQ LIMIT	96 – Non-covered charge(s).	N435 – Exceeds number/ frequency approved /allowed within time period without support documentation.	The system has already paid for the procedure entered in field 74. Verify the procedure code is correct. If this is a replacement claim, attach appropriate clinical documentation for review and consideration for payment to the ECF and resubmit. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment.
747	OTHER SURG PROC EXCEEDS FREQ LIMIT	96 – Non-covered charge(s).	N435 – Exceeds number/ frequency approved /allowed within time period without support documentation.	Follow the resolution for edit code 746. The two digits in front of the edit code identify which other surgical procedure's (field 74 A - E) frequency limitation has been exceeded.
748	PRINCIPAL SURG PROC REQUIRES DOC	16 – Claim/service lacks information which is needed for adjudication.	N102 – This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	Procedure requires documentation. Attach appropriate clinical documentation (i.e., discharge summary, operative note, etc.) for the principal surgical procedure in field 74 to the ECF and resubmit. Documentation will not be reviewed or retained by Medicaid until the provider corrects all other edits. Refer to the appropriate policy manual for specific Medicaid coverage guidelines and documentation requirements.
749	OTHER SURG PROC REQUIRES DOC/MAN REVIEW	16 – Claim/service lacks information which is needed for adjudication.	N102 – This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	Procedure requires documentation. Attach appropriate clinical documentation (i.e., discharge summary, operative note, etc.) for the other surgical procedure in field 74 A-E to the ECF and resubmit. Documentation will not be reviewed or retained by Medicaid until the provider corrects all other edits. Refer to the appropriate policy manual for specific Medicaid coverage guidelines and documentation requirements.

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Edit Code	Description	CARC	RARC	Resolution
750	PRIN SURG PROC NOT COV OR NOT COV ON DOS	96 – Non-covered charge(s).	N303 – Missing/ incomplete/ invalid principal procedure date.	Check the procedure code in field 74 and the date of service to verify their accuracy. Check to see if the procedure code in field 74 is listed on the non-covered surgical procedures list in the manual. Check the most recent edition of the ICD-9 to be sure the code you are using has not been deleted or changed to another code. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
751	OTHER SURG PROC NOT COV/NOT COV ON DOS	96 – Non-covered charge(s).	N302 – Missing/ incomplete/ invalid other procedure date(s).	Follow the resolution for edit code 750. The two digits in front of the edit code identify which other surgical procedure code in field 74 A - E is not covered on the date of service.
752	PRINCIPAL SURGICAL PROCEDURE ON REVIEW	133 – The disposition of this claim/service is pending further review.		Attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) which supports the principal surgical procedure in field 74 to the ECF for review and consideration for payment and resubmit.
753	OTHER SURGICAL PROCEDURE ON REVIEW	133 – The disposition of this claim/service is pending further review.		Attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) which supports the other surgical procedure in field 74 A-E to the ECF for review and consideration for payment and resubmit.
754	REVENUE CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M50 – Incomplete/invalid revenue code(s).	Revenue code is invalid. Verify revenue code. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
755	REVENUE CODE REQUIRES PA/PEND FOR REVIEW	133 – The disposition of this claim/service is pending further review.		Enter prior authorization number in field 63 on ECF and resubmit.
757	OTHER DIAG REQUIRES PA/NO PA NUMBER	15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.		**CMS-1500 CLAIM:** Enter prior authorization number in field 3 on ECF and resubmit. **UB CLAIM:** Enter prior authorization number in field 63 on ECF and resubmit.
758	PRIM/PRINCIPAL DIAG REQUIRES DOC	16 – Claim/service lacks information which is needed for adjudication.	N223-Missing documentation of benefit to the patient during the initial treatment period.	If primary/principal diagnosis is correct, attach appropriate clinical documentation (i.e., operative report, chart notes, etc.) to ECF for review and consideration for payment and resubmit.

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Edit Code	Description	CARC	RARC	Resolution
759	SEC/OTHER DIAG REQUIRES DOC/MAN REVIEW	16 – Claim/service lacks information which is needed for adjudication.	N223-Missing documentation of benefit to the patient during the initial treatment period.	If secondary/other diagnosis is correct, attach appropriate clinical documentation (i.e., operative report, chart notes, etc.) to ECF for review and consideration for payment and resubmit.
760	PRIMARY DIAG CODE NOT COVERED ON DOS	96 – Non-covered charge(s).	N314 – Missing/ incomplete/ invalid diagnosis date.	Check the current ICD-9 manual to verify that the primary diagnosis is correctly coded. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. If the diagnosis code is correct, then it is not covered and will not be considered for payment.
761	SEC/OTHER DIAG CODE NOT COVERED ON DOS	96 – Non-covered charge(s).	N337 – Missing/ incomplete/ invalid secondary diagnosis date.	Check the current ICD-9 manual to verify that the secondary or other diagnosis is correctly coded. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. If the diagnosis code is correct, then it is not covered and will not be considered for payment.
762	PRINCIPAL DIAG ON REVIEW/MANUAL REVIEW	133 – The disposition of this claim/service is pending further review.		The principal diagnosis code requires manual review by SCDHHS. Resubmit the ECF with appropriate clinical documentation (i.e., history, physical, and discharge summary, etc.) for review and consideration for payment.
763	OTHER DIAG ON REVIEW/MANUAL REVIEW	133 – The disposition of this claim/service is pending further review.		Follow the resolution for edit code 762. The two digits before the edit code identify which other diagnosis code in fields 67 A-Q requires manual review by DHHS.
764	REVENUE CODE REQUIRES DOC/MANUAL REVIEW	16 – Claim/service lacks information which is needed for adjudication.	N102 – This claim has been denied without reviewing the medical record because the requested records were not received or were received timely.	The revenue code requires manual review by SCDHHS. Resubmit the ECF with appropriate clinical documentation for review and consideration for payment.

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Edit Code	Description	CARC	RARC	Resolution
765	RECIPIENT AGE/REVENUE CODE INCONSIST	6 – The procedure/ revenue code is inconsistent with the patient's age.		Check the recipient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the recipient served. Check the revenue code in field 42 to be sure it is correct. Make the appropriate correction to the recipient number or to the revenue code in field 42 and resubmit the ECF. The date of birth on the ECF indicates the date of birth in our system as of the claim run date. Call your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has made the correction and updated the system, submit a new claim.
766	NEED TO PRICE OP SURG	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	Verify that the correct procedure code was entered in field 44. If the procedure code is incorrect, mark through the code with red ink and write in the correct code and resubmit the ECF. If the code is correct, resubmit the ECF with appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) for review and considered for payment.
768	ADMIT DIAGNOSIS CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA65 – Incomplete/invalid admitting diagnosis.	Medicaid requires the complete diagnosis code as specified in the current edition of the ICD-9-CM manual, (including fifth digit sub-classification when listed). Check the diagnosis code in the ICD-9 manual. Mark through the existing code and write in the correct code on the ECF and resubmit.
769	ASST. SURGEON NOT ALLOWED FOR PROC CODE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Procedure does not allow reimbursement for an assistant surgeon. If the edit appears unjustified or an assistant surgeon was medically necessary, attach clinical documentation to the ECF to justify the assistant surgeon and resubmit for review and consideration for payment.
771	PROV NOT CERTIFIED TO PERFORM THIS SERV	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		**CMS-1500 CLAIM:** Verify the procedure code in field 17. If correct, attach FDA certificate to the ECF and resubmit. If you are not a certified mammography provider, or a lab provider, this edit code is not correctable.

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Edit Code	Description	CARC	RARC	Resolution
773	INAPPROPRIATE PROCEDURE CODE USED	16 – Claim/service lacks information which is needed for adjudication.	M51 – Incomplete/invalid, procedure code(s) and/or rates, including "not otherwise classified" or "unlisted" procedure codes submitted without a narrative description or the description is insufficient. (Add to message by Medicare carriers only: "Refer to the HCPCS Directory. If an appropriate procedure code(s) does not exist, refer to Item 19 on the HCFA-1500 instructions.")	Verify the procedure code in field 17. If incorrect, enter the correct code in field 17 on the ECF and resubmit.
774	LINE ITEM SERV CROSSES STATE FISCAL YEAR	16 – Claim/service lacks information which is needed for adjudication.	N63 – Rebill services on separate claim lines.	Change the units in field 22 to reflect days billed on or before 6/30. Add a line to the ECF to reflect days billed on or after 07/01. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
775	EARLY DELIVERY < 39 WEEKS NOT MEDICALLY NECESSARY	50 – These are non-covered services because this is not deemed a "medical necessity" by the payer.		For review and consideration for payment, attach appropriate clinical documentation (medical necessity, entire obstetrical records, radiology, laboratory, and pharmacy records) to substantiate the services being billed and resubmit the ECF.
778	SEC CARRIER PRIOR PAYMENT NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	Prior payment (field 54) for a carrier secondary to Medicaid should not appear on claim. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.

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Edit Code	Description	CARC	RARC	Resolution
780	REVENUE CODE REQUIRES PROCEDURE CODE	16 – Claim/service lacks information which is needed for adjudication.	M51 – Incomplete/invalid, procedure code(s) and/or rates, including "not otherwise classified" or "unlisted" procedure codes submitted without a narrative description or the description is insufficient. (Add to message by Medicare carriers only: "Refer to the HCPCS Directory. If an appropriate procedure code(s) does not exist, refer to Item 19 on the HCFA-1500 instructions.")	Some revenue codes (field 42) require a CPT/HCPCS code in field 44. Enter the appropriate CPT/HCPCS code in field 44 on the ECF and resubmit. A list of revenue codes that require a CPT/HCPCS code is located under the outpatient hospital section in the provider manual.
786	ELECTIVE ADMIT,PROC REQ PRE-SURG JUSTIFY	197 – Precertification / authorization/ notification absent.		When type of admission (field 14) is elective, and the procedure requires prior authorization, a prior authorization number from QIO must be entered in field 63. Make the appropriate correction to the ECF and resubmit. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
791	PRIN SURG PROC NOT CLASSED-MANUAL REVIEW	16 – Claim/service lacks information which is needed for adjudication.	M85 – Subjected to review of physician evaluation and management services.	Verify that the correct procedure code was entered in field 74. If the procedure code on the ECF is incorrect, make the appropriate corrections and resubmit the ECF. If correct, resubmit the ECF with appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) for review and consideration for payment. If the ECF cannot be corrected, submit a new claim.
792	OTHER SURG PROC NOT CLASSED - MANUAL REV	16 – Claim/service lacks information which is needed for adjudication.	M85 – Subjected to review of physician evaluation and management services.	Follow the resolution for edit code 791. The two digits in front of the edit identify which other procedure code has not been classed.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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Edit Code	Description	CARC	RARC	Resolution
794	PRINCIPAL MINOR SURGICAL PROCEDURE REQUIRES QIO APPROVAL	16 – Claim/service lacks information which is needed for adjudication.	N241 – Incomplete/invalid review organization approval.	Prior authorization is required from QIO. Enter PA number in field 63 and resubmit the ECF. If the ECF cannot be corrected, submit a new claim with the corrected information. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
795	SURG RATE CLASS/NOT ON FILE-NOT COV DOS	16 – Claim/service lacks information which is needed for adjudication.	N65 – Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	Verify that the correct procedure code and date of service was entered. If the procedure code and date of service on the ECF is incorrect, make corrections and resubmit. If code is correct, resubmit the ECF with appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) for review and consideration for payment. If the ECF cannot be corrected, submit a new claim.
796	PRINC DIAG NOT ASSIGNED LEVEL-MAN REVIEW	133 – The disposition of this claim/service is pending further review.		Verify that the correct diagnosis code (field 67) was submitted. If incorrect, make the appropriate change to the ECF and resubmit. If correct, attach appropriate clinical documentation to support the diagnosis to the ECF for review and consideration for payment and resubmit.
797	OTHER DIAG NOT ASSIGNED LEVEL-MAN REVIEW	133 – The disposition of this claim/service is pending further review.		Follow the resolution for edit code 796. The two digits in front of the edit code identify which other diagnosis code has not been assigned a level. If correct, attach appropriate clinical documentation to support the diagnosis to the ECF for review and consideration for payment and resubmit.
798	SURGERY PROCEDURE REQUIRES PA# FROM QIO	197 – Precertification/ authorization/ notification absent.	N241 – Incomplete/invalid review organization approval.	**CMS-1500 CLAIM:** Contact QIO for authorization number. Enter authorization number in field 3 on the ECF and resubmit. **UB CLAIM:** Contact QIO for authorization number. Enter authorization number in field 63 on the ECF and resubmit. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.

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Edit Code	Description	CARC	RARC	Resolution
799	OP PRIN/OTHER PROC REQ QIO APPROVAL	197 – Precertification/ authorization/ notification absent.	N241 – Incomplete/invalid review organization approval.	Prior authorization is required from QIO. Enter PA number in field 63. Make the appropriate correction to the ECF and resubmit. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
808	HEALTH OPPORTUNITY ACCOUNT (HOA) IN DEDUCTIBLE PERIOD	A1 – Claim/Service denied.	MA07 – The claim information has also been forwarded to Medicaid for review.	Attach supporting documentation to the ECF to indicate the recipient's HOA status and deductible payments and resubmit for review and consideration for payment. If corrections are needed, make the appropriate corrections to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
820	SERVICES REQUIRE ICORE PA-PA MISSING OR NOT ON FILE	15–The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62–Missing/incomplete/invalid treatment authorization code.	Service Requires Prior Authorization from ICORE prior to rendering the service. No authorization number is on the claim or the authorization number is not on file for the recipient on the claim. If the authorization number is missing, add it to the claim and resubmit. If an authorization number is on the claim, the number needs to be reviewed and updated. Contact ICORE for the system to be updated. After ICORE has updated the system, submit a new claim. **CMS-1500 CLAIM:** Enter authorization number in field 3 on the ECF and resubmit. **UB CLAIM:** Enter authorization number in field 63 on the ECF and resubmit. If the prior authorization number was not obtained from ICORE prior to rendering the service, you will not be considered for payment. Contact ICORE for consideration for payment for retroactive eligibility and emergency services.

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Edit Code	Description	CARC	RARC	Resolution
821	SERVICES REQUIRE ICORE PA–PA ON CLAIM NOT VALID	15–The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62–Missing/incomplete/invalid treatment authorization code.	Service Requires Prior Authorization from ICORE and the Prior Authorization on claim is not valid. Compare the Prior Authorization received from ICORE to the ECF to determine if there are any differences. For example, check the date of service/date of admission on the ECF to see if it is within the service authorization dates for the PA and if the PA number on the claim matches the ICORE letter. If changes are needed, make the appropriate corrections to the ECF and resubmit. If the PA number and authorization date(s) on the ECF match the ICORE PA letter; attach the ICORE PA letter to the ECF for review and consideration for payment and resubmit. **CMS-1500 CLAIM:** Enter the valid authorization number in field 3 on the ECF and resubmit. **UB CLAIM:** Enter the valid authorization number in field 63 on the ECF and resubmit. If the prior authorization number was not obtained from ICORE prior to rendering the service, you will not be considered for payment. Contact ICORE for consideration for payment for retroactive eligibility and emergency services.

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Edit Code	Description	CARC	RARC	Resolution
837	SERVICE REQUIRES QIO PA–PA MISSING OR NOT ON FILE	15–The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62–Missing/incomplete/ invalid treatment authorization code.	Service Requires Prior Authorization from the QIO prior to rendering the service. No authorization number is on the claim or the authorization number is not on file for the recipient on the claim. If the authorization number is missing, add it to the claim and resubmit. If an authorization number is on the claim, the number needs to be reviewed and updated. Contact the QIO for the system to be updated. After the QIO has updated the system, submit a new claim. CMS-1500 CLAIM: Enter authorization number in field 3 on the ECF and resubmit. UB CLAIM: Enter authorization number in field 63 on the ECF and resubmit. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.

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Edit Code	Description	CARC	RARC	Resolution
838	SERVICE REQUIRES QIO PA – PA ON CLAIM NOT VALID	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62 – Missing/incomplete/ invalid treatment authorization code.	Service Requires Prior Authorization from the QIO and the Prior Authorization on claim is not valid. Compare the Prior Authorization received from the QIO to the ECF to determine if there are any differences. For example, check the date of service/date of admission on the ECF to see if it is within the service authorization dates for the PA and if the PA number on the claim matches the QIO PA letter. If changes are needed, make the appropriate corrections to the ECF and resubmit. If the PA number and authorization date(s) on the ECF match the QIO PA letter; attach the QIO PA letter to the ECF for review and consideration for payment and resubmit. **CMS-1500 CLAIM:** Enter the valid authorization number in field 3 on the ECF and resubmit. **UB CLAIM:** Enter the valid authorization number in field 63 on the ECF and resubmit. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
839	IP ADMISSION REQUIRES QIO PA – PA MISSING OR NOT ON FILE	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62 – Missing/incomplete/ invalid treatment authorization code.	IP Admission Requires Prior Authorization from the QIO for claims with dates of admission on or after June 15, 2012. No prior authorization number on the ECF or authorization number is not on file for the recipient on the ECF. If the authorization number is missing, add it to the ECF and resubmit. If an authorization number is on the claim, the number needs to be reviewed and updated. **UB CLAIM:** Contact QIO for authorization number. Enter authorization number in field 63 on the ECF and resubmit. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.

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Edit Code	Description	CARC	RARC	Resolution
840	RADIOLOGY SERVICES REQUIRE PA – PA MISSING OR NOT ON FILE	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62 – Missing/incomplete/invalid treatment authorization code.	**CMS-1500 CLAIM: If** the prior authorization number does not appear in field 3 please make the correction on the ECF by entering the prior authorization number in field 3 and resubmit the ECF. **UB CLAIM**: Enter the prior authorization number in field 63 and resubmit. If the prior authorization is correct, attach documentation (DHHS Form 945 Verification of Retroactive Eligibility or documentation on MedSolutions letterhead) to the ECF and resubmit for review and consideration for payment.
841	RADIOLOGY SERVICES REQUIRE PA – PA ON CLAIM IS NOT VALID	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62 – Missing/incomplete/invalid treatment authorization code.	**CMS-1500 CLAIM: If** the prior authorization number in field 3 is incorrect, draw a line through the incorrect prior authorization number and enter the correct prior authorization number and resubmit the ECF. **UB CLAIM**: Enter the correct prior authorization number in field 63 and resubmit. If the prior authorization is correct, attach documentation (DHHS Form 945 Verification of Retroactive Eligibility or documentation on MedSolutions letterhead) to the ECF and resubmit for review and consideration for payment.
843	RTF SERVICES REQUIRE PA	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.		Enter the prior authorization number from DHHS Form 257 to the ECF in field 63 and resubmit. Contact the referring state agency to obtain the prior authorization number.
844	IMD SERVICES REQUIRE PA	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.		Enter the prior authorization number from DHHS Form 257 to the ECF in field 63 and resubmit. Contact the referring state agency to obtain the prior authorization number.

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Edit Code	Description	CARC	RARC	Resolution
845	BH SERVICES REQUIRE PA	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.		Enter the prior authorization number from DHHS Form 254 to the ECF in field 3 and resubmit. If a PA number is on the ECF, check to be sure the PA number matches the number on the DHHS Form 254. If incorrect, make the appropriate corrections and resubmit the ECF. Contact the referring state agency or QIO to obtain the prior authorization number.
850	HOME HEALTH VISITS FREQUENCY EXCEEDED	B1 – NON-Covered visits.		The frequency for visits has exceeded the allowed amount. If there is an error, make the appropriate correction to the ECF and resubmit if the dates of service are prior to October 1, 2012. Effective for dates of service on and after October 1, 2012, prior authorization is required from the QIO. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment.
851	DUP SERVICE, PROVIDER SPEC and DIAGNOSIS	18 – Duplicate Claim/service.		Verify that the procedure code and the diagnosis code were billed correctly. If incorrect, make the appropriate corrections to the ECF and resubmit. If correct, the first provider will be paid. The second provider of the same practice specialty will not be reimbursed for services rendered for the same diagnosis. If the 2nd provider should be reviewed and considered for payment, attach appropriate clinical documentation to the ECF which substantiates the services rendered and resubmit.

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Edit Code	Description	CARC	RARC	Resolution
852	DUPLICATE PROV/ SERV FOR DATE OF SERVICE	B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.		1. Review the ECF for payment date, which appears within a block named Claims/Line Payment Information, on the right side under other edit information. 2. Check the patient's financial record to see whether payment was received. If so, discard the ECF. 3. If two or more of the same procedures were performed on the same date of service and you only received payment for the first date of service, initiate a void and replacement claim to void the original paid claim and replace with the corrected information on the replacement claim. 4. If a void and replacement claim cannot be done, attach supporting documentation to the ECF and resubmit for review and consideration for payment. 5. If two or more of the same procedures were performed on the same date of service by different individual providers, attach appropriate clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the ECF for review and consideration for payment and resubmit. Please refer to your manual for further instructions on Void and Replacement claims. **FOR PHYSICIANS:** 1. Review the ECF for payment date, which appears within a block named Claims/Line Payment Information, on the right side under other edit information. 2. Check the patient's financial record to see if payment was received. If so, discard the ECF. 3. If two or more of the same procedures were performed on the same date of service and only one procedure was paid, make the appropriate change to the modifier (field 18) to indicate a repeat procedure. Refer to your manual for applicable modifiers. 4. Initiate a void and replacement claim as indicated above.

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Edit Code	Description	CARC	RARC	Resolution
853	DUPLICATE SERV/DOS FROM MULTIPLE PROV	B20 – Payment adjusted because procedure/ service was partially or fully furnished by another provider.		Medicaid will not reimburse a physician if the procedure was also performed by a laboratory, radiologist, or a cardiologist. If none of the above circumstances apply, attach appropriate clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the ECF for review and consideration for payment and resubmit. Verify that the procedure code and date of service were billed correctly. If incorrect, make the appropriate corrections to the ECF and resubmit. If correct, this indicates that the first provider was paid and additional providers should attach appropriate clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the ECF for review and consideration for payment and resubmit.
854	VISIT WITHIN SURG PKG TIME LIMITATION	16 – Claim/service lacks information which is needed for adjudication.	M144 – Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	If the visit is related to the surgery and is the only line on the ECF, disregard the ECF. The visit will not be paid. If the visit is related to the surgery and is on the ECF with other payable lines, draw a red line through the line with the 854 edit and resubmit. This indicates you do not expect payment for this line. If the visit is unrelated to the surgical package, enter the appropriate modifier, 24 or 25, in field 18 on the ECF and resubmit.
855	SURG PROC/PAID VISIT/TIME LIMIT CONFLICT	151 – Payment adjusted because the payer deems the information submitted does not support this many services.		If the visit and surgery are related, request recoupment of the visit to pay the surgery. If the visit and surgery are non-related, attach clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the ECF to justify the circumstances and resubmit for review and consideration of payment.
856	2 PRIM SURGEON BILLING FOR SAME PROC/DOS	B20 – Payment adjusted because procedure/ service was partially or fully furnished by another provider.		Check to see if individual provider number (in field 19 on the ECF) is correct, and the appropriate modifier is used to indicate different operative session, assistant surgeon, surgical team, etc. Make appropriate changes to ECF and resubmit. If no modifier is applicable, and field is correct, attach appropriate clinical documentation (i.e., operative notes, etc.) to the ECF for review and consideration for payment and resubmit.

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Edit Code	Description	CARC	RARC	Resolution
857	DUP LINE – REV CODE, DOS, PROC CODE, MODIFIER	18 – Duplicate claim/service.		The two-digit number in front of the edit code identifies which line of field 42 or 44 contains the duplicate code. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. Duplicate revenue or CPT/HCPCS codes should be combined into one line by deleting the whole duplicate line and adding the units and charges to the other line.
858	TRANSFER TO ANOTHER INSTITUTION DETECTED	B20 – Payment adjusted because procedure/ service was partially or fully furnished by another provider.		Check to make sure the dates of service are correct. If there are errors, make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim.
859	DUPLICATE PROVIDER FOR DATES OF SERVICE	18 – Duplicate Claim/service.		Check the claims/line payment info box on the right of your ECF for the dates of previous payments that conflict with this claim. If this is a duplicate claim or if the additional charges do not change the payment amount, disregard the ECF. If additional services were performed on the same day and will result in a different payment amount, complete a replacement claim. If services were not done on the same date of service, a new claim should be filed with the correct date of service. Itemized statements for both the paid claim and new claim(s) with an inquiry form explaining the situation should be attached.
860	RECIP SERV FROM MULTI PROV FOR SAME DOS	B20 – Payment adjusted because procedure/ service was partially or fully furnished by another provider.		This edit most frequently occurs with a transfer from one hospital to another. One or both of the hospitals entered the wrong "from" or "through" dates. Verify the date(s) of service. If incorrect, enter the correct dates of service and resubmit the ECF. Attach appropriate clinical documentation (i.e., discharge summary, transfer document, ambulance document, etc.) to the ECF for review and consideration for payment and resubmit. If the claim has a 618 carrier code in field 50, the claim may be duplicating against another provider's Medicare primary inpatient or outpatient claim, or against the provider's own Medicare primary inpatient or outpatient claim. Attach the Medicare EMB to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.

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Edit Code	Description	CARC	RARC	Resolution
863	DUPLICATE PROV/SERV FOR DATES OF SERVICE	B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.		Check the claims/line payment information box on the right of the ECF for the dates of paid claims that conflict with this claim. If all charges are paid for the date(s) of service disregard ECF. Send a replacement claim, if it will result in a different payment amount. Payment changes usually occur when there is a change in the inpatient DRG or reimbursement type, or a change in the outpatient reimbursement type.
865	DUP PROC/SAME DOS/DIFF ANES MOD	B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.		You have been paid for this procedure with a different modifier. Verify by the anesthesia record the correct modifier. Make appropriate corrections to the ECF, if applicable, and resubmit. If the paid claim is correct, discard the ECF. For review and consideration for payment, attach appropriate clinical documentation to the ECF.
866	NURS HOME CLAIM DATES OF SERVICE OVERLAP	B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80 – Not covered when performed during the same session/date as a previously processed service for patient.	Check the claim/line payment information on the ECF for the dates of paid claims that conflict with this claim. If all charges are paid for the date(s) of service, discard the ECF. Send a replacement claim, if it will result in a different payment amount.
867	DUPLICATE ADJ< ORIGINAL CLM ALRDY VOIDED	18 – Duplicate claim/service		Provider has submitted an adjustment claim for an original claim that has already been voided. An adjustment cannot be made on a previously voided claim. Discard the ECF.
877	SURGICAL PROCS ON SEPERATE CLMS/SAME DOS	B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.		This edit indicates payment has been made for a primary surgical procedure at 100%. The system has identified that another surgical procedure for the same date of service was paid after manual pricing and approval. This indicates a review is necessary to ensure correct payment of the submitted claim. Make corrections to the ECF by entering appropriate modifiers to indicate different operative sessions, assistant surgeon, surgical team, etc. Attach appropriate clinical documentation to the ECF for review and consideration for payment and resubmit.

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Edit Code	Description	CARC	RARC	Resolution
883	CARE CALL SERVICE BILLED OUTSIDE THE CARE CALL SYSTEM	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N30 – Recipient ineligible for this service.	This edit cannot be manually corrected. The provider needs to submit billing through the Care Call System. Discard the ECF.
884	OVERLAPPING PROCEDURES (SERVICES) SAME DOS/SAME PROVIDER	B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80 – Not covered when performed during the same session/date as a previously processes service for patient.	Review the ECF for the payment date, listed under Claims/Line Payment Information. Check the patient's financial records to see whether payment was received. If payment was received, discard the ECF. If the claim/service is incorrect, void the claim and submit a new claim with the corrected information. For review and consideration, attach appropriate clinical documentation to substantiate the services being billed and resubmit the ECF.
885	PROVIDER BILLED AS ASST and PRIMARY SURGEON	B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.		Verify which surgeon was primary and which was the assistant. Check the individual provider number in field 19. The modifier may need correcting to indicate different operative sessions, surgical team, etc. Make appropriate corrections to the ECF and resubmit. Attach applicable clinical documentation to the ECF for review and consideration for payment and resubmit, if applicable. If you have been paid incorrectly as a primary and/or assistant surgeon, void the paid claim and submit a new claim with the corrected information.
887	PROV SUBMITTING MULT CLAIMS FOR SURGERY	B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment		First check your records to see if this claim has been paid. If it has, discard the ECF. If multiple procedures were performed and some have been paid, attach appropriate clinical documentation (i.e., Medicare EOB, sterilization consent forms, etc.) and remittance advice from original claim to ECF and resubmit for review. If two surgical procedures were performed at different times on this DOS (two different operative sessions), correct the ECF (in red) by entering the modifier 78 or 79 and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.

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Edit Code	Description	CARC	RARC	Resolution
888	DUP DATES OF SERVICE FOR EXTENDED NH CLM	B13 – Previously Paid. Payment for this claim/service may have been provided in a previous payment.	M80 – Not covered when performed during the same session/date as a previously processed service for patient.	Check your records to see if this claim has been paid. If this is a duplicate claim, disregard the ECF. If additional services were performed on the same day and will result in a different payment amount, complete a replacement claim. If services were not rendered on the same date of service, make the appropriate corrections and resubmit the ECF or submit a new claim with the corrected information.
889	PROVIDER PREVIOUSLY PD AS AN ASST SURGEON	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		Verify which surgeon was primary and which was the assistant. If the surgeon has been paid as the assistant, and was the primary surgeon, void the paid claim and submit a new claim with the corrected information. If a review is needed, attach applicable clinical documentation to the ECF for review and consideration for payment and resubmit.
892	DUP DATE OF SERVICE,PROC/MOD ON SAME CLM	18 – Duplicate claim/service.		**CMS-1500 CLAIM:** If duplicate services were not provided, mark through the duplicate line on the ECF. If duplicate services were provided, verify whether the correct modifier was billed. If not, make the correction in field 18 on the ECF and resubmit. If duplicate services were provided and the correct duplicate modifier was billed, attach support clinical documentation and resubmit the ECF for review and consideration for payment.
893	CONFLICTING AA/QK MOD SUBMITTED SAME DOS	B20 – Payment adjusted because procedure/ service was partially or fully furnished by another provider.		Claims are conflicting for the same date of service regardless of the procedure code, one with AA modifier and one with QK/QY modifier. Verify the correct modifier and/or procedure code for the date of service by the anesthesia record. Make the appropriate correction to the ECF and resubmit. Attach applicable clinical documentation to the ECF for review and consideration for payment and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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Edit Code	Description	CARC	RARC	Resolution
894	CONFLICTING QX/QZ MOD SUBMITTED SAME DOS	B20 – Payment adjusted because procedure/ service was partially or fully furnished by another provider.		Claims are conflicting for the same date of service regardless of the procedure code, one with QX modifier and one with QZ modifier. Verify by the anesthesia record if the procedure was rendered by a supervised or independent CRNA. Make the appropriate correction to the ECF and resubmit. Attach applicable clinical documentation to the ECF for review and consideration for payment and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
895	CONFL AA and QX/QZ MOD SAME PROC/DOS	B20 – Payment adjusted because procedure/ service was partially or fully furnished by another provider.		Claims have been submitted by an anesthesiologist as personally performed anesthesia services and a CRNA has also submitted a claim. Verify by the anesthesia record the correct modifier for the procedure code on the date of service. Make the appropriate correction to the ECF and resubmit. Attach applicable clinical documentation to the ECF for review and consideration for payment and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
897	MULT. SURGERIES ON CONFLICTING CLM/DOS	59 – Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.		First check your records to see if this claim has been paid. If it has, discard the ECF. If multiple procedures were performed and some have been paid, attach appropriate clinical documentation (i.e., operative note and remittance from original claim, etc.) to ECF and resubmit for review and consideration for payment. If two surgical procedures were performed at different times on this DOS (two different operative sessions), correct the ECF (in red) by entering the modifier 78 or 79 and resubmit.

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Edit Code	Description	CARC	RARC	Resolution
899	CONFLICTING QK/QZ MOD FOR SAME DOS	B20 – Payment adjusted because procedure/ service was partially or fully furnished by another provider.		Verify by the anesthesia record the correct modifier and procedure code for the date of service. If this procedure was rendered by an anesthesia team, the supervising physician should bill with QK modifier and the supervised CRNA should bill with the QX modifier. The QY modifier indicates the physician was supervising a single procedure. Make the appropriate correction to the ECF and resubmit. Attach applicable clinical documentation to the ECF for review and consideration for payment and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
900	PROVIDER ID IS NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	N77-Missing/incomplete/invalid designated provider number.	Check your records to make sure that the provider ID number on the ECF is correct. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
901	INDIVIDUAL PROVIDER ID NUM NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	N77-Missing/incomplete/invalid designated provider number.	**CMS-1500 CLAIM:** Check your records to make sure that the individual provider ID number in field 19 of the ECF is correct. Enter correct individual ID# in field 19 and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
902	PROVIDER NOT ELIGIBLE ON DATE OF SERVICE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Pay-to-provider was not eligible for date of service or was not enrolled when service was rendered. Verify whether the date of service on ECF is correct. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. For provider's eligibility status, contact Provider Enrollment at 1-888-289-0709. **Note:** If the provider was not eligible on the date of service, you will not be considered for payment. Discard the ECF.

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Edit Code	Description	CARC	RARC	Resolution
903	INDIV PROVIDER INELIGIBLE ON DTE OF SERV	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Verify whether the date of service on ECF is correct. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. For provider's eligibility status, contact Provider Enrollment at 1-888-289-0709. **Note:** If the provider was not eligible on the date of service, you will not be considered for payment. Discard the ECF.
904	PROVIDER SUSPENDED ON DATE OF SERVICE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Verify whether the date of service on ECF is correct. If not, correct and resubmit the ECF. Direct further questions to SCDHHS Program Integrity at (803) 898-2640.
905	INDIVIDUAL PROVIDER SUSPENDED ON DOS	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Verify whether the date of service on ECF is correct. If not, correct and resubmit the ECF. Direct further questions to SCDHHS Program Integrity at (803) 898-2640.
906	PROVIDER ON PREPAYMENT REVIEW	16 – Claim/service lacks information which is needed for adjudication.	N35 – Program Integrity/ utilization review decision.	For assistance, direct questions to SCDHHS Program Integrity at (803) 898-2640.
907	INDIVIDUAL PROVIDER ON PREPAYMENT REVIEW	16 – Claim/service lacks information which is needed for adjudication.	N35 – Program Integrity/ utilization review decision.	For assistance, direct questions to SCDHHS Program Integrity at (803) 898-2640.
908	PROVIDER TERMINATED ON DATE OF SERVICE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Verify whether the date of service on ECF is correct. If not, correct and resubmit the ECF. Direct further questions to SCDHHS Program Integrity at (803) 898-2640.

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Edit Code	Description	CARC	RARC	Resolution
909	INDIVIDUAL PROVIDER TERMINATED ON DOS	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Verify whether the date of service on ECF is correct. If not, correct and resubmit the ECF. Direct further questions to SCDHHS Program Integrity at (803) 898-2640.
911	INDIV PROV NOT MEMBER OF BILLING GROUP	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Verify whether the provider number is correct. If incorrect, make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. If the provider number is correct, contact Provider Enrollment at 1-888-289-0709 to have the individual provider number added to the billing group ID number. After the system has been updated, submit a new claim.
912	PROV REQUIRES PA/NO PA NUMBER ON CLAIM	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.		Prior authorization approval is required. If the authorization number is missing, enter the correct PA number on the ECF and resubmit. If you do not have a PA number, attach the authorization approval letter to the ECF and resubmit. For emergency services, attach the appropriate clinical documentation to the ECF for review and consideration for payment and resubmit.
914	INDIV PROV REQUIRES PA/NO PA NUM ON CLM	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.		Prior authorization approval is required. If the authorization number is missing, enter the correct PA number on the ECF and resubmit. If you do not have a PA number, attach the authorization approval letter to the ECF and resubmit. For emergency services, attach the appropriate clinical documentation to the ECF for review and consideration for payment and resubmit.
915	GROUP PROV ID/NO INDIV ID ON CLAIM/LINE	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	**CMS-1500 CLAIM:** Verify the rendering individual physician and enter his or her provider ID number in field 19 on ECF and resubmit.
916	CRD PRIM DIAG CODE/PROV NOT CERTIFIED	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Verify the correct primary diagnosis code. Make the appropriate corrections to the ECF and resubmit. Attach clinical documentation to the ECF for review and consideration for payment and resubmit, if applicable. If the ECF cannot be corrected, submit a new claim with the corrected information.

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Edit Code	Description	CARC	RARC	Resolution
917	CRD SEC DIAG CODE/PROV NOT CERTIFIED	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Verify the correct secondary diagnosis code. Make the appropriate corrections to the ECF and resubmit. Attach clinical documentation to the ECF for review and consideration for payment and resubmit, if applicable. If the ECF cannot be corrected, submit a new claim with the corrected information.
918	CRD PROCEDURE CODE/PROV NOT CERTIFIED	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Verify the correct procedure code. Make the appropriate corrections to the ECF and resubmit. Attach clinical documentation to the ECF for review and consideration for payment and resubmit, if applicable. If the ECF cannot be corrected, submit a new claim with the corrected information.
919	NO PA# ON CLM/PROV OUT OF 25 MILE RADIUS	40 – Charges do not meet qualifications for emergent/urgent care.		Prior authorization approval is required for services outside of the SC Medicaid service area. If the authorization number is missing, enter the correct PA number on the ECF and resubmit. If you do not have a PA number, attach the authorization approval letter to the ECF and resubmit. For emergency services, attach the appropriate clinical documentation to the ECF for review and consideration for payment and resubmit.
920	Transportation Service is covered by Contractual Transportation Broker / not covered fee-for-service	109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.	N157 – Transportation to/from this destination is not covered.	The transportation service is covered by a Contractual Transportation Broker and not fee-for-service by Medicaid. Contact the recipient's contracted provider for payment.
921	Ambulance service is payable by Contractual Transportation Broker / not covered fee-for-service	109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.	N157 – Transportation to/from this destination is not covered.	The ambulance service is covered by a Contractual Ambulance Broker and not fee-for-service by Medicaid. Contact the recipient's contracted provider for payment.
922	URGENT SERVICE/OOS PROVIDER	16 – Claim/service lacks information which is needed for adjudication.	MA07 – The claim information has also been forwarded to Medicaid for review.	Verify the urgent service/out-of-state provider requirements were followed. Attach the appropriate clinical documentation to the ECF for review and consideration for payment and resubmit.

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Edit Code	Description	CARC	RARC	Resolution
923	PROVIDER TYPE / CAT. INCONSIST W/ LEVEL OF CARE	150 – Payment adjusted because the payer deems the information submitted does not support this level of service.		Verify that the provider information, procedure code and level of care are correct. If not, make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. Refer to the applicable provider manual for appropriate provider type and level of care.
924	RCF PROV/RECIP PAY CAT NOT 85 OR 86	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	Check the recipient's eligibility to verify the payment category for the date of service that was rendered. If the ECF is incorrect, make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. Attach a copy of the recipient's eligibility screen to indicate the payment category (85 or 86) to the ECF for review and consideration for payment and resubmit.
925	AGES > 21 &< 65 / IMD HOSPITAL NON-COVERED	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	Check the claim to make sure the recipient's age is from 21-64. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. Attach appropriate clinical documentation (i.e., admission forms/ psychiatric prior authorizations, etc.), to the ECF for review and consideration for payment and resubmit.
926	AGE 21-22/MENTAL INST SERV N/C - MAN REV	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	Check the claim to make sure the recipient's age is from 21-22. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. Attach appropriate clinical documentation (i.e., admission forms/ psychiatric prior authorizations, etc.), to the ECF for review and consideration for payment and resubmit.
927	PROVIDER NOT AUTHORIZED AS HOSPICE PROV	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Provider was not authorized or enrolled as a hospice provider when service was rendered and will not be considered for payment. For provider's enrollment or eligibility status, contact Provider Enrollment at 1-888-289-0709.

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Edit Code	Description	CARC	RARC	Resolution
928	RECIP UNDER 21/HOSP SERVICE REQUIRES PA	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.		No authorization number from the referring state agency is on the ECF. Make the appropriate correction and resubmit the ECF. Attach appropriate clinical documentation to the ECF for review and consideration for payment and resubmit, if applicable.
929	NON QMB RECIPIENT	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	Provider is Medicare only provider attempting to bill for a non-QMB (Medicaid only) recipient. Medicaid does provide reimbursement to QMB providers for non-QMB recipients.
932	PAY TO PROV NOT GROUP/LINE PROV NOT SAME	16 – Claim/service lacks information which is needed for adjudication.	N77-Missing/incomplete/invalid designated provider number.	Verify provider ID and/or NPI in field 1 is the same as the Provider ID and/or NPI on the line(s). If not, strike through the incorrect provider ID and/or NPI and enter the correct information in the appropriate fields on the ECF and resubmit.
933	REV CODE 172 OR 175/NO NICU RATE ON FILE	147 – Provider contracted/negotiated rate expired or not on file.		Verify the correct revenue code was billed. If the revenue code is incorrect, make the appropriate correction to the ECF and resubmit. If the provider was not contracted when the service was rendered, the negotiated rate expired, or the codes were not on file, the edit is valid and will not be considered for payment.
934	PRIOR AUTHORIZATION NH PROV ID NOT AUTHORIZED	15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.		Enter the correct Nursing Facility Provider number in field #3 on the ECF (Prior Authorization) and resubmit.
935	PROVIDER WILL NOT ACCEPT TITLE 18 (MEDICARE) ASSIGNMENT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Provider cannot bill for services on a beneficiary who is dually eligible. Services can only be billed for beneficiaries who are Medicaid only. Contact Provider Enrollment at 1-888-289-0709 regarding changes to enrollment status.
936	NON EMERGENCY SERVICE/OOS PROVIDER	40 – Charges do not meet qualifications for emergent/ urgent care.		If diagnosis and surgical procedure codes have been coded correctly, this outpatient service is not covered for out-of-state providers. No payment is due from Medicaid.

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Edit Code	Description	CARC	RARC	Resolution
938	PROV WILL NOT ACCEPT TITLE 19 (MEDICAID) ASSIGNMENT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Provider cannot bill for services on a beneficiary who is Medicaid only. Services can only be billed for a beneficiary who is dually eligible. Contact Provider Enrollment at 1-888-289-0709 regarding changes to enrollment status.
939	IND PROV WILL NOT ACCEPT T-19 (MEDICAID) ASSIGNMENT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Provider cannot bill for services on a beneficiary who is Medicaid only. Services can only be billed for a beneficiary who is dually eligible. Contact Provider Enrollment at 1-888-289-0709 regarding changes to enrollment status.
940	BILLING PROV NOT RECIP IPC PHYSICIAN	CARC 170 - Payment is denied when performed/billed by this type of provider.		Contact that recipient's IPC physician to obtain the authorization for the service. Correct the ECF by entering the authorization number provided by the IPC physician and resubmit.
941	NPI ON CLAIM NOT FOUND ON PROVIDER FILE	208 – National Provider Identifier – Not matched.	N77 – Missing/incomplete/invalid designated provider number.	Check the NPI on the ECF to ensure it is correct. If so, register the NPI with Provider Enrollment. Medicaid Provider Enrollment Mailing address: PO Box 8809, Columbia, SC 29202-8809 Phone: 1-888-289-0709 Fax: (803) 870-9022
942	INVALID NPI	207 – National Provider Identifier – invalid format.	N77 – Missing/incomplete/invalid designated provider number.	The NPI used on the claim is inconsistent with numbering scheme utilized by NPPES. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information.
943	TYPICAL PROVIDER, NO NPI ON CLAIM	206 – National Provider Identifier – missing.	N77 – Missing/incomplete/invalid designated provider number.	Typical providers must use the NPI and six-character Medicaid Legacy Provider Number or NPI only for each rendering and billing/pay-to provider. When billing with NPI only, the taxonomy code for each rendering and billing/pay-to provider must also be included. Make corrections to the ECF or resubmit a new claim.

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Edit Code	Description	CARC	RARC	Resolution
944	TAXONOMY ON CLAIM HAS NOT BEEN REGISTERED WITH PROVIDER ENROLLMENT FOR THE NPI USED ON THE CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N94 – Claim/service denied because a more specific taxonomy code is required for adjudication.	Either update the taxonomy on the ECF so that it is one that the provider registered with SCDHHS and resubmit the ECF or contact Provider Enrollment to add the taxonomy that is being used on the ECF. Once Provider Enrollment has updated the system, submit a new claim. Medicaid Provider Enrollment Mailing address: PO Box 8809, Columbia, SC 29202-8809 Phone: 1-888-289-0709 Fax: (803) 870-9022
945	PROFESSIONAL COMPONENT REQUIRED FOR PROV	16 – Claim/service lacks information which is needed for adjudication.	N13 – Payment based on professional/technical component modifier(s).	The services were rendered on an inpatient or outpatient basis. Enter a "26" modifier in field 18 on the ECF and resubmit. Services described in this manual do not require a modifier.
946	UNABLE TO CROSSWALK TO LEGACY PROVIDER NUMBER	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	The NPI, taxonomy code, and/or zip code + 4 must be entered on the claim and must match the NPI information that the provider registered with SC Medicaid. Make the appropriate corrections to the ECF and resubmit or submit a new claim with the corrected information. Contact Provider Enrollment at 1-888-289-0709 to verify the NPI information which was registered or to make any updates to the NPI information contained on the provider's file.
947	ATYPICAL PROVIDER AND NPI UTILIZED ON THE CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Atypical providers must continue to use their legacy number on the claim. Do not include an NPI if you are an atypical provider. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information
948	CONTRACT RATE NOT ON FILE/SERV NC ON DOS	147 – Provider contracted/ negotiated rate expired or not on file.		Review your contract to verify if the correct procedure code/rate and date of service were billed. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. If the procedure code/rate needs to be added, attach appropriate documentation to the ECF for review and consideration for payment and resubmit.
949	CONTRACT NOT ON FILE FOR ELECTRONIC CLAIMS	16 – Claim/service lacks information which is needed for adjudication.	N51-Electronic interchange agreement not on file for provider/submitter.	Contact the EDI Support Center at 1-888-289-0709 for further assistance.

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Edit Code	Description	CARC	RARC	Resolution
950	RECIPIENT ID NUMBER NOT ON FILE	31 – Claim denied, as patient cannot be identified as our insured.		**CMS-1500 CLAIM:** Check the patient's Medicaid number in field 2 of the ECF to make sure it was entered correctly. Remember, the patient's Medicaid numbers is 10 digits (no alpha characters). If the number on the ECF is different than the number in the patient's file, mark through the incorrect number and enter the correct number above field 2 and resubmit. If there is a discrepancy with the patient's Medicaid ID, contact the Medicaid Eligibility office in the patient's county of residence to correct the number on the patient's file. After the county Medicaid Eligibility office has updated the system, submit a new claim. **UB CLAIM:** Check the patient's Medicaid number in field 60 of the ECF to make sure it was entered correctly. Remember, the patient's Medicaid number is 10 digits (no alpha characters). If the number on the ECF is different than the number in the patient's file, mark through the incorrect number and enter the correct number above field 60 and resubmit. If there is a discrepancy with the patient's Medicaid ID, contact the Medicaid Eligibility office in the patient's county of residence to correct the number on the patient's file. After the county Medicaid Eligibility office has updated the system, submit a new claim.
951	RECIPIENT INELIGIBLE ON DATES OF SERVICE	26 – Expenses incurred prior to coverage terminated.		Always check the patient's Medicaid eligibility on each date of service. Medicaid eligibility may change. If the patient was eligible, contact your county Medicaid Eligibility office and have them update the patient's Medicaid eligibility on the system. After the county Medicaid Eligibility office has updated, submit a new claim. If the patient was not eligible for Medicaid on the date of service, the patient is responsible for your charges. If the patient was eligible for some but not all of your charges, mark through the lines when the patient was ineligible.
952	RECIPIENT PREPAYMENT REVIEW REQUIRED	15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.		Verify the correct prior authorization number. If the authorization number is incorrect, make the appropriate correction to the ECF and resubmit. Attach appropriate documentation to the ECF for review and consideration for payment and resubmit, if applicable.

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Edit Code	Description	CARC	RARC	Resolution
953	BUYIN INDICATED - POSSIBLE MEDICARE	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	**CMS-1500 CLAIM:** File with Medicare first. If this has already been done, enter the Medicare carrier code, Medicare number, and Medicare payment in fields 24, 25, 26, and 28 on the ECF and resubmit. If no payment was made, enter '1' in field 4 and resubmit. **UB CLAIM:** (Inpatient/Outpatient): File with Medicare first. If this has already been done, enter the Medicare carrier code, Medicare number, and Medicare payment in fields 50, 54, 60. If no payment was made, enter 0.00 in field 54 and occurrence code 24 or 25 in fields 32A – 35B and the date Medicaid denied. Make the correction to the ECF and resubmit a new claim with the corrected information. **UB CLAIM:** (Inpatient Only): Attach the Medicare EOMB to the ECF, if Medicare (Part A) benefits are exhausted or non-existent, prior to admission and patient is still in the same spell of illness, enter the 620 carrier code in field 50, enter the Medicare ancillary payment(s) in field 54A and enter the recipient's Medicare ID in field 60A and resubmit the ECF or submit a new claim with the corrected information and the Medicare EOMB.
954	RURAL BEHAVIORAL HLTH. SERVICES	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	The recipient is enrolled in the Rural Behavioral Health Services program and is not eligible for this service.
955	RURAL BEHAVIORAL HLTH. RECIP/SERV	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		The recipient is enrolled in the Rural Behavioral Health Services program and the rendering provider is not eligible for this service.
956	PROVIDER NOT RURAL BEHAVIORAL HLTH. SERV	CARC B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		The recipient is enrolled in the Rural Behavioral Health Services program and the rendering provider is not the Rural Behavioral Health Services provider.
957	DIALYSIS PROC CODE/PAT NOT CIS ENROLLED	16 – Claim/service lacks information which is needed for adjudication.	N188 – The approved level of care does not match the procedure code submitted.	Attach the ESRD enrollment form (Form 218) for the first date of service to ECF and resubmit.

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Edit Code	Description	CARC	RARC	Resolution
958	IPC DAYS EXCEEDED OR NOT AUTH ON DOS	B5 -Payment adjusted because coverage/program guidelines were not met or were exceeded.		Integrated Personal Care services are authorized with start and end dates of service. Compare the ECF to make sure the time frames are correct. If the start and end dates of service are incorrect, make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. Attach a copy of the service provision form and/or any applicable DHHS forms to the ECF for review and consideration for payment and resubmit.
960	EXCEEDS ESRD M'CARE 90 DAY ENROLL PERIOD	16 – Claim/service lacks information which is needed for adjudication.	MA92 – Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	For review and consideration for payment, attach the letter or document from the Social Security Administration (SSA) denying benefits to the ECF and resubmit.
961	RECIP NOT ELIG FOR NH TRANSITION	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	The recipient was not eligible when service was rendered and the provider will not be considered for payment.
964	FFS CLAIM FOR SLMB/QDWI RECIP NOT CVRD	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	Medicaid pays Medicare premiums only for recipients in these Medicaid payment categories. Fee-for-service Medicaid claims are not reimbursed.
965	PCCM RECIP/PROV NOT PCP-PROC REQ REFERAL	CARC 243 - Services not authorized by network/primary care providers.	N54-Claim information is inconsistent with pre-certified/ authorized services	**CMS 1500 CLAIM:** Contact the recipient's primary care physician (PCP) and obtain authorization for the procedure. Make the correction on the ECF by entering the authorization number provided by the PCP in field 7 (Primary Care Coordinator) and resubmit the ECF. **UB CLAIM:** Contact the recipient's primary care physician (PCP) and obtain authorization for the procedure. Make the correction on the ECF by entering the authorization number provided by the PCP in field 63 (Treatment Authorization Code) and resubmit the ECF.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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Edit Code	Description	CARC	RARC	Resolution
966	RECIP NOT ELIP FOR VENT WAIVER SERV	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	The claim was submitted with a Mechanical Ventilator Dependent Waiver (MVDW) specific procedure code, but the patient was not a participant in the MVDW. Verify the procedure code and Medicaid ID number. If incorrect, make the appropriate corrections and resubmit the ECF. If the patient Medicaid ID number is correct, the procedure code is correct and a MVDW form has been obtained, contact the service coordinator listed at the bottom of the waiver form. Once the system has been updated, submit a new claim.
967	RECIP NOT ELIG. FOR HD and SPINAL SERVICES	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	The claim was submitted with a Head and Spinal Cord Injured (HASCI) waiver-specific procedure code, but the patient was not a participant in the HASCI waiver. Verify the procedure code and Medicaid ID number. If incorrect, make the appropriate corrections and resubmit the ECF. If the patient Medicaid ID number is correct, the procedure code is correct and the HASCI waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form. Once the system has been updated, submit a new claim.
969	RECIP NOT ELIG. FOR ROOM AND BOARD	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	This edit will occur only when billing for procedure code H0043. Check the PA number in field 3 of the ECF to ensure it matches the PA number on the authorization form. You may not bill room and board charges through Medicaid. Mark through this line in red. Deduct the charge from the total charge. Mark through both the Total Charge, field 27, and Balance Due, field 29, and enter the corrected amount for both and resubmit the ECF. Be sure to make this correction in red. If the PA number on the ECF is correct, contact the local MTS office to determine if appropriate notification has been made to the MTS state office. Ask for the date the child's eligibility went into effect to ensure it corresponds with the dates of service for which you are billing. If the dates correspond and no corrections are necessary, submit a new claim. If the dates do not correspond, ask the case manager to update the child's eligibility to correspond to the authorization dates on the DHHS Form 257 you were provided and submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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Edit Code	Description	CARC	RARC	Resolution
970	HOSPICE SERV/RECIP NOT ENROLLED FOR DOS	16 – Claim/service lacks information which is needed for adjudication.	N143 – The patient was not in a hospice program during all or part of the service dates billed.	Service is hospice. Recipient is not enrolled in hospice for the date of service.
974	RECIP IN HMO/HMO COVERS FIRST 90 DAYS	24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		If you are a provider with the HMO plan, bill the HMO for the first 90 days.
975	PACE PARTICIPANT/ALL SERVICES PROVIDED BY PACE	109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.		Contact recipient's PACE organization.
976	HOSPICE RECIPIENT/ SERVICE REQUIRES PA	B9 – Services not covered because the patient is enrolled in a Hospice.		**CMS-1500 CLAIM:** Use the SCDHHS Web Tool to determine who the Hospice provider is. Contact the hospice provider to obtain the prior authorization number. Enter the authorization number in field 7 on the ECF resubmit. **UB CLAIM:** Use the SCDHHS Web Tool to determine who the Hospice provider is. Contact the hospice provider to obtain the prior authorization number. Enter the authorization number in field 63 on the ECF resubmit.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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Edit Code	Description	CARC	RARC	Resolution
977	FREQUENCY FOR AMBULATORY VISITS EXCEEDED	B1 – Non-covered visits.		Exceptions may be made to this edit under the following criteria: 1. An ECF must be returned within six months of the rejection with a copy of verification of coverage attached indicating ambulatory visits were available for the date of service being billed. The availability of ambulatory visits must have been verified on the actual date of service being billed or the day before. 2. If the visit code was a line item rejection and other services paid on the claim, the provider must file a new claim within six months of the rejection with a copy of verification of coverage indicating ambulatory visits were available for the date of service being billed. The availability of ambulatory visits must have been verified on the actual date of service being billed or the day before. 3. All timely filing requirements must be met. A provider has two options: Bill the patient for the non-covered office visit only. Medicaid will reimburse lab work, injections, x-rays, etc., done in addition to the office visit, **or** Change the office visit code in field 17 to the minimal established office E/M code, 99211, and accept the lower reimbursement. This code does not count toward the ambulatory visits.
978	FREQUENCY FOR IP HOSPITAL VISITS EXCEEDED	B1 – Non-covered visits.		The frequency for visits has exceeded the allowed amount. If there is an error, make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. For review and consideration for payment of additional visits, attach appropriate clinical documentation to substantiate the services being billed and resubmit the ECF.
979	FREQ. FOR CHIROPRACTIC VISITS EXCEEDED	B1 – Non-covered visits.		The frequency for visits has exceeded the allowed amount. If there is an error, make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. For review and consideration for payment of additional visits, attach appropriate clinical documentation to substantiate the services being billed and resubmit the ECF.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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Edit Code	Description	CARC	RARC	Resolution
980	H HLTH NURS CARE N/C FOR DUAL ELIG RECIP	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	File your claim with the Medicare intermediary.
984	RECIP LIVING ARR INDICATES MEDICAL FAC	5 – The procedure code/bill type is inconsistent with the place of service.	N30 – Recipient ineligible for this service.	Verify patient's place of residence on date of service. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. For review and consideration for payment, attach applicable documentation to the ECF which verifies the place of residence and resubmit.
985	RECIP NOT ELIG FOR CHILDREN'S PCA SERV	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	Check to make sure you have billed the correct Medicaid number, procedure code and that this client is in the CHPC program. If you have not billed the correct Medicaid number or procedure code, or the client is not in the CHPC program, submit a new claim with the corrected information.
986	RECIP NOT ELIG FOR E/D WAIVER SERV	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	The claim was submitted with an Elderly/Disabled Waiver-specific procedure code, but the patient was not a participant in the Elderly/Disabled Waiver. Check the procedure code and Medicaid ID number. If incorrect, make the appropriate corrections to the ECF and resubmit. If the patient Medicaid number is correct, the procedure code is correct, and an Elderly/Disabled Waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form. Once the system has been updated, submit a new claim.
987	RECIP NOT ELIG FOR HIV/AIDS WAIVER SERV	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	The claim was submitted with a HIV/AIDS Waiver-specific procedure code, but the patient was not a participant in the HIV/AIDS Waiver. Check the procedure code and Medicaid ID number. If incorrect, make the appropriate corrections to the ECF and resubmit. If the patient Medicaid number is correct, the procedure code is correct, and a HIV/AIDS Waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form. Once the system has been updated, submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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Edit Code	Description	CARC	RARC	Resolution
988	CRD PROCEDURE/DOS PRIOR TO COVERAGE	26 – Expenses incurred prior to coverage.		Call PSC representative to see what the recipient's first date of treatment is. If dates of service on the ECF are prior to enrollment date, verify enrollment date. If enrollment date is correct, change dates on ECF and resubmit. If enrollment date is wrong, the recipient's file will need to be updated. Attach a new enrollment form (DHHS Form 218) to the ECF along with the first claim and resubmit.
989	RECIP IN HMO PLAN/SERV COVERED BY HMO	24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		If you are a provider with the HMO plan, bill the HMO for the equipment or supply. Discard the ECF. If you have an EOB denial from the MCO, attach a copy of the ECF and resubmit.
990	FP RECIP/SERVICE IS NOT FP	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	Make sure the Medicaid ID number matches the patient served. Check the diagnosis code(s), procedure code(s), and/or modifier to ensure the correct codes were billed. If incorrect, make the appropriate changes by adding a family planning diagnosis code, procedure code, and/or FP modifier. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. If this service was not directly related to family planning it is non-covered under the Family Planning Waiver and by Medicaid, therefore the patient is responsible for the charges.
991	RECIP ISCEDC/COSY-LIMITED SERVS. COVERED	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	Limited services are covered for this recipient. This is not a covered service.
993	RECIP NOT ELIG FOR PACE SERV	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	The recipient was not eligible for PACE when the service was rendered. Verify that the information on the ECF is correct. If not correct, make corrections to the ECF and resubmit. If the recipient's PACE eligibility status has been updated in the system, submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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Edit Code	Description	CARC	RARC	Resolution
994	RECIP ELIG FOR EMERGENCY SVCS ONLY	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	Recipient is eligible for "emergency medical services" only. Transportation services are non-covered for these recipients.
995	INMATE RECIP ELIG FOR INSTIT. SVCS ONLY	A1 – Claim/Service denied.	N30 – Recipient ineligible for this service.	Recipient eligible for institutional services only. Review the ECF to determine if the services were directly related to institutional services. Make the appropriate correction to the ECF and resubmit. If the ECF cannot be corrected, submit a new claim with the corrected information. If the services are not directly related to institutional services, the services are non-covered and will not be considered for payment. **UB CLAIM:** Only inpatient claims will be reimbursed.

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
754	1199 SEIU NATIONAL BENEFIT FUND	PO BOX 1007	NEW YORK	NY	101081007	6464739200	
710	21ST CENTURY HEALTH AND BENEFITS INC	PO BOX 5037	CHERRY HILL	NJ	08034	8003234890	
B14	A.C.S. CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON SALEM	NC	271022000	3367592013	
B14DN	A.C.S. CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON SALEM	NC	271022000	3367592013	
650	ABBEVILLE COUNTY	-	-	-	-		
266	ACMG ADMINISTRATORS OF SOUTH CAROLINA	2570 TECHNICAL DR.	MIAMISBURG	OH	45342	8002326242	
903	ACORDIA NATIONAL	PO BOX 11064	CHARLESTON	WV	253391064	8004354351	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
355	ACTIVA HEALTH GROUP	4350 E. CAMELBACK RD. # 200	PHOENIX	AZ	85018	6024689500	
341	ADMINISTRATIVE CONCEPTS INC.	994 OLD EAGLE SCHOOL RD STE 1005	WAYNE	PA	19087	8882939229	
563	ADMINISTRATIVE SERVICE CONSULTANTS	3301 E ROYALTON RD. BLDG D	BROADVIEW HEIGHTS	OH	44147		
346	ADMINISTRATIVE SERVICES, INC.	2187 NORTHLAKE PARKWAY STE. 106 BLD #9	TUCKER	GA	30084-	7709343953	
829	ADMINISTRATIVE SOLUTIONS	PO BOX 2490	ALPHARETTA	GA	30023	6783390211	
731	ADOVA HEALTH	PO BOX 725549	ATLANTA	GA	31139	8664704959	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C15	ADVANCE PCS	PO BOX 52188	PHOENIX	AZ	850722196	4803914600	SEE CARRIER 471
D11	ADVANCED BENEFIT SOLUTIONS	PO BOX 71490	PHOENIX	AZ	85050	8884191094	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA MEDICARE SUPPLEMENTAL PLAN
310	ADVANCED DATA SOLUTIONS	PO BOX 723097	ATLANTA	GA	31139	8007425246	
C72	ADVANCED INSURANCE ADMINISTRATION	125 MERRILL DR. STE. 2000	LITTLE ROCK	AR	72211	8882424800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D33	ADVANTRA FREEDOM	PO BOX 7154	LONDON	KY	407427154	8007135095	MEDICARE ADVANTAGE PLAN
C88	ADVENTIST RISK MANAGEMENT	PO BOX 1928	GRAPEVINE	TX	76099	8006380589	
899	AETNA HEALTH PLANS OF THE CAROLINAS INC	3 CENTERVIEW DR.	GREENSBORO	NC	27407	8004591466	HMO PLAN ONLY
A55	AETNA LIFE AND CASUALTY	PO BOX 36890	LOUISVILLE	KY	40232	8004233289	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D16	AETNA MEDICARE OPEN PLAN	PO BOX 14079	LEXINGTON	KY	405124079	8006240756	MEDICARE ADVANTAGE PLAN

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100RX	AETNA PHARMACY	PO BOX 14024	LEXINGTON	KY	40512	8002386279	
100	AETNA US HEALTHCARE	PO BOX 14079	LEXINGTON	KY	40512	8003334432	
100DN	AETNA US HEALTHCARE	PO BOX 14094	LEXINGTON	KY	40512	8004517715	
B43	AFFINITY HEALTH PLAN	PO BOX 981726	EL PASO	TX	799981726	8662475678	
595	AFLAC -AMERICAN FAMILY LIFE ASSO CO	1932 WYNNTON RD.	COLUMBUS	GA	31999	8009923522	
289	AFTRA HEALTH FUND	261 MADISON AVE	NEW YORK	NY	10016	8005624690	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
651	AIKEN COUNTY	-	-	-	-		
455	ALASKA TEAMSTER TRUST	520 E 34TH AVE. STE. 107	ANCHORAGE	AK	995034116	8004784450	CODE ASSIGNED BY SCHA
344	ALIA CLAIMS DEPARTMENT	PO BOX 9060	PHOENIX	AZ	850689060	8008825707	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
299	ALICARE	PO BOX 1447	NEW YORK	NY	10116	2125395115	
200	ALL AMERICAN LIFE INSURANCE CO.	8501 WEST HIGGINS RD.	CHICAGO	IL	60631	7733996645	
199	ALL OTHER CARRIERS	-	-	-	-		
560	ALLEN MEDICAL CLAIMS ADMINISTRATORS	PO BOX 978	FT. VALLEY	GA	310300978	8008255406	
652	ALLENDALE COUNTY	-	-	-	-		
272	ALLIANCE HEALTH BENEFIT PLAN	PO BOX 6443	ROCKVILLE	MD	20850	8003423289	
521	ALLIANCE PPO, INC.	PO BOX 934	FREDERICK	MD	21705	8002350123	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A33	ALLIANT HEALTH PLANS, INC.	PO BOX 21109	ROANOKE	VA	24108	8002834927	
413	ALLIED BENEFITS SYSTEM	PO BOX 909786	CHICAGO	IL	60690	8002882078	
135	ALLIED NATIONAL, INC.	PO BOX 419233	KANSAS CITY	MO	641416233	8008257531	CARRIER WAS ALLIED GROUP INSURANCE TRUST
115	ALLSTATE INSURANCE	PO BOX 7068	COLUMBIA	SC	29202	8003668997	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
193	ALLSTATE WORKPLACE DIVISION	PO BOX 853916	RICHARDSON	TX	750853916	8009377039	
581	ALTA RX	PO BOX 30081	SALT LAKE CITY	UT	84130	8009985033	
A02	ALTERNATIVE BENEFITS PLANS, INC.	2920 BRANDYWINE RD. STE. 106	ATLANTA	GA	30341	8002417319	
234	ALWAYSCARE BENEFITS INC	PO BOX 80139	BATON ROUGE	LA	70898	8887295433	DENTAL PLAN
161	AMA INSURANCE AGNECY, INC.	200 N. LASALLE ST. STE. 400	CHICAGO	IL	606819785	8004585736	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED

APPENDIX 2 CARRIER CODES

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297	AMALGAMATED LIFE INSURANCE	PO BOX 1451	NEW YORK	NY	101161451	2124735700	
C07	AMERIBEN SOLUTIONS	PO BOX 7186	BOISE	ID	83707	8007867930	
910	AMERICAN ADMINISTRATIVE GROUP	PO BOX 5227	LISLE	IL	605325227	8003545112	WAS GALLAGER & BASSETT SERVICES
469	AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP)	PO BOX 740819	ATLANTA	GA	30374	8005235880	
968	AMERICAN BENEFIT ADMINISTRATIVE SERVICES	PO BOX 0928	BROOKFIELD	WI	53008	6304161111	
271	AMERICAN BENEFIT PLAN ADMINISTRATOR	22OO-B ROSSELLE ST.	JACKSONVILLE	FL	32204	8004685126	
488	AMERICAN BENEFITS MANAGEMENT	8310 PORT JACKSON AVE NORTHWEST	NORTH CANTON	OH	44720	3309665500	
B44	AMERICAN CHOICE HEALTH PLAN, LLC	PO BOX 922043	HOUSTON	TX	77292	8006334226	
B44DN	AMERICAN CHOICE HEALTH PLAN, LLC	PO BOX 922009	HOUSTON	TX	77292	8005989799	
A93	AMERICAN COLLEGE OF SURGEONS	PO BOX 2522	FORT WORTH	TX	761132522	8004331672	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D48	AMERICAN CONTINENTAL INSURANCE CO	PO BOX 2368	BRENTWOOD	TN	37024	6153371300	MEDICARE ADVANTAGE PLAN
106	AMERICAN FIDELITY ASSURANCE BENEFITS	PO BOX 25160	OKLAHOMA CITY	OK	731250160	8006548489	
150	AMERICAN GENERAL LIFE AND ACCIDENT INS CO	PO BOX 1500	NASHVILLE	TN	372021500	8008882452	
951	AMERICAN GROUP ADMINISTRATORS	101 CONVENTION CENTER DR. STE. 200	LAS VEGAS	NE	89109	8008424742	
A57	AMERICAN GROUP ADMINISTRATORS, INC.	101 CONVENTION CENTER DR. STE 200	LAS VEGAS	NV	89109	8008424742	CODE ASSIGNED BY SCHA
118	AMERICAN HEALTH & LIFE INSURANCE	300 ST. PAUL PLACE	BALTIMORE	MD	21202	3013323000	
C92	AMERICAN HEALTH CARE	2217 PLAZA DR STE. 100	ROCKLIN	CA	95765	8008728276	
C92DN	AMERICAN HEALTH CARE	3001 DOUGLAS ST	ROSEVILLE	CA	95661	8008728276	
919	AMERICAN HEALTH GROUP, INC.	PO BOX 1500	MAUMEE	OH	43537	8008728276	
383	AMERICAN HEALTHCARE ALLIANCE	PO BOX 8530	KANSAS CITY	MO	641140530	8772840102	
119	AMERICAN HERITAGE LIFE INSURANCE	1776 AMERICAN HERITAGE LIFE DR.	JACKSONVILLE	FL	32224	8005358086	
840	AMERICAN INCOME LIFE INSURANCE COMPANY	PO BOX 2608	WACO	TX	76797	8177723050	
B69	AMERICAN INSURANCE ADMINISTRATORS	PO BOX 2348	COLUMBUS	OH	432162348	8009221245	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA.
D38	AMERICAN INSURANCE ADMINISTRATORS	PO BOX 2348	COLUMBUS	OH	43216	8009221245	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

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369	AMERICAN INTERNATIONAL GROUP	PO BOX 25050	WILMINGTON	DE	19899	8004687077	
167	AMERICAN INTERNATIONAL GROUP (AIG) ACCIDENT	PO BOX 3726	SEATTLE	WA	98124	8775039095	CODE ASSIGNED BY SCHA
A62	AMERICAN MEDICAL AND LIFE INSURANCE (AMLI)	PO BOX 1353	CHICAGO	IL	60690	8882641512	
532	AMERICAN MEDICAL SECURITY	PO BOX 19032	GREENBAY	WI	543079032	8002325432	
120	AMERICAN NATIONAL INSURANCE COMPANY	PO BOX 1790	GALVESTON	TX	77553	8008996803	
B98	AMERICAN PIONEER LIFE INSURANCE COMPANY	PO BOX 130	PENSACOLA	FL	32591	8005381053	
321	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	PO BOX 188004	CHATTANOOGA	TN	37422	8002222798	
164	AMERICAN PROGRESSIVE INSURANCE	PO BOX 130	PENSACOLA	FL	325910130	8006268913	
A05	AMERICAN PUBLIC LIFE INSURANCE CO.	PO BOX 925	JACKSON	MS	39205	8002568606	
722	AMERICAN REPUBLIC INSURANCE COMPANY	PO BOX 21670	EAGAN	MN	55121	8002472190	
875	AMERICAN SENTINEL	PO BOX 61140	HARRISBURG	PA	171061140	8006927338	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
503	AMERICAN SPECIAL RISK MANAGEMENT	509 SOUTH LENOLA RD. BLDG TWO	MOORESTOWN	NJ	08057	8003597475	
C82	AMERICAN STANDARD LIFE & ACCIDENT INS. CO.	P O DRAWER 3248, 224 NORTH INDEPENDENT	ENID	OK	73701	4052334000	CODE IN OPEN STATUS BY SCHA
253	AMERICAN STERLING INSURANCE SERVICES	PO BOX 26103	OVERLAND PARK	KS	66225	8772926037	
125	AMERICAN TRAVELERS LIFE INSURANCE COMPANY	3220 TILLMAN DR.	BEN SALEM	PA	19020	2152441600	
275	AMERICAN TRUST ADMINISTRATORS	PO BOX 87	SHAWNEE MISSION	KS	66201	9134514900	
496	AMERICAN VETERINARIAN MEDICINE ASSN.	PO BOX 909720	CHICAGO	IL	606049720	8006216360	
D61	AMERICA'S 1ST CHOICE	PO BOX 210769	COLUMBIA	SC	29210	8663213947	MEDICARE ADVANTAGE PLAN
D23	AMERICA'S HEALTH CHOICE MEDICAL PLANS,(HMO)	762 SOUTH US HWY. ONE PMB 224	VERO BEACH	FL	32962	8003089823	MEDICARE ADVANTAGE PLAN
557	AMERICORP INS. CO	PO BOX 3430	CARMEL	IN	46082	8666994186	
D51	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	8006004441	MEDICAID HMO
D94	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	8006004441	MEDICAID HMO
E51	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	8006004441	
D60	AMERIGROUP COMMUNITY CARE OF SC	PO BOX 31789	VIRGINIA BEACH	VA	234661789	8006004441	CODE ASSIGNED BY SCHA
284	AMERIHEALTH ADMINISTRATORS	720 BLAIR RD.	HORSHAM	PA	19044	8003454017	
110	AMERIHEALTH HMO, INC.	PO BOX 41574	PHILADELPHIA	PA	191011574	8886323862	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
894	AMERIHEALTH MERCY HEALTH PLAN	PO BOX 7118	LONDON	KY	40742	8889917200	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A10	AMERISCRIPT	4301 DARROW RD. STE. 4200	STOW	OH	44224	8006816912	
210	AMERITAS LIFE INSURANCE	PO BOX 82520	LINCOLN	NE	68501	8002559678	
B08	AMFIRST INSURANCE CO	PO BOX 16708	JACKSON	MS	93236	8888882519	
653	ANDERSON COUNTY	-	-	-	-		
330	ANNUITY BOARD OF SOUTHERN BAPTIST CONVENTION	PO BOX 2190	NASHVILLE	TN	37234	2147200511	
X0Y	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 105187	ATLANTA	GA	30348	8006224822	
X0YDN	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 659444	SAN ANTONIO	TX	78265	8006224822	
X0YRX	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 37010	LOUISVILLE	KY	40233	8006224822	
529	ANTHEM HEALTH	3575 KROGER BLVD., STE. 400	DULUTH	GA	30316	8008881966	
579	ANTHEM PRESCRIPITION MANAGEMENT	PO BOX 145433	CINCINNATI	OH	45250	8006620210	USE CARRIER A24
D65	ANTHEM SENIOR ADVANTAGE	PO BOX 37690	LOUISVILLE	KY	402337180	8882909160	MEDICARE ADVANTAGE PLAN
171	AON	PO BOX 66	WINSTON SALEM	NC	27102	8003683804	
523	APA PARTNERS, INC.	PO BOX 1506	LATHAM	NY	121108006	8008333650	
705	APS HEALTHCARE, INC.	PO BOX 1307	ROCKVILLE	MD	20849	8002218699	
D13	ARCADIAN	PO BOX 4946	COVINA	CA	91723	8007756490	CODE ORIGINALLY ASSIGNED AS MA IN ERROR USE CODE 816 FOR MA PLAN
816	ARCADIAN MEMBER CARE	PO BOX 4946	COVINA	CA	91723	8005738597	MEDICARE ADVANTAGE PLAN
981	ARGUS HEALTH SYSTEMS	PO BOX 419019	KANSAS CITY	MO	64141	8005227487	
A49	ARIZONA FOUNDATION FOR MEDICAL CARE	PO BOX 2909	PHONEIX	AZ	850622909	6022318855	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B78	ARKANSAS BEST CORP. CHOICE BENEFITS	PO BOX 10048	FT SMITH	AR	72917	4797856178	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X1I	ARKANSAS BLUE CROSS AND BLUE SHIELD, INC	PO BOX 2181	LITTLE ROCK	AR	72203	5013782010	
972	ASR CORP (ADMINISTRATION SYSTEM RESEARCH)	PO BOX 6392	GRAND RAPIDS	MI	49512	8009682449	
505	ASSOCIATED ADMINISTRATORS	PO BOX 27806	BALTIMORE	MD	212857806	8006382972	
898	ASSOCIATION & SOCIETY INS. CORP	PO BOX 2510	ROCKVILLE	MD	20847	8006382610	
934	ASSOCIATION & SOCIETY INS. CORP.	PO BOX 2510	ROCKVILLE	MD	20847	8006382610	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
386	ASSURANT HEALTH	PO BOX 2806	CLINTON	IA	527332806	8005537654	WAS FORTIS INSURANCE COMPANY
386DN	ASSURANT HEALTH	PO BOX 2940	CLINTON	IA	52733	8004427742	WAS FORTIS INSURANCE COMPANY
448	ASSURANT HEALTH INSURANCE	PO BOX 42033	HAZELWOOD	MD	63042	8005537654	CODE ASSIGED BY SCHA
451	ASSURECARE RISK MANAGEMENT	340 QUANRINGLE BLVD	BOILING BROOK	IL	60440	8007597422	
105	ATHENE ANNUITY AND LIFE ASSURANCE COMPANY	PO BOX 19038	GREENVILLE	SC	29602	8646098111	
971	ATLANTA ADMINISTRATIONS	135 BEAVER ST.	WALTHAM	MA	02452	8005481256	
B34	ATLANTA LIFE INSURANCE COMPANY	100 AUBURN AVE., NE	ATLANTA	GA	30303	4046592100	
122	ATLANTIC COAST LIFE INSURANCE COMPANY	PO BOX 20010	CHARLESTON	SC	294130010	8437638680	
B45	ATLANTICARE	PO BOX 613	HAMMONTON	NJ	08037	8883282287	
526	AULTCARE	PO BOX 6910	CANTON	OH	44706	8003448858	
588	AUTOMATED BENEFIT SERVICES INC.	PO BOX 321223	DETROIT	MI	482321223	8002751896	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C40	AVERA HEALTH PLANS	PO BOX 381506	BIRMINGHAM	AL	35238	8883222115	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
494	AVESIS PHARMACY NETWORK	3724 N 3RD ST STE 300	PHOENIX	AZ	85012	6022413400	
B58	AVMED HEALTH	PO BOX 569000	MIAMI	FL	332569000	8004528633	
A72	BABB, INC.	850 RIDGE AVE	PITTSBURGH	PA	15212	8002456102	
358	BAKERY & CONFECTIONERY UNION	10401 CONNECTICUT AVE STE 300	KENSINGTON	MD	208953960	3014683742	
654	BAMBERG COUNTY	-	-	-	-		
987	BANKERS FIDELITY LIFE INS CO	PO BOX 190240	ATLANTA	GA	311190240	4042665500	
815	BANKERS FIDELITY LIFE INSURANCE COMPANY	PO BOX 260040	PLANTO	TX	75026	8664587499	THID CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
123	BANKERS LIFE & CASUALTY	PO BOX 66927	CHICAGO	IL	606660927	8006213724	
655	BARNWELL COUNTY	-	-	-	-		
644	BCBS OF GEORGIA	PO BOX 9907	COLUMBUS	GA	31908	8004412273	MEDICARE INTERMEDIARY
X0BDN	BCBS OF GEORGIA DENTAL	PO BOX 9201	OXNARD	CA	930319201	4048428000	
X0MDN	BCBS OF MASSACHUSETTS	PO BOX 986005	BOSTON	MA	02298	800253521-	DENTAL ONLY
C62	BCBS OF SC MEDICARE BLUE PRIVATE (PFFS)	PO BOX 100133	COLUMBIA	SC	29202	8006053256	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C63	BCBS OF SC MEDICARE BLUE&MEDICARE BLUE PLUS (PPO)	PO BOX 100133	COLUMBIA	SC	29202	8006053256	MEDICARE ADVANTAGE PLAN
643	BCBS OF TENNESSEE	730 CHESTNUT ST	CHATTANOOGA	TN	37402	8772966189	MEDICARE INTERMEDIARY
656	BEAUFORT COUNTY	-	-	-	-		
750	BENEFIT ADMINISTRATIVE SERVICES	PO BOX 4509	ROCKFORD	IL	61110	8159699663	
C79	BENEFIT ADMINISTRATIVE SYSTEM, LTD	PO BOX 17475 JOVANNA DR. STE. 1B	HOMEWOOD	IL	60430	7087997400	
B37	BENEFIT ADMINISTRATORS	PO BOX 21308	COLUMBIA	SC	29221	8778400936	
B37DN	BENEFIT ADMINISTRATORS	PO BOX 1957	BEATTYVILLE	KY	41311	8003258424	
300	BENEFIT ADMINISTRATORS INC	PO BOX 6279	ERIE	PA	16512	8007772524	
300DN	BENEFIT ADMINISTRATORS INC	PO BOX 6279	ERIE	PA	16512	8007772524	
475	BENEFIT ASSISTANCE CORP.	PO BOX 950	HURRICANE	WV	25526	3045621913	
319	BENEFIT CONCEPTS	PO BOX 60608	KING OF PRUSSIA	PA	19406	8002202600	
A86	BENEFIT MANAGEMENT CO	PO BOX 269000	WESTON	FL	333269000	8002629175	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C11	BENEFIT MANAGEMENT SERVICES INC	PO BOX 1178	MATTHEWS	NC	28106	7048455608	
C11DN	BENEFIT MANAGEMENT SERVICES INC	PO BOX 1317	MATTHEWS	NC	28106	7048455608	
301	BENEFIT PLAN ADMINISTRATORS	2145 FORD PARKWAY, STE. 300	ST. PAUL	MN	55116	8002778973	
C28	BENEFIT PLAN MANAGEMENT	PO BOX 536	ROCKLYN	MA	02370	8776427500	
311	BENEFIT PLANNERS, INC	PO BOX 682010	SAN ANTONIO	TX	78269----	2106991872	
980	BENEFIT SUPPORT, INC.	PO BOX 2977	GAINSVILLE	GA	30503	8007774752	
772	BENEFIT SYSTEMS INC	PO BOX 6001	INDIANAPOLIS	IN	462066001	8008243216	
127	BENEFITSOURCE, INC	PO BOX 240	MONROE	MI	48161	8004231028	CODE ASSIGNED BY SCHA
A25	BENESCRIPT	8300 E. MAPLEWOOD AVE	GREENWOOD VILLAGE	CO	80111	8003453189	
985	BENESIGHT	PO BOX 340	PUEBLO	CO	81002	8003621116	
A81	BENESYS	PO BOX 90082	LUBBOCK	TX	79402	3372341789	
256	BENICOMP	8310 CLINTON PARK DR	FT WAYNE	IN	46825	8008377400	CODE ASSIGNED BY SCHA
C12	BENICOMP, INC.	8310 CLINTON PARK DR	FT WAYNE	IN	46825	8008377400	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B67	BENISTAR TRUST AKA MARSH AFFINITY GROUP SERVICES	PO BOX 10432	DES MOINES	IA	50306	8668109452	
380	BENMARK, INC.	PO BOX 16767	JACKSON	MS	39236	6013660596	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
481	BENOVATION	3481 CENTRAL PARKWAY, STE 200	CINCINNATI	OH	45223	8006816912	CODE ASSIGNED BY SCHA
657	BERKELEY COUNTY	-	-	-	-		
904	BEST CHOICE HEALTH PLAN	PO BOX 21128	FORT LAUDERDALE	FL	33335	8008674446	
905	BETTER BENEFITS	PO BOX 93929	SOUTHLAKE	TX	76092	8664163605	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D08	BIG LOTS ASSOCIATE BENEFIT PLAN	PO BOX 9071	DUBLIN	OH	430170971	8772542363	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X2X	BLUE CROSS BLUE SHIELD OF HAWAII	PO BOX 44500	HONOLULU	HI	96801	8007764672	
C64	BLUE CHOICE HEALTH PLAN (PPO)	PO BOX 6170	COLUMBIA	SC	29260	8772753256	MEDICARE ADVANTAGE (PPO)
922	BLUE CHOICE HEALTHPLAN	PO BOX 6170	COLUMBIA	SC	292606170	8037868466	WAS COMPANION HEALTHCARE NAME CHANGE EFFECTIVE 7/1/05
403	BLUE CHOICE/MEDICAID	PO BOX 6170	COLUMBIA	SC	29260	8772753256	MEDICAID HMO
X2G	BLUE CROSS & BLUE SHIELD CENTRAL NEW YORK, INC.	PO BOX 4809	SYRACUSE	NY	132214809	3154483801	
X2W	BLUE CROSS & BLUE SHIELD OF ARIZONA, INC.	PO BOX 13466	PHOENIX	AZ	850023466	6028644100	
X1V	BLUE CROSS & BLUE SHIELD OF COLORADO	700 BRD.WAY	DENVER	CO	80273	3038312131	
X1H	BLUE CROSS & BLUE SHIELD OF CONNECTICUT INC	PO BOX 504	NEW HAVEN	CT	06473	2032394961	
X0L	BLUE CROSS & BLUE SHIELD OF DELAWARE INC	PO BOX 1991	WILMINGTON	DE	19899	3024210260	
X0B	BLUE CROSS & BLUE SHIELD OF GEORGIA/ATLANTA INC	PO BOX 9907	COLUMBUS	GA	319086007	4048428000	FOR GEORGIA STATE EMPLOYEES USE CARRIER 419 GEORGIA STATE HEALTH BENEFIT PLAN
X1M	BLUE CROSS & BLUE SHIELD OF KANSAS	1133 SOUTHWEST TOPEKA BLVD.	TOPEKA	KS	66629	7852914180	
X2B	BLUE CROSS & BLUE SHIELD OF KANSAS CITY	PO BOX 419169	KANSAS CITY	MO	641416169	8008926048	
X0U	BLUE CROSS & BLUE SHIELD OF KENTUCKY INC	9901 LINN STATION RD.	LOUISVILLE	KY	40223	5024232011	
X1L	BLUE CROSS & BLUE SHIELD OF LOUISIANA	PO BOX 98029	BATON ROUGE	LA	708989029	5042915370	
X1Q	BLUE CROSS & BLUE SHIELD OF MAINE	2 GANNETT DR.	SOUTH PORTLAND	ME	041066911	2077751550	
X01	BLUE CROSS & BLUE SHIELD OF MARYLAND, INC.	PO BOX 14115	LEXINGTON	KY	405124115	8005244555	
X0I	BLUE CROSS & BLUE SHIELD OF MARYLAND, INC.	PO BOX 9836	BALTIMORE	MD	21204	8005244555	USE CARRIER X01
X1K	BLUE CROSS & BLUE SHIELD OF MEMPHIS	85 NORTH DANNY THOMAS BLVD	MEMPHIS	TN	38103	9015293111	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X0Q	BLUE CROSS & BLUE SHIELD OF MICHIGAN	600 LAFAYETTE EAST	DETROIT	MI	482262998	8004820898	
X0QDN	BLUE CROSS & BLUE SHIELD OF MICHIGAN	PO BOX 49	DETROIT	MI	48231	8888268152	
X1P	BLUE CROSS & BLUE SHIELD OF MINNESOTA	PO BOX 64338	ST PAUL	MN	55164	8003822000	
X0Z	BLUE CROSS & BLUE SHIELD OF MISSISSIPPI INC	PO BOX 1043	JACKSON	MS	39208	6019323800	
X2U	BLUE CROSS & BLUE SHIELD OF MISSOURI	1831 CHESTNUT ST.	ST LOUIS	MO	63103	3149234444	AKA ALLIANCE BLUE CROSS BLUE SHIELD
X1U	BLUE CROSS & BLUE SHIELD OF NEBRASKA	PO BOX 3248, MAIN PO BOXSTATION	OMAHA	NE	681800001	4023901820	
X0S	BLUE CROSS & BLUE SHIELD OF NEW JERSEY, INC.	PO BOX 1938	NEWARK	NJ	07102	8003552583	AKA HORIZON BCBS OF NEW JERSEY
X0SDN	BLUE CROSS & BLUE SHIELD OF NEW JERSEY, INC.	PO BOX 420	NEWARK	NJ	07102	8003552583	AKA HORIZON BCBS OF NEW JERSEY
X0C	BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA	PO BOX 35	DURHAM	NC	27702	8002144844	
X0CDN	BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA	PO BOX 2100	WINSTON SALEM	NC	271022100	9194897431	
X2J	BLUE CROSS & BLUE SHIELD OF NORTH DAKOTA	4510 13TH AVE. SW	FARGO	ND	581210001	8003682312	
X2T	BLUE CROSS & BLUE SHIELD OF OKLAHOMA	PO BOX 3283	TULSA	OK	74102	9185603535	
X1F	BLUE CROSS & BLUE SHIELD OF RHODE ISLAND	500 EXCHANGE ST.	PROVIDENCE	RI	02903	4018317300	
X0P	BLUE CROSS & BLUE SHIELD OF TENNESSEE	1 CAMERON HILL CIRCLE	CHATTANOOGA	TN	374020002	8004689736	
X0PDN	BLUE CROSS & BLUE SHIELD OF TENNESSEE	1 CAMERON HILL CIRCLE STE. 0002	CHATTANOOGA	TN	374020002	8005659140	
X1W	BLUE CROSS & BLUE SHIELD OF UTAH	PO BOX 30270	SALT LAKE CITY	UT	841300270	8013332100	
X2H	BLUE CROSS & BLUE SHIELD OF UTICA-WATERTOWN, INC.	12 RHOADS DR., UTICA BUSINESS DISTRICT	UTICA	NY	13501	3157984238	
X2S	BLUE CROSS & BLUE SHIELD OF VERMONT	PO BOX 186	MONTPELIER	VT	05602	8022472583	
X0F	BLUE CROSS & BLUE SHIELD OF VIRGINIA	PO BOX 27401	RICHMOND	VA	23279	8009916061	
X2O	BLUE CROSS & BLUE SHIELD OF WEST VIRGINIA INC	PO BOX 1353	CHARLESTON	WV	25325	3043477709	
X1J	BLUE CROSS & BLUE SHIELD OF WESTERN NEW YORK, INC.	PO BOX 80	BUFFALO	NY	142400080	8008880757	
X0H	BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN	PO BOX 2025	MILWAUKEE	WI	53201	4142246100	
X1D	BLUE CROSS /BLUE SHIELD OF NATIONAL CAPITAL AREA	550 12TH ST. SW	WASHINGTON	DC	20024	2024798000	
X0O	BLUE CROSS AND BLUE SHIELD OF ALABAMA	PO BOX 2294	BIRMINGHAM	AL	35298	8005176425	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X0ODN	BLUE CROSS AND BLUE SHIELD OF ALABAMA	PO BOX 995	BIRMINGHAM	AL	35298	8005176425	
X0D	BLUE CROSS AND BLUE SHIELD OF FLORIDA	PO BOX 1798	JACKSONVILLE	FL	322310014	8007272227	
401	BLUE CROSS AND BLUE SHIELD OF SC	PO BOX 100300	COLUMBIA	SC	29202	8037883860	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE. ST. ADDRESS 4101 PERVICAL RD. COLA 29219
401DN	BLUE CROSS AND BLUE SHIELD OF SC	4101 PERCIVAL RD.	COLUMBIA	SC	29219	8037883860	THIS CODE USED ONLY FOR DENTAL CLAIMS WHERE BCBS IS THE INSURANCE CARRIER
X0N	BLUE CROSS AND BLUE SHIELD OF TEXAS	PO BOX 660044	DALLAS	TX	752660044	8004510287	
X0NDN	BLUE CROSS AND BLUE SHIELD OF TEXAS	PO BOX 660247	DALLAS	TX	75266	8004947218	
X2F	BLUE CROSS AND BLUE SHIELD OF THE ROCHESTER AREA	PO BOX 22999	ROCHESTER	NY	14692	7163253630	
453	BLUE CROSS ANTHEM MEDICARE ADVANTAGE	2100 CORPORATE CENTER	NEWBURY PARK	CA	913201431	8006762583	MEDICARE ADVANTAGE PLAN
X2Y	BLUE CROSS BLUE SHIELD OF MONTANA	PO BOX 5004	GREAT FALLS	MT	59403	4067914000	
X1A	BLUE CROSS BLUE SHIELD OF NEW MEXICO	PO BOX 27630	ALBUQUERQUE	NM	87125	8007113795	
X0W	BLUE CROSS OF CALIFORNIA	PO BOX 60007	LOS ANGELES	CA	90060	8888878969	
D67	BLUE CROSS OF FLORIDA HEALTH OPTIONS	PO BOX 1798	JACKSONVILLE	FL	32231	8773522583	MEDICARE ADVANTAGE PLAN
X0A	BLUE CROSS OF GEORGIA/COLUMBUS INC	PO BOX 9907	COLUMBUS	GA	319089907	8004412273	POLICIES SHOULD BE ADDED WITH XOB. BCBS OF GA.
X0ARX	BLUE CROSS OF GEORGIA/COLUMBUS INC	PO BOX 9907	COLUMBUS	GA	319089907	8004412273	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
X2V	BLUE CROSS OF IDAHO HEALTH SERVICE, INC.	PO BOX 7408	BOISE	ID	83707	2083447411	
X0T	BLUE CROSS OF ILLINOIS	PO BOX 805107	CHICAGO	IL	60680	8006348644	
X0TDN	BLUE CROSS OF ILLINOIS	PO BOX 23059	BELLEVILLE	IL	62223	8668260914	
X0M	BLUE CROSS OF MASSACHUSETTS INC	PO BOX 986020	BOSTON	MA	022986020	8002535210	
XOV	BLUE CROSS OF NORTHEASTERN NEW YORK INC	PO BOX 15013	ALBANY	NY	12212	5184385500	
X2L	BLUE CROSS OF NORTHEASTERN PENNSYLVANIA	70 NORTH MAIN ST.	WILKES-BARRE	PA	18711	8008298599	
X1X	BLUE CROSS OF OHIO	PO BOX 956	TOLEDO	OH	43696	8003621279	
X1E	BLUE CROSS OF PUERTO RICO	PO BOX 366068	SAN JUAN	PR	009366068	8097599898	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X2M	BLUE CROSS OF WASHINGTON AND ALASKA	PO BOX 91059	SEATTLE	WA	981119159	8007221471	
X1YDN	BLUE SHEILD OF CALIFORNIA	PO BOX 272590	CHICO	CA	959272590	8887024171	
X1Y	BLUE SHIELD OF CALIFORNIA	PO BOX 272540	CHICO	CA	959272590	8882351765	
X0V	BLUE SHIELD OF NORTHEASTERN NEW YORK	PO BOX 15013	ALBANY	NY	12212	5184534600	
D41	BLUEGRASS FAMILY HEALTH	PO BOX 22738	LEXINGTON	KY	40522	8007872680	
390	BOARD OF PENSIONS EVANGELICAL LUTHERAN CHURCH	PO BOX 59093	MINNEAPOLIS	MN	554590093	6123337651	
337	BOARD OF PENSIONS OF THE PRESBYTERIAN CHURCH OF	PO BOX 13896	PHILADELPHIA	PA	19101	8007737752	
404	BOB JONES UNIVERSITY	1700 WADE HAMPTON BLVD.	GREENVILLE	SC	29614	8643701800	
190	BOILERMAKERS NATIONAL HEALTH & WELFARE FUND	754 MINNESOTA AVE., STE. 522	KANSAS CITY	KS	661012762	9133426555	
739	BOLLINGER INC	PO BOX 727	SHORT HILLS	NJ	07078	8662670092	
702	BOON CHAPMAN BENEFIT ADMINISTRATORS	PO BOX 9201	AUSTIN	TX	787669201	8002529653	CODE ASSIGNED BY SCHA
C22	BOSTON MUTUAL LIFE INSURANCE COMPANY	120 ROYALL ST.	CANTON	MA	02021	6178287000	
854	BOYD CARE (BOYD BROTHERS TRANSPORTATION)	PO BOX 70	CLAYTON	AL	36016	3347751284	
D58	BRAVO HEALTH MEDICARE ADVANTAGE	P.O, BOX 4433	BALTIMORE	MD	21223	8005561570	MEDICARE ADVANTAGE PLAN
294	BRIDGESTONE/FIRESTONE COMPANIES	PO BOX 26605	AKRON	OH	44319	8002378447	
304	BUTLER BENEFIT SERVICE, INC.	PO BOX 3310	DAVENPORT	IA	528083310	8669272200	
262	CAIC (CONTINENTAL AMERICAN INS. CO)	PO BOX 6080226	MISSION VIEJO	CA	926906080	8887302244	
658	CALHOUN COUNTY	-	-	-	-		
973	CAMBRIDGE INTERGRATED SERVICES GROUP INC.	PO BOX 1687	GRAND RAPIDS	MI	49501	8007669780	USE CARRIER 171 AON
832	CAMERON AND ASSOCIATES	6100 LAKE FOREST DR.	ATLANTA	GA	30328	8003879919	
998	CANADA LIFE ASSURANCE CO.	6201 POWERS FERRY RD. STE. 100	ATLANTA	GA	30348	8003332542	
X2K	CAPITAL BLUE CROSS	PO BOX 779503	HARRISBURG	PA	171779503	8009622242	
274	CAPITAL DISTRICT PHYSICIANS PLAN	PO BOX 66602	ALBANY	NY	122066602	8009267526	
966	CAPITOL ADMINISTRATORS OF THE SOUTHEAST	PO BOX 346	ALPHARETTA	GA	30009	8886506566	
166	CAPITOL AMERICAN LIFE INSURANCE COMPANY	PO BOX 94953	CLEVELAND	OH	441014953	2166966400	
128	CAPITOL LIFE INSURANCE COMPANY	PO BOXBXO 1200	DENVER	CO	80201	8005252115	PER HOSP. ASSO. 07/02, THIS IS STILL A VALID CARRIER
D42	CARE IMPROVEMENT PLUS	PO BOX 4347	SCRANTON	PA	18505	8666862506	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
764	CARE LINK HEALTH PLAN	PO BOX 7373	LONDON	KY	407427373	8003482922	
B92	CARE SOURCE	ONE SOUTH MAIN	DAYTON	OH	45402	8004880134	
151	CARELINK	PO BOX 7373	LONDON	KY	40742	8003482922	MEDICAID HMO
471	CAREMARK	PO BOX 52195	PHOENIX	AZ	850722195	8003030187	
280	CAREMARK PRESCRIPTION SERVICES	PO BOX 52188	PHOENIX	AZ	850722196	8008415550	USE CARRIER 471
B04	CARITEN HEALTHCARE	PO BOX 22987	KNOXVILLE	TN	37933	8002840042	CODE IN OPEN STATUS BY SCHA
D21	CARITEN SENIOR HEALTH	PO BOX 22885	KNOXVILLE	TN	37933	8656707790	MEDICARE ADVANTAGE PLAN
945	CAROLINA ATLANTIC MEDICAL SERVICES ORGANIZATION	PO BOX 22528	CHARLESTON	SC	29413	8008100906	DORMANT 8/06
A71	CAROLINA BEHAVIORAL HEALTH ALLIANCE	PO BOX 571137	WINSTON SALEM	NC	271571137	8004757900	
498	CAROLINA BENEFIT ADMINISTRATORS	PO BOX 3257	SPARTANBURG	SC	29304	8645736937	
445	CAROLINA CARE PLAN/MEDICAL MUTUAL INS. CO. OF OHIO	PO BOX 6018	CLEVELAND	OH	441011018	8003153143	ALSO KNOWN AS SUPERMED ANOTHER PHONE # 800-232-3143
723	CAROLINA CONTINENTAL INSURANCE	PO BOX 427	COLUMBIA	SC	29202	8032566265	
E12	CAROLINA CRESCENT	1201 MAIN ST. STE 970	COLUMBIA	SC	29201	8032516630	HEALTHY KIDS CONNECTION
559	CAROLINA HOSPITAL SYSTEMS BENEFIT PLAN	PO BOX 100569	FLORENCE	SC	295010659	8436613875	
623	CAROLINA MEDICARE PRIME HMO	201 EXECUTIVE CENTER DR.	COLUMBIA	SC	29210	8037507473	MEDICARE ADVANTAAGE PLAN
C77	CARPENTERS HOSPITALIZATION PLAN	3611 CHESTER AVE	CLEVELAND	OH	44114	8004213959	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
877	CARTER-JONES LUMBER CO	WELFARE PLAN	FLORENCE	SC	295010659		CODE ASSIGBED BY SCHA
336	CASEBP (CATSKILL AREA SCHOOLS EMPLOYEE PLAN	PO BOX 220	STAMFORD	NY	12167	8009626294	CODE IN OPEN STATUS BY SCHA
CAS	CASUALTY CASE	-	-	-	-		
366	CATALYST RX	PO BOX 1069	ROCKVILLE	MD	20849	8009973784	
572	CATAMARAN	8300 E MAPLEWOOD AVE	GREENWOOD VILLAGE	CO	80111	8778398119	FORMERLY HEALTH TRANS
C66	CATERPILLAR, INC.	PO BOX 62920	COLORADO SPRINGS	CO	809622920	3094942363	
B11	CBCA ADMINISTRATORS, INC.	PO BOX 1272	MINNEAPOLIS	MN	554400535	8884465710	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
339	CELTIC INDIVIDUAL HEALTH	PO BOX 33839	INDIANAPOLIS	IN	462030839	8004777870	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
907	CELTIC LIFE INSURANCE CO.	PO BOX 46337	MADISON	WI	53744	8007662525	
X0X	CENTRAL BENEFITS MUTUAL INSURANCE COMPANY	PO BOX 16526	COLUMBUS	OH	43216	6144645870	
273	CENTRAL BENEFITS USA (CENBEN USA)	PO BOX 619059	DALLAS	TX	85261	8007725924	CODE ASSIGNED BY SCHA
C13	CENTRAL RESERVE LIFE OF NORTH AMERICA INSURANCE CO	17800 ROYALTON RD.	STRONGSVILLE	OH	441365197	8003213997	
507	CENTRAL STATES HEALTH & LIFE CO. OF OMAHA	PO BOX 34350	OMAHA	NE	68134	4023971111	
476	CENTRAL STATES, SOUTHEAST & SOUTHWEST	PO BOX 5116	DEPLAINES	IL	60017	8003235000	
476DN	CENTRAL STATES, SOUTHEAST & SOUTHWEST	PO BOX 5116	DEPLAINES	IL	60017	8003235000	
C84	CENTRAL UNITED & CHRISTIAN MUTUAL LIFE INS. CO.	2727 ALLEN PARKWAY	HOUSTON	TX	770192115	7135290045	
A54	CENTURY HEALTHCARE	PO BOX 2256	GRAPEVINE	TX	76099	8884441995	NEIC 30018
813	CENTURY PLANNER	9201 WATSON RD, STE. 350	ST. LOUIS	MO	631261509	8007762453	
604	CHAMPVA	PO BOX 469064	DENVER	CO	80246	3033317599	
659	CHARLESTON COUNTY	-	-	-	-		
E66	CHCCARE OF SOUTH CAROLINA	140 STONE RIDGE DR	COLUMBIA	SC	29210	8668022474	
D66	CHCCARES OF SOUTH CAROLINA	140 STONE RIDGE DR	COLUMBIA	SC	29210	8668022474	MEDICAID HMO
B71	CHCS SERVICES, INC.	PO BOX 12467	PENSACOLA	FL	325912457	8888031780	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
660	CHEROKEE COUNTY	-	-	-	-		
A99	CHEROKEE INSURANCE	PO BOX 853925	RICHARDSON	TX	750853925	8002010450	
B03	CHESAPEAKE LIFE INS. CO.	PO BOX 809025	DALLAS	TX	753809025	8887563534	
661	CHESTER COUNTY	-	-	-	-		
662	CHESTERFIELD COUNTY	-	-	-	-		
992	CHESTERFIELD RESOURCES, INC.	PO BOX 1884	AKRON	OH	44309	8003210935	
541	CHILDRENS REHAB SERVICES	PO BOX 4217	SPATANBURG	SC	293054217	8645962227	CODE ASSIGNED BY SCHA
535	CHP DIRECT/SUPERMED	PO BOX 94648	CLEVELAND	OH	441014648	8007731445	
B91	CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST	1205 WINDHAM PARKWAY	ROMEOVILLE	IL	60446	8008070400	
B65	CHRISTIAN CARE MEDI SHARE	PO BOX 674	STERLING	IL	61081	8156258595	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
511	CIGNA BEHAVIORAL HEALTH	PO BOX 46270	EDEN PRAIRIE	MN	55344	8003364091	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
134	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 182223	CHATTANOOGA	TN	374227223	8008824462	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
134DN	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 188037	CHATTANOOGA	TN	37422	8002446224	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
134RX	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 42005	PHOENIX	AZ	850802005	8002510670	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
136	CIGNA FLEXCARE	PO BOX 30575	CHARLOTTE	NC	282303211		CODE ASSIGNED BY SCHA
999	CIGNA HEALTHCARE OF SC/HEALTHSOURCE SC	PO BOX 190024	CHARLESTON	SC	294199024	8007203150	BOUGHT BY CIGNA HEALTHCARE CC 134
452	CIGNA INTERNATIONAL EXPATRIATE BENEFITS	PO BOX 15050	WILMINGTON	DE	19850	8004412668	
D57	CIGNA MEDICARE ACCESS	PO BOX 22174	TEMPE	AZ	852852174	8005779410	MEDICARE ADVANTAGE PLAN
646	CIGNA-MEDICARE	PO BOX 671	NASHVILLE	TN	37202	6152445600	MEDICARE INTERMEDIARY
407	CINERGY HEALTH INS.	1844 N. NOB HILL RD. #623	PLANTATION	FL	33322	8008471148	
177	CINERGY HEALTH PREFERRED PLAN	144 N BEVERWYCK RD #332	LAKE HIAWATHA	NJ	080341997	8008471148	CODE IN OPEN STATUS BY SCHA
A63	CITIZENS INSURANCE	PO BOX 1627	ANDERSON	SC	29622	8643340090	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
839	CITIZENS SECURITY LIFE INS.	PO BOX 436149	LOUISVILLE	KY	402536149	5022442420	
D56	CITRUS HEALTH CARE, INC.	PO BOX 20547	TAMPA	FL	33622	8667691157	MEDICARE ADVANTAGE PLAN
574	CITY OF AMARILLO GROUP HEALTH	PO BOX 15130	AMARILLO	TX	79105	8063784235	CODE IN OPEN STATUS BY SCHA
114	CLAIMEDIX INC.	PO BOX 140067	KANSAS CITY	MO	64114	8009224262	CODE ASSIGNED BY SCHA
A41	CLAIMS MANAGEMENT SERVICES	PO BOX 10888	GREENBAY	WI	54307	8004727130	
219	CLAIMS PRO	PO BOX 577	SOUTHFIELD	MI	48075	8008379600	RX CARRIER ONLY
A73	CLAIMS TECHNOLOGY, INC.	100 CT. AVE. STE. 306	DES MOINES	IA	50309	8002458813	
536	CLAIMSWARE MANAGEMED	PO BOX 6125	GREENVILLE	SC	29606	8642348200	
536DN	CLAIMSWARE MANAGEMED	PO BOX 6125	GREENVILLE	SC	29606	8642348200	
663	CLARENDON COUNTY	-	-	-	-		
259	CNA HEALTHCARE PARTNERS	PO BOX 34197	LITTLE ROCK	AK	72203	8005083772	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
887	CNIC HEALTH SOLUTIONS	PO BOX 3559	ENGLEWOOD	CO	80155	8004267453	
A51	COAL MINE WORKERS COMP PROGRAM	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C14	COASTAL LUMBER CO	PO BOX 1576	WALTERBORO	SC	29488	8435382876	CODE IN OPEN STATUS BY SCHA
664	COLLETON COUNTY	-	-	-	-		
132	COLONIAL LIFE AND ACCIDENT INSURANCE COMPANY	PO BOX 1365	COLUMBIA	SC	29202	8037987000	
A06	COLONIAL PENN FRANKLIN LIFE INSURANCE COMPANY	1818 MARKET ST.	PHILADELPHIA	PA	191811250	8005234000	THIS CARRIER PART OF CONSECO INSURANCE GROUP
744	COLUMBIA PHARMACY SOLUTIONS	PO BOX 30 COLUMBIA PLAZA	GREENSBURG	PA	15601	8007131983	
175	COLUMBIA UNIVERSAL LIFE INSURANCE CO.	PO BOX 200225	AUSTIN	TX	787200225	5123453200	
589	COMBINED ADMINISTRATIVE SERVICES	PO BOX 4539	DALTON	GA	307194539	7062727391	CODE IN OPEN STATUS BY SCHA
133	COMBINED INSURANCE COMPANY OF AMERICA	5050 BROADWAY	CHICAGO	IL	60640	8002254500	
609	COMM FOR BLIND						
974	COMMERCE BENEFIT GROUP	PO BOX 900	ELYRIA	OH	44036	8002239941	
986	COMMON WEALTH BENEFIT ADMINISTRATORS	115 HANOVER ST.	ASHLAND	VA	23005	8005261677	
B36	COMMONWEALTH INDEMITY PLAN	PO BOX 9016	ANDOVER	MA	01810	8004429033	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D18	COMMUNITY CARE SENIOR HEALTH PLAN	PO BOX 3249	TULSA	OK	741013249	8006428065	MEDICARE ADVANTAGE PLAN
911	COMMUNITY HEALTH PARTNERS	PO BOX 5787	SPARTANBURG	SC	29304	8889628437	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
287	COMMUNITY HEALTH PLAN	PO BOX 14467	CINCINNATI	OH	45250	8888008717	
X1S	COMMUNITY MUTUAL INSURANCE COMPANY	1351 WILLIAM HOWARD TAFT RD.	CINCINNATI	OH	45206	5132821016	CODE IN OPEN STATUS BY SCHA
416	COMPANION BENEFIT ALTERNATIVES	PO BOX 100185	COLUMBIA	SC	29202	8008681032	THIS CARRIER ASSIGNED BY SCHA NOT REQUESTED OR USED BY DHHS.
433	COMPANION LIFE	PO BOX 100102	COLUMBIA	SC	29202	8037880500	
548	COMPBENEFITS INSURANCE CO.	PO BOX 804483	CHICAGO	IL	606804106	8005940977	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C56	COMPDENT	1930 BISHOP LANE SUIT 132	LOUISVILLE	KY	40218	8006331262	
A39	COMPLETE BENEFITS SOLUTIONS	PO BOX 3649	GREENVILLE	SC	29603	8662702316	
A58	COMPREHENSIVE BENEFITS	PO BOX 8955	MELVILLE	NY	11747	8008283605	
853	COMPSYCH CORP.	PO BOX 8379	CHICAGO	IL	60680	8775955282	
412	CONNECTICARE	PO BOX 546	FARRINGTON	CT	06034	8002517722	
331	CONSECO HEALTH INS. CO	PO BOX 66904	CHICAGO	IL	606660904	8005412254	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
525	CONSECO MEDICAL INSURANCE CO.	PO BOX 1205	ROCKFORD	IL	61105	8009470319	USE CODE 282 WASHINGTON NATIONAL
309	CONSOLIDATED BENEFIT SERVICES, INC.	PO BOX 1391	DAYTON	OH	45401	8004766789	CODE NOT REQUSTED BY MEDICAID. ASSIGNED BY SCHA
C16	CONSOLIDATED BENEFITS, INC	PO BOX 23686	COLUMBIA	SC	29224	8037365088	
286	CONSOLIDATED GROUP	PO BOX 248	BATTLEBORO	VT	05302	8002411121	CODE IN OPEN STATUS BY SCHA
970	CONSOLIDATED WORKERS ASSOCIATION (CWA)	PO BOX 2647	CHINO HILLS	CA	91709	8009195514	CODE ASSIGNED BY SCHA
802	CONSTITUTION LIFE INSURANCE CO	PO BOX 130	PENSACOLA	FL	325910130	8007896364	
A04	CONSULTEC PRESCRIPTION BENEFITS MANAGEMENT	9040 ROSWELL RD. STE. 700	ATLANTA	GA	303501853	8003654944	
154	CONSUMER DRIVEN BENEFITS ASSO.	PO BOX 6080-228	MISSION VIEIO	CA	926906080	8884114208	CODE ASSIGNED BY SCHA
C31	CONSUMER HEALTH SOLUTIONS	PO BOX 3492	SPARTANBURG	SC	29304	8645739541	THE CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C39	CONTINENTAL GENERAL INSURANCE COMPANY	PO BOX 247007	OMAHA	NE	681247007	4023973200	
895	CONTINENTAL LIFE INS. OF TENNESSEE	PO BOX 1188	BRENTWOOD	TN	37024	6153771300	
A07	CONTINENTAL LIFE INSURANCE CO. OF SOUTH CAROLINA	PO BOX 6138	COLUMBIA	SC	29260	8037824947	
830	CONTRACTORS EMPLOYEE BENEFIT ADM. (CEBA)	PO BOX 559017	AUSTIN	TX	78755	8002477724	
192	CONVENTRY HEALTHCARE OF NEBRASKA, INC.	PO BOX 7705	LONDON	KY	40742	8002883343	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
928	COOK INSURANCE	PO BOX 1029	BLOOMINGTON	IN	47402	8005932080	
483	COOPERATIVE BENEFITS ADMINISTRATORS	PO BOX 6249	LINCOLN	NE	68506	4024839250	
551	COOPERATIVE MANAGED CARE SERVICES LLC	PO BOX 502530	INDIANAPOLIS	IN	46250	8668734516	CODE IN OPEN STATUS BY SCHA
211	COORDINATED BENEFIT PLANS INC.	PO BOX 853925	RICHARDSON	TX	750853925	8007531000	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
843	CORE MANAGEMENT RESOURCES GROUP	PO BOX 840	MACON	GA	31202	8887412673	
138	CORESOURCE	PO BOX 2920	CLINTON	IA	527332920	8775433935	
552	CORESOURCE INC	6100 FAIRVIEW RD.	CHARLOTTE	NC	28210	8003275462	
552DN	CORESOURCE INC	6100 FAIRVIEW RD.	CHARLOTTE	NC	28210	8003275462	
571	CORESOURCE, INC.	PO BOX 8215	LITTLE ROCK	AR	722218215	8886049397	CODE IN OPEN STATUS BY SCHA
364	CORESTAR	PO BOX 1195	MINNEAPOLIS	MN	55440	8004446965	
857	CORPORATE BENEFIT SERVICES INC	PO BOX 981800	EL PASO	TX	79998	7043730447	
857DN	CORPORATE BENEFIT SERVICES INC	PO BOX 12954	CHARLOTTE	NC	28220	7043730447	
A98	CORPORATE BENEFIT SERVICES OF AMERICA INC	PO BOX 738	HOPKINS	MN	55343	8007654224	
831	CORPORATE BENEFIT SOLUTIONS, INC.	PO BOX 8215	LITTLE ROCK	AR	72221	8886049397	
780	CORPORATE SYSTEMS ADMINISTRATION INC	PO BOX 4985	JOHNSON CITY	TN	376024985	8002752847	
213	COVENANT ADMINISTRATORS	PO BOX 105738	ATLANTA	GA	30348	7702396230	
245	COVENTRY HEALTH CARE	PO BOX 8400	LONDON	KY	40742	8009357284	
480	COVENTRY HEALTH CARE OF THE CAROLINAS	PO BOX 7715	LONDON	KY	40742	8008891947	COVENTRY HEALTH CARE IS PARENT CO. OF SOUTHERN HEALTH AND WELLPATH
191	COVENTRY HEALTHCARE OF DELAWARE, INC.	PO BOX 7713	LONDON	KY	40742	8008337423	CODE NOT REQUESTED BY MEDICAID. ASSIGNED MY SCHA
482	COVENTRY HEALTHCARE OF GEORGIA	PO BOX 7711	LONDON	KY	40742	8667321017	
246	COVENTRY HEATLH CARE RX	PO BOX 8400	LONDON	KY	40742	8009476824	
B62	COX HEALTH SYSTEMS INS. CO	PO BOX 5750	SPRINGFIELD	MO	658015750	8005613265	
632	CRIME VICTIMS	-	-	-	-----		
169	CROWN CORK & SEAL COMPANY, INC.	930 BEAUMONT AVE.	SPARTANBURG	SC	29303	8645856456	
420	CUNA MUTUAL INSURANCE GROUP	PO BOX 391	MADISON	WI	53701	6082385851	
194	DAKOTACARE	1323 S. MINNESOTA AVE	SIOUX FALLS	SD	57105		CODE ASSIGNED BY SCHA
665	DARLINGTON COUNTY	-	-	-	-		
D74	DART MANAGEMENT CORP	PO BOX 318	MASON	MI	488540318	8002480457	
A65	DATARX	5920 ODELLE ST	CUMMINGS	GA	30040	8778231273	
436	DAVIS-GARVIN AGENCY	#1 FERNANDINA CT.	COLUMBIA	SC	29212	8037320060	
B09	DEARBORN NATIONAL	PO BOX 23060	BELLEVILLE	IL	62223	8003484512	
834	DEFINITY HEALTH	PO BOX 9525	AMHERST	NY	14226	8663334648	BROUGHT OUT BY UNITED HEALTCARE CARRIER 113

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
500	DELTA DENTAL	PO BOX 1809	ALPHARETTA	GA	30023	8005212651	
C68	DENTAL BENEFIT PROVIDERS	PO BOX 389	ROCKVILLE	MD	20848	8004459090	
901	DENTAL CARE PLUS	100 CROWNE POINT PLACE	CINCINNATI	OH	45241	8003679466	
858	DENTAQUEST	PO BOX 2136	COLUMBIA	SC	29202	8003076553	NAIC 52040 MEDICAID DENTAL CLAIMS PROCESSOR
621	DEPT CORRECTIONS						
179	DESERET MUTUAL BENEFIT ADMINISTRATOR	PO BOX 45530	SALT LAKE CITY	UT	84145	8007773622	
955	DESIGN SAVERS PLAN	2814 SPRING RD. STE. 122	ATLANTA	GA	30339	8006165709	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
611	DHEC C. CHILDREN						
610	DHEC CANCER						
629	DHEC FAMILY PLANNING	-	-	-	-----		
627	DHEC HEART	-	-	-	-----		
628	DHEC HEMOPHILIA	-	-	-	-----		
613	DHEC HIGH RISK MATERNITY						
612	DHEC LOW RISK MATERNITY						
625	DHEC MIGRANT HEALTH						
626	DHEC SICKLE CELL						
615	DHEC STERILIZATION						
630	DHEC TB	-	-	-	-----		
725	DIALYSIS CLINIC, INC.	203 FREEMONT AVE.	SPARTANBURG	SC	29303	8645852046	
554	DIAMOND G EMPLOYEE BENEFIT TRUST	PO BOX 1298	GREENVILLE	TN	37744	4236396145	
666	DILLON COUNTY	-	-	-	-		
707	DILLON YARN MEDICAL BENEFITS	1019 TITAN RD	DILLON	SC	29536	8437747353	
516	DIRECT REIMBURSEMENT BENEFIT PLANS	1111 ALDERMAN DR STE. 420	ALPHARETTA	GA	30202	7706645594	
774	DISNEY WORLDWIDE SERVICES	PO BOX 10130	LAKE BUENA VISTA	FL	33830	8003922978	
258	DIVERSIFIED ADMINISTRATION CORPORATION	PO BOX 299	MARLBOROUGH	CT	06447	8883222524	
474	DIVERSIFIED PHARMACUETICAL	PO BOX 169052	DELUTH	MN	55816	8002338065	USE CODE 333 EXPRESS SCRIPTS
667	DORCHESTER COUNTY	-	-	-	-		
765	DRIVERS CHOICE	PO BOX 25427	COLUMBIA	SC	29224	8777724642	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
778	DUKE BENEFIT SERVICES, INC.	3078 BRICKHOUSE CT.	VIRGINIA BEACH	VA	23452	757-485-25	CODE ASSIGNED BY SCHA
786	E S BEVERIDGE & ASSO., CIN.	PO BOX 636	MANSFIELD	OH	44901	8004413961	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
849	E.O.S. HEALTH	PO BOX 27088	TEMPE	AZ	85285	8884568417	
567	EASTERN BENEFIT SYSTEMS	200 FREEWAY DR. E.	EAST ORANGE	NJ	07018	8005240227	
735	EATON BENEFIT PAYMENT OFFICE	PO BOX 16691	COLUMBUS	OH	43214	8002216036	
A14	EB RX	2045 MIDWAY DR	TWINSBURG	OH	44087	8008007153	
461	ECKERD HEALTH SERVICES	620 EPSILON DR.	PITTSBURGH	PA	15230	8005815300	USE CODE 712 TDI MANAGED CARE SERVICES
668	EDGEFIELD COUNTY	-	-	-	-		
137	EDUCATORS MUTUAL LIFE INSURANCE COMPANY	PO BOX 3149	LANCASTER	PA	17601	7173972751	
721	EHD ADMINISTRATORS	PO BOX 83080	LANCASTER	PA	176083080		CODE ASSIGNED BY SCHA
C80	ELDER HEALTH (MHN/HMC)	PO BOX 4433	BALTIMORE	MD	21223	8887768851	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D25	ELDER PLAN, INC. (HMO)	PO BOX 199100	BROOKLYN	NY	11219	7189218818	MEDICARE ADVANTAGE
B70	ELECTRICAL WELFARE TRUST FUND	4601 PRESIDENTS DR, #300	LANHAM	MD	20706	3017311050	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA.
B24	EMBLEM HEALTH CARE CO.	PO BOX 3000	NEW YORK	NY	10116	2125014444	
X0E	EMPIRE BLUE CROSS AND BLUE SHIELD	PO BOX 1407 CHURCH ST. STATION	NEW YORK	NY	10008	8003429816	
D64	EMPIRE HEALTHCHOICE ASSURANCE, INC.	PO BOX 100300 CLAIMS PROCESSING	COLUMBIA	SC	29204	8037888562	MEDICARE ADVANTAGE PLAN
C43	EMPLOYEE BENEFIT ADMINISTRATORS	PO BOX 5150	GREENVILLE	SC	29606	8642356474	
A90	EMPLOYEE BENEFIT CLAIMS INC	9501 WEST DEVON	ROSEMONT	IL	60018	3126963660	
499	EMPLOYEE BENEFIT CONSULTANTS	PO BOX 928	FINDLAY	OH	45839	8005587798	
869	EMPLOYEE BENEFIT MANAGEMENT SERVICES	PO BOX 21367	BILLINGS	MT	59104	8007773575	
506	EMPLOYEE BENEFIT PLAN ADMINISTRATORS	PO BOX 2000	HAMPTON	NH	03842	8002587298	
446	EMPLOYEE BENEFIT SERVICES	PO BOX 9888	SAVANNAH	GA	314120088	8035778051	USE CODE 345 EMPLOYEE BENEFIT SERVICES
345	EMPLOYEE BENEFIT SERVICES INC	PO BOX 1929	FORT MILL	SC	29716	8002421510	
345DN	EMPLOYEE BENEFIT SERVICES INC	PO BOX 1929	FORT MILL	SC	29716	8002421510	
761	EMPLOYEE BENEFIT STRATEGIES	229 EAST MICHIGAN AVE. STE. 235	KALAMAZOO	MI	49007	8003257477	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
317	EMPLOYEE BENEFITS MANAGEMENT CORPORATION	4789 RINGS RD.	DUBLIN	OH	43017	8005520455	
450	EMPLOYEE BENEFITS TRUST	PO BOX 8788	WILMINGTON	DE	19899	8007522677	OPEN 6/06
CO9	EMPLOYEE BENEFITS TRUST	PO BOX 1431	WICHITA FALLS	TX	76307	8177617611	CODE ASSIGNED WITH LETTER O INSTEAD OF NUMERIC ZERO.
405	EMPLOYEE HEALTH GROUP PLAN	101 LYNHAVEN RD.	VIRGINIA BEACH	VA	23451		
743	EMPLOYEE PLANS, INC.	PO BOX 2362	FT WAYNE	IN	468012362	2606257500	
550	EMPLOYEE SECURITY, INC	7125 THOMAS EDISON DR STE. 105	COLUMBIA	MD	21046	8006381134	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A97	EMPLOYER PLAN SERVICES, INC.	2180 NORTH LOOP WEST, STE. 400	HOUSTON	TX	77018	8004476588	
247	EMPLOYERS DIRECT HEALTH	5050 SPRING VALLEY RD.	DALLAS	TX	752443909	8008729934	CARRIER WAS FIRST INTERGRATED HEALTH
130	EMPLOYERS LIFE INSURANCE COMPANY	PO BOX 6305	SPARTANBURG	SC	29304	8889628437	CARRIER WAS COASTAL STATE LIFE INS. CO.
852	EMPLOYERS MUTUAL	1000 RIVERSIDE AVE, STE. 400	JACKSONVILLE	FL	32257	8006972235	
C24	ENCOMPASS HEALTH MANAGMENT SYSTEM	6000 WEST TOWN PARKWAY STE 350	DES MOINES	IA	50266	8005113389	
824	ENVISION RX OPTIONS	2181 EAST AURORA RD STE 201	TWINSBURG	OH	44087	8003614542	
509	EQUITABLE LIFE AND CASUALTY	PO BOX 2460	SALT LAKE CITY	UT	84110	8003525150	
510	EQUITABLE PLAN SERVICES	PO BOX 720460	OKLAHOMA	OK	73172	8007492631	
C94	ERIN GROUP ADMINISTRATORS	PO BOX 7777	LANCASTER	PA	17604	8004333746	ANOTHER PHONE NUMBER 717-581-1300
C94DN	ERIN GROUP ADMINISTRATORS	PO BOX 7777	LANCASTER	PA	17604	8004333746	ANOTHER PHONE NUMBER 717-581-1300
788	ERISA DESIGN SYSTEMS ADM.(EDSA)	PO BOX 1557	BALTIMORE	MD	21203	8008203372	DORMANT 8/06
180	ESIS	PO BOX 31122	TAMPA	FL	33631	8008847975	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C18	EVOLUTIONS HEALTHCARE SYSTEMS	PO BOX 5001	NEW PORT RICHEY,	FL	34656	8008814474	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D20	EXCELLUS MEDICARE BLUE CHOICE OPTIMUM	PO BOX 41915	ROCHESTER	NY	14604	8778839577	MEDICARE ADVANTAGE PLAN
333	EXPRESS SCRIPTS	PO BOX 2849	CLINTON	IA	527332849	8004516245	
A35	FABRI-KAL CORPORATION	PO DRAWER C	PIEDMONT	SC	29773	8642991720	CODE IN OPEN STATUS BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
669	FAIRFIELD COUNTY	-	-	-	-		
B49	FALLON COMMUNITY HEALTH PLAN	PO BOX 15121	WORCHESTER	MA	01615	8008685200	
A16	FCE BENEFIT ADMINISTRATOR	4615 WALZEM RD. STE 300	SAN ANTONIO	TX	782181610	8008999355	
402	FEDERAL EMPLOYEE PLAN BLUE CROSS	I-20 AT ALPINE RD.	COLUMBIA	SC	29260	8037883860	
A50	FEDERAL EMPLOYEES COMPENSATION ACT	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
441	FEDERAL MOGUL HEALTHCARE	PO BOX 1999	DETROIT	MI	48235	8005220041	
290	FEDERATED MUTUAL INSURANCE COMPANY (REGIONAL)	PO BOXBOX31716	TAMPA	FL	336313716	8134968100	
769	FEDEX FREIGHTWAYS	PO BOX 840	HARRISON	AR	72602	8008744723	
738	FHA-TPA DIVISION	PO BOX 327810	FT LAUDERDALE	FL	333329711	8037988698	CODE IN OPEN STATUS BY SCHA
205	FIDELITY LIFE SECURITY	3130 BROADWAY	KANSAS CITY	MO	641112406	8006488624	
941	FIDELITY SECURITY LIFE INSURANCE CO	419 E MAIN ST	MIDDLETOWN	NY	10940	8008267531	THE CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A36	FIELDCREST CANNON (CANNON MILLS)	PO BOX 5000	EDEN	NC	272895000	8002223693	
467	FIRSERV HEALTH	PO BOX 182173	COLUMBUS	OH	432182173	8008482664	USE CODE 139
288	FIRST ADMINISTRATORS, INC.	PO BOX 9900	SIOUX CITY	IA	51102	8002060827	
348	FIRST AGENCY, INC.	5071 WEST H AVE	KALAMAZOO	MI	490098501	2693816630	THIS CODE ASSIGNED BY SCHA 8/28/07
354	FIRST BENEFITS CORP	PO BOX 879	ANDERSON	IN	46015		CODE ASSIGNED BY SCHA
A74	FIRST CAROLINA CARE, INC.	PO BOX 381686	BIRMINGHAM	AL	35238	8008113298	
775	FIRST CHOICE BENEFITS MANAGEMENT	PO BOX 658	BELOIT	WI	535120658	8003035770	
803	FIRST CONTINENTAL LIFE INSURANCE	PO BOX 1911	CARMEL	IN	46032	8005381235	
946	FIRST HEALTH	PO BOX 1377	THOMASVILLE	GA	31799	8668478235	
245RX	FIRST HEALTH	PO BOX 23070	TUCSON	AZ	85734	8005544954	
249	FIRST HEALTH WORKERS COMP ONLY	PO BOX 23070	TUCSON	AZ	85735	8005544954	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
351	FISERV	PO BOX 8077	WAUSAU	WI	544028077	8666848090	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
139	FISERV HEALTH	PO BOX 8013	WAUSAU,	WI	544028013	8008269781	WAS WAUSAU INS. CO.

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
352	FISERV HEALTH-COLORADO	PO BOX 720	PUEBLO	CO	810020720	8004468182	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
670	FLORENCE COUNTY	-	-	-	-		
C75	FLORIDA 1ST SERVICE ADMINISTRATORS, INC.	PO BOX 3607	WINTER HAVEN	FL	338853067	8002263155	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
719	FLORIDA HEALTH ALLIANCE	PO BOX 10269	JACKSONVILLE	FL	322470269	9043548335	
913	FLORIDA HOSPITAL HEALTHCARE SYSTEM	PO BOX 536847	ORLANDO	FL	328536847	8007414810	
B20	FMH BENEFIT SERVICES, INC.	PO BOX 25946	OVERLAND PARK	KS	66225	8009909058	
B05	FOCUS HEALTHCARE MANAGEMENT, INC.	720 COOL SPRINGS BLVD	FRANKLIN	TN	37067	6157784000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A94	FORETHOUGHT LIFE INSURANCE COMPANY	PO BOX 981721	EL PASO	TX	79998	8774925870	
C02	FOUNDATION BENEFITS ADMINISTRATORS	6300 BRIDGEPOINT PKWAY, BLDG 3 #400	AUSTIN	TX	78730	8883687910	
870	FOUNDATION HEALTH	PO BOX 453219	SUNRISE	FL	33345	8004415501	
393	FOUNTAINHEAD ADMINISTRATORS, INC.	PO BOX 13188	BIRMINGHAM	AL	35202	8009919155	
C83	FREEDOM LIFE INSURANCE CO. OF AMERICA	PO BOX 24294	LOUISVILLE	KY	40224	8005281057	
587	FUTURE SCRIPTS	PO BOX 419019	KANSAS CITY	MO	64141	8886787012	
842	GARDNER AND WHITE INC	PO BOX 40619	INDIANAPOLIS	IN	462400619	3172579131	
842DN	GARDNER AND WHITE INC	PO BOX 40619	INDIANAPOLIS	IN	462400619	3172579131	
443	GATES HEALTH CARE PLAN	PO BOX 5887	DENVER	CO	80217	8007770595	
D54	GATEWAY HEALTH PLAN MEDICARE ASSURED	PO BOX 11560	ALBANY	NY	122110655	8006855209	MEDICARE ADVANTAGE PLAN
864	GE GROUP ADMINISTRATORS	PO BOX 150809	ARLINGTON	TX	76015	8882558961	
442	GE LIFE & ANNUITY ASSURANCE CO.	PO BOX 6700	LYNCHBURG	VA	24505	8002530856	
B63	GE PENSIONER HEALTH BENEFITS	PO BOX 740801	ATLANTA	GA	303740801	8008488406	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
845	GEISINGER HEALTH PLAN GOLD	PO BOX 8200	DANVILLE	PA	178218200	8004989731	MEDICARE ADVANTAGE PLAN
C97	GEM GROUP	1200 THREE GATEWAY CENTER	PITTSBURGH	PA	15222	8002428923	
232	GENERAL ADJUSTMENT BUREAU	PO BOX 81808	ALTANTA	GA	30366	4044579555	CODE ASSIGNED BY SCHA
142	GENERAL AMERICAN LIFE INSURANCE	719 TEACO RD.	KENNETH	MO	63857	8004452158	USE CODE 308 GREAT WEST LIFE INACTIVE 8-02
728	GENERAL PRESCRIPTION PROGRAMS INC	305 MEDICINE BLVD.	NEW YORK	NY	10165	8003412234	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
799	GENWORTH FINANCIAL	PO BOX 8021	SAN RAFAEL	CA	949129974	8008764582	WAS G E FINANCIAL SERVICES
997	GENWORTH FINANCIAL	PO BOX 10821	CLEARWATER	FL	33757	8778259337	CODE IN OPEN STATUS BY SCHA
671	GEORGETOWN COUNTY	-	-	-	-		
730	GEORGIA HEALTHCARE PARTNERSHIP	PO BOX 16388	SAVANNAH	GA	314163088	8005666710	
419	GEORGIA STATE HEALTH BENEFIT PLAN	PO BOX 38151	ATLANTA	GA	30334	8006266402	
365	GERBER CHILDRENS WEAR, INC.	PO BOX 2126	GREENVILLE	SC	29602	8649875200	
749	GERBER LIFE INSURANCE COMPANY	PO BOX 2088	GRAND RAPIDS	MI	49501	8002533074	
B88	GETTYSBURG HEALTH ADMINISTRATORS	PO BOX 1169	FREDERICK	MD	21702	8004974474	
183	GILSBAR INSURANCE COMPANY	PO BOX 2947	COVINGTON	LA	70434	8002342643	
459	GLASS MOTORS & PLASTIC (GMPA)	5245 BIG PINE WAY, SE 33907	FORT MYERS	FL	33907	8139366242	
A44	GLOBAL MEDICAL MANAGEMENT, INC	7901 SW 36TH ST. STE 100	DAVIE	FL	33328	9543706404	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
144	GLOBE LIFE & ACCIDENT INSURANCE	204 N. ROBINSON	OKLAHOMA CITY	OK	73102	4052701400	
145	GMP EMPLOYERS RETIREE TRUST	5245 BIG PINE WAY SE	FORT MYERS	FL	33907	9419366242	
584	GOLDEN RULE INSURANCE COMPANY	PO BOX 31374	SALT LAKE CITY	UT	841310374	6189438000	
931	GOOD SAMARITAN PROGRAM	5151 WEST HWY 40	BEACHGROVE	IN	46140	3178942000	
379	GOODYEAR TIRE & RUBBER COMPANY	PO BOX 677 DEPT. 609	AKRON	OH	44309	2167966531	
302	GOVERNMENT EMPLOYEE HOSP. ASSN (GEHA)	PO BOX 4665	INDEPENDENCE	MO	640514665	8162575500	
B31	GREAT AMERICAN LIFE INS. CO (GALIC)	PO BOX 559002	AUSTIN	TX	787553010	8008802745	
313	GREAT WEST HEALTHCARE	1000 GREAT WEST DR	KENNETT	MO	63857	8006638081	
308	GREAT WEST LIFE	1000 GREAT WEST DR	KENNETT	MO	63857	8006638081	
308DN	GREAT WEST LIFE	PO BOX 11111	FORT SCOTT	KS	66701	8776314227	
121	GREATER HEALTHCARE	PO BOX 3400	MONROE	NC	28110	7042258887	
672	GREENVILLE COUNTY	-	-	-	-		
673	GREENWOOD COUNTY	-	-	-	-		
B99	GROUP & PENSION ADMINISTRATORS, INC.	PO BOX 749075	DALLAS	TX	75374	8662063224	
181	GROUP ADMINISTRATORS, LTD.	450 E. REMINGTON RD.	SCHAUMBURG	IL	60173	8475191880	
745	GROUP BENEFIT SERVICES	1312 BELLONE AVE.	LUTHERVILLE	MD	21093	8006386085	
343	GROUP BENEFITS ADMINISTRATORS	70 GRAND AVE.	RIVEREDGE	NJ	07661	2013433003	
906	GROUP HEALTH ADMINISTRATOR INC	PO BOX 6244	CHARLOTTE	NC	282071018	8002225790	
508	GROUP HEALTH INC. /EMBLEM HEALTH COMPANY	PO BOX 3000	NEW YORK	NY	101163000	2125014444	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
889	GROUP INSURANCE ADMINISTRATION INC	3350 PEACHTREE RD NE STE. 1040	ATLANTA	GA	30326	8006210683	
889DN	GROUP INSURANCE ADMINISTRATION INC	3350 PEACHTREE RD NE STE. 1040	ATLANTA	GA	30326	8006210683	
729	GROUP INSURANCE SERVICES (GIS)	PO BOX 2291	DURHAM	NC	27702	9194904391	CODE IN OPEN STATUS BY SCHA
389	GROUP LINK	PO BOX 20593	INDIANAPOLIS	IN	46220	8003597408	
A83	GROUP RESOURCES INC	PO BOX 100043	DULUTH	GA	300969343	7706238383	
D46	GROUPHEALTH OPTIONS, INC	PO BOX 34585	SEATTLE	WA	98124	8887674670	MEDICARE ADVANTAGE PLAN
727	GUARANTEE MUTUAL LIFE CO.	8801 INDIAN HILLS DR.	OMAHA	NE	68114	8004624660	
236	GUARANTEE TRUST LIFE INSURANCE	1275 MILWAUKEE AVE.	GLENVIEW	IL		8476990600	
283	GUARDIAN HEALTHCARE	PO BOX 4197	SCRANTON	PA	77010	8668501256	MEDICARE ADVANTAGE PLAN
362	GUARDIAN HEALTHCARE	PO BOX 4197	SCRANTON	PA	18505	8668501253	MEDICARE ADVANTAGE PLAN
418	GUARDIAN INSURANCE COMPANY	PO BOX 8007	APPLETON	WI	549128007	8006854542	CODE ASSIGNED BY SCHA
237DN	GUARDIAN LIFE INSURANCE CO. OF AMERICA	PO BOX 2459	SPOKANE	WA	99210	8005417846	
237	GUARDIAN LIFE INSURANCE COMPANY OF AMERICA	PO BOX 8019	APPLETON	WI	54913	8008734542	
176	GUIDESTAR HEALTH SYSTEMS	PO BOX 35238	BIRMINGHAM	AL	35238	8005956949	
776	GULF SOUTH ADMINISTRATORS	PO BOX 8570	METAIRIE	LA	700118570	8003662475	CODE IN OPEN STATUS BY SCHA
674	HAMPTON COUNTY	-	-	-	-		
A96	HAMRICKS INC	742 PEACHOID RD.	GAFFNEY	SC	29340	8644877505	
547	HARRINGTON HEALTH	PO BOX 30544	SALT LAKE CITY	UT	841300544	8777370769	
146	HARTFORD INSURANCE GROUP	PO BOX 25600	CHARLOTTE	NC	28212	7045366230	
197	HARVARD PILGRIM HEALTH CARE	505 S LENOLA RD, STE. 231	MOORESTOWN	NJ	08057	866-375-07	
162	HARVARD PILGRIM HEALTHCARE	PO BOX 656653	SAN ANTONIO	TX	82655	8004213550	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A84	HCC LIFE INSURANCE COMPANY	PO BOX 863	INDIANAPOLIS	IN	46206	8664007102	
201	HCH ADMINISTRATORS	PO BOX 1986	PEORIA	IL	61656	8003221516	
201DN	HCH ADMINISTRATORS	PO BOX 1986	PEORIA	IL	61656	8003221516	
B95	HDR EMPLOYEE BENEFITS ADMINISTRATORS	PO BOX 5150	GREENVILLE	SC	29606	8004765150	CODE IN OPEN STATUS BY SCHA
837	HEALTH ADMINISTRATION SERVICES	PO BOX 6724208	HOUSTON	TX	77267	8008655440	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B87	HEALTH ALLIANCE	PO BOX 6003	URBANA	IL	616036003	8003227451	
823	HEALTH ALLIANCE PLAN	2850 W GRAND BLVD	DETROIT	MI	495254501	8004224641	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
264	HEALTH AMERICA	PO BOX 7089	LONDON	KY	40742	8007888445	
B25	HEALTH AND WELFARE FUND LOCAL 218	PO BOX 115027	ATLANTA	GA	30310	4047555665	
B84	HEALTH CARE CORPORATION	203 JANDERS RD.	CARY	IL	60013		CODE IN OPEN STATUS BY SCHA
713	HEALTH CARE CREDIT UNION ASSOC. HCCUA	PO BOX 260957	PLANT	TX	750260957	8663736366	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
748	HEALTH CARE SAVINGS, INC.	4530 PARK RD	CHARLOTTE	NC	28209	-	CODE ASSIGNED BY SCHA
203	HEALTH CARE SUPPORT/PRIVATE HEALTH CARE SYSTEM	29 COLUMBIA HEIGHTS	BROOKLYN	NY	11201	8005544022	CODE ASSIGNED BY SCHA
394	HEALTH CHOICES, INC	PO BOX 5003	DUBURQUE	IA	520045003	8003257442	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
562	HEALTH CLAIMS SERVICES, INC.	PO BOX 9615	DEERFIELD BEACH	FL	33442	8002223560	
A75	HEALTH COST SOLUTIONS	PO BOX 1439	HENDERSONVILLE	TN	37077	8882295020	WAS LIFECARE CENTERS OF AMERICA
B75	HEALTH DESIGN PLUS	PO BOX 2584	HUDSON	OH	442362584	8008930777	
960	HEALTH EOS	PO BOXBX 6090	DER PERE	WI	541156090	8004355694	CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
B27	HEALTH FIRST (PPO)	PO BOX 17709	GREENVILLE	SC	29606	8642893000	
884	HEALTH FIRST HEALTH PLANS	PO BOX 565001	ROCKLEDGE	FL	329565001	8007167737	CODE IN OPEN STATUS BY SCHA
447	HEALTH NET	PO BOX 14700	LEXINGTON	KY	405125225	9004387886	MEDICARE ADVANTAGE PLAN
874	HEALTH NET	PO BOX 14700	LEXINGTON	KY	40512	8887477823	THIS CODE NOT REQUESTED BY SCHA. ASSIGNED BY SCHA
281	HEALTH NETWORK AMERICA/TRIVERIS	PO BOX 307	EATONTOWN	NJ	07724	8003371421	CODE ASSIGNED BY SCHA
220	HEALTH NEW ENGLAND	ONE MONARCH PLACE,STE 1500	SPRINGFIELD	MA	011441500	8003102835	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B01	HEALTH PARTNERS	PO BOX 1289	MINNEAPOLIS	MN	554401289	8889222313	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C09	HEALTH PLAN ADMINISTRATORS	PO BOX 2638	ROCKFORD	IL	61132	8156335800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
382	HEALTH PLAN OF NEVADA	PO BOX 15645	LAS VEGAS	NV	891145615	8007771840	MEDICARE ADVANTAGE PLAN
349	HEALTH PLAN SELECT	PO BOX 382767	BIRMINGHAM	AL	352382767	8002936260	
357	HEALTH PLAN SERVICES	PO BOX 30298	TAMPA	FL	33630-	8002377767	
126	HEALTH PLAN SERVICES (COVENTRY HEALTH CARE)	PO BOX 24146	SEATTLE	WA	98124	8008610056	CODE ASSIGNED BY SCHA
332	HEALTH PLANS INC.	PO BOX 5199	WESTBOROUGH	MA	01581	8005327575	
324	HEALTH REIMBURSEMENT MANAGMENT PARTNERSHIP	5 HUTCHINSON DR	DANVERS	MA	01923	8889994767	CODE IN OPEN STATUS BY SCHA
225	HEALTH SERVICES FOUNDATION	PO BOX 2109	LIVERMORE	CA	94551	5104497070	
A79	HEALTH SPECIAL RISK	4001 N. JOSEY LANE	CARROLLTON	TX	75007	9724926474	
A27	HEALTHCARE SUPPORT	25 COLUMBIA HEIGHTS	BROOKLYN HEIGHTS	NY	112012482	8005544022	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
758	HEALTHCHOICE	PO BOX 24870	OKLAHOMA	OK	731270870	8004892974	CODE ASSIGNED BY SCHA
814	HEALTHCOMP ADMINISTRATORS	PO BOX 45018	FRESNO	CA	93718	8004427247	
524	HEALTHFIRST	PO BOX 130217	TYLER	TX	75713	8004778957	CODE ASSIGNED BY SCHA TPA
D19	HEALTHFIRST 65 PLUS	PO BOX 5196	NEW YORK	NY	10274	8882601010	MEDICARE ADVANTAGE PLAN
639	HEALTHFIRST HMO	255 ENTERPRISE BLVE. STE. 20	GREENVILLE	SC	29615	8644551100	MEDICAID HMO
440	HEALTHNET	PO BOX 14702	LEXINGTON	KY	40512	8006417761	
753	HEALTHNET	PO BOXBXO 2226	AUGUSTA	GA	309032226	9009778221	
A67	HEALTHSCOPE BENEFITS	PO BOX 99005	LUBBOCK	TX	794906831	8009676831	
553DN	HEALTHSCOPE BENEFITS, INC.	PO BOX 8076	LITTLE ROCK	AR	72203	8008277026	
553	HEALTHSCOPE BENEFITS, INC.	PO BOX 8076	LITTLE ROCK	AR	72203	8883736102	
305	HEALTHSMART	PO BOX 2801	CHARLESTON	WV	253302801	8668695597	
920	HEALTHSMART PREFERRED CARE	PO BOX 53010	LUBBOCK	TX	794533010	8064732500	
876	HEALTHSOURCE OF NC INC	PO BOX 28087	RALEIGH	NC	27611	8008499000	USE CODE 134 CIGNA HEALTHCARE
519	HEALTHSOURE ADMINISTRATORS	PO BOX 382617	BIRMINGHAM	AL	35238	8778939294	
242	HELLER ASSOCIATES	8228 MAYFIELD RD. STE 5B	CHESTERLANDE	OH	44026	4405272955	CODE IN OPEN STATUS BY SCHA
848	HERITAGE	PO BOX 1730	AUBURNDALE	FL	33823	8002822460	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
732	HERTZ CLAIM MANAGEMENT	P.O BOX 726	PARK RIDGE	NJ	07656	2013072177	
117	HEWITT COLEMAN AND ASSOCIATES	PO BOX 6708	GREENVILLE	SC	29606	8642405840	
X1R	HIGHMARK BLUE CROSS BLUE SHIELD	PO BOX 535053	PITTSBURGH	PA	152535053	4125447000	
D45	HIGHMARK SECURITY BLUE	120 5TH AVE	PITTSBURGH	PA	15222309	8005473627	MEDICARE ADVANTAGE PLAN
A78	HIGHWAY TO HEALTH (HTH)	PO BOX 968	HORSHAM	PA	19044	8883502002	THIS CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
B15	HILLCREST BENEFIT ADMINISTRATORS	PO BOX 1516	MT. DORA	FL	32756	8007439264	
502	HIP HEALTH PLAN	PO BOX 2803	NEW YORK	NY	101162803	8004478255	MEDICARE ADVANTAGE PLAN
B81	HM BENEFITS ADMINISTRATORS, INC.	PO BOX 535078	PITTSBURGH	PA	152535078	8002792624	
A13	HOLDEN & COMPANY	PO BOX 10411	SAVANNAH	GA	31412	8004043344	
A68	HOLLINGSWORTH SACO LOWELL CORP.	P O DRAWER 2327	GREENVILLE	SC	29602	8648593211	DORMANT 8/06
984	HOMELAND HEALTHCARE	PO BOX 3726	SEATTLE	WA	98124	8004934240	
D36	HOP/PSERS HEALTH ADMINISTRATION UNIT	PO BOX 2921	CLINTON	IA	52733	8007737725	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
239	HORACE MANN LIFE INSURANCE COMPANY	1 HORACE MANN PLAZA	SPRINGFIELD	IL	62715	2177892500	
238	HORIZON HEALTHCARE	PO BOX 1028	WEST TRENTON	NJ	08628	8007923666	
675	HORRY COUNTY	-	-	-	-		
782	HOUSING BENEFIT PLAN	PO BOX 542077	DALLAS	TX	753542077	8009372036	
C34	HTH WORLDWIDE INSURANCE SERVICES	PO BOX 39	MINNEAPOLIS	MN	554400039	8665108780	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
836	HUMANA	1100 EMPLOYERS BLVD	GREEN BAY	WI	543440620	8005584444	
C59	HUMANA CHOICE (PPO)	P.O .BOX 14605	LEXINGTON	KY	405784602	8004574708	MEDICARE ADVANTAGE PLAN
B68	HUMANA GOLD CHOICE	PO BOX 202047	FLORENCE	SC	295022047	8775115000	THIS CODE INCORRECTLY ASSIGNED BY HOSP. ASSO. USE CODE 648 FOR THE MEDICARE ADVANTAGE PLAN 648
648	HUMANA GOLD CHOICE (PFFS)	PO BOX 7060	CAMDEN	SC	29020	8775115000	MEDICARE ADVANTAGE PLAN
793	HUMANA GOLD PLUS	PO BOX 14601	LEXINGTON	KY	405124601	8004574708	MEDICARE ADVANTAGE PLAN
216	HUMANA HEALTH INSURANCE OF FLORIDA	PO BOX 19080-F	JACKSONVILLE	FL	32245	8004574708	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
752	HYGEIA CORPORATION	15500 NEW BARN RD.	MIAMI LAKES	FL	33014	8005912650	CODE ASSIGNED BY SCHA
371	ICON BENEFIT ADMINISTRATORS, INC.	PO BOX 53010	LUBBOCK	TX	794533070	8006589777	
250	IDEAL SCRIPTS	144 METRO CENTER BLVD	WARWICK	RI	02886	8007176614	
B80	IMB-SBC MEDICAL PLAN	PO BOX 1746	INDIANAPOLIS	IN	462061746		THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
801	IMERICA LIFE AND HEALTH INS. CO	PO BOX 3287	ENGLEWOOD	CO	80155	8882738020	
B26	IMSCO HEALTH PLAN	PO BOX 697	BUCKEYSTOWN	MD	217170697	8009442833	IMSCO - INTERNATIONAL MANAGEMENT SERVICE CO.
798	INCENTUS	1710 FIRMAN	RICHARDSON	TX	75081	8005591322	USE CODE B44 AMERICA CHOICE HEALTH PLAN
716	INDECS CORP	PO BOX 668	LYNDHURST	NJ	07071	8884463327	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A08	INDEPENDENCE AMERICAN INS. CO.(IHC HEALTH SOLUTION	PO BOX 21456	EAGON	MN	55121	8664290608	
X1G	INDEPENDENCE BLUE CROSS	PO BOX 69352	HARRISBURG	PA	171069352	8002752583	
892	INDEPENDENT HEALTH	PO BOX 9066	BUFFALO	NY	14231	8002471466	
D44	INDEPENDENT HEALTH	PO BOX 9066	BUFFALO	NY	14231	8666178585	MEDICARE ADVANTAGE PLAN
975	INFORMED RX	PO BOX 5206	LISLE	IL	60532	8006453332	WAS NATIONAL MEDICAL HEALTH CARD
B51	INNOVIANT	PO BOX 8082	WAUSAU	WI	54402	8775592955	
C60	INSTILL HEALTH SYSTEMS (FFS)	PO BOX 7061	CAMDEN	SC	290207845	8774467845	MEDICARE ADVANTAGE PLAN
C61	INSTILL HEALTH SYSTEMS (PPO)	PO BOX 7061	CAMDEN	SC	290207845	8774467845	MEDICARE ADVANTAGE PLAN
863	INSURANCE ADMINISTRATION CORP.	PO BOX 39119	PHOENIX	AZ	85069	8008433106	
D02	INSURANCE ADMINISTRATOR OF AMERICA	PO BOX 5082	MT. LAUREL	NJ	08054	8009896739	
149	INSURANCE COMPANY OF NORTH AMERICA (INA)	195 BROADWAY 11TH FLOOR	NEW YORK	NY	100073100	2126184000	
726	INSURANCE SERVICE AND BENEFITS	3218 HIGHWAY 67 STE. 218	MESQUITE	TX	75150	8008783157	
C41	INSUREX BENEFITS ADMINISTRATORS, INC.	PO BOX 41779	MEMPHIS	TN	381741799	9017256435	
C41DN	INSUREX BENEFITS ADMINISTRATORS, INC.	PO BOX 41779	MEMPHIS	TN	381741799	9017256435	
484	INTEGRITY BENEFITS NETWORK	PO BOX 4537	MARIETTA	GA	30061	7704281604	
B72	INTEGRITY NATIONAL LIFE INS.	PO BOX 32350	LOUISVILLE	KY	40232	5024261843	CODE ASSIGNED BY SCHA
A45	INTEQ GROUP	5445 LASIERRA DR STE. 400	DALLAS	TX	75231	8009593953	
465	INTER CARE BENEFIT SYSTEMS	PO BOX 3559	ENGLEWOOD	CO	801553559	3037705710	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C26	INTERACTIVE MEDICAL SYSTEMS, INC.	PO BOX 19108	RALEIGH	NC	27619	9198468400	
C54	INTER-AMERICAS INS. CORP. (OOIDA)	PO BOX 9510	WICHITA	KS	672770510		THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
129	INTERGROUP SERVICES CORPORATION	101 LINDENWOOD DR, STE 150	MALVERN	PA	19355	8005379389	
D01	INTERLINK HEALTH SERVICES	4950 NE BELNAP CT #205	HILLSBORO	OR	97124	5036402000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B76	INTERNATIONAL ASSO. BENEFITS	1747 PENNSYLVANIA AVE NORTH WEST	WASHINGTON	DC	20006	8002751171	
983	INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS	3901 E. WINSLOW AVE	PHOENIX	AZ	85040	6022340497	
101	INTERNATIONAL CLAIMS SERVICES	27092 BURBANK ST	FOOTHILL RANCH	CA	92610	8779167920	ASSIGNED BY SCHA
189	INTERNATIONAL EDUCATION EXCHANGE SERVICES	PO BOX 370	ITHACA	NY	148510307	8664337462	
464	INTERNATIONAL MEDICAL GROUP	407 N. FULTON ST.	INDIANAPOLIS	IN	46202	8006284664	
473	INTERNATIONAL MISSION BOARD (IMB)	PO BOX 6767	RICHMOND	VA	232300767	8042191585	CODE ASSIGNED BY SCHA
454	INTERNATIONAL UNION OF OPERATING ENGINEERS	166 WEST KELLY ST.	METUCHEN	NJ	08840	9085486662	
411	INTERPLAN HEALTH GROUP	PO BOX 90613	ARLINGTON	TX	76006	8660511-47	CODE ASSIGNED BY SCHA
A19	ISLAND GROUP ADMINISTRATION, INC`	3 TOILSOME LANE	EAST HAMPTON	NY	11937	8009262306	CODE ASSIGNED BY SCHA
958	ITPE-NMU HEALTH AND WELFARE FUND	PO BOX 13817	SAVANNAH	GA	31416	9123527169	
958DN	ITPE-NMU HEALTH AND WELFARE FUND	PO BOX 13817	SAVANNAH	GA	31416	9123527169	
757	J C PENNEY LIFE INSURANCE COMPANY	PO BOX 869090	PLANO	TX	750860909	9728816000	
827	J. SMITH LANIER	PO BOX 72749	NEWNAN	GA	30271	8882954864	
996	J.F. MOLLOY & ASSO.	PO BOX 68947	INDIANAPOLIS	IN	46268	8003313287	SEE CARRIER 942 PRINCIPAL FINANCIAL GROUP
335	J.P. FARLEY CORP.	PO BOX 458022	WESTLAKE	OH	441468022	4402504300	
676	JASPER COUNTY	-	-	-	-		
109	JEFFERSON PILOT INSURANCE COMPANY	PO BOX 26011	GREENSBORO	NC	27420	3366913000	
514	JLT SERVICES (TPA FOR NY LIFE)	PO BOX 1511	LATHAM	NY	12110	8007933773	NOT REQUESTED BY MEDCAID. ASSIGNED BY SCHA
D09	JM FAMILY ENTERPRISES	8019 BAYBERRY RD	JACKSONVILLE	FL	32256	8008920059	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
885	JOHN ALDEN INSURANCE COMPANY	PO BOX 020270	MIAMI	FL	33102	8003284316	
885DN	JOHN ALDEN INSURANCE COMPANY	PO BOX 020270	MIAMI	FL	33102	8003284316	
202	JOHN HANCOCK INSURANCE COMPANY	PO BOX 852	BOSTON	MA	02117	8002331449	
B12	JOHN HANCOCK LIFE AND HEALTH INSURANCE	JOHN HANCOCK B5-03 200 BERKELEY STEET	BOSTON	MA	02116	8003777311	
C71	JOHNS HOPKINS HEALTHCARE	6704 CURTIS CT.	GLEN BURNIE	MD	21060	8002612393	
417	JULY PRODUCTS	5 GATEWAY CENTER STE 60	PITTSBURG	PA	15222	8669008322	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
A69	KAISER FOUNDATION HEALTH PLAN OF SOUTHERN CA	PO BOX 7004	DOWNEY	CA	902427004	8003310420	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
104	KAISER FOUNDATION HEALTH PLAN OF SOUTHERN CA.	PO BOX 7004	DOWNEY	CA	90242	8003903510	CODE ASSIGNED BY SCHA
528	KAISER PERMANENTE	PO BOX 190849	ALTANTA	GA	31119	8006111811	MEDICARE ADVANTAGE PLAN
C78	KAISER PERMANENTE	PO BOX 190849	ATLANTA	GA	31119	4042612590	
537	KAISER PERMANENTE-OHIO REGION	PO BOX 5316-9774	CLEVELAND	OH	441010316	8006348816	CODE ASSIGNED BY SCHA
C47	KANAWHA BENEFIT SERVICES	PO BOX 50098	KNOXVILLE	TN	379500098	8008221274	
C47DN	KANAWHA BENEFIT SERVICES	PO BOX 50098	KNOXVILLE	TN	379500098	8008221274	
153	KANAWHA LIFE INSURANCE COMPANY	PO BOX 6000	LANCASTER	SC	29721	8032862440	
153DN	KANAWHA LIFE INSURANCE COMPANY	PO BOX 6000	LANCASTER	SC	29721	8032862440	
868	KANSAS CITY LIFE	PO BOX 219325	KANSAS CITY	MO	64121	8008745254	
C30	KEENAN AND COMPANY	PO BOX 11431	TORRANCE	CA	90510	8006533626	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
677	KERSHAW COUNTY	-	-	-	-		
760	KEY BENEFIT ADMINISTRATORS	PO BOX55230	INDIANAPOLIS	IN	46205	8003314757	
936	KEY BENEFITS-TRANSCHOICE PLUS	PO BOX 1279	FORT MILL	SC	297161279	8005916764	CODE ASSIGNED BY SCHA
893	KEYSTON HEALTH PLAN EAST	PO BOX 8339	PHILADELPHIA	PA	19101	8002273116	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D71	KEYSTONE 65	PO BOX 7799	PHILADELPHIA	PA	191017799	8002273116	MEDICARE ADVANTAGE PLAN
B66	KIRKE-VAN ORSDEL, INC.	PO BOX 9126	DES MOINES	IA	503069126	8002472192	USE CODE 759 MEDIPLUS PER SCHA
318	KLAIS & COMPANY	1867 WEST MARKET ST.	AKRON	OH	443136977	3308678443	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
900	KOHLER COMPANY	444 HIGHLAND DR.	KOHLER	WI	530441515	9204574441	
711	LABORERS DISTRICT COUNCIL OF GA AND SC	PO BOX 607	JONESBORO	GA	302370607	4044771888	
456	LAIDLAW EMPLOYEE BENEFIT PLAN, INC.	4144 NORTH CENTRAL EXPRESSWAY	DALLAS	TX	75204	2148269090	CODE ASSIGNED BY SCHA
320	LAMAR LIFE INSURANCE COMPANY	PO BOX 880	JACKSON	MS	39201	6019493100	
678	LANCASTER COUNTY	-	-	-	-		
457	LAQUINTA INN	PO BOX 2636	SAN ANTONIO	TX	782790064		CODE ASSIGNED BY SCHA
679	LAURENS COUNTY	-	-	-	-		
D04	LBA HEALTH PLANS, INC./PRIMARY SELECT	PO BOX 17098	OWINGS MILL	MD	211177098	8008158240	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B59	LDI INTEGRATED PHARMACY SERVICES	701 EMERSON RD. STE. 301	CREVE COEUR	MO	63141	8665163121	
680	LEE COUNTY	-	-	-	-		
978	LEGGETT & PLATT	PO BOX 7687	HIGH POINT	NC	27264	8773112150	
D31	LEON MEDICAL CENTER HEALTH PLAN	PO BOX 65-9006	MIAMI	FL	33265	3055595366	MEDICARE ADVANTAGE PLAN
681	LEXINGTON COUNTY	-	-	-	-		
943	LIBERTY MUTUAL LIFE INSURANCE	5 HUTCHINSON DR	DANVERS	MA	01923	8889994767	CODE IN OPEN STATUS BY SCHA
540	LIBERTY NATIONAL LIFE INSURANCE COMPANY	PO BOX 2612	BIRMINGHAM	AL	35202	2053252722	
243	LIFE & CASUALTY INSURANCE COMPANY OF TENNESSEE	AMERICAN GENERAL CENTER	NASHVILLE	TN	37250	6157491000	
B02	LIFE INSURANCE CO. OF ALABAMA	PO BOX 349	GADSDEN	AL	35902	8002262371	
156	LIFE INSURANCE COMPANY OF GEORGIA	PO BOX 105006	ATLANTA	GA	303485006	7709805100	
157	LIFE INSURANCE COMPANY OF VIRGINIA, THE	PO BOX 27601	RICHMOND	VA	23230	8042816000	
408	LIFE INVESTORS INSURANCE COMPANY OF AMERICA	PO BOX 8043	LITTLE ROCK	AR	72203	5013760426	AKA AEGON
515	LIFE OF THE SOUTH INSURANCE COMPANY	PO BOX 45237	JACKSONVILLE	FL	32232	8006616385	THIS CODE ASSIGNED BY SCHA NOT A MEDICAID REQUEST
396	LIFE PARTNERS INS GROUP	7887 E. BELLEVIEW AVE	ENGLEWOOD	CO	80111	8005257662	CODE ASSIGNED BY SCHA
241	LIFE REINSURANCE CO.	PO BOX 792070	SAN ANTONIO	TX	78279	8002291024	
B82	LIFEGUARD BENEFITS	PO BOX 93929	SOUTHLAKE	TX	76092	8664163617	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B23	LINCOLN FINANCIAL GROUP	PO BOX 614008	ORLANDO	FL	32861	8004232765	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
323	LINCOLN HERITAGE LIFE INSURANCE CO	PO BOX 10843	CLEARWATER	FL	337578843	8885868810	
158	LINCOLN NATIONAL LIFE INSURANCE COMPANY	PO BOX 614008	ORLANDO	FL	32861	8004232765	
796	LINECO	2000 SPRINGER DR.	LOMBARD	IL	60148	8003237268	CODE ASSIGNED BY SCHA
543	LONE STAR LIFE INSURANCE	PO BOX 709009	DALLAS	TX	753709009	2144476400	CODE ASSIGNED BY SCHA
A53	LONGSHORE & HARBOR WORKERS COMP PROGRAM	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
367	LOOMIS INSURANCE COMPANY	PO BOX 7011	WYOMISSING	PA	196107011	8007820392	
C85	LOYAL AMERICAN LIFE INSURANCE COMPANY	PO BOX 559004	AUSTIN	TX	78755	8006336752	
492	LT11-LIFETRAC NETWORK	111100 WAYZATA BLVD	MINNEAPOLIS	MN	55305		CODE ASSIGNED BY SCHA
B18	LUMENOS	PO BOX 69309	HARRISBURG	PA	17106	8774957223	
504	M CARE	PO BOX 130799	ANN ARBOR	MI	481130779	2156578920	CODE IN OPEN STATUS BY SCHA
902	M CARE	PO BOX 130799	ANN ARBOR	MI	481130779	8006588878	CODE ASSIGNED BY SCHA. THIS IS THE HMO TO CC 504 WHICH IS THE POS
A32	MAGELLEN BEHAVIORAL HEALTH	PO BOX 1659	MARYLAND HEIGHTS	MO	63043	8003592422	
B07	MAGNACARE	PO BOX 1001	GARDEN CITY	NY	11530	8666246259	
847	MAHONEY BENEFIT ADMINISTRATORS	PO BOX 7260	FORT LAUDERDALE	FL	33338	8002807093	
327	MAIL HANDLERS BENEFIT PLAN	PO BOX 8402	LONDON	KY	40742	8004107778	
812	MAJOR LEAGUE BASEBALL BENEFIT PLAN	PO BOX 7003	PARKERSBURG	WV	261027003	8006692255	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
159	MAKSIN MANAGMENT CORP	CN98000	PENNSAUKEN	NJ	08110	8002570625	
438	MAMSI LIFE AND HEALTH INSURANCE CO	PO BOX 993	FREDRICKS	MD	21705	8002576458	
860	MANAGED HEALTH NETWORK	PO BOX 209010	AUSTIN	TX	78720	8008352094	
915	MANAGED HEALTH RESOURCES	PO BOX 30742	CHARLOTTE	NC	28208	7043555200	
835	MANAGED PHARMACY BENEFITS	1100 NORTH LINDBERGH	ST. LOUIS	MO	63132	8006729540	THIS CARRIER BOUGHT OUT BY EXPRESS SCRIPTS.
A15	MANAGED PRESCRIPTIONS SERVICES (MPS)	ONE CITY CENTRE STE. 1100	ST LOUIS	MO	631016922	8007596959	
932	MANHATTAN INSURANCE GROUP	PO BOX 925309	HOUSTON	TX	772925309	8006699030	CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
756	MANUS INSURANCE COMPANY	6350 W ANDREW JACKSON HWY	TALBOTT	TN	37877	8009933401	
682	MARION COUNTY	-	-	-	-		
A26	MARKEL SMART STM	PO BOX 15953	LUBBOCK	TX	79490	8002792290	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
683	MARLBORO COUNTY	-	-	-	-		
268	MARQUETTE NATIONAL LIFE INS. CO.	PO BOX 130	PENSACOLA	FL	32591	8009348203	
709DN	MARSH ADVANTAGE AMERICA	501 NORTH BROADWAY, STE. 500	ST LOUIS	MO	63102	8008687526	FORMERLY BENEFIT PLAN SERVICES
531	MARY BLACK HEALTHNETWORK	1690 SKYLYN DR., STE.,130	SPARTANBURG	SC	29307	8645733535	
569	MARYLAND PHYSICIANS CARE	PO BOX 61778	PHOENIX	AZ	85082	8009538854	CODE IN OPEN STATUS BY SCHA
178	MASHANTUCKET PLAN ADMINISTRATORS	PO BOX 3620	MASHANTUCKET	CT	06338	8887796872	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
226	MASTER HEALTH PLAN	PO BOX 16367	AUGUSTA	GA	303919123	7068635955	
B32	MAXCARE	PO BOX 18024	OKLAHOMA CITY	OK	73154	8002597765	
586	MCA ADMINISTRATORS (MANAGED CARE OF AMERICA)	MANOR OAK TWO, STE 605 1910 COCHRAN RD	PITTSBURGH	PA	15220	4129220780	WAS DIVERSIFIED GROUP ADMINISTRATORS
684	MCCORMICK COUNTY	-	-	-	-		
361	MDI GOVERNMENT HEALTH SERVICES	822 HIGHWAY A1A NORTH STE 310	PONTE VEDRA BEACH	FL	32082	8008416288	CODE ASSIGNED BY SCHA
368	MED BENEFITS SYSTEM	PO BOX 177	SOUTH BEND	IN	46601	2192370560	
206	MED COST BENEFITS SERVICES	PO BOX 25307	WINSTON SALEM	NC	271145307	8007951023	
223	MED COST PREFERRED	PO BOX 25437	WINSTON SALEM	NC	27114	8008247406	CODE ASSIGNED BY SCHA
B38	MEDBEN	PO BOX 1009	NEWARK	OH	43058	8006868425	
873	MEDCO HEALTH	PO BOX 8190	MADISON	WI	537088190	8002217006	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY THE SCHA
C46	MEDCO HEALTH SOLUTIONS	PO BOX 14713	LEXINGTON	KY	40512	8002727243	AS OF 8/1/02 MERCK-MEDCO AND THEIR SUBSIDIARY PAID PRESCRIPTIONS IS NOW MEDCO HEALTH.
152	MEDICA	PO BOX 30990	SALT LAKE CITY	UT	84130	8004585512	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA
222	MEDICA	PO BOX 30990	SALT LAKE CITY	UT	84107	8009523455	
619	MEDICAID, SC						
616	MEDICAID-OUT-OF-STATE						
C98	MEDICAL BENEFIT ADM. OF MARYLAND, INC.	P.O .BOX 950	FORREST HILL	MA	60631	8885323467	
295	MEDICAL BENEFIT ADMINISTRATORS	5940 SEMINOLE CENTER CT.	MADISON	WI	53711	6082731776	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
781	MEDICAL CLAIMS MANAGEMENT CORP	PO BOX 12995	CHARLOTTE	NC	282202995	8003340609	
781DN	MEDICAL CLAIMS MANAGEMENT CORP	PO BOX 12995	CHARLOTTE	NC	282202995	8003340609	
C25	MEDICAL CLAIMS SERVICES	1 WALL ST. STE 2A	RAVENSWOOD	WV	26164	8882250522	
C08	MEDICAL DEVELOPMENT INTERNATION	19450 DEERFIELD AVE. STE. 400	LANSTOWNE	VA	20176	8008416188	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
822	MEDICAL MUTUAL	PO BOX 6018	CLEVELAND	OH	44101	8002582873	CODE ASSIGNED BY SCHA
539	MEDICAL MUTUAL INSURANCE OF OHIO	PO BOX 94648	CLEVELAND	OH	44101	8003621279	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X0R	MEDICAL MUTUAL OF OHIO	2060 EAST 9TH ST.	CLEVELAND	OH	441151355	2166877000	
979	MEDICAL REIMBURSEMENT OF AMERICA	113 SEABOARD LANE	FRANKLIN	TN	37067	6159633826	THIS CODE IS USED BY SCHA NOT AN ACTIVE MEDICAID CODE
207	MEDICAL SAVINGS HEALTH PLAN	419 E. MAIN ST	MIDDLETON	NY	10940	3173298222	
B39	MEDICAL SAVINGS INSURANCE CO.	5835 WEST 74TH ST	INDIANAPOLIS	IN	462781758	3173298222	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
X1N	MEDICAL SERVICE CORPORATION OF EASTERN WASHINGTON	PO BOX 3048	SPOKANE	WA	99220	5095364900	
D99	MEDICARE ADVANTAGE						MEDICARE ADVANTAGE PLAN GENERIC CODE
D32	MEDICARE COMPLETE (UNITED HEALTH CARE)	PO BOX 659735	SAN ANTONIO	TX	782659735	8778423210	MEDICARE ADVANTAGE PLAN
618	MEDICARE PART A						
620	MEDICARE PART B ONLY						
D14	MEDICARE PLUS BLUE (BCBS OF MICHIGAN)	27000 ELEVEN MILE RD	SOUTHFIELD	MI	48034	8002495103	MEDICARE ADVANTAGE PLAN
617	MEDICARE RAILROAD (PGBA) PROFESSIONAL PART B	PO BOX 10066	AUGUSTA	GA	30999	8772887600	
995	MEDIMPACT	10680 TREENA ST,STOP 5	SAN DIEGO	CA	92131	8007882949	
372	MEDIPLAN	502 VALLEY RD.	WAYNE	NJ	07410	9736963111	
759	MEDIPLUS	PO BOX 9126	DES MOINES	IA	50309	8002472192	AKA TROA
B56	MEDSAVE USA	3035 LAKELAND HILLS BLVD	LAKELAND	FL	33805	8002263155	
746	MED-TAC CLAIMS	PO BOX 9110	NEWTON	MA	02160	8003479355	
C96	MEDTRACK SERVICES	6310 LAMAR AVE. STE 230	OVERLAND PARK	KS	66202	8007714648	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
477	MEGA LIFE AND HEALTH INSURANCE COMPANY	PO BOX 982009	NORTH RICHLAND HILLS	TX	761828009	8005272845	
B50	MEMBER HEALTH	PO BOX 391180	CLEVELAND	OH	44139	8888685854	
709	MERCER ADMINISTRATION	PO BOX 4546	IOWA CITY	IA	52244	8008687526	
833	MERCY HEALTH PLANS	PO BOX 4568	SPRINGFIELD	MO	658084568	8006472240	
377	MERITAIN HEALTH	PO BOX 853921	RICHARDSON	TX	75085	7163195399	WAS NORTH AMERICAN ADMINISTRATORS, INC.
A29	MERITAN HEALTH	PO BOX 80884	INDIANAPOLIS	IN	46280	8006064841	
108	METROPOLITAN LIFE INSURANCE COMPANY	PO BOX 981282	EL PASO	TX	79998	8006386626	
916	MHEALTH	PO BOX 742567	HOUSTON	TX	77274	8886425040	
961	MHN (MANAGED HEALTH NETWORK)	PO BOX 27018	LAS VEGAS	NV	89126	8004584642	CODE ASSIGNED BY SCHA
790	MHNET BEHAVIORAL HEALTH	PO BOX 7802	LONDON	KY	40742	8007527242	
988	MID WEST NATIONAL LIFE INS. CO.	PO BOX 981606	EL PASO	TX	799981610	8007331110	
742	MIDA DENTAL PLAN	2000 TOWN CENTER, STE. 2200	SOUTHFIELD	MI	48075	8009376432	
C95	MIDWEST SECURITY	2700 MIDWEST DR	ONALASKA	WI	54650	8002368672	
D40	MINNESOTA POWER HEALTH PLANS	30 W SUPERIOR ST	DULUTH	MN	55802	8888128800	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C06	MISSIONARY MEDICAL	PO BOX 45730	SALT LAKE CITY	UT	84145	8007771647	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
820	MMSI MAYO MANAGEMENT SERVICES	4001 41ST ST. WEST	ROCHESTER	NM	41154	8006356671	CODE ASSIGNED BY SCHA SEE CARRIER CODE 536
545	MOLINA HEALTHCARE OF OHIO	PO BOX 22712	LONGBEACH	CA	90801	8006424148	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
597	MONARCH DIRECT	PO BOX 9004	SPRINGFIELD	MA	01101	8006289000	
227	MONUMENTAL GENERAL INSURANCE COMPANY	1111 N CHARLES ST.	BALTIMORE	MD	20201	8007529797	
148	MONUMENTAL LIFE INSURANCE COMPANY	PO BOX 61	DURHAM	NC	27702	8004445431	
460	MORRIS ASSOCIATES	PO BOX 50440	INDIANAPOLIS	IN	462500440	3175549000	
C04	MOTOR CITY WELFARE FUND	2075 W BIG BEAVER STE 700	TROY	MI	48084	2488227044	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D24	MOUNT CARMEL HEALTH PLAN (MCHP) MEDIGOLD (HMO)	PO BOX 6111	WESTERVILLE	OH	43086	8002403870	
733	MOUNTAIN CLAIMS MANAGEMENT	PO BOX 1008	FRUITLAND	ID	83619	2084527979	CODE IN OPEN STATUS BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A12	MOUNTAIN CLAIMS MANAGEMENT	PO BOX 1008	FRUITLAND	ID	83616	8669527979	
X2P	MOUNTAIN STATE BLUE CROSS & BLUE SHIELD, INC.	PO BOX 1948	PARKERSBERG	WV	26102	3044247700	
993	MPI INTERNATIONAL, INC.	PO BOX 81913	ROCHESTER	MI	483081913	2488539010	
432	M-PLAN CARDINAL HEALTH	P.O .BOX 357	LINTHICUM	MD	210900357	8006752605	CODE ASSIGNED BY SCHA
A18	MSH MOBILITY BENEFITS	PO BOX 77	BEEBE PLAIN	VT	05823	8888421530	CODE ASSIGNED BY SCHA
564	MULTINATIONAL UNDERWRITERS	PO BOXBXO 863	INDIANAPOLIS	IN	46206	8006052282	CODE ASSIGNED BY SCHA
954	MULTIPLAN	115 5TH AVE	NEW YORK	NY	100031004	8005463887	
593	MUTUAL ASSURANCE ADMINISTRATORS, INC	PO BOX 42096	OKLAHOMA CITY	OK	73123	8006489652	
724	MUTUAL MEDICAL PLANS	PO BOX 689	PEORIA	IL	61652	8004484689	CODE ASSIGNED BY SCHA
107	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	8002289090	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
635	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	4023427600	MEDICARE INTERMEDIARY PART A
636	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175		MEDICARE INTERMEDIARY PART B
C99	MUTUAL PROTECTIVE MEDICO LIFE INS. CO.	1515 S. 75TH ST	OMAHA	NE	68124	8002286080	CARRIER WAS PREVIOUSLY C35.
C35	MUTUAL PROTECTIVE MEDICO LIFE INSURANCE COMPANIES	1515 S 75TH ST.	OMAHA	NE	68124	8002286080	SEE CODE C99
937	MVP HEALTH CARE	PO BOX 1434	SCHENECTADY	NY	12301	8002295851	NAME CHANGE ONLY 4/09. WAS PERFERRED CARE
291	NALC HEALTH BENEFIT PLAN	20547 WAVERLY CT.	ASHBURN	VA	20149	7037294677	
522	NATIONAL AUTOMATIC SPRINKLER INDUSTRY	800 CORPORATE DR.	LANDOVER	MD	20785	3015771700	
312	NATIONAL BENEFIT ADMINISTRATORS	PO BOX 690903	CHARLOTTE	NC	282277016	8004826736	
312DN	NATIONAL BENEFIT ADMINISTRATORS	PO BOX 690903	CHARLOTTE	NC	282277016	8004826736	
C17	NATIONAL BENEFITS	110 GIBRALTAR RD.	HORSHAM	PA	19044	2154430404	
789	NATIONAL CASUALTY COMPANY	PO BOX 1250	ROCKFORD	IL	611051250	8002751896	CODE IN OPEN STATUS BY SCHA
260	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 10136	FAIRFAX	VA	220388022	8662199292	CODE IN OPEN STATUS BY SCHA
267	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 220887	CHARLOTTE	NC	282220887	7043643865	CODE ASSIGNED BY SCHA
C74	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 981610	EL PASO	TX	799981610	7043643865	
C74DN	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 220887	CHARLOTTE	NC	28222	7043643865	
444	NATIONAL DISASTER MEDICAL SYSTEM						

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
599	NATIONAL ELEVATOR INDUSTRY HEALTH BENEFITS	PO BOX 477	NEWTOWN SQUARE	PA	190730477	8005234702	
A70	NATIONAL EMPLOYEE BENEFIT ADMINISTRATORS	1920 N. FLORIDA MANGO RD	WEST PALM BEACH	FL	33409	8008225899	
263	NATIONAL FINANCIAL COMPANY	110 WEST 7TH ST. STE. 300	FT WORTH	TX	76102	8007251407	
B53	NATIONAL FOUNDATION LIFE INSURANCE COMPANY	110 WEST 7TH ST. STE. 300	FORT WORTH	TX	76102	8002219039	
472	NATIONAL HEALTH CARE HEALTH BENEFITS PLAN(NHC)	PO BOX 1398	MURFREESBORO	TN	371331398	6158902020	
929	NATIONAL HEALTH INSURANCE COMPANY	PO BOX 619999	DALLAS/FORT WORTH AIRPORT	TX	752619999	8002371900	
828	NATIONAL PHARMACEUTICAL SERVICES	PO BOX 407	BOYSTOWN	NE	68017	8005465677	
495	NATIONAL PRESCRIPTION ADMINISTRATORS	PO BOX 1981	EAST HANOVER	NJ	079361981	8005226727	BOUGHT OUT BY EXPRESS SCRIPTS CC333
334	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1750 PENNSYLVANIA AVE., NW	WASHINGTON	DC	20006	8006388432	
C86	NATIONAL STATES INSURANCE COMPANY	PO BOX 27321, 1830 CRAIG PARK CT.	ST LOUIS	MO	63141	3148780101	
914	NATIONAL TEACHERS ASSO LIFE INSURANCE CO.	PO BOX 2369	ADDISON	TX	75001	8886716771	
414	NATIONAL TELEPHONE COOP. ASSN.	1 WEST PACK SQUARE, STE. 600	ASHEVILLE	NC	28801	8282529776	
558	NATIONAL TRAVELERS LIFE INS. CO.	PO BOX 9197	DES MOINES	IA	50306	8002325818	INACTIVE 8/02
388	NATIONALWAY HEALTHCARE ASSOCIATES	PO BOX 682708	HOUSTON	TX	77268	8008107856	
163	NATIONWIDE LIFE INSURANCE COMPANY	PO BOX 182202	COLUMBUS	OH	432182202	6142497111	
A52	NATIONWIDE SPECIALITY HEALTH CLAIMS	PO BOX 420	SPRINGFIELD	MA	01101	8005174791	
518	NAT'L ASBESTOS WORKERS MED FUND	4600 POWDER MILL RD.	BELTSVILLE	MD	20705	8003863632	
800	NEBCO (TENNECO)	PO BOX 97	SCRATNON	PA	185040097	8007177562	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
141	NEOA HEALTH BENEFITS FUND	428 E SCOTT AVE. - PO BOX 3070	KNOXVILLE	TN	37927	-	
806	NETWORK HEALTH PLAN	PO BOX 568	MENASHA	WI	54952	9207201300	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
360	NEW ENGLAND FINANCIAL	PO BOX 190019	N. CHARLESTON	SC	29419	8004087681	USE CARRIER 859 NEW ENGLAND GROUP TRUST
859	NEW ENGLAND GROUP TRUST	PO BOX 30466	TAMPA	FL	33630	8006541731	
248	NEW ENGLAND LIFE INSURANCE	25145 COUNTRY CLUB BLVD	NORTH OLMSTED	OH	440705300	8002558063	
437	NEW ERA LIFE INSURANCE CO	PO BOX 4884	HOUSTON	TX	772104884	2813687200	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
520	NEW JERSERY CARPENTERS	PO BOX 7818	EDISON	NJ	088180846	8006243096	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
808	NEW MARKET DIMENSION	PO BOX 1338	COCKEYVILLE	MD	21031	8005706745	
C89	NEW SOURCES BENEFITS	PO BOX 6305	SPARTANBURG	SC	29304	8004761555	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
165	NEW YORK LIFE INSURANCE COMPANY	PO BOX 105095	ATLANTA	GA	30348	8003884580	
D39	NEW YORK WELFARE FUND	101-49 WOOKHAVEN BLVD	OZONE PARK	NY	11416	7188455800	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
685	NEWBERRY COUNTY	-	-	-	-		
B54	NGS AMERICAN INC	PO BOX 7676	ST. CLAIR SHORES	MI	48080	8107797676	
B97	NIPPON LIFE INSURANCE CO.	PO BOX 25951	SHAWNEE MISSION	KS	662255951	8003741835	
174	NMU PENSION & WELFARE FUND	360 WEST 31ST ST., 3RD FL	NEW YORK	NY	10001	2123374900	
350	NORTH AMERICA ADMINISTRATORS	PO BOX 1984	NASHVILLE	TN	37203	6152563561	
384	NORTH AMERICAN BENEFIT NETWORK	PO BOX 94928	CLEVELAND	OH	441014928	8003214085	
C36	NORTH AMERICAN INSURANCE COMPANY	PO BOX 44160	MADISON	WI	53744	6086621232	
359	NORTH CAROLINA MUTUAL LIFE INSURANCE	411 W. CHAPEL HILL ST.	DURHAM	NC	27701	9196829201	
A17	NOVA HEALTHCARE ADMINISTRATORS	2680 GRAND ISLAND BLVD	GRAND ISLAND	NY	140720308	8003333195	
A64	NTCA (NAT'L TELECOMMUNICATIONS COOPERATIVE ASSO.)	ONE WEST PACK SQUARE STE 600	ASHEVILLE	NC	288013459	8282819000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
458	OBA MIDWEST	8160 SOUTH CASS AVE	DARIEN	IL	60561	6309602035	WHEN CALLING THE ABOVE PHONE NUMBER, YOU ARE ASKED TO DIAL AN EXTENSION. DIAL EXTENSION 23.
170	OCCIDENTAL LIFE INSURANCE COMPANY OF NC	PO BOX 10324	RALEIGH	NC	27605	9198318189	
686	OCONEE COUNTY	-	-	-	-		
821	ODS HEALTH PLAN ADVANTAGE	PO BOX 4030	PORTLAND	OR	972084030	8773370650	CODE ASSIGNED BY SCHA
982	OFFICE OF GROUP BENEFITS STATE OF LOUISIANA	PO BOX 44036	BATON ROUGE	LA	708044036	8002728451	
809	OHIP CARPENTERS HEALTH & WELFARE FUND	8281 YOUNGSTOWN WARREN RD #240	NILES	OH	44446	8003629354	CODE ASSIGNED BY SCHA
591	OLD AMERICAN INSURANCE COMPANY	PO BOX 418573	KANSAS CITY	MO	64141	8167534900	
C37	OLD SURETY LIFE INSURANCE CO	PO BOX 54407	OKLAHOMA CITY	OK	731541407	8002725466	
866	OLYMPIC HEALTH MANAGEMENT	PO BOX 5348	BELLINGHAM	WA	98227	3607349888	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
353	ONE HEALTH PLAN OF SC	PO BOX 190019	N CHARLESTON	SC	29419	8003149010	CODE ASSIGNED BY SCHA
583	ONE NATION BENEFIT ADMINISTRATORS	PO BOX 528	COLUMBUS	OH	43216	8008246796	NAME CHANGE WAS ANTHEM BENEFIT ADMINISTRATORS
850	ONENET PPO	PO BOX 934	FREDERICK	MD	217050934	8003423289	CODE ASSIGNED BY SCHA
807	OPTIMA HEALTH PLAN	PO BOX 5028	TROY	MI	460071199	8002291199	
896	OPTIMED HEALTH PLAN	4 TERRY DR., STE 1	NEWTOWN	PA	18940	8004828770	
891	OPTIMUM CHOICE OF THE CAROLINAS INC	4 TAFT CT.	ROCKVILLE	MD	20850	8003438205	
880	OPTIMUM HEALTH PARTNERS	PO BOX 2243	GREENVILLE	SC	29602	8642134992	
XYZ	OPTUM RX	PO BOX 29044	HOT SPRINGS	AR	71903	8007887871	FORMERLY PRESCRIPTION SOLUTIONS
687	ORANGEBURG COUNTY	-	-	-	-		
603	OTHER INDIGENT (HOSPITAL CHARITY)			SC			
624	OTHER SPONSOR						
696	OUT-OF-STATE GA	-	-	-	-		
697	OUT-OF-STATE NC	-	-	-	-		
698	OUT-OF-STATE OTHER	-	-	-	-		
963	OXFORD HEALTH PLANS	PO BOX 2083	NASHUA	NH	030612083	8882014111	
215	OXFORD LIFE INSURANCE COMPANY	PO BOX 46518	MADISON	WI	53744	8774693073	
D26	OXFORD MEDICARE ADVANTAGE (HMO)	PO BOX 7082	BRIDGEPORT	CT	06601	8002341228	MEDICARE ADVANTAGE PLAN
370	P5 HEALTH PLAN SOLUTIONS	PO BOX 9554	SALT LAKE	UT	84109	8774740605	WAS P5 ELECTRONIC HEALTH SERVICES
771	PACIFIC FIDELITY LIFE INSURANCE CO (P.F.L.)	PO BOX 982009	N RICHLAND HILLS	TX	761828009	8176566040	USE CODE 477 MEGA LIFE
784	PACIFIC HEALTH ADMINISTRATORS	PO BOX 620123	ORLANDO	FL	328620123	8007766070	CODE ASSIGNED BY SCHA
399	PACIFIC LIFE AND ANNUITY	PO BOX 34799	PHOENIX	AZ	85067	8007332285	
254	PACIFIC MUTUAL LIFE INSURANCE COMPANY	700 NEWPORT CENTER DR.	NEWPORT BEACH	CA	92660	8004512513	
D03	PACIFIC SOURCE	PO BOX 7068	EUGENE	OR	97401	8006246052	
747	PACIFICARE	PO BOX 6099	CYPRESS	CA	90630	8663169776	CODE ASSIGNED BY SCHA
787	PACIFICARE SENIOR SUPPLEMENT PLAN	PO BOX 6072	CYPRESS	CA	906300072	8008513802	
766	PALMER & CAY/CARSWELL, INC.	PO BOX 1286	SAVANNAH	GA	31402	9122346621	
766DN	PALMER & CAY/CARSWELL, INC.	PO BOX 1286	SAVANNAH	GA	31402	9122346621	
B29	PANAMERICAN BENEFIT SOLUTIONS	PO BOX 619008	DALLAS	TX	75261	8006949888	WAS US NOW INSURANCE GROUP
255	PAN-AMERICAN LIFE INSURANCE COMPANY	PO BOX 60219	NEW ORLEANS	LA	70160	5045661300	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
976	PARAGON BENEFITS, INC.	PO BOX 12288	COLUMBUS	GA	31917	7062776710	
293	PARAMOUNT HEALTH CARE	PO BOX 497	TOLEDO	OH	43697	8888912564	
B16	PARTNER RX MANAGEMENT	PO BOX 12119	SCOTTSDALE	AZ	85260	8006594112	
890	PARTNERS NATIONAL HEALTH PLANS OF NORTH CAROLINA	PO BOX 17368	WINSTON SALEM	NC	271167368	8009425695	
172	PAUL REVERE LIFE INSURANCE COMPANY	PO BOX 15118	WORCESTER	MA	016150118	5087994441	
A21	PC HEALTH PLAN ADMINISTRATION	P.O BOX 1377	THOMASVILLE	GA	31799	8884261937	CODE ASSIGNED BY SCHA
363	PEARCE ADMINISTRATION	PO BOX 2437	FLORENCE	SC	29503	8886226001	GM SOUTHWEST IS THE CLAIMS PROCESSOR FOR PEARCE ADMINISTRATION
538	PENN GENERAL SERVICES	PO BOX 72077	ATLANTA	GA	303581535	8004441535	CODE ASSIGNED BY SCHA
B96	PENN TREATY & AMERICAN NETWORK	PO BOX 130	PENSACOLA	FL	32591	8006357418	
805	PENN TREATY NETWORK AMERICA (PTNA)	PO BOX 130	PENSACOLA	FL	325910130	8006357418	CODE ASSIGNED BY SCHA
182	PENN TREATY NETWORK AMERICA INS. CO.	PO BOX 7066	ALLENTOWN	PA	181057066	8003620700	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C49	PENN WESTERN BENEFITS, INC	PO BOX 7834	GREENSBORO	NC	27417	3366659400	
C49DN	PENN WESTERN BENEFITS, INC	PO BOX 7834	GREENSBORO	NC	27417	3366659400	
X0J	PENNSYLVANIA BLUE SHIELD	PO BOX 890089	CAMP HILL	PA	17089	8006373493	
173	PENNSYLVANIA LIFE INSURANCE COMPANY	PO BOX 130	PENSACOLA	FL	325910100	8002757366	
878	PENSION AND GROUP SERVICE/HRM CLAIM MANAGEMENT	PO BOX 4022	KALAMAZOO	MI	490034022	8002530966	
770	PEOPLES BENEFIT LIFE INSURANCE	PO BOX 484	VALLEY FORGE	PA	19493	8005237900	
708	PERFORMAX	PO BOX 61505	KING OF PRUSSIA	PA	19406	8885547629	CODE NOT REQUESTED BY MEDCAID. ASSIGNED BY SCHA
862	PERFORMAX	300 CORPORATE PARKWAY	AMHERST	NY	11226	8777776076	
325	PERSONAL CARE	PO BOX 7141	LONDON	KY	40742	8004311211	
740	PHARMACARE	PO BOX 52188	PHOENIX	AZ	850722196	8002376184	AS OF 1/1/08 CO. MERGED WITH CAREMARK (471) ADD NEW POLICIES WITH 471
964	PHARMACEUTICAL CARE NETWORK	9343 TECH CENTER DR.	SACRAMENTO	CA	95826	8007770074	
314	PHARMACY ADVANTAGE NETWORK	50 LENNOX POINTE	ATLANTA	GA	30324	8887275560	SEE CARRIER 366 CATALYST RX
B47	PHARMACY DATA MANAGEMENT, INC	1170 E WESTERN RESERVE RD	POLAND	OH	44514	8007740890	
257	PHARMACY NETWORK NATIONAL OF N.C.	4000 OLD WAKEFOREST RD STE. 101	RALEIGH	NC	27609	8003317108	SEE CARRIER 366 CATALYST RX

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B33	PHARMAVAIL DRUG COMPANY	3380 TRICKHUM RD. BLDG 400, UNIT 100	WOODSTOCK	GA	30188	8009333734	
948	PHILADELPHIA AMERICAN LIFE INS. CO.	PO BOX 2465	HOUSTON	TX	77252	8005527879	
555	PHILADELPHIA AMERICAN LIFE INSURANCE CO	PO BOX 4884	HOUSTON	TX	772104882	8005527879	CODE ASSIGNED BY SCHA
468	PHOENIX HEALTHCARE	PO BOX 150809	ARLINGTON	TX	76015	8003976241	
561	PHOENIX MUTUAL LIFE INSURANCE COMPANY	ONE AMERICAN ROW	HARTFORD	CT	06115	8004512513	THIS CARRIER PURCHASED BY CC864 GE GROUP ADMINISTRATORS
533	PHYSICIANS CARE NETWORK	PO BOX 101111	COLUMBIA	SC	292111111	8883239271	
326	PHYSICIANS HEALTH PLAN OF MID MICHIGAN	PO BOX 247	ALPHARETTA	GA	300090247	8008329186	
590	PHYSICIANS HEALTH SERVICES	PO BOX 981	BRIDGEPORT	CT	06601	8008484747	
773	PHYSICIANS MUTUAL INSURANCE COMPANY	PO BOX2018	OMAHA	NE	681032018	8002289100	DO NOT USE THIS CODE FOR MEDICARE ADVANTAGE PLANS OFFERED BY THIS CARRIER
228	PHYSICIANS PLUS INS. CO.	PO BOX 909953	MILWAUKEE	WI	53209	8005455015	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
462	PICCADILLY INSURANCE EMPLOYEE BENEFITS DEPT.	PO BOX 2467	BATON ROUGE	LA	70821	5042968382	
688	PICKENS COUNTY	-	-	-	-		
A22	PIEDMONT ADMINISTRATORS	PO BOX 78030	GREENSBORO	NC	274270830	8008527040	
804	PIEDMONT COMMUNITY HEALTHCARE INC.	PO BOX 14408	CINCINNATI	OH	452500408	8004007247	
434	PIEDMONT HEALTH ALLIANCE	116 BONHAM CT.	ANDERSON	SC	29621	8643759661	
487	PIEDMONT INS COMPANY	PO BOX 979	MARION	SC	29571	8434235541	
B10	PILGRIM HEALTH & LIFE INSURANCE	PO BOX 897	ATLANTA	GA	30303	4046592100	CODE IN OPEN STATUS BY SCHA
B21	PIONEER HEALTH	PO BOX 6600	HOLYOKE	MA	01041	8004234586	
792	PIONEER LIFE INSURANCE COMPANY OF ILLINOIS	PO BOX 1250	ROCKFORD	IL	611051250	8159875000	USE CODE 282 WASHINGTON NATIONAL
338	PITTMAN & ASSOCIATES, INC.	PO BOX 111047	MEMPHIS	TN	38111	8002381344	
C55	PLAN ADMINISTRATORS (MATURE AMERICAN)	734 15TH ST. NW STE. 500	WASHINGTON	DC	20005	2023936600	
276	PLAN HANDLERS	930 CANTERBURY PLACE	ESCONDIDO	CA	92025	8005385512	
886	PLANNED ADMINISTRATORS INC	PO BOX 6927	COLUMBIA	SC	29260	8037540041	
886DN	PLANNED ADMINISTRATORS INC	PO BOX 6927	COLUMBIA	SC	29260	8037540041	
706	PLUMBERS & PIPEFITTERS LOCAL NO. 421	PO BOX 840	MACON	GA	312020840	8887412673	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
585	PLUMBERS & STEAMFITTERS WELFARE FUND	1024 MCKINLEY ST	PEEKSILL	NY	10566	9147377220	
751	POLARIS BENEFIT ADMINISTRATORS	PO BOX 2010	WESTERVILLE	OH	43086-	8002340225	
751DN	POLARIS BENEFIT ADMINISTRATORS	PO BOX 1008	DELAWARE	OH	43015-	8002340225	
751RX	POLARIS BENEFIT ADMINISTRATORS	PO BOX 1008	DELAWARE	OH	43015-	8002340225	
391	POMCO	PO BOX 6329	SYRACUSE	NY	13217	8002344393	
385	POSTMASTERS BENEFIT PLAN	1019 N. ROYAL ST.	ALEXANDRIA	VA	22314	7036835585	
168	PRECISE BENEFIT ADMINISTRATORS	PO BOX 9064	JERICHO	NY	11753	5163906000	
A11	PREFERRED ADMINISTRATORS	PO BOX 18263	TAMPA	FL	336798263	8772767198	
486	PREFERRED CARE	PO BOX 22920	ROCHESTER	NY	146922920	8009993920	MEDICARE ADVANTAGE PLAN
347	PREFERRED CARE INC (PCI)	1300 VIRGINIA DIRVE STE. 315	FORT WASHINGTON	PA	19034	8002223085	
909	PREFERRED HEALTH ALLIANCE CORP.	PO BOX 382048	BIRMINGHAM	AL	35238	8007228477	
909DN	PREFERRED HEALTH ALLIANCE CORP.	300 CORPORATE PKWY. STE. 3	BIRMINGHAM	AL	35242	2059691155	
270	PREFERRED HEALTH PLAN OF THE CAROLINAS	P.O, BOX 220397	CHARLOTTE	NC	28222	8666360239	
303	PREFERRED HEALTH PLAN, INC.	PO BOX 24125	LOUISVILLE	KY	40224	5023397500	
933	PREFERRED HEALTHCARE SYSTEMS	620 HOWARD AVE	ALTOONA	PA	166014899		CODE ASSIGNED BY SCHA
B86	PREFERRED ONE ADMINISTRATIVE SERVICES	PO BOX 59212	MINNEAPOLIS	MN	55459	8009971750	
A43	PREMIER BENEFIT MANAGEMENT, INC.	7070-A KAIGHN AVE	PENSAUKEN	NJ	08109	800-966-01	CODE ASSIGNED BY SCHA
939	PREMIER HEALTH SYSTEMS	PO BOX 1640	COLUMBIA	SC	292021640	8032968999	CODE ASSIGNED BY SCHA
229	PRESCRIPTION HEALTH SERVICES	PO BOX 80716	LOS ANGELES	CA	90080	8004212342	CODE ASSIGNED BY SCHA
421	PRIMARILY CARE	75 SOCKANOSSET CROSSROAD STE 300	CRANSTON	RI	02920	4147975000	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
387	PRIMARY PHYSICIANS CARE	PO BOX 11088	CHARLOTTE	NC	28220	7045232758	
397	PRIME THERAPEUDIC	PO BOX 14624	LEXINGTON	KY	405124624	8004231973	
844	PRIME TIME HEALTH PLAN	PO BOX 6905	CANTON	OH	44706	8006177446	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A42	PRIMERICA LIFE INSURANCE COMPANY	3120 BRECKINRIDGE BLVD.	DULUTH	GA	30199	4043811000	
479	PRIMEXTRA	PO BOX 1088	TWINSBURG	OH	44087	8004334893	
942	PRINCIPAL FINANCIAL GROUP	PO BOX 10357	DES MOINES	IA	503060357	8002474695	
817	PRIORITY HEALTH	1231 E BELTLINE NE	GRAND RAPIDS	MI	495254501	8004465674	
940	PRIVATE HEALTH CARE SYSTEMS (PHCS)	PO BOX 2914	DES PLAINES	IL	600172914	8005317662	CODE ASSIGNED BY SCHA 6/18/07

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B35	PROCARE RX PBM	3090 PREMIERE PARKWAY, STE 100	DULUTH	GA	30097	8006993542	
578	PROFESSIONAL ADMINISTRATORS, INC.	3751 MAGUIRE BLVD. STE. 100	ORLANDO	FL	32814	8007410521	
965	PROFESSIONAL BENEFIT ADMINISTRATORS, INC. (PBA)	PO BOX 4687	OAKBROOK	IL	605223755	6306553755	
A20	PROFESSIONAL CLAIMS MANAGEMENT	PO BOX 35276	CANTON	OH	443155276	8003258424	
A20DN	PROFESSIONAL CLAIMS MANAGEMENT	PO BOX 35276	CANTON	OH	443155276	8003258424	
316	PROFESSIONAL INSURANCE CORPORATION	2610 WYCLIFF RD	RALEIGH	NC	27607	8002891122	
534	PROVANTAGE PRESCRIPTION BENEFIT MANAGEMENT SERVICE	PO BOX 1662	WAUKEHA	WI	53187	2627844600	
A92	PROVIDENT AMERICAN LIFE & HEALTH INS.	PO BOX 29158	SHAWNEE MISSION	KS	66201915	8007535133	
485	PROVIDENT HEALTH PLAN	PO BOX 3125	PORTLAND	OR	972083125	8006283912	CODE ASSIGNED BY SCHA
381	PROVIDENT INDEMNITY LIFE INSURANCE COMPANY	PO BOX 511	NORRISTOWN	PA	19404	8005199175	
110RX	PROVIDENT/CAREMARK	PO BOX 686005	SAN ANTONIO	TX	78268	8008415550	USE CODE 280 CAREMARK
328	PROVIDER SELECT, INC.	PO BOX 330070	FORT WORTH	TX	76163	8667747766	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
882	PRUDENTIAL HEALTHCARE SYSTEM OF NC	2701 COLTSGATE RD STE 100	CHARLOTTE	NC	28211		CODE ASSIGNED BY SCHA
111	PRUDENTIAL INSURANCE COMPANY OF AMERICA	841 PRUDENTIAL DR.	JACKSONVILLE	FL	32207	8003463778	THIS CARRIER BOUGHT OUT BY AETNA CC100
251	PYMARID LIFE INSURANCE CO.	PO BOX 12922	PENSACOLA	FL	325912922	8006581413	CODE IN OPEN STATUS BY SCHA MEDICARE SUPPLEMENTAL PLAN G
D28	PYRAMID LIFE INSURANCE CO (PFFS)	PO BOX 958465	LAKE MARY	FL	327958465	4076281776	MEDICARE ADVANTAGE PLAN
230	PYRAMID LIFE INSURANCE COMPANY	PO BOX 772	SHAWNEE MISSION	KS	66201	8004440321	
221	QUAL CARE	PO BOX 249	PISCATHAWAY	NJ	08855	8009926613	CODE ASSIGNED BY SCHA
A85	QUALCHOICE	PO BOX 25610	LITTLE ROCK	AR	722219914	8002357111	
A48	QUALMED OF OREGON	PO BOX 286	CLACKMAS	OR	970150286	8005685628	DORMANT 8/06
X0KRS	REGENCE BCBS OF OREGON	PO BOX 12625 MAILSTOP S4P	SALEM OREGON	OR	97309	8884371508	RX PLAN ONLY MM CODE X0K
X0KRX	REGENCE BCBS OF OREGON	P.O .BOX 12625 MAILSTOP S4P	SALEM	OR	97309	8884371508	RX PLAN ONLY X0K IS MM PLAN
XOKRX	REGENCE BCBS OF OREGON RX PLAN	PO BOX 12625 MAILSTOP S4P	SALEM	OR	97309	8884371508	RX PLAN ONLY MM PLAN IS X0K
X0K	REGENCE BLUE CROSS BLUE SHIELD OF OREGON	PO BOX 1271	PORTLAND	OR	97207	5032255221	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
795	REGIONAL MEDICAL ADMINISTRATORS INC.	PO BOX 4128	GLEN RAVEN	NC	272150901	3362267950	
187	RELIANCE STANDARD LIFE INS. CO.	PO BOX 82520	LINCOLN	NE	68501	8004977044	
B19	RENAISSANCE DENTAL	PO BOX 17250	INDIANAPOLIS	IN	46217	8883589484	
296	RESERVE NATIONAL INSURANCE	PO BOX 26620	OKLAHOMA CITY	OK	73126	8006549106	
375	RESTAT	PO BOX 758	WEST BEND	WI	530950758	8002481062	
A95	REYNOLDS & REYNOLDS	PO BOX 1272	DAYTON	OH	45401	8007363539	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
689	RICHLAND COUNTY	-	-	-	-		
398	RIGHT CHOICE BENEFITS ADMINISTRATORS	12250 WEBER HILL RD. STE 100	ST LOUIS	MO	63127	8003659036	CODE ASSIGNED BY SCHA
214	RISK BENEFIT MANAGEMENT SERVICES, LLC (RBMS)	PO BOX 241569	ANCHORAGE	AK	99524	8007703740	
546	RISK MANGEMENT SERVICES	PO BOX 6309	SYRACUSE	NY	13217	3154489228	
A30	RMSCO, INC.	PO BOX 678	LIVERPOOL	NY	130880678	8772047086	
A30DN	RMSCO, INC.	PO BOX 678	LIVERPOOL	NY	130880678	8772047086	
592	ROBEY BARBER INSURANCE SERVICES	PO BOX 10100	TAMPA	FL	33679	8007497409	USE CODE A98 CORPORATE BENEFIT SERVICES DORMANT 8/02
218	ROCKY MOUNTAIN HEALTH PLAN (RMHP)	PO BOX 4517	ENGLEWOOD	CO	80155	8884792000	
278	ROCKY MOUNTIAN HEALTH PLAN	PO BOX 10600	GRAND JUNCTION	CO	81502	8008544558	
762	ROYAL NEIGHBORS OF AMERICA	PO BOX 10850	CLEARWATER	FL	337578850	8778158857	CODE ASSIGNED BY SCHA
A09	RX AMERICA	221 N CHARLES LINDBERG DR	SALT LAKE CITY	UT	84116	8007708014	
718	RX PRIME/CIGNA PHARMACY SERVICES	PO BOX 3598	SCRANTON	PA	185050598	8006225579	
C44	S C MEDICAL ASSOCIATION-MEMBERS INSURANCE TRUST	PO BOX 11188	COLUMBIA	SC	29211	8037986207	
185	S&S HEALTHCARE STRATEGIES	PO BOX 46511	CINCINNATI	OH	45216	8888008717	
410	SAFECO INSURANCE COMPANY	PO BOX 34699	REDMOND	WA	981241699	2068678000	
690	SALUDA COUNTY	-	-	-	-		
570	SAMBA HEALTH BENEFIT PLAN	11301 OLD GEORGETOWN RD	ROCKVILLE	MD	20852	8006386589	
231	SAVERS LIFE INSURANCE COMPANY	8064 NORTH POINT BLVD STE. 201	WINSTON SALEM	NC	27106	8006420483	
489	SAVRX	PO BOX 8	FREEMONT	NE	68026	8003506714	
C20	SCREEN ACTORS GUILD-PRODUCERS HEALTH PLAN	PO BOX 7830	BURBANK	CA	915107830	8007774013	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
846	SCRIPT CARE, INC.	6380 FOLSOM DR	BEAUMONT	TX	77706	8008809988	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
435	SEABURY AND SMITH COMPANY, INC.	PO BOX 2545	NASHVILLE	TN	37219	8005822498	
818	SEAFARERS HEALTH & BENEFIT PLAN (SHBP)	PO BOX 380	PINEY POINT	MD	20674	8002524674	
596	SECURE HORIZONS	PO BOX 659787	SAN ANTONIO	TX	782659787	8665798811	MEDICARE ADVANTAGE PLAN
D62	SECURE HORIZONS DIRECT (UNITED HEALTHCARE)	PO BOX 31353	SALT LAKE CITY	UT	84131	8665798774	MEDICARE ADVANTAGE PLAN
D27	SECURE HORIZONS PACIFICARE	PO BOX 25032	SANTA ANA	CA	927995032	7148253828	MEDICARE ADVANTAGE PLAN
D12	SECUREHORIZONS DIRECT PFFS	PO BOX 12466	PENSACOLA	FL	325912466	8882024340	MEDICARE ADVANTAGE PLAN
865	SECURIAN DENTAL PLANS	PO BOX 9385	MINNEAPOLIS	MN	554409385	8002349009	NAIC 93742
184	SECURITY LIFE INSURANCE CO. OF AMERICA	PO BOX 3199	WINSTON-SALEM	NC	27102	8003009566	
D15	SECURITYCHOICE ENHANCED PLUS	PO BOX 795180	SAN ANTONIO	TX	78279	8884458916	MEDICARE ADVANTAGE PLAN
C27	SELECT BENEFIT ADMINISTRATORS	PO BOX 440	ASHLAND	WI	54806	8004973699	
C27DN	SELECT BENEFIT ADMINISTRATORS	PO BOX 440	ASHLAND	WI	54806	8004973699	
B48	SELECT HEALTH	PO BOX 30192	SALT LAKE CITY	UT	84123	8005385038	
E37	SELECT HEALTH	PO BOX 7120	LONDON	KY	40742	8882762020	HEALTHY KIDS CONNECTION
883	SELECT HEALTH OF SOUTH CAROLINA INC	7410 NORTHSIDE DR. STE. 208	CHARLESTON	SC	29420	8435691759	CODE IN OPEN STATUS BY SCHA
637	SELECT HEALTH/FIRST CHOICE	PO BOX 7120	LONDON	KY	40742	8882762020	MEDICAID HMO
392	SELF FUNDED GROUP INSURANCE ADMINISTRATORS	PO BOX 1719	KALAMAZOO	MI	490051790	8003421895	
C76	SELF FUNDING ADMINISTRATORS	PO BOX 6596	ANNAPOLIS	MD	21401	8004248622	
204	SELF INSURED BENEFIT ADMINISTRATORS	18167 US HWY 19N	CLEARWATER	FL	33764	7275320400	
378	SELF INSURERS SERVICE INC.	2218 SOUTH PRIEST DR.	TEMPE	AZ	85282		
930	SENTRY LIFE INSURANCE COMPANY	PO BOX 8025	STEVENS POINT	WI	54481	8004267234	
A23	SERV U PRESCRIPTION	PO BOX 23237	MILWAUKEE	WI	532230237	8007593203	
D10	SEVEN CORNERS INC	PO BOX 3430	CARMEL	IN	46082	8666994186	
B79	SHASTA ADMINISTRATIVE SERVICES	PO BOX 5735	CINCINNATI	OH	45201	5136291800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
235	SHAW INDUSTRIES	PO BOX 10	DALTON	GA	30722	8003211855	
490	SHEET METAL LOCAL 20	PO BOX 42489	INDIANAPOLIS	IN	43242	8002482141	CODE ASSIGNED BY SCHA
A28	SHENANDOAH LIFE INSURANCE CO	PO BOX 12847	ROANOKE	VA	24029	8008485433	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
838	SHESFIELD, OLSON & MCQUEEN	PO BOX 16608	ST PAUL	MN	55116	8883308408	
631	SHRINERS	-	-	-	-----		
208	SIEBA, LTD	PO BOX 5000	ENDICOTT	NY	13761	8002524624	
D53	SIERRA OPTIMA PLUS CLAIMS	PO BOX 15645	LAS VEGAS	NV	891145645	8882742207	MEDICARE ADVANTAGE PLAN
C87	SIHO INSURANCE SERVICES	PO BOX 1787	COLUMBUS	IN	47202	8008732022	
568	SIMPLIFI	PO BOX 1339	MINNEAPOLIS	MN	554401339	8884465710	FORMELY CBCA ADMINISTRATORS
576	SIOUX VALLEY HEALTH	PO BOX 91110	SIOUX FALLS	SD	57109	8007525863	
A77	SISCO	PO BOX 389	DUDUQUE	IA	52004	8004574725	
D22	SMART VALUE (BC OF GA) (PFFS)	PO BOX 3897	SCRANTON	PA	18505	8668659329	MEDICARE ADVANTAGE PLAN
478	SMITH ADMINISTRATORS	PO BOX 163289	FORT WORTH	TX	76161	8008672582	
298	SMITH PREMIERE PHARMACY PLAN	PO BOX 5824	SPARTANBURG	SC	29304	8002474526	
329	SMITHFIELD FOODS HEALTHCARE	PO BOX 158	SMITHFIELD	VA	23431	8008095916	
B06	SOUTHCARE HEALTHCARE PREFERRED	1100 CIRCLE 75 PARKWAY, STE 1400	ATLANTA	GA	30339	8004702004	
A87	SOUTHEAST COMMUNITY CARE (ARCADIAN HEALTH)	PO BOX 4946	COVINA	CA	91723	8005738597	
D43	SOUTHEAST COMMUNITY CARE BY ARCADIAN HEALTH	PO BOX 4946	COVINA	CA	91723	8005738597	MEDICARE ADVANTAGE PLAN
888	SOUTHEASTERN BENEFIT PLANS INC.	335 ARCHDALE DR.	CHARLOTTE	NC	282174246	7045295400	
C48	SOUTHERN ADMINISTRATIVE SERVICES	PO BOX 8069	COLUMBUS	GA	31908	8004268803	
897	SOUTHERN BENEFIT ADM.	5305 VIRGINIA BEACH BLVD	NORFOLK	VA	23502	7574618091	
A66	SOUTHERN BENEFIT ADMINISTRATORS, INC.	PO BOX 1449	GOODLETTSVILLE	TN	37070	8008310420	
B30	SOUTHERN BENEFITS, SOUTHEASTERN PIPE TRADERS	PO BOX 1449	GOODLETTSVILLE	TN	370701449	8008314914	
D06	SOUTHERN CALIFORNIA BAKERY & CONFECTIONARY	PO BOX 22041	COMMERCE	CA	90022	3237227171	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B73	SOUTHERN CALIFORNIA PIPE TRADES TRUST FUND	501 SHATTO PLACE, 5TH FLOOR	LOS ANGELES	CA	90020	2133856161	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
224	SOUTHERN ELEC. HEALTH FUND	3928 VOLUNTEER DR.	CHATTANOOGA	TN	37416	4238992593	
B57	SOUTHERN FARM BUREAU LIFE INS. CO.	PO BOX 78	JACKSON	MS	39205	8004579611	
990	SOUTHERN GROUP ADMINISTRATORS, INC.	200 SOUTH MARSHALL ST.	WINSTON SALEM	NC	27101	8003348159	
B22	SOUTHERN HEALTH SERVICES	PO BOX 7704	LONDON	KY	40742	8006274872	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B52	SOUTHERN PLANNED ADMINISTRATORS	PO BOX 218180	HOUSTON	TX	77218	2818291033	
186	SOUTHLAND LIFE INSURANCE COMPANY	PO BOX 105006	ATLANTA	GA	303485006	7709805100	
691	SPARTANBURG COUNTY	-	-	-	-		
811	SPARTANBURG REGIONAL HEALTHCARE SYSTEM	PO BOX 1000	LANCASTER	SC	29721	877-629-00	CODE ASSIGNED BY SCHA
A89	SPECIAL INSURANCE SERVICES (SIS)	PO BOX 250349	PLANO	TX	750250349	8007676811	CODE ASSIGNED BY SCHA
736	SPECTERA	2811 LORD BALTIMORE DR.	BALTIMORE	MD	212442644	8006383120	
741	SPENCER & ASSOCIATES INS.	1 S. LIMESTONE ST STE 301	SPRINGFIELD	OH	45502	8667669016	CODE ASSIGNED BY SCHA
573	ST JOHN'S CLAIMS ADMINISTRATION	PO BOX 14409	SPRINGFIELD	MO	65814	8778757700	
512	ST11-STRATEGIC HEALTH	9501 NE 2ND AVE	MIAMI SHORES	FL	33138		CODE ASSIGNED BY SCHA
A46	STANDARD INSURANCE COMPANY	PO BOX 209	PORTLAND	OR	972070209	5033217000	
C42	STANDARD CORPORATION	1400 MAIN ST. STE 1300	COLUMBIA	SC	29201	8037716785	
C38	STANDARD LIFE & ACCIDENT INSURANCE COMPANY	PO BOX 1800	GALVESTON	TX	775531800	8883501488	
188	STANDARD LIFE & CASUALTY INSURANCE COMPANY	PO DRAWER 1514	FORT MILL	SC	29716	8035483657	
307	STANDARD SECURITY LIFE INS. CO OF NEW YORK	PO BOX 828	PARK RIDGE	IL	60068	8665131479	
B74	STAR HRG	PO BOX 54150	PHOENIX	AZ	850784150	8002881474	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
240	STARBRIDGE	PO BOX 55270	PHOENIX	AZ	85078	8003085948	
952	STARK TRUSS CO., INC.	PO BOX 2080C	STOW	OH	44224	8004564002	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A03	STARMARK	PO BOX 2942	CLINTON	IA	52733	8005221246	THIS CARRIER HANDLES GROUPS WITH LESS THAN 50 EMPLOYEES. SEE CC212 FFOR GROUPS OVER 50 EMPLOYEES.
400	STATE EMPLOYEES HEALTH PLAN BLUE CROSS	4101 PERCIVAL RD.	COLUMBIA	SC	29219	8008682520	CLAIMS SHOULD BE SENT TO THE ATTN OF SARAH TOWNES AX-B10
373	STATE FARM INSURANCE COMPANIES	7401 CYPRESS GARDENS BLVD	WINTERHAVEN,	FL	338880007	8633183000	
147	STATE MUTUAL INSURANCE	PO BOX 10811	CLEARWATER	FL	337578811	8887806388	
B60	STATE MUTUAL LIFE ASSURANCE COMPANY OF AMERICA	1100 31ST ST.	DOWNERS GROVE	IL	60515	8003233359	CODE IN OPEN STATUS BY SCHA
B83	STATE OF LOUISIANA EMPLOYEES	PO BOX 44036	BATON ROUGE	LA	70804	8002728451	THIS CODE NOT REQUESTED BY MEDICAID. ASSSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
867	STATE OF NC COMP. HEALTH BENEFIT	PO BOX 30025	DURHAM	NC	27702	9194897431	
A91	STATES GENERAL LIFE INS. CO	115 WEST 7TH ST. STE. 1200	FORT WORTH	TX	761027012	8007828375	
A47	STATESMAN NATIONAL LIFE INSURANCE COMPANY	3815 MONTROSE BLVD.	HOUSTON	TX	77006	7135266000	
244	STERLING INVESTORS LIFE INS. CO.	PO BOX 10844	CLEARWATER	FL	337578844	8776045240	
233	STERLING LIFE INSURANCE	PO BOX 5348	BELLINGHAM	WA	98227	8006880010	
645	STERLING MEDICARE CHOICE HMO	PO BOX 70	LINTHIEUM	MD	21900	6152445600	MEDICARE ADVANTAGE PLAN
140	STERLING OPTION I (PFFS)	PO BOX 5348	BELLINGHAM	WA	982270010		MEDICARE ADVANTAGE PLAN
374	STONEBRIDGE LIFE INSURANCE CO.	2700 W. PLANO PARKWAY	PLANO	TX	75075	8003319955	
714	STOWE ASSOCIATES	2872 WOODCOCK BLVD. #200	ATLANTA	GA	30341	8005337896	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B61	STOWE-PHARR MILLS	100 MAIN ST.	MCADENVILLE	NC	28101	7048243551	CODE IN OPEN STATUS BY SCHA
734	STRATEGIC OUTBURSTING INC.	PO BOX 241508	CHARLOTTE	NC	28224	8888367764	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA
C05	STRATEGIC OUTSOURCING, INC. (SOI)	PO BOX 241508	CHARLOTTE	NC	28224	8888367764	
A40	STRATEGIC RESOURCE COMPANY	PO BOX 14079	LEXINGTON	KY	40512	8887729682	
C93	STUDENT ASSURANCE INSURANCE SERVICES	PO BOX 196	STILL WATER	MN	55085	8003282739	
209	SUMMIT AMERICA INSURANCE SERVICES	7400 COLLEGE BLVD. STE. 100	OVERLAND PARK	KS	66210	8772466997	
692	SUMTER COUNTY	-	-	-	-		
342	SUN LIFE INSURANCE COMPANY OF CANADA	ONE SUN LIFE EXECUTIVE PARK	WELLESLEY	MA	02181	8002253950	
861	SUPERIOR ESSEX	PO BOX 724907	ATLANTA	GA	31139	8772917920	
395	T R PAUL GROUP SERVICES, INC.	PO BOX 5508	NEWTOWN	CT	064705508	2034268161	CODE ASSIGNED BY SCHA
C45	TALL TREE ADMINISTRATORS	PO BOX 71747	SALT LAKE CITY	UT	841710747	8774534201	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C19	TAYLOR BENEFIT RESOURCES, INC.	PO BOX 6580	THOMASVILLE	GA	31758	8883525246	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
712	TDI MANAGED CARE SERVICES	620 EPSILON DR.	PITTSBURG	PA	15238	8005815300	CARRIER BOUGHT OUT BY PHARMACARE CC 740
C50	TENNESSEE BENEFIT ADMINISTATORS	PO BOX 3257	SPARTANBURG	SC	29304	901-685-89	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C01	TERMINIX SERVICE	PO BOX 2627	COLUMBIA	SC	29202	8037721783	CODE ASSIGNED BY SCHA
497	TEXAS INTERNATIONAL	PO BOX 11007	WINSTON SALEM	NC	27116	8663074711	
B94	THE CAPELLA GROUP	PO BOX 200368	ARLINGTON	TX	76006	8884113888	
C33	THE DESTINY HEALTH PLAN	PO BOX 4628	OAKBROOK	IL	60522	8668269345	
269	THE EPOCH GROUP	PO BOX 12170	OVERLAND PARK	KS	66212	8002556065	
785	THE HARVEST INSURANCE CO.	PO BOX 956003	LAKE MARY	FL	327950856	8002530856	CODE ASSIGNED BY SCHA
763	THE PROVIDENT	PO BOX 31499	TAMPA	FL	33631	8005257268	
B28	THE STANDARD	PO BOX 82622	LINCOLN	NE	68501	8005479515	
767	THIELE KAOLIN CO.	PO BOX 1868	STATESBORO	GA	30459	4785523951	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
542	THIRD PARTY ADMINISTRATORS/AMERICAN BENEFIT	1733 PARK ST.	NAPERVILLE	IL	60563	8006315917	
315	THOMAS COOPER AND COMPANY	PO BOX 22557	CHARLESTON	SC	29413	8437222115	
315DN	THOMAS COOPER AND COMPANY	PO BOX 22557	CHARLESTON	SC	29413	8437222115	
A01	THRIVENT FINANCIAL FOR LUTHERANS	4341 N. BALLARD RD	APPLETON	WI	54919	8008474836	
463	TIM BAR CORP	PO BOX 449	HANOVER	PA	17331	7176324727	
322	TIME INSURANCE COMPANY	PO BOX 981602	EL PASO	TX	799980624	8005537654	USE 386 ASSURANT HEALTH
265	TODAY'S OPTION	PO BOX 391883	CAMBRIDGE	MA	02139	8662225137	MEDICARE ADVANTAGE PLAN
797	TODAY'S OPTIONS UNIVERSAL AMERICAN	PO BOX 742528	HOUSTON	TX	77274	8664225009	MEDICARE ADVANTAGE PLAN
755	TOTAL BENEFIT SERVICES INC	PO BOX 30180	NEW ORLEANS	LA	70190	800596 315	
D69	TOTAL CARE/HEALTHSPRING	PO BOX 20000	NASHVILLE	TN	372024070	8007437141	MEDICARE ADVANTAGE PLAN
E55	TOTAL CAROLINA CARE INC.	1441 MAIN ST	COLUMBIA	SC	29210	8664336041	
D55	TOTAL CAROLINA CARE, INC	1441 MAIN ST	COLUMBIA	SC	29210	8664336031	MEDICAID HMO
B40	TOTAL CLAIMS SOLUTION (TCS)	PO BOX 10888	GREEN BAY	WI	543070888	8003760110	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B46	TOTAL CLAIMS SOLUTION (TCS)	PO BOX 10888	GREEN BAY	WI	54307	8003760110	
C03	TOTAL PLAN SERVICES, INC.	PO BOX 251369	PLANO	TX	75025	8009695238	
A80	TOTAL SCRIPT	10901 WEST 120TH AVE. STE 110	BROOMFIELD	CO	80021	8007522211	
D47	TOUCHSTONE HEALTH PSO	PO BOX 33519	INDIANAPOLIS	IN	462030519	8887770204	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A76	TOWER LIFE INS. CO.	310 S. MARY ST	SAN ANTONIO	TX	78205	8006606077	
X3B	TPA EXCHANGE	PO BOX 4363	ST AUGUSTINE	FL	32085	8885022789	
C52	TPA OF GEORGIA	4574 LAWRENCEVILLE HWY, STE 201	LILBURN	GA	30047	7704517550	
856	TRANSAMERICA OCCIDENTAL LIFE	PO BOX 2101 TERMINAL ANNEX	LOS ANGELES	CA	90051	2137422111	
112	TRAVELERS INSURANCE COMPANY	PO BOX 473500	CHARLOTTE	NC	282473500	7045443665	USE CODE 113 UNITED HEALTHCARE INACTIVE 8-02
406	TRAVELERS PLAN ADMINISTRATORS OF ARIZONA	PO BOX 52100	PHOENIX	AZ	85072	6028661066	CODE IN OPEN STATUS BY SCHA
642	TRICARE FOR LIFE	PO BOX 7890	MADISON	WI	537077890	8667730404	
819	TRICARE OVERSEAS PROGRAM	PO BOX 7985	MADISON	WI	537077985	8009826257	CODE ASSIGNED BY SCHA 6/07/10
614	TRICARE SOUTH REGION	PO BOX 7031	CAMDEN	SC	290207031	8004033950	INTERNET WWW.MYTRICARE.COM
C29	TRUE CHOICE USA	PO BOX 251369	PLANO	TX	75025	8002519665	THIS CODE NOT REQUESTED BY MEDCAID. ASSIGNED BY SCHA
212	TRUSTMARK INSURANCE CO.	PO BOX 2942	CLINTON	IA	52733	8476151500	USE THIS CARRIER FOR GROUPS WITH MORE THAN 50 EMPLOYEES. USE CCA03 FOR GROUPS LESS THAN 50 EMPLOYEES
703	TUCKER COMPANY & ADMINISTRATORS	9140 ARROW POINT BLVD. #200	CHARLOTTE	NC	282738102	7045259666	
B85	TUFTS HEALTHCARE	PO BOX 9185	WATERTOWN	MA	02471	8004238080	
376	TUFTS HEATH PLAN	PO BOX 9171	WATERTOWN	MA	024719171	8004620224	CODE ASSIGNED BY SCHA
261	UICI ADMINISTRATORS	PO BOX 30087	RENO	NV	895203087	8003153440	
B17	ULTRA BENEFITS	PO BOX 763	WESTBORO	MA	01581	8668587223	
143	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	
356	UMR	PO BOX 2697	WICHITA	KS	67201	8008269781	USE CODE 139
139DN	UMR	PO BOX 188037	CHATTANOOGA	TN	374228037	8008269781	WAS WAUSAU INS. CO.
B42	UMR	PO BOX 266	ONALASKA	WI	546568764	8002368672	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
967	UNDERWRITERS SAFETY AND CLAIMS	PO BOX 23507	LOUISVILLE	KY	40223	8006781536	
701	UNI-CARE CHOICE HEALTH BENEFITS	PO BOX 51130	SPRINGFIELD	MA	01151	8002888630	
160DN	UNICARE HEALTH AND LIFE INSURANCE	PO BOX 4059	SCHAUMBURG	IL	601684059	8772179677	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
160	UNI-CARE HEALTH AND LIFE INSURANCE CO	PO BOX 4458	CHICAGO	IL	606804458	8772179677	WAS MASS MUTUAL
D29	UNICARE LIFE & HEALTH INS. CO (PFFS)	233 S WACKER DR. STE. 3900	CHICAGO	IL	68606	3123247000	MEDICARE ADVANTAGE PLAN
556	UNIFIED GROUP SERVICES	PO BOX 10	PENDLETON	IN	46064	7657781535	
566	UNIFIED GROUP SERVICES	PO BOX 10	PENDLETON	IN	46064	7657781535	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
517	UNIFORM MEDICAL PLAN	PO BOX 34850	SEATTLE	WA	98124	8007626004	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
195	UNION BANKERS INSURANCE COMPANY	PO BOX 655433	DALLAS	TX	752655433	2149547840	
693	UNION COUNTY	-	-	-	-		
501	UNION FIDELITY INSURANCE COMPANY	4850 ST. RD.	TREVOSE	PA	19049-	8005236599	
306	UNION LABOR LIFE INSURANCE	111 MASSACHUSETTS AVE., NW	WASHINGTON	DC	20001	8004438087	
C73	UNION PACIFIC RAILROAD EMPLOYEES HEALTH	795 NORTH 400 WEST	SALT LAKE	UT	84103	8005470421	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
439	UNION SECURITY INSURANCE CO	PO BOX 981602	EL PASO	TX	79998	8004446254	USE 386 ASSURANT HEALTH
825	UNISON ADVANTAGE	PO BOX 1138	MONROEVILLE	PA	151465138	8002904009	MEDICARE ADVANTAGE PLAN
E38	UNISON HEALTH PLAN	250 BERRYHILL RD	COLUMBIA	SC	29210	8037985852	HEALTHY KIDS CONNECTION
638	UNISON HEALTH PLAN HMO	250 BERRYHILL RD	COLUMBIA	SC	29210	8037985852	MEDICAID HMO
779	UNISYS	PO BOX 13500	TALLAHASEE	FL	32317	8007677829	DORMANT 8/06
449	UNITED SERVICE ASSO. FOR HEALTHCARE	PO BOX 6080-288	MISSION VAIEJO	CA	926906080	8008721187	CODE ASSIGNED BY SCHA
277	UNITED AMERICAN INSURANCE COMPANY	PO BOX 8080	MCKINNEY	TX	750708080	9725295085	
871	UNITED BEHAVIORAL HEALTH	PO BOX 169053	DULUTH	MN	55816	8008776003	CODE ASSIGNED BY SCHA
A37	UNITED BEHAVIORAL/DENTAL SYSTEMS	PO BOX 30755	SALT LAKE CITY	UT	84130	8005575745	
196	UNITED BENEFIT LIFE INSURANCE	3909 HULEN ST	FT. WORTH	TX	76107	8007320657	
565	UNITED BENEFITS	PO BOX 2480	DAYTONA BEACH	FL	321152480	8004344890	WAS POE & BROWN
103	UNITED CLAIMS SOLUTIONS	10835 N. 25TH AVE. 105	PHOENIX	AZ	85029	8667448482	CODE ASSIGNED BY SCHA
124	UNITED COMMERCIAL TRAVELERS OF AMERICA	PO BOX 159019	COLUMBUS	OH	43215	8008480123	
737	UNITED CONCORDIA	PO BOX 69421	HARRISBURG	PA	17106	8003320366	
794	UNITED FAMILY LIFE INSURANCE COMPANY	PO BOX 2204	ATLANTA	GA	30371	4046593300	
577	UNITED FIDELITY LIFE INSURANCE COMPANY	PO BOX 13487	KANSAN CITY	MO	64199	8163912134	OPEN 1/06

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
704	UNITED FOOD & COMMERCIAL WORKERS (UFCW)	1800 PHOENIX BLVD. STE. 310	ATLANTA	GA	30349	8002417701	
340	UNITED HEALTCARE PLAN OF RIVER VALLEY	3800 23RD AVE OF THE CITIES, STE 200	MOLINE	IL	61265	8002246602	THIS COMPANY BOUGHT OUT JOHN DEERE INS. CO. 6/29/07
715	UNITED HEALTH & LIFE INSURANCE COMPANY	PO BOX 169050	DULUTH	MN	558168200	8005262414	USE CC113 UNITED HEALTHCARE
113	UNITED HEALTHCARE	PO BOX 740800	ATLANTA	GA	303740800	8778423210	
113DN	UNITED HEALTHCARE	PO BOX 30567	SALT LAKE CITY	UT	84130	8005215505	
927	UNITED HEALTHCARE HERITAGE PLUS	UHC OF RIVER VALLEY PO BOX 5230	KINGSTON	NY	102425230	8002246602	
A82	UNITED HEALTHCARE INDEMNITY	PO BOX 740801	ATLANTA	GA	303740801	8008488406	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D30	UNITED HEALTHCARE INS. CO (PPO)	PO BOX 150450	HARTFORD	CT	061150450	8607025000	MEDICARE ADVANTAGE PLAN
881	UNITED HEALTHCARE OF NC	PO BOX 26303	GREENSBORO	NC	274386303	8009991147	CODE ASSIGNED BY SCHA
A38	UNITED HEALTHCARE OF NC	PO BOX 2604	GREENSBORO	NC	274386304	8009991147	
B77	UNITED HEALTHCARE PLAN ADMINISTRATORS	PO BOX 121212	MARIETTA	GA	300670092	8005627079	USE CODE 985 BENESIGHT
872	UNITED HEALTHCARE PLAN OF RIVER VALLED	3800 23RD AVE. #200	MOLINE	IL	61215	8002246602	CODE ASSIGNED BY SCHA THESE COMPANY BOUGHT OUT JOHN DEERE INS. CO. THIS WAS THE HMO FOR JOHN DEERE 6/29/07
279	UNITED INSURANCE COMPANY OF AMERICA	1 E WACKER DR.	CHICAGO	IL	60601	8007778467	
B64	UNITED MEDICAL RESOURCES INC.	PO BOX 145804	CINCINNATI	OH	45214	5136193000	
720	UNITED MINE WORKERS HEALTH & RETIREMENT FUND	RTE. 2 BOX 218A	BIG STONE GAP	VA	24219	8006549763	
C81	UNITED PAYORS & UNITED PROVIDERS	2273 RESEARCH BLVD	ROCKVILLE	MD	20850	8002474144	
994	UNITED PROVIDER SERVICES	PO BOX 820277	FORT WORTH	TX	76182	8005198374	CARRIER BOUGHT OUT BY CC 740 PHARMACARE
810	UNITED RESOURCE NETWORK	PO BOX 30758	SALT LAKE CITY	UT	84130	877-801-35	CODE ASSIGNED BY SCHA
X3A	UNITED TEACHERS ASSO. INS. CO.	PO BOX 30010	AUSTIN	TX	78755	8008808824	
493	UNITED TEACHERS ASSOCIATION	PO BOX 30010	AUSTIN	TX	787553010	8668808824	
217	UNITED WORLD LIFE INS. CO.	3316 FARNAM ST.	OMAHA	NE	68175	8776175587	
791	UNITEDHEALTH INTEGRATED SERVICES	PO BOX 30783	SALT LAKE CITY	UT	841300786	8665968447	
A31	UNITY HEALTH INSURANCE	PO BOX 610	SAUK CITY	WI	535831374	8003623308	
989	UNIVERA HEALTHCARE	PO BOX 23000	ROCHESTER	NY	14692	8772429464	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D63	UNIVERA SENIOR CHOICE SECURE	PO BOX 23000	ROCHESTER	NY	15692	8006171114	MEDICARE ADVANTAGE PLAN
530	UNIVERSAL BENEFITS CORPORATION	PO BOX 97	SCRANTON	PA	185040097	8007470622	CODE ASSIGNED BY SCHA
198	UNIVERSAL FIDELITY LIFE INS. CO.	PO BOX 1428	DUNCAN	OK	735344	8003668355	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D34	UNIVERSAL HEALTH CARE	PO BOX 3211	ST PETERSBURG	FL	33731	8666904842	MEDICARE ADVANTAGE PLAN
855	UNIVERSITY HEALTH PLANS	PO BOX 830926 DEPT 003	BIRMINGHAM	AL	35283	8778780914	
D05	UPMC HEALTH BENEFITS, INC.	PO BOX 2999	PITTSBURGH	PA	15230	8773813764	MEDICARE ADVANTAGE PLAN
409	UPSTATE ADMINISTRATIVE SERVICES	PO BOX 6589	SYRACUSE	NY	132176589	3154221533	
777	US HEALTH AND LIFE	PO BOX 37504	OAK PARK	MI	482370504	8002259674	THIS CODE NOT REQUESTED BY SCHA. ASSIGNED BY SCHA
B55	US SCRIPTS	2425 WEST SHAW AVE	FRESNO	CA	93711	8004608988	
717	USA HEALTH CARE (MVP HEALTH CARE)	PO BOX 22920	ROCHESTER	NY	146922920	8009993920	CODE ASSIGNED BY SCHA
953	USA HEALTHCARE ORGANIZATION	7301 N. 16TH ST STE 201	PHOENIX	AZ	85020	8008723860	CODE ASSIGNED BY SCHA
582	USAA GENERAL INDEMNITY CO.	PO BOX 15506	SACRAMENTO	CA	958521506	8005318222	
131	USI	PO BOX 9888	SAVANNAH	GA	31412	9126911551	THIS CARRIER BOUGHT JONES, HILL & MERCER INS.
513	VALUE OPTIONS	PO BOX 1079	TROY	NY	121811079	8002880882	
466	VALUE RX	PO BOX 421150	PLYMOUTH	MN	554420150	8009554879	USE CODE 333 EXPRESS SCRIPTS
633	VETERANS ADMINISTRATION	-	-	-	-		
962	VICARE PLUS	PO BOX 1710	SUFFOLK	VA	23439	8779344403	
491	VISION SERVICE PLAN	PO BOX 997100	SACRAMENTO	CA	958997100	8006227444	
606	VOCA.REHAB GENERAL						
608	VOCATIONAL REHAB DISABILITY						
A56	VULCAN MATERIALS COMPANY	PO BOX 530187	BIRMINGHAM	AL	352530187	8642772371	DORMANT 8/06
B41	VYTRA HEALTHCARE	PO BOX 9091	MELVILLE	NY	11747	8668089399	
549	WAL-MART STORES GROUP HEALTH PLAN	922 W WALNUT STE A	ROGERS	AR	72756 320	5016212929	USE CODE 401 BLUE CROSS BLUE SHIELD OF SC
282	WASHINGTON NATIONAL INSURANCE COMPANY	PO BOX 1934	DES PLAINES	IL	60017	8009470319	
841	WATKINS ASSOCIATED INDUSTRIES	PO BOX 1738	ATLANTA	GA	30301	8003333841	CODE ASSIGNED BY SCHA
139RX	WAUSAU INSURANCE COMPANY	PO BOX 8013	WAUSAU,	WI	544028013	8008269781	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B13	WEB TPA	PO BOX 99906	GRAPEVINE	TX	760999706	8007582851	
C32	WELL FARGO INSURANCE	PO BOX 2801	CHARLESTON	WV	253302801	8004354351	
D17	WELLCARE	PO BOX 795184	SAN ANTONIO	TX	78279	8662352770	MEDICARE ADVANTAGE PLAN
D52	WELLCARE OF GEORGIA	PO BOX 31224	TAMPA	FL	33531	8662311821	MEDICARE ADVANTAGE PLAN
292	WELLMARK ADMINISTRATORS	PO BOX 9901	SIOUX CITY	IO	51102	8005265710	
X1O	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 5023	SIOUX FALLS	SD	57104	5152454500	USE CARRIER CODE X2A
X2A	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 5023	SIOUX FALLS	SD	571175023	8005268995	
252	WELLNET HEALTHCARE	57 ST. RD	SOUTH HAMPTON	PA	18966	8007271733	
879	WELLPATH SELECT	PO BOX 7102	LONDON	KY	40742	8662083610	WELLPATH SELECT IS A PLAN UNDER THE PARENT CO. COVENTRY HEALTH CARE
A24	WELLPOINT NEXT RX	PO BOX 145433	CINCINNATI	OH	45250	8009627378	USE CARRIER 333 EXPRESS SCRIPTS
C32DN	WELLS FARGO	PO BOX 11064	CHARLESTON	WV	253321064	8004354351	
594	WELLS FARGO FINANCIAL	206 EIGHTH ST.	DES MOINES	IA	50309	5152432131	WAS NORTHWEST FINANCIAL
912	WELLS FARGO TPA-NC OFFICES	PO BOX 2857	FAYETTEVILLE	NC	28302	8003376288	
991	WEST PORT BENEFITS	PO BOX 66743	ST. LOUIS	MO	63166	8883065299	
D37	WEST VIRGINIA LOCAL 152 HEALTH & WELFARE	5 HOT METAL ST. STE. 200	PITTSBURGH	PA	15203	8668258152	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B89	WESTERN & SOUTHERN FINANCIAL GROUP	PO BOX 5735	CINCINNATI	OH	45201	5136291800	
B90	WESTERN FIDELITY INSURANCE	PO BOX 901010	FORT WORTH	TX	76101	8174517200	
B93	WESTERN STATES ADMINISTRATION	PO BOX 8082	FRESNO	CA	937478082	2092514891	CODE ASSIGNED BY SCHA
415	WEYCO, INC.	PO BOX 30132	LANSING	MI	48909	5173497010	
415DN	WEYCO, INC.	PO BOX 30132	LANSING	MI	48909	5173497010	
969	WHP HEALTH INITIATIVE	PO BOXBXO 545	DEERFIELD	IL	60015	8002072568	
694	WILLIAMSBURG COUNTY	-	-	-	-		
116	WILLIS CORROON ADMINISTRATIVE SERVICES	PO BOX 305154	NASHVILLE	TN	372305154	8002558109	
826	WILLSE & ASSOCIATES, INC.	PO BOX 1196	BALTIMORE	MD	21203	4105470454	
D75	WINDSOR MEDICARE EXTRA	PO BOX 269025	PLANTO	TX	750269025	8662705223	MEDICARE ADVANTAGE PLAN
A88	WINDSOR STERLING	PO BOX 269003	PLANO	TX	750269003	8888588551	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
575	WISCONSIN ELECTRICAL EMPLOYEES	PO BOX 2430	BROOKFIELD	WI	53008	6082769111	CODE IN OPEN STATUS BY SCHA
768	WISCONSIN PHYSICIANS SERVICES	1717 WEST BROADWAY ST.	MADISON	WI	53708	8889154158	
923	WJ JONES ADMINISTRATIVE SERVICES INC	1979 MARCUS AVE	LAKE SUCCESS	NY	11042	8008317783	DORMANT 8/06
598	WJB DORN VA MEDICAL CENTER	6439 GARNERS FERRY RD	COLUMBIA	SC	292091639	8037764000	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
285	WOODMAN OF THE WORLD LIFE INSURANCE SOCIETY	1700 FARNAM ST.	OMAHA	NE	68102	8002253108	
A34	WOODS & GROOM	2549 17TH ST.	COLUMBUS	IN	47202	8003683429	DORMANT 8/06
622	WORKMEN'S COMP						
580	WORLD INSURANCE COMPANY	PO BOX 3160	OMAHA	NE	681030160	4024968000	
C57	WORLD TRAVEL PROTECTION	4600 WITMER INDUSTRIAL ESTATES #2	NIAGARA FALLS	NY	14305	8004564553	THIS CODE NOT REQUESTED BY MEDCAID. ASSIGNED BY SCHA
155	WORLDWIDE INSURANCE & CLAIM SERVICE	4675 S HOLLAND	SPRINGFIELD	MO	65810	4178828100	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
607	WPS TRICARE FOR LIFE	PO BOX 7889	MADISON	WI	537077889	8667730404	
C51	YALE HEALTH PLAN	PO BOX 208217	NEW HAVEN	CT	065208217	2034320250	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
470	YODER BROTHERS	1001 LEBANON RD	PENDLETON	SC	29670	8646468331	
695	YORK COUNTY	-	-	-	-		
C10	ZAVATA	PO BOX 1208	AMERICUS	GA	31709	8008417735	WAS PARADIGM CARE PLAN
977	ZENITH ADMINISTRATION	PO BOX 91014	SEATTLE	WA	98111	8004265980	DORMANT 8/06

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED ALPHABETICALLY

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APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
100	AETNA US HEALTHCARE	PO BOX 14079	LEXINGTON	KY	40512	8003334432	
101	INTERNATIONAL CLAIMS SERVICES	27092 BURBANK ST	FOOTHILL RANCH	CA	92610	8779167920	ASSIGNED BY SCHA
102							
103	UNITED CLAIMS SOLUTIONS	10835 N. 25TH AVE. 105	PHOENIX	AZ	85029	8667448482	CODE ASSIGNED BY SCHA
104	KAISER FOUNDATION HEALTH PLAN OF SOUTHERN CA.	PO BOX 7004	DOWNEY	CA	90242	8003903510	CODE ASSIGNED BY SCHA
105	ATHENE ANNUITY AND LIFE ASSURANCE COMPANY	PO BOX 19038	GREENVILLE	SC	29602	8646098111	
106	AMERICAN FIDELITY ASSURANCE BENEFITS	PO BOX 25160	OKLAHOMA CITY	OK	731250160	8006548489	
107	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	8002289090	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
108	METROPOLITAN LIFE INSURANCE COMPANY	PO BOX 981282	EL PASO	TX	79998	8006386626	
109	JEFFERSON PILOT INSURANCE COMPANY	PO BOX 26011	GREENSBORO	NC	27420	3366913000	
110	AMERIHEALTH HMO, INC.	PO BOX 41574	PHILADELPHIA	PA	191011574	8886323862	CODE ASSIGNED BY SCHA
111	PRUDENTIAL INSURANCE COMPANY OF AMERICA	841 PRUDENTIAL DR.	JACKSONVILLE	FL	32207	8003463778	THIS CARRIER BOUGHT OUT BY AETNA CC100
112	TRAVELERS INSURANCE COMPANY	PO BOX 473500	CHARLOTTE	NC	282473500	7045443665	USE CODE 113 UNITED HEALTHCARE INACTIVE 8-02
113	UNITED HEALTHCARE	PO BOX 740800	ATLANTA	GA	303740800	8778423210	
114	CLAIMEDIX INC.	PO BOX 140067	KANSAS CITY	MO	64114	8009224262	CODE ASSIGNED BY SCHA
115	ALLSTATE INSURANCE	PO BOX 7068	COLUMBIA	SC	29202	8003668997	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
116	WILLIS CORROON ADMINISTRATIVE SERVICES	PO BOX 305154	NASHVILLE	TN	372305154	8002558109	
117	HEWITT COLEMAN AND ASSOCIATES	PO BOX 6708	GREENVILLE	SC	29606	8642405840	
118	AMERICAN HEALTH & LIFE INSURANCE	300 ST. PAUL PLACE	BALTIMORE	MD	21202	3013323000	
119	AMERICAN HERITAGE LIFE INSURANCE	1776 AMERICAN HERITAGE LIFE DR.	JACKSONVILLE	FL	32224	8005358086	
120	AMERICAN NATIONAL INSURANCE COMPANY	PO BOX 1790	GALVESTON	TX	77553	8008996803	
121	GREATER HEALTHCARE	PO BOX 3400	MONROE	NC	28110	7042258887	
122	ATLANTIC COAST LIFE INSURANCE COMPANY	PO BOX 20010	CHARLESTON	SC	294130010	8437638680	
123	BANKERS LIFE & CASUALTY	PO BOX 66927	CHICAGO	IL	606660927	8006213724	
124	UNITED COMMERCIAL TRAVELERS OF AMERICA	PO BOX 159019	COLUMBUS	OH	43215	8008480123	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
125	AMERICAN TRAVELERS LIFE INSURANCE COMPANY	3220 TILLMAN DR.	BEN SALEM	PA	19020	2152441600	
126	HEALTH PLAN SERVICES (COVENTRY HEALTH CARE)	PO BOX 24146	SEATTLE	WA	98124	8008610056	CODE ASSIGNED BY SCHA
127	BENEFITSOURCE, INC	PO BOX 240	MONROE	MI	48161	8004231028	CODE ASSIGNED BY SCHA
128	CAPITOL LIFE INSURANCE COMPANY	PO BOXBXO 1200	DENVER	CO	80201	8005252115	PER HOSP. ASSO. 07/02, THIS IS STILL A VALID CARRIER
129	INTERGROUP SERVICES CORPORATION	101 LINDENWOOD DR, STE 150	MALVERN	PA	19355	8005379389	
130	EMPLOYERS LIFE INSURANCE COMPANY	PO BOX 6305	SPARTANBURG	SC	29304	8889628437	CARRIER WAS COASTAL STATE LIFE INS. CO.
131	USI	PO BOX 9888	SAVANNAH	GA	31412	9126911551	THIS CARRIER BOUGHT JONES, HILL & MERCER INS.
132	COLONIAL LIFE AND ACCIDENT INSURANCE COMPANY	PO BOX 1365	COLUMBIA	SC	29202	8037987000	
133	COMBINED INSURANCE COMPANY OF AMERICA	5050 BROADWAY	CHICAGO	IL	60640	8002254500	
134	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 182223	CHATTANOOGA	TN	374227223	8008824462	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
135	ALLIED NATIONAL, INC.	PO BOX 419233	KANSAS CITY	MO	641416233	8008257531	CARRIER WAS ALLIED GROUP INSURANCE TRUST
136	CIGNA FLEXCARE	PO BOX 30575	CHARLOTTE	NC	282303211		CODE ASSIGNED BY SCHA
137	EDUCATORS MUTUAL LIFE INSURANCE COMPANY	PO BOX 3149	LANCASTER	PA	17601	7173972751	
138	CORESOURCE	PO BOX 2920	CLINTON	IA	527332920	8775433935	
139	FISERV HEALTH	PO BOX 8013	WAUSAU,	WI	544028013	8008269781	WAS WAUSAU INS. CO.
140	STERLING OPTION I (PFFS)	PO BOX 5348	BELLINGHAM	WA	982270010		MEDICARE ADVANTAGE PLAN
141	NEOA HEALTH BENEFITS FUND	428 E SCOTT AVE. - PO BOX 3070	KNOXVILLE	TN	37927	-	
142	GENERAL AMERICAN LIFE INSURANCE	719 TEACO RD.	KENNETH	MO	63857	8004452158	USE CODE 308 GREAT WEST LIFE INACTIVE 8-02
143	UMR	PO BOX 30541	SALT LAKE CITY	UT	841300541	8008269781	
144	GLOBE LIFE & ACCIDENT INSURANCE	204 N. ROBINSON	OKLAHOMA CITY	OK	73102	4052701400	
145	GMP EMPLOYERS RETIREE TRUST	5245 BIG PINE WAY SE	FORT MYERS	FL	33907	9419366242	
146	HARTFORD INSURANCE GROUP	PO BOX 25600	CHARLOTTE	NC	28212	7045366230	
147	STATE MUTUAL INSURANCE	PO BOX 10811	CLEARWATER	FL	337578811	8887806388	
148	MONUMENTAL LIFE INSURANCE COMPANY	PO BOX 61	DURHAM	NC	27702	8004445431	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
149	INSURANCE COMPANY OF NORTH AMERICA (INA)	195 BROADWAY 11TH FLOOR	NEW YORK	NY	100073100	2126184000	
150	AMERICAN GENERAL LIFE AND ACCIDENT INS CO	PO BOX 1500	NASHVILLE	TN	372021500	8008882452	
151	CARELINK	PO BOX 7373	LONDON	KY	40742	8003482922	MEDICAID HMO
152	MEDICA	PO BOX 30990	SALT LAKE CITY	UT	84130	8004585512	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA
153	KANAWHA LIFE INSURANCE COMPANY	PO BOX 6000	LANCASTER	SC	29721	8032862440	
154	CONSUMER DRIVEN BENEFITS ASSO.	PO BOX 6080-228	MISSION VIEIO	CA	926906080	8884114208	CODE ASSIGNED BY SCHA
155	WORLDWIDE INSURANCE & CLAIM SERVICE	4675 S HOLLAND	SPRINGFIELD	MO	65810	4178828100	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
156	LIFE INSURANCE COMPANY OF GEORGIA	PO BOX 105006	ATLANTA	GA	303485006	7709805100	
157	LIFE INSURANCE COMPANY OF VIRGINIA, THE	PO BOX 27601	RICHMOND	VA	23230	8042816000	
158	LINCOLN NATIONAL LIFE INSURANCE COMPANY	PO BOX 614008	ORLANDO	FL	32861	8004232765	
159	MAKSIN MANAGMENT CORP	CN98000	PENNSAUKEN	NJ	08110	8002570625	
160	UNI-CARE HEALTH AND LIFE INSURANCE CO	PO BOX 4458	CHICAGO	IL	606804458	8772179677	WAS MASS MUTUAL
161	AMA INSURANCE AGNECY, INC.	200 N. LASALLE ST. STE. 400	CHICAGO	IL	606819785	8004585736	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
162	HARVARD PILGRIM HEALTHCARE	PO BOX 656653	SAN ANTONIO	TX	82655	8004213550	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
163	NATIONWIDE LIFE INSURANCE COMPANY	PO BOX 182202	COLUMBUS	OH	432182202	6142497111	
164	AMERICAN PROGRESSIVE INSURANCE	PO BOX 130	PENSACOLA	FL	325910130	8006268913	
165	NEW YORK LIFE INSURANCE COMPANY	PO BOX 105095	ATLANTA	GA	30348	8003884580	
166	CAPITOL AMERICAN LIFE INSURANCE COMPANY	PO BOX 94953	CLEVELAND	OH	441014953	2166966400	
167	AMERICAN INTERNATIONAL GROUP (AIG) ACCIDENT	PO BOX 3726	SEATTLE	WA	98124	8775039095	CODE ASSIGNED BY SCHA
168	PRECISE BENEFIT ADMINISTRATORS	PO BOX 9064	JERICHO	NY	11753	5163906000	
169	CROWN CORK & SEAL COMPANY, INC.	930 BEAUMONT AVE.	SPARTANBURG	SC	29303	8645856456	
170	OCCIDENTAL LIFE INSURANCE COMPANY OF NC	PO BOX 10324	RALEIGH	NC	27605	9198318189	
171	AON	PO BOX 66	WINSTON SALEM	NC	27102	8003683804	
172	PAUL REVERE LIFE INSURANCE COMPANY	PO BOX 15118	WORCESTER	MA	016150118	5087994441	
173	PENNSYLVANIA LIFE INSURANCE COMPANY	PO BOX 130	PENSACOLA	FL	325910100	8002757366	
174	NMU PENSION & WELFARE FUND	360 WEST 31ST ST., 3RD FL	NEW YORK	NY	10001	2123374900	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
175	COLUMBIA UNIVERSAL LIFE INSURANCE CO.	PO BOX 200225	AUSTIN	TX	787200225	5123453200	
176	GUIDESTAR HEALTH SYSTEMS	PO BOX 35238	BIRMINGHAM	AL	35238	8005956949	
177	CINERGY HEALTH PREFERRED PLAN	144 N BEVERWYCK RD #332	LAKE HIAWATHA	NJ	080341997	8008471148	CODE IN OPEN STATUS BY SCHA
178	MASHANTUCKET PLAN ADMINISTRATORS	PO BOX 3620	MASHANTUCKET	CT	06338	8887796872	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
179	DESERET MUTUAL BENEFIT ADMINISTRATOR	PO BOX 45530	SALT LAKE CITY	UT	84145	8007773622	
180	ESIS	PO BOX 31122	TAMPA	FL	33631	8008847975	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
181	GROUP ADMINISTRATORS, LTD.	450 E. REMINGTON RD.	SCHAUMBURG	IL	60173	8475191880	
182	PENN TREATY NETWORK AMERICA INS. CO.	PO BOX 7066	ALLENTOWN	PA	181057066	8003620700	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
183	GILSBAR INSURANCE COMPANY	PO BOX 2947	COVINGTON	LA	70434	8002342643	
184	SECURITY LIFE INSURANCE CO. OF AMERICA	PO BOX 3199	WINSTON-SALEM	NC	27102	8003009566	
185	S&S HEALTHCARE STRATEGIES	PO BOX 46511	CINCINNATI	OH	45216	8888008717	
186	SOUTHLAND LIFE INSURANCE COMPANY	PO BOX 105006	ATLANTA	GA	303485006	7709805100	
187	RELIANCE STANDARD LIFE INS. CO.	PO BOX 82520	LINCOLN	NE	68501	8004977044	
188	STANDARD LIFE & CASUALTY INSURANCE COMPANY	PO DRAWER 1514	FORT MILL	SC	29716	8035483657	
189	INTERNATIONAL EDUCATION EXCHANGE SERVICES	PO BOX 370	ITHACA	NY	148510307	8664337462	
190	BOILERMAKERS NATIONAL HEALTH & WELFARE FUND	754 MINNESOTA AVE., STE. 522	KANSAS CITY	KS	661012762	9133426555	
191	COVENTRY HEALTHCARE OF DELAWARE, INC.	PO BOX 7713	LONDON	KY	40742	8008337423	CODE NOT REQUESTED BY MEDICAID. ASSIGNED MY SCHA
192	CONVENTRY HEALTHCARE OF NEBRASKA, INC.	PO BOX 7705	LONDON	KY	40742	8002883343	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
193	ALLSTATE WORKPLACE DIVISION	PO BOX 853916	RICHARDSON	TX	750853916	8009377039	
194	DAKOTACARE	1323 S. MINNESOTA AVE	SIOUX FALLS	SD	57105		CODE ASSIGNED BY SCHA
195	UNION BANKERS INSURANCE COMPANY	PO BOX 655433	DALLAS	TX	752655433	2149547840	
196	UNITED BENEFIT LIFE INSURANCE	3909 HULEN ST	FT. WORTH	TX	76107	8007320657	
197	HARVARD PILGRIM HEALTH CARE	505 S LENOLA RD, STE. 231	MOORESTOWN	NJ	08057	866-375-07	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
198	UNIVERSAL FIDELITY LIFE INS. CO.	PO BOX 1428	DUNCAN	OK	735344	8003668355	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
199	ALL OTHER CARRIERS	-	-	-	-		
200	ALL AMERICAN LIFE INSURANCE CO.	8501 WEST HIGGINS RD.	CHICAGO	IL	60631	7733996645	
201	HCH ADMINISTRATORS	PO BOX 1986	PEORIA	IL	61656	8003221516	
202	JOHN HANCOCK INSURANCE COMPANY	PO BOX 852	BOSTON	MA	02117	8002331449	
203	HEALTH CARE SUPPORT/PRIVATE HEALTH CARE SYSTEM	29 COLUMBIA HEIGHTS	BROOKLYN	NY	11201	8005544022	CODE ASSIGNED BY SCHA
204	SELF INSURED BENEFIT ADMINISTRATORS	18167 US HWY 19N	CLEARWATER	FL	33764	7275320400	
205	FIDELITY LIFE SECURITY	3130 BROADWAY	KANSAS CITY	MO	641112406	8006488624	
206	MED COST BENEFITS SERVICES	PO BOX 25307	WINSTON SALEM	NC	271145307	8007951023	
207	MEDICAL SAVINGS HEALTH PLAN	419 E. MAIN ST	MIDDLETON	NY	10940	3173298222	
208	SIEBA, LTD	PO BOX 5000	ENDICOTT	NY	13761	8002524624	
209	SUMMIT AMERICA INSURANCE SERVICES	7400 COLLEGE BLVD. STE. 100	OVERLAND PARK	KS	66210	8772466997	
210	AMERITAS LIFE INSURANCE	PO BOX 82520	LINCOLN	NE	68501	8002559678	
211	COORDINATED BENEFIT PLANS INC.	PO BOX 853925	RICHARDSON	TX	750853925	8007531000	
212	TRUSTMARK INSURANCE CO.	PO BOX 2942	CLINTON	IA	52733	8476151500	USE THIS CARRIER FOR GROUPS WITH MORE THAN 50 EMPLOYEES. USE CCA03 FOR GROUPS LESS THAN 50 EMPLOYEES
213	COVENANT ADMINISTRATORS	PO BOX 105738	ATLANTA	GA	30348	7702396230	
214	RISK BENEFIT MANAGEMENT SERVICES, LLC (RBMS)	PO BOX 241569	ANCHORAGE	AK	99524	8007703740	
215	OXFORD LIFE INSURANCE COMPANY	PO BOX 46518	MADISON	WI	53744	8774693073	
216	HUMANA HEALTH INSURANCE OF FLORIDA	PO BOX 19080-F	JACKSONVILLE	FL	32245	8004574708	
217	UNITED WORLD LIFE INS. CO.	3316 FARNAM ST.	OMAHA	NE	68175	8776175587	
218	ROCKY MOUNTAIN HEALTH PLAN (RMHP)	PO BOX 4517	ENGLEWOOD	CO	80155	8884792000	
219	CLAIMS PRO	PO BOX 577	SOUTHFIELD	MI	48075	8008379600	RX CARRIER ONLY
220	HEALTH NEW ENGLAND	ONE MONARCH PLACE,STE 1500	SPRINGFIELD	MA	011441500	8003102835	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
221	QUAL CARE	PO BOX 249	PISCATHAWAY	NJ	08855	8009926613	CODE ASSIGNED BY SCHA
222	MEDICA	PO BOX 30990	SALT LAKE CITY	UT	84107	8009523455	
223	MED COST PREFERRED	PO BOX 25437	WINSTON SALEM	NC	27114	8008247406	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
224	SOUTHERN ELEC. HEALTH FUND	3928 VOLUNTEER DR.	CHATTANOOGA	TN	37416	4238992593	
225	HEALTH SERVICES FOUNDATION	PO BOX 2109	LIVERMORE	CA	94551	5104497070	
226	MASTER HEALTH PLAN	PO BOX 16367	AUGUSTA	GA	303919123	7068635955	
227	MONUMENTAL GENERAL INSURANCE COMPANY	1111 N CHARLES ST.	BALTIMORE	MD	20201	8007529797	
228	PHYSICIANS PLUS INS. CO.	PO BOX 909953	MILWAUKEE	WI	53209	8005455015	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
229	PRESCRIPTION HEALTH SERVICES	PO BOX 80716	LOS ANGELES	CA	90080	8004212342	CODE ASSIGNED BY SCHA
230	PYRAMID LIFE INSURANCE COMPANY	PO BOX 772	SHAWNEE MISSION	KS	66201	8004440321	
231	SAVERS LIFE INSURANCE COMPANY	8064 NORTH POINT BLVD STE. 201	WINSTON SALEM	NC	27106	8006420483	
232	GENERAL ADJUSTMENT BUREAU	PO BOX 81808	ALTANTA	GA	30366	4044579555	CODE ASSIGNED BY SCHA
233	STERLING LIFE INSURANCE	PO BOX 5348	BELLINGHAM	WA	98227	8006880010	
234	ALWAYSCARE BENEFITS INC	PO BOX 80139	BATON ROUGE	LA	70898	8887295433	DENTAL PLAN
235	SHAW INDUSTRIES	PO BOX 10	DALTON	GA	30722	8003211855	
236	GUARANTEE TRUST LIFE INSURANCE	1275 MILWAUKEE AVE.	GLENVIEW	IL		8476990600	
237	GUARDIAN LIFE INSURANCE COMPANY OF AMERICA	PO BOX 8019	APPLETON	WI	54913	8008734542	
238	HORIZON HEALTHCARE	PO BOX 1028	WEST TRENTON	NJ	08628	8007923666	
239	HORACE MANN LIFE INSURANCE COMPANY	1 HORACE MANN PLAZA	SPRINGFIELD	IL	62715	2177892500	
240	STARBRIDGE	PO BOX 55270	PHOENIX	AZ	85078	8003085948	
241	LIFE REINSURANCE CO.	PO BOX 792070	SAN ANTONIO	TX	78279	8002291024	
242	HELLER ASSOCIATES	8228 MAYFIELD RD. STE 5B	CHESTERLANDE	OH	44026	4405272955	CODE IN OPEN STATUS BY SCHA
243	LIFE & CASUALTY INSURANCE COMPANY OF TENNESSEE	AMERICAN GENERAL CENTER	NASHVILLE	TN	37250	6157491000	
244	STERLING INVESTORS LIFE INS. CO.	PO BOX 10844	CLEARWATER	FL	337578844	8776045240	
245	COVENTRY HEALTH CARE	PO BOX 8400	LONDON	KY	40742	8009357284	
246	COVENTRY HEATLH CARE RX	PO BOX 8400	LONDON	KY	40742	8009476824	
247	EMPLOYERS DIRECT HEALTH	5050 SPRING VALLEY RD.	DALLAS	TX	752443909	8008729934	CARRIER WAS FIRST INTERGRATED HEALTH
248	NEW ENGLAND LIFE INSURANCE	25145 COUNTRY CLUB BLVD	NORTH OLMSTED	OH	440705300	8002558063	
249	FIRST HEALTH WORKERS COMP ONLY	PO BOX 23070	TUCSON	AZ	85735	8005544954	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
250	IDEAL SCRIPTS	144 METRO CENTER BLVD	WARWICK	RI	02886	8007176614	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
251	PYMARID LIFE INSURANCE CO.	PO BOX 12922	PENSACOLA	FL	325912922	8006581413	CODE IN OPEN STATUS BY SCHA MEDICARE SUPPLEMENTAL PLAN G
252	WELLNET HEALTHCARE	57 ST. RD	SOUTH HAMPTON	PA	18966	8007271733	
253	AMERICAN STERLING INSURANCE SERVICES	PO BOX 26103	OVERLAND PARK	KS	66225	8772926037	
254	PACIFIC MUTUAL LIFE INSURANCE COMPANY	700 NEWPORT CENTER DR.	NEWPORT BEACH	CA	92660	8004512513	
255	PAN-AMERICAN LIFE INSURANCE COMPANY	PO BOX 60219	NEW ORLEANS	LA	70160	5045661300	
256	BENICOMP	8310 CLINTON PARK DR	FT WAYNE	IN	46825	8008377400	CODE ASSIGNED BY SCHA
257	PHARMACY NETWORK NATIONAL OF N.C.	4000 OLD WAKEFOREST RD STE. 101	RALEIGH	NC	27609	8003317108	SEE CARRIER 366 CATALYST RX
258	DIVERSIFIED ADMINISTRATION CORPORATION	PO BOX 299	MARLBOROUGH	CT	06447	8883222524	
259	CNA HEALTHCARE PARTNERS	PO BOX 34197	LITTLE ROCK	AK	72203	8005083772	
260	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 10136	FAIRFAX	VA	220388022	8662199292	CODE IN OPEN STATUS BY SCHA
261	UICI ADMINISTRATORS	PO BOX 30087	RENO	NV	895203087	8003153440	
262	CAIC (CONTINENTAL AMERICAN INS. CO)	PO BOX 6080226	MISSION VIEJO	CA	926906080	8887302244	
263	NATIONAL FINANCIAL COMPANY	110 WEST 7TH ST. STE. 300	FT WORTH	TX	76102	8007251407	
264	HEALTH AMERICA	PO BOX 7089	LONDON	KY	40742	8007888445	
265	TODAY'S OPTION	PO BOX 391883	CAMBRIDGE	MA	02139	8662225137	MEDICARE ADVANTAGE PLAN
266	ACMG ADMINISTRATORS OF SOUTH CAROLINA	2570 TECHNICAL DR.	MIAMISBURG	OH	45342	8002326242	
267	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 220887	CHARLOTTE	NC	282220887	7043643865	CODE ASSIGNED BY SCHA
268	MARQUETTE NATIONAL LIFE INS. CO.	PO BOX 130	PENSACOLA	FL	32591	8009348203	
269	THE EPOCH GROUP	PO BOX 12170	OVERLAND PARK	KS	66212	8002556065	
270	PREFERRED HEALTH PLAN OF THE CAROLINAS	P.O, BOX 220397	CHARLOTTE	NC	28222	8666360239	
271	AMERICAN BENEFIT PLAN ADMINISTRATOR	22OO-B ROSSELLE ST.	JACKSONVILLE	FL	32204	8004685126	
272	ALLIANCE HEALTH BENEFIT PLAN	PO BOX 6443	ROCKVILLE	MD	20850	8003423289	
273	CENTRAL BENEFITS USA (CENBEN USA)	PO BOX 619059	DALLAS	TX	85261	8007725924	CODE ASSIGNED BY SCHA
274	CAPITAL DISTRICT PHYSICIANS PLAN	PO BOX 66602	ALBANY	NY	122066602	8009267526	
275	AMERICAN TRUST ADMINISTRATORS	PO BOX 87	SHAWNEE MISSION	KS	66201	9134514900	
276	PLAN HANDLERS	930 CANTERBURY PLACE	ESCONDIDO	CA	92025	8005385512	
277	UNITED AMERICAN INSURANCE COMPANY	PO BOX 8080	MCKINNEY	TX	750708080	9725295085	
278	ROCKY MOUNTIAN HEALTH PLAN	PO BOX 10600	GRAND JUNCTION	CO	81502	8008544558	
279	UNITED INSURANCE COMPANY OF AMERICA	1 E WACKER DR.	CHICAGO	IL	60601	8007778467	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
280	CAREMARK PRESCRIPTION SERVICES	PO BOX 52188	PHOENIX	AZ	850722196	8008415550	USE CARRIER 471
281	HEALTH NETWORK AMERICA/TRIVERIS	PO BOX 307	EATONTOWN	NJ	07724	8003371421	CODE ASSIGNED BY SCHA
282	WASHINGTON NATIONAL INSURANCE COMPANY	PO BOX 1934	DES PLAINES	IL	60017	8009470319	
283	GUARDIAN HEALTHCARE	PO BOX 4197	SCRANTON	PA	77010	8668501256	MEDICARE ADVANTAGE PLAN
284	AMERIHEALTH ADMINISTRATORS	720 BLAIR RD.	HORSHAM	PA	19044	8003454017	
285	WOODMAN OF THE WORLD LIFE INSURANCE SOCIETY	1700 FARNAM ST.	OMAHA	NE	68102	8002253108	
286	CONSOLIDATED GROUP	PO BOX 248	BATTLEBORO	VT	05302	8002411121	CODE IN OPEN STATUS BY SCHA
287	COMMUNITY HEALTH PLAN	PO BOX 14467	CINCINNATI	OH	45250	8888008717	
288	FIRST ADMINISTRATORS, INC.	PO BOX 9900	SIOUX CITY	IA	51102	8002060827	
289	AFTRA HEALTH FUND	261 MADISON AVE	NEW YORK	NY	10016	8005624690	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
290	FEDERATED MUTUAL INSURANCE COMPANY (REGIONAL)	PO BOXBOX31716	TAMPA	FL	336313716	8134968100	
291	NALC HEALTH BENEFIT PLAN	20547 WAVERLY CT.	ASHBURN	VA	20149	7037294677	
292	WELLMARK ADMINISTRATORS	PO BOX 9901	SIOUX CITY	IO	51102	8005265710	
293	PARAMOUNT HEALTH CARE	PO BOX 497	TOLEDO	OH	43697	8888912564	
294	BRIDGESTONE/FIRESTONE COMPANIES	PO BOX 26605	AKRON	OH	44319	8002378447	
295	MEDICAL BENEFIT ADMINISTRATORS	5940 SEMINOLE CENTER CT.	MADISON	WI	53711	6082731776	
296	RESERVE NATIONAL INSURANCE	PO BOX 26620	OKLAHOMA CITY	OK	73126	8006549106	
297	AMALGAMATED LIFE INSURANCE	PO BOX 1451	NEW YORK	NY	101161451	2124735700	
298	SMITH PREMIERE PHARMACY PLAN	PO BOX 5824	SPARTANBURG	SC	29304	8002474526	
299	ALICARE	PO BOX 1447	NEW YORK	NY	10116	2125395115	
300	BENEFIT ADMINISTRATORS INC	PO BOX 6279	ERIE	PA	16512	8007772524	
301	BENEFIT PLAN ADMINISTRATORS	2145 FORD PARKWAY, STE. 300	ST. PAUL	MN	55116	8002778973	
302	GOVERNMENT EMPLOYEE HOSP. ASSN (GEHA)	PO BOX 4665	INDEPENDENCE	MO	640514665	8162575500	
303	PREFERRED HEALTH PLAN, INC.	PO BOX 24125	LOUISVILLE	KY	40224	5023397500	
304	BUTLER BENEFIT SERVICE, INC.	PO BOX 3310	DAVENPORT	IA	528083310	8669272200	
305	HEALTHSMART	PO BOX 2801	CHARLESTON	WV	253302801	8668695597	
306	UNION LABOR LIFE INSURANCE	111 MASSACHUSETTS AVE., NW	WASHINGTON	DC	20001	8004438087	
307	STANDARD SECURITY LIFE INS. CO OF NEW YORK	PO BOX 828	PARK RIDGE	IL	60068	8665131479	
308	GREAT WEST LIFE	1000 GREAT WEST DR	KENNETT	MO	63857	8006638081	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
309	CONSOLIDATED BENEFIT SERVICES, INC.	PO BOX 1391	DAYTON	OH	45401	8004766789	CODE NOT REQUSTED BY MEDICAID. ASSIGNED BY SCHA
310	ADVANCED DATA SOLUTIONS	PO BOX 723097	ATLANTA	GA	31139	8007425246	
311	BENEFIT PLANNERS, INC	PO BOX 682010	SAN ANTONIO	TX	78269----	2106991872	
312	NATIONAL BENEFIT ADMINISTRATORS	PO BOX 690903	CHARLOTTE	NC	282277016	8004826736	
313	GREAT WEST HEALTHCARE	1000 GREAT WEST DR	KENNETT	MO	63857	8006638081	
314	PHARMACY ADVANTAGE NETWORK	50 LENNOX POINTE	ATLANTA	GA	30324	8887275560	SEE CARRIER 366 CATALYST RX
315	THOMAS COOPER AND COMPANY	PO BOX 22557	CHARLESTON	SC	29413	8437222115	
316	PROFESSIONAL INSURANCE CORPORATION	2610 WYCLIFF RD	RALEIGH	NC	27607	8002891122	
317	EMPLOYEE BENEFITS MANAGEMENT CORPORATION	4789 RINGS RD.	DUBLIN	OH	43017	8005520455	
318	KLAIS & COMPANY	1867 WEST MARKET ST.	AKRON	OH	443136977	3308678443	
319	BENEFIT CONCEPTS	PO BOX 60608	KING OF PRUSSIA	PA	19406	8002202600	
320	LAMAR LIFE INSURANCE COMPANY	PO BOX 880	JACKSON	MS	39201	6019493100	
321	AMERICAN POSTAL WORKERS UNION HEALTH PLAN	PO BOX 188004	CHATTANOOGA	TN	37422	8002222798	
322	TIME INSURANCE COMPANY	PO BOX 981602	EL PASO	TX	799980624	8005537654	USE 386 ASSURANT HEALTH
323	LINCOLN HERITAGE LIFE INSURANCE CO	PO BOX 10843	CLEARWATER	FL	337578843	8885868810	
324	HEALTH REIMBURSEMENT MANAGMENT PARTNERSHIP	5 HUTCHINSON DR	DANVERS	MA	01923	8889994767	CODE IN OPEN STATUS BY SCHA
325	PERSONAL CARE	PO BOX 7141	LONDON	KY	40742	8004311211	
326	PHYSICIANS HEALTH PLAN OF MID MICHIGAN	PO BOX 247	ALPHARETTA	GA	300090247	8008329186	
327	MAIL HANDLERS BENEFIT PLAN	PO BOX 8402	LONDON	KY	40742	8004107778	
328	PROVIDER SELECT, INC.	PO BOX 330070	FORT WORTH	TX	76163	8667747766	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
329	SMITHFIELD FOODS HEALTHCARE	PO BOX 158	SMITHFIELD	VA	23431	8008095916	
330	ANNUITY BOARD OF SOUTHERN BAPTIST CONVENTION	PO BOX 2190	NASHVILLE	TN	37234	2147200511	
331	CONSECO HEALTH INS. CO	PO BOX 66904	CHICAGO	IL	606660904	8005412254	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
332	HEALTH PLANS INC.	PO BOX 5199	WESTBOROUGH	MA	01581	8005327575	
333	EXPRESS SCRIPTS	PO BOX 2849	CLINTON	IA	527332849	8004516245	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
334	NATIONAL RURAL LETTER CARRIERS ASSOCIATION	1750 PENNSYLVANIA AVE., NW	WASHINGTON	DC	20006	8006388432	
335	J.P. FARLEY CORP.	PO BOX 458022	WESTLAKE	OH	441468022	4402504300	
336	CASEBP (CATSKILL AREA SCHOOLS EMPLOYEE PLAN	PO BOX 220	STAMFORD	NY	12167	8009626294	CODE IN OPEN STATUS BY SCHA
337	BOARD OF PENSIONS OF THE PRESBYTERIAN CHURCH OF	PO BOX 13896	PHILADELPHIA	PA	19101	8007737752	
338	PITTMAN & ASSOCIATES, INC.	PO BOX 111047	MEMPHIS	TN	38111	8002381344	
339	CELTIC INDIVIDUAL HEALTH	PO BOX 33839	INDIANAPOLIS	IN	462030839	8004777870	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
340	UNITED HEALTCARE PLAN OF RIVER VALLEY	3800 23RD AVE OF THE CITIES, STE 200	MOLINE	IL	61265	8002246602	THIS COMPANY BOUGHT OUT JOHN DEERE INS. CO. 6/29/07
341	ADMINISTRATIVE CONCEPTS INC.	994 OLD EAGLE SCHOOL RD STE 1005	WAYNE	PA	19087	8882939229	
342	SUN LIFE INSURANCE COMPANY OF CANADA	ONE SUN LIFE EXECUTIVE PARK	WELLESLEY	MA	02181	8002253950	
343	GROUP BENEFITS ADMINISTRATORS	70 GRAND AVE.	RIVEREDGE	NJ	07661	2013433003	
344	ALIA CLAIMS DEPARTMENT	PO BOX 9060	PHOENIX	AZ	850689060	8008825707	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
345	EMPLOYEE BENEFIT SERVICES INC	PO BOX 1929	FORT MILL	SC	29716	8002421510	
346	ADMINISTRATIVE SERVICES, INC.	2187 NORTHLAKE PARKWAY STE. 106 BLD #9	TUCKER	GA	30084-	7709343953	
347	PREFERRED CARE INC (PCI)	1300 VIRGINIA DIRVE STE. 315	FORT WASHINGTON	PA	19034	8002223085	
348	FIRST AGENCY, INC.	5071 WEST H AVE	KALAMAZOO	MI	490098501	2693816630	THIS CODE ASSIGNED BY SCHA 8/28/07
349	HEALTH PLAN SELECT	PO BOX 382767	BIRMINGHAM	AL	352382767	8002936260	
350	NORTH AMERICA ADMINISTRATORS	PO BOX 1984	NASHVILLE	TN	37203	6152563561	
351	FISERV	PO BOX 8077	WAUSAU	WI	544028077	8666848090	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
352	FISERV HEALTH-COLORADO	PO BOX 720	PUEBLO	CO	810020720	8004468182	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
353	ONE HEALTH PLAN OF SC	PO BOX 190019	N CHARLESTON	SC	29419	8003149010	CODE ASSIGNED BY SCHA
354	FIRST BENEFITS CORP	PO BOX 879	ANDERSON	IN	46015		CODE ASSIGNED BY SCHA
355	ACTIVA HEALTH GROUP	4350 E. CAMELBACK RD. # 200	PHOENIX	AZ	85018	6024689500	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
356	UMR	PO BOX 2697	WICHITA	KS	67201	8008269781	USE CODE 139
357	HEALTH PLAN SERVICES	PO BOX 30298	TAMPA	FL	33630-	8002377767	
358	BAKERY & CONFECTIONERY UNION	10401 CONNECTICUT AVE STE 300	KENSINGTON	MD	208953960	3014683742	
359	NORTH CAROLINA MUTUAL LIFE INSURANCE	411 W. CHAPEL HILL ST.	DURHAM	NC	27701	9196829201	
360	NEW ENGLAND FINANCIAL	PO BOX 190019	N. CHARLESTON	SC	29419	8004087681	USE CARRIER 859 NEW ENGLAND GROUP TRUST
361	MDI GOVERNMENT HEALTH SERVICES	822 HIGHWAY A1A NORTH STE 310	PONTE VEDRA BEACH	FL	32082	8008416288	CODE ASSIGNED BY SCHA
362	GUARDIAN HEALTHCARE	PO BOX 4197	SCRANTON	PA	18505	8668501253	MEDICARE ADVANTAGE PLAN
363	PEARCE ADMINISTRATION	PO BOX 2437	FLORENCE	SC	29503	8886226001	GM SOUTHWEST IS THE CLAIMS PROCESSOR FOR PEARCE ADMINISTRATION
364	CORESTAR	PO BOX 1195	MINNEAPOLIS	MN	55440	8004446965	
365	GERBER CHILDRENS WEAR, INC.	PO BOX 2126	GREENVILLE	SC	29602	8649875200	
366	CATALYST RX	PO BOX 1069	ROCKVILLE	MD	20849	8009973784	
367	LOOMIS INSURANCE COMPANY	PO BOX 7011	WYOMISSING	PA	196107011	8007820392	
368	MED BENEFITS SYSTEM	PO BOX 177	SOUTH BEND	IN	46601	2192370560	
369	AMERICAN INTERNATIONAL GROUP	PO BOX 25050	WILMINGTON	DE	19899	8004687077	
370	P5 HEALTH PLAN SOLUTIONS	PO BOX 9554	SALT LAKE	UT	84109	8774740605	WAS P5 ELECTRONIC HEALTH SERVICES
371	ICON BENEFIT ADMINISTRATORS, INC.	PO BOX 53010	LUBBOCK	TX	794533070	8006589777	
372	MEDIPLAN	502 VALLEY RD.	WAYNE	NJ	07410	9736963111	
373	STATE FARM INSURANCE COMPANIES	7401 CYPRESS GARDENS BLVD	WINTERHAVEN,	FL	338880007	8633183000	
374	STONEBRIDGE LIFE INSURANCE CO.	2700 W. PLANO PARKWAY	PLANO	TX	75075	8003319955	
375	RESTAT	PO BOX 758	WEST BEND	WI	530950758	8002481062	
376	TUFTS HEATH PLAN	PO BOX 9171	WATERTOWN	MA	024719171	8004620224	CODE ASSIGNED BY SCHA
377	MERITAIN HEALTH	PO BOX 853921	RICHARDSON	TX	75085	7163195399	WAS NORTH AMERICAN ADMINISTRATORS, INC.
378	SELF INSURERS SERVICE INC.	2218 SOUTH PRIEST DR.	TEMPE	AZ	85282		
379	GOODYEAR TIRE & RUBBER COMPANY	PO BOX 677 DEPT. 609	AKRON	OH	44309	2167966531	
380	BENMARK, INC.	PO BOX 16767	JACKSON	MS	39236	6013660596	
381	PROVIDENT INDEMNITY LIFE INSURANCE COMPANY	PO BOX 511	NORRISTOWN	PA	19404	8005199175	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
382	HEALTH PLAN OF NEVADA	PO BOX 15645	LAS VEGAS	NV	891145615	8007771840	MEDICARE ADVANTAGE PLAN
383	AMERICAN HEALTHCARE ALLIANCE	PO BOX 8530	KANSAS CITY	MO	641140530	8772840102	
384	NORTH AMERICAN BENEFIT NETWORK	PO BOX 94928	CLEVELAND	OH	441014928	8003214085	
385	POSTMASTERS BENEFIT PLAN	1019 N. ROYAL ST.	ALEXANDRIA	VA	22314	7036835585	
386	ASSURANT HEALTH	PO BOX 2806	CLINTON	IA	527332806	8005537654	WAS FORTIS INSURANCE COMPANY
387	PRIMARY PHYSICIANS CARE	PO BOX 11088	CHARLOTTE	NC	28220	7045232758	
388	NATIONALWAY HEALTHCARE ASSOCIATES	PO BOX 682708	HOUSTON	TX	77268	8008107856	
389	GROUP LINK	PO BOX 20593	INDIANAPOLIS	IN	46220	8003597408	
390	BOARD OF PENSIONS EVANGELICAL LUTHERAN CHURCH	PO BOX 59093	MINNEAPOLIS	MN	554590093	6123337651	
391	POMCO	PO BOX 6329	SYRACUSE	NY	13217	8002344393	
392	SELF FUNDED GROUP INSURANCE ADMINISTRATORS	PO BOX 1719	KALAMAZOO	MI	490051790	8003421895	
393	FOUNTAINHEAD ADMINISTRATORS, INC.	PO BOX 13188	BIRMINGHAM	AL	35202	8009919155	
394	HEALTH CHOICES, INC	PO BOX 5003	DUBURQUE	IA	520045003	8003257442	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
395	T R PAUL GROUP SERVICES, INC.	PO BOX 5508	NEWTOWN	CT	064705508	2034268161	CODE ASSIGNED BY SCHA
396	LIFE PARTNERS INS GROUP	7887 E. BELLEVIEW AVE	ENGLEWOOD	CO	80111	8005257662	CODE ASSIGNED BY SCHA
397	PRIME THERAPEUDIC	PO BOX 14624	LEXINGTON	KY	405124624	8004231973	
398	RIGHT CHOICE BENEFITS ADMINISTRATORS	12250 WEBER HILL RD. STE 100	ST LOUIS	MO	63127	8003659036	CODE ASSIGNED BY SCHA
399	PACIFIC LIFE AND ANNUITY	PO BOX 34799	PHOENIX	AZ	85067	8007332285	
400	STATE EMPLOYEES HEALTH PLAN BLUE CROSS	4101 PERCIVAL RD.	COLUMBIA	SC	29219	8008682520	CLAIMS SHOULD BE SENT TO THE ATTN OF SARAH TOWNES AX-B10
401	BLUE CROSS AND BLUE SHIELD OF SC	PO BOX 100300	COLUMBIA	SC	29202	8037883860	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE. ST. ADDRESS 4101 PERVICAL RD. COLA 29219
402	FEDERAL EMPLOYEE PLAN BLUE CROSS	I-20 AT ALPINE RD.	COLUMBIA	SC	29260	8037883860	
403	BLUE CHOICE/MEDICAID	PO BOX 6170	COLUMBIA	SC	29260	8772753256	MEDICAID HMO
404	BOB JONES UNIVERSITY	1700 WADE HAMPTON BLVD.	GREENVILLE	SC	29614	8643701800	
405	EMPLOYEE HEALTH GROUP PLAN	101 LYNHAVEN RD.	VIRGINIA BEACH	VA	23451		

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
406	TRAVELERS PLAN ADMINISTRATORS OF ARIZONA	PO BOX 52100	PHOENIX	AZ	85072	6028661066	CODE IN OPEN STATUS BY SCHA
407	CINERGY HEALTH INS.	1844 N. NOB HILL RD. #623	PLANTATION	FL	33322	8008471148	
408	LIFE INVESTORS INSURANCE COMPANY OF AMERICA	PO BOX 8043	LITTLE ROCK	AR	72203	5013760426	AKA AEGON
409	UPSTATE ADMINISTRATIVE SERVICES	PO BOX 6589	SYRACUSE	NY	132176589	3154221533	
410	SAFECO INSURANCE COMPANY	PO BOX 34699	REDMOND	WA	981241699	2068678000	
411	INTERPLAN HEALTH GROUP	PO BOX 90613	ARLINGTON	TX	76006	8660511-47	CODE ASSIGNED BY SCHA
412	CONNECTICARE	PO BOX 546	FARRINGTON	CT	06034	8002517722	
413	ALLIED BENEFITS SYSTEM	PO BOX 909786	CHICAGO	IL	60690	8002882078	
414	NATIONAL TELEPHONE COOP. ASSN.	1 WEST PACK SQUARE, STE. 600	ASHEVILLE	NC	28801	8282529776	
415	WEYCO, INC.	PO BOX 30132	LANSING	MI	48909	5173497010	
416	COMPANION BENEFIT ALTERNATIVES	PO BOX 100185	COLUMBIA	SC	29202	8008681032	THIS CARRIER ASSIGNED BY SCHA NOT REQUESTED OR USED BY DHHS.
417	JULY PRODUCTS	5 GATEWAY CENTER STE 60	PITTSBURG	PA	15222	8669008322	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
418	GUARDIAN INSURANCE COMPANY	PO BOX 8007	APPLETON	WI	549128007	8006854542	CODE ASSIGNED BY SCHA
419	GEORGIA STATE HEALTH BENEFIT PLAN	PO BOX 38151	ATLANTA	GA	30334	8006266402	
420	CUNA MUTUAL INSURANCE GROUP	PO BOX 391	MADISON	WI	53701	6082385851	
421	PRIMARILY CARE	75 SOCKANOSSET CROSSRD. STE 300	CRANSTON	RI	02920	4147975000	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
432	M-PLAN CARDINAL HEALTH	P.O .BOX 357	LINTHICUM	MD	210900357	8006752605	CODE ASSIGNED BY SCHA
433	COMPANION LIFE	PO BOX 100102	COLUMBIA	SC	29202	8037880500	
434	PIEDMONT HEALTH ALLIANCE	116 BONHAM CT.	ANDERSON	SC	29621	8643759661	
435	SEABURY AND SMITH COMPANY, INC.	PO BOX 2545	NASHVILLE	TN	37219	8005822498	
436	DAVIS-GARVIN AGENCY	#1 FERNANDINA CT.	COLUMBIA	SC	29212	8037320060	
437	NEW ERA LIFE INSURANCE CO	PO BOX 4884	HOUSTON	TX	772104884	2813687200	
438	MAMSI LIFE AND HEALTH INSURANCE CO	PO BOX 993	FREDRICKS	MD	21705	8002576458	
439	UNION SECURITY INSURANCE CO	PO BOX 981602	EL PASO	TX	79998	8004446254	USE 386 ASSURANT HEALTH
440	HEALTHNET	PO BOX 14702	LEXINGTON	KY	40512	8006417761	
441	FEDERAL MOGUL HEALTHCARE	PO BOX 1999	DETROIT	MI	48235	8005220041	
442	GE LIFE & ANNUITY ASSURANCE CO.	PO BOX 6700	LYNCHBURG	VA	24505	8002530856	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
443	GATES HEALTH CARE PLAN	PO BOX 5887	DENVER	CO	80217	8007770595	
444	NATIONAL DISASTER MEDICAL SYSTEM						
445	CAROLINA CARE PLAN/MEDICAL MUTUAL INS. CO. OF OHIO	PO BOX 6018	CLEVELAND	OH	441011018	8003153143	ALSO KNOWN AS SUPERMED ANOTHER PHONE # 800-232-3143
446	EMPLOYEE BENEFIT SERVICES	PO BOX 9888	SAVANNAH	GA	314120088	8035778051	USE CODE 345 EMPLOYEE BENEFIT SERVICES
447	HEALTH NET	PO BOX 14700	LEXINGTON	KY	405125225	9004387886	MEDICARE ADVANTAGE PLAN
448	ASSURANT HEALTH INSURANCE	PO BOX 42033	HAZELWOOD	MD	63042	8005537654	CODE ASSIGED BY SCHA
449	UNITED SERVICE ASSO. FOR HEALTHCARE	PO BOX 6080-288	MISSION VAIEJO	CA	926906080	8008721187	CODE ASSIGNED BY SCHA
450	EMPLOYEE BENEFITS TRUST	PO BOX 8788	WILMINGTON	DE	19899	8007522677	OPEN 6/06
451	ASSURECARE RISK MANAGEMENT	340 QUANRINGLE BLVD	BOILING BROOK	IL	60440	8007597422	
452	CIGNA INTERNATIONAL EXPATRIATE BENEFITS	PO BOX 15050	WILMINGTON	DE	19850	8004412668	
453	BLUE CROSS ANTHEM MEDICARE ADVANTAGE	2100 CORPORATE CENTER	NEWBURY PARK	CA	913201431	8006762583	MEDICARE ADVANTAGE PLAN
454	INTERNATIONAL UNION OF OPERATING ENGINEERS	166 WEST KELLY ST.	METUCHEN	NJ	08840	9085486662	
455	ALASKA TEAMSTER TRUST	520 E 34TH AVE. STE. 107	ANCHORAGE	AK	995034116	8004784450	CODE ASSIGNED BY SCHA
456	LAIDLAW EMPLOYEE BENEFIT PLAN, INC.	4144 NORTH CENTRAL EXPRESSWAY	DALLAS	TX	75204	2148269090	CODE ASSIGNED BY SCHA
457	LAQUINTA INN	PO BOX 2636	SAN ANTONIO	TX	782790064		CODE ASSIGNED BY SCHA
458	OBA MIDWEST	8160 SOUTH CASS AVE	DARIEN	IL	60561	6309602035	WHEN CALLING THE ABOVE PHONE NUMBER, YOU ARE ASKED TO DIAL AN EXTENSION. DIAL EXTENSION 23.
459	GLASS MOTORS & PLASTIC (GMPA)	5245 BIG PINE WAY, SE 33907	FORT MYERS	FL	33907	8139366242	
460	MORRIS ASSOCIATES	PO BOX 50440	INDIANAPOLIS	IN	462500440	3175549000	
461	ECKERD HEALTH SERVICES	620 EPSILON DR.	PITTSBURGH	PA	15230	8005815300	USE CODE 712 TDI MANAGED CARE SERVICES
462	PICCADILLY INSURANCE EMPLOYEE BENEFITS DEPT.	PO BOX 2467	BATON ROUGE	LA	70821	5042968382	
463	TIM BAR CORP	PO BOX 449	HANOVER	PA	17331	7176324727	
464	INTERNATIONAL MEDICAL GROUP	407 N. FULTON ST.	INDIANAPOLIS	IN	46202	8006284664	
465	INTER CARE BENEFIT SYSTEMS	PO BOX 3559	ENGLEWOOD	CO	801553559	3037705710	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
466	VALUE RX	PO BOX 421150	PLYMOUTH	MN	554420150	8009554879	USE CODE 333 EXPRESS SCRIPTS
467	FIRSERV HEALTH	PO BOX 182173	COLUMBUS	OH	432182173	8008482664	USE CODE 139
468	PHOENIX HEALTHCARE	PO BOX 150809	ARLINGTON	TX	76015	8003976241	
469	AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP)	PO BOX 740819	ATLANTA	GA	30374	8005235880	
470	YODER BROTHERS	1001 LEBANON RD	PENDLETON	SC	29670	8646468331	
471	CAREMARK	PO BOX 52195	PHOENIX	AZ	850722195	8003030187	
472	NATIONAL HEALTH CARE HEALTH BENEFITS PLAN(NHC)	PO BOX 1398	MURFREESBORO	TN	371331398	6158902020	
473	INTERNATIONAL MISSION BOARD (IMB)	PO BOX 6767	RICHMOND	VA	232300767	8042191585	CODE ASSIGNED BY SCHA
474	DIVERSIFIED PHARMACUETICAL	PO BOX 169052	DELUTH	MN	55816	8002338065	USE CODE 333 EXPRESS SCRIPTS
475	BENEFIT ASSISTANCE CORP.	PO BOX 950	HURRICANE	WV	25526	3045621913	
476	CENTRAL STATES, SOUTHEAST & SOUTHWEST	PO BOX 5116	DEPLAINES	IL	60017	8003235000	
477	MEGA LIFE AND HEALTH INSURANCE COMPANY	PO BOX 982009	NORTH RICHLAND HILLS	TX	761828009	8005272845	
478	SMITH ADMINISTRATORS	PO BOX 163289	FORT WORTH	TX	76161	8008672582	
479	PRIMEXTRA	PO BOX 1088	TWINSBURG	OH	44087	8004334893	
480	COVENTRY HEALTH CARE OF THE CAROLINAS	PO BOX 7715	LONDON	KY	40742	8008891947	COVENTRY HEALTH CARE IS PARENT CO. OF SOUTHERN HEALTH AND WELLPATH
481	BENOVATION	3481 CENTRAL PARKWAY, STE 200	CINCINNATI	OH	45223	8006816912	CODE ASSIGNED BY SCHA
482	COVENTRY HEALTHCARE OF GEORGIA	PO BOX 7711	LONDON	KY	40742	8667321017	
483	COOPERATIVE BENEFITS ADMINISTRATORS	PO BOX 6249	LINCOLN	NE	68506	4024839250	
484	INTEGRITY BENEFITS NETWORK	PO BOX 4537	MARIETTA	GA	30061	7704281604	
485	PROVIDENT HEALTH PLAN	PO BOX 3125	PORTLAND	OR	972083125	8006283912	CODE ASSIGNED BY SCHA
486	PREFERRED CARE	PO BOX 22920	ROCHESTER	NY	146922920	8009993920	MEDICARE ADVANTAGE PLAN
487	PIEDMONT INS COMPANY	PO BOX 979	MARION	SC	29571	8434235541	
488	AMERICAN BENEFITS MANAGEMENT	8310 PORT JACKSON AVE NORTHWEST	NORTH CANTON	OH	44720	3309665500	
489	SAVRX	PO BOX 8	FREEMONT	NE	68026	8003506714	
490	SHEET METAL LOCAL 20	PO BOX 42489	INDIANAPOLIS	IN	43242	8002482141	CODE ASSIGNED BY SCHA
491	VISION SERVICE PLAN	PO BOX 997100	SACRAMENTO	CA	958997100	8006227444	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
492	LT11-LIFETRAC NETWORK	111100 WAYZATA BLVD	MINNEAPOLIS	MN	55305		CODE ASSIGNED BY SCHA
493	UNITED TEACHERS ASSOCIATION	PO BOX 30010	AUSTIN	TX	787553010	8668808824	
494	AVESIS PHARMACY NETWORK	3724 N 3RD ST STE 300	PHOENIX	AZ	85012	6022413400	
495	NATIONAL PRESCRIPTION ADMINISTRATORS	PO BOX 1981	EAST HANOVER	NJ	079361981	8005226727	BOUGHT OUT BY EXPRESS SCRIPTS CC333
496	AMERICAN VETERINARIAN MEDICINE ASSN.	PO BOX 909720	CHICAGO	IL	606049720	8006216360	
497	TEXAS INTERNATIONAL	PO BOX 11007	WINSTON SALEM	NC	27116	8663074711	
498	CAROLINA BENEFIT ADMINISTRATORS	PO BOX 3257	SPARTANBURG	SC	29304	8645736937	
499	EMPLOYEE BENEFIT CONSULTANTS	PO BOX 928	FINDLAY	OH	45839	8005587798	
500	DELTA DENTAL	PO BOX 1809	ALPHARETTA	GA	30023	8005212651	
501	UNION FIDELITY INSURANCE COMPANY	4850 ST. RD.	TREVOSE	PA	19049-	8005236599	
502	HIP HEALTH PLAN	PO BOX 2803	NEW YORK	NY	101162803	8004478255	MEDICARE ADVANTAGE PLAN
503	AMERICAN SPECIAL RISK MANAGEMENT	509 SOUTH LENOLA RD. BLDG TWO	MOORESTOWN	NJ	08057	8003597475	
504	M CARE	PO BOX 130799	ANN ARBOR	MI	481130779	2156578920	CODE IN OPEN STATUS BY SCHA
505	ASSOCIATED ADMINISTRATORS	PO BOX 27806	BALTIMORE	MD	212857806	8006382972	
506	EMPLOYEE BENEFIT PLAN ADMINISTRATORS	PO BOX 2000	HAMPTON	NH	03842	8002587298	
507	CENTRAL STATES HEALTH & LIFE CO. OF OMAHA	PO BOX 34350	OMAHA	NE	68134	4023971111	
508	GROUP HEALTH INC. /EMBLEM HEALTH COMPANY	PO BOX 3000	NEW YORK	NY	101163000	2125014444	
509	EQUITABLE LIFE AND CASUALTY	PO BOX 2460	SALT LAKE CITY	UT	84110	8003525150	
510	EQUITABLE PLAN SERVICES	PO BOX 720460	OKLAHOMA	OK	73172	8007492631	
511	CIGNA BEHAVIORAL HEALTH	PO BOX 46270	EDEN PRAIRIE	MN	55344	8003364091	
512	ST11-STRATEGIC HEALTH	9501 NE 2ND AVE	MIAMI SHORES	FL	33138		CODE ASSIGNED BY SCHA
513	VALUE OPTIONS	PO BOX 1079	TROY	NY	121811079	8002880882	
514	JLT SERVICES (TPA FOR NY LIFE)	PO BOX 1511	LATHAM	NY	12110	8007933773	NOT REQUESTED BY MEDCAID. ASSIGNED BY SCHA
515	LIFE OF THE SOUTH INSURANCE COMPANY	PO BOX 45237	JACKSONVILLE	FL	32232	8006616385	THIS CODE ASSIGNED BY SCHA NOT A MEDICAID REQUEST
516	DIRECT REIMBURSEMENT BENEFIT PLANS	1111 ALDERMAN DR STE. 420	ALPHARETTA	GA	30202	7706645594	
517	UNIFORM MEDICAL PLAN	PO BOX 34850	SEATTLE	WA	98124	8007626004	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
518	NAT'L ASBESTOS WORKERS MED FUND	4600 POWDER MILL RD.	BELTSVILLE	MD	20705	8003863632	
519	HEALTHSOURE ADMINISTRATORS	PO BOX 382617	BIRMINGHAM	AL	35238	8778939294	
520	NEW JERSERY CARPENTERS	PO BOX 7818	EDISON	NJ	088180846	8006243096	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
521	ALLIANCE PPO, INC.	PO BOX 934	FREDERICK	MD	21705	8002350123	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
522	NATIONAL AUTOMATIC SPRINKLER INDUSTRY	800 CORPORATE DR.	LANDOVER	MD	20785	3015771700	
523	APA PARTNERS, INC.	PO BOX 1506	LATHAM	NY	121108006	8008333650	
524	HEALTHFIRST	PO BOX 130217	TYLER	TX	75713	8004778957	CODE ASSIGNED BY SCHA TPA
525	CONSECO MEDICAL INSURANCE CO.	PO BOX 1205	ROCKFORD	IL	61105	8009470319	USE CODE 282 WASHINGTON NATIONAL
526	AULTCARE	PO BOX 6910	CANTON	OH	44706	8003448858	
528	KAISER PERMANENTE	PO BOX 190849	ALTANTA	GA	31119	8006111811	MEDICARE ADVANTAGE PLAN
529	ANTHEM HEALTH	3575 KROGER BLVD., STE. 400	DULUTH	GA	30316	8008881966	
530	UNIVERSAL BENEFITS CORPORATION	PO BOX 97	SCRANTON	PA	185040097	8007470622	CODE ASSIGNED BY SCHA
531	MARY BLACK HEALTHNETWORK	1690 SKYLYN DR., STE.,130	SPARTANBURG	SC	29307	8645733535	
532	AMERICAN MEDICAL SECURITY	PO BOX 19032	GREENBAY	WI	543079032	8002325432	
533	PHYSICIANS CARE NETWORK	PO BOX 101111	COLUMBIA	SC	292111111	8883239271	
534	PROVANTAGE PRESCRIPTION BENEFIT MANAGEMENT SERVICE	PO BOX 1662	WAUKEHA	WI	53187	2627844600	
535	CHP DIRECT/SUPERMED	PO BOX 94648	CLEVELAND	OH	441014648	8007731445	
536	CLAIMSWARE MANAGEMED	PO BOX 6125	GREENVILLE	SC	29606	8642348200	
537	KAISER PERMANENTE-OHIO REGION	PO BOX 5316-9774	CLEVELAND	OH	441010316	8006348816	CODE ASSIGNED BY SCHA
538	PENN GENERAL SERVICES	PO BOX 72077	ATLANTA	GA	303581535	8004441535	CODE ASSIGNED BY SCHA
539	MEDICAL MUTUAL INSURANCE OF OHIO	PO BOX 94648	CLEVELAND	OH	44101	8003621279	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
540	LIBERTY NATIONAL LIFE INSURANCE COMPANY	PO BOX 2612	BIRMINGHAM	AL	35202	2053252722	
541	CHILDRENS REHAB SERVICES	PO BOX 4217	SPATANBURG	SC	293054217	8645962227	CODE ASSIGNED BY SCHA
542	THIRD PARTY ADMINISTRATORS/AMERICAN BENEFIT	1733 PARK ST.	NAPERVILLE	IL	60563	8006315917	
543	LONE STAR LIFE INSURANCE	PO BOX 709009	DALLAS	TX	753709009	2144476400	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
545	MOLINA HEALTHCARE OF OHIO	PO BOX 22712	LONGBEACH	CA	90801	8006424148	CODE NOT REQUESTED BY MEDICAID. SCHA ASSIGNED
546	RISK MANGEMENT SERVICES	PO BOX 6309	SYRACUSE	NY	13217	3154489228	
547	HARRINGTON HEALTH	PO BOX 30544	SALT LAKE CITY	UT	841300544	8777370769	
548	COMPBENEFITS INSURANCE CO.	PO BOX 804483	CHICAGO	IL	606804106	8005940977	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
549	WAL-MART STORES GROUP HEALTH PLAN	922 W WALNUT STE A	ROGERS	AR	72756 320	5016212929	USE CODE 401 BLUE CROSS BLUE SHIELD OF SC
550	EMPLOYEE SECURITY, INC	7125 THOMAS EDISON DR STE. 105	COLUMBIA	MD	21046	8006381134	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
551	COOPERATIVE MANAGED CARE SERVICES LLC	PO BOX 502530	INDIANAPOLIS	IN	46250	8668734516	CODE IN OPEN STATUS BY SCHA
552	CORESOURCE INC	6100 FAIRVIEW RD.	CHARLOTTE	NC	28210	8003275462	
553	HEALTHSCOPE BENEFITS, INC.	PO BOX 8076	LITTLE ROCK	AR	72203	8883736102	
554	DIAMOND G EMPLOYEE BENEFIT TRUST	PO BOX 1298	GREENVILLE	TN	37744	4236396145	
555	PHILADELPHIA AMERICAN LIFE INSURANCE CO	PO BOX 4884	HOUSTON	TX	772104882	8005527879	CODE ASSIGNED BY SCHA
556	UNIFIED GROUP SERVICES	PO BOX 10	PENDLETON	IN	46064	7657781535	
557	AMERICORP INS. CO	PO BOX 3430	CARMEL	IN	46082	8666994186	
558	NATIONAL TRAVELERS LIFE INS. CO.	PO BOX 9197	DES MOINES	IA	50306	8002325818	INACTIVE 8/02
559	CAROLINA HOSPITAL SYSTEMS BENEFIT PLAN	PO BOX 100569	FLORENCE	SC	295010659	8436613875	
560	ALLEN MEDICAL CLAIMS ADMINISTRATORS	PO BOX 978	FT. VALLEY	GA	310300978	8008255406	
561	PHOENIX MUTUAL LIFE INSURANCE COMPANY	ONE AMERICAN ROW	HARTFORD	CT	06115	8004512513	THIS CARRIER PURCHASED BY CC864 GE GROUP ADMINISTRATORS
562	HEALTH CLAIMS SERVICES, INC.	PO BOX 9615	DEERFIELD BEACH	FL	33442	8002223560	
563	ADMINISTRATIVE SERVICE CONSULTANTS	3301 E ROYALTON RD. BLDG D	BROADVIEW HEIGHTS	OH	44147		
564	MULTINATIONAL UNDERWRITERS	PO BOXBXO 863	INDIANAPOLIS	IN	46206	8006052282	CODE ASSIGNED BY SCHA
565	UNITED BENEFITS	PO BOX 2480	DAYTONA BEACH	FL	321152480	8004344890	WAS POE & BROWN
566	UNIFIED GROUP SERVICES	PO BOX 10	PENDLETON	IN	46064	7657781535	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
567	EASTERN BENEFIT SYSTEMS	200 FREEWAY DR. E.	EAST ORANGE	NJ	07018	8005240227	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
568	SIMPLIFI	PO BOX 1339	MINNEAPOLIS	MN	554401339	8884465710	FORMELY CBCA ADMINISTRATORS
569	MARYLAND PHYSICIANS CARE	PO BOX 61778	PHOENIX	AZ	85082	8009538854	CODE IN OPEN STATUS BY SCHA
570	SAMBA HEALTH BENEFIT PLAN	11301 OLD GEORGETOWN RD	ROCKVILLE	MD	20852	8006386589	
571	CORESOURCE, INC.	PO BOX 8215	LITTLE ROCK	AR	722218215	8886049397	CODE IN OPEN STATUS BY SCHA
572	CATAMARAN	8300 E MAPLEWOOD AVE	GREENWOOD VILLAGE	CO	80111	8778398119	FORMERLY HEALTH TRANS
573	ST JOHN'S CLAIMS ADMINISTRATION	PO BOX 14409	SPRINGFIELD	MO	65814	8778757700	
574	CITY OF AMARILLO GROUP HEALTH	PO BOX 15130	AMARILLO	TX	79105	8063784235	CODE IN OPEN STATUS BY SCHA
575	WISCONSIN ELECTRICAL EMPLOYEES	PO BOX 2430	BROOKFIELD	WI	53008	6082769111	CODE IN OPEN STATUS BY SCHA
576	SIOUX VALLEY HEALTH	PO BOX 91110	SIOUX FALLS	SD	57109	8007525863	
577	UNITED FIDELITY LIFE INSURANCE COMPANY	PO BOX 13487	KANSAN CITY	MO	64199	8163912134	OPEN 1/06
578	PROFESSIONAL ADMINISTRATORS, INC.	3751 MAGUIRE BLVD. STE. 100	ORLANDO	FL	32814	8007410521	
579	ANTHEM PRESCRIPITION MANAGEMENT	PO BOX 145433	CINCINNATI	OH	45250	8006620210	USE CARRIER A24
580	WORLD INSURANCE COMPANY	PO BOX 3160	OMAHA	NE	681030160	4024968000	
581	ALTA RX	PO BOX 30081	SALT LAKE CITY	UT	84130	8009985033	
582	USAA GENERAL INDEMNITY CO.	PO BOX 15506	SACRAMENTO	CA	958521506	8005318222	
583	ONE NATION BENEFIT ADMINISTRATORS	PO BOX 528	COLUMBUS	OH	43216	8008246796	NAME CHANGE WAS ANTHEM BENEFIT ADMINISTRATORS
584	GOLDEN RULE INSURANCE COMPANY	PO BOX 31374	SALT LAKE CITY	UT	841310374	6189438000	
585	PLUMBERS & STEAMFITTERS WELFARE FUND	1024 MCKINLEY ST	PEEKSILL	NY	10566	9147377220	
586	MCA ADMINISTRATORS (MANAGED CARE OF AMERICA)	MANOR OAK TWO, STE 605 1910 COCHRAN RD	PITTSBURGH	PA	15220	4129220780	WAS DIVERSIFIED GROUP ADMINISTRATORS
587	FUTURE SCRIPTS	PO BOX 419019	KANSAS CITY	MO	64141	8886787012	
588	AUTOMATED BENEFIT SERVICES INC.	PO BOX 321223	DETROIT	MI	482321223	8002751896	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
589	COMBINED ADMINISTRATIVE SERVICES	PO BOX 4539	DALTON	GA	307194539	7062727391	CODE IN OPEN STATUS BY SCHA
590	PHYSICIANS HEALTH SERVICES	PO BOX 981	BRIDGEPORT	CT	06601	8008484747	
591	OLD AMERICAN INSURANCE COMPANY	PO BOX 418573	KANSAS CITY	MO	64141	8167534900	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
592	ROBEY BARBER INSURANCE SERVICES	PO BOX 10100	TAMPA	FL	33679	8007497409	USE CODE A98 CORPORATE BENEFIT SERVICES DORMANT 8/02
593	MUTUAL ASSURANCE ADMINISTRATORS, INC	PO BOX 42096	OKLAHOMA CITY	OK	73123	8006489652	
594	WELLS FARGO FINANCIAL	206 EIGHTH ST.	DES MOINES	IA	50309	5152432131	WAS NORTHWEST FINANCIAL
595	AFLAC -AMERICAN FAMILY LIFE ASSO CO	1932 WYNNTON RD.	COLUMBUS	GA	31999	8009923522	
596	SECURE HORIZONS	PO BOX 659787	SAN ANTONIO	TX	782659787	8665798811	MEDICARE ADVANTAGE PLAN
597	MONARCH DIRECT	PO BOX 9004	SPRINGFIELD	MA	01101	8006289000	
598	WJB DORN VA MEDICAL CENTER	6439 GARNERS FERRY RD	COLUMBIA	SC	292091639	8037764000	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
599	NATIONAL ELEVATOR INDUSTRY HEALTH BENEFITS	PO BOX 477	NEWTOWN SQUARE	PA	190730477	8005234702	
603	OTHER INDIGENT (HOSPITAL CHARITY)			SC			
604	CHAMPVA	PO BOX 469064	DENVER	CO	80246	3033317599	
606	VOCA.REHAB GENERAL						
607	WPS TRICARE FOR LIFE	PO BOX 7889	MADISON	WI	537077889	8667730404	
608	VOCATIONAL REHAB DISABILITY						
609	COMM FOR BLIND						
610	DHEC CANCER						
611	DHEC C. CHILDREN						
612	DHEC LOW RISK MATERNITY						
613	DHEC HIGH RISK MATERNITY						
614	TRICARE SOUTH REGION	PO BOX 7031	CAMDEN	SC	290207031	8004033950	INTERNET WWW.MYTRICARE.COM
615	DHEC STERILIZATION						
616	MEDICAID-OUT-OF-STATE						
617	MEDICARE RAILROAD (PGBA) PROFESSIONAL PART B	PO BOX 10066	AUGUSTA	GA	30999	8772887600	
618	MEDICARE PART A						
619	MEDICAID, SC						
620	MEDICARE PART B ONLY						
621	DEPT CORRECTIONS						
622	WORKMEN'S COMP						

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
623	CAROLINA MEDICARE PRIME HMO	201 EXECUTIVE CENTER DR.	COLUMBIA	SC	29210	8037507473	MEDICARE ADVANTAAGE PLAN
624	OTHER SPONSOR						
625	DHEC MIGRANT HEALTH						
626	DHEC SICKLE CELL						
627	DHEC HEART	-	-	-	-----		
628	DHEC HEMOPHILIA	-	-	-	-----		
629	DHEC FAMILY PLANNING	-	-	-	-----		
630	DHEC TB	-	-	-	-----		
631	SHRINERS	-	-	-	-----		
632	CRIME VICTIMS	-	-	-	-----		
633	VETERANS ADMINISTRATION	-	-	-	-		
635	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175	4023427600	MEDICARE INTERMEDIARY PART A
636	MUTUAL OF OMAHA	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175		MEDICARE INTERMEDIARY PART B
637	SELECT HEALTH/FIRST CHOICE	PO BOX 7120	LONDON	KY	40742	8882762020	MEDICAID HMO
638	UNISON HEALTH PLAN HMO	250 BERRYHILL RD	COLUMBIA	SC	29210	8037985852	MEDICAID HMO
639	HEALTHFIRST HMO	255 ENTERPRISE BLVE. STE. 20	GREENVILLE	SC	29615	8644551100	MEDICAID HMO
642	TRICARE FOR LIFE	PO BOX 7890	MADISON	WI	537077890	8667730404	
643	BCBS OF TENNESSEE	730 CHESTNUT ST	CHATTANOOGA	TN	37402	8772966189	MEDICARE INTERMEDIARY
644	BCBS OF GEORGIA	PO BOX 9907	COLUMBUS	GA	31908	8004412273	MEDICARE INTERMEDIARY
645	STERLING MEDICARE CHOICE HMO	PO BOX 70	LINTHIEUM	MD	21900	6152445600	MEDICARE ADVANTAGE PLAN
646	CIGNA-MEDICARE	PO BOX 671	NASHVILLE	TN	37202	6152445600	MEDICARE INTERMEDIARY
648	HUMANA GOLD CHOICE (PFFS)	PO BOX 7060	CAMDEN	SC	29020	8775115000	MEDICARE ADVANTAGE PLAN
650	ABBEVILLE COUNTY	-	-	-	-		
651	AIKEN COUNTY	-	-	-	-		
652	ALLENDALE COUNTY	-	-	-	-		
653	ANDERSON COUNTY	-	-	-	-		
654	BAMBERG COUNTY	-	-	-	-		
655	BARNWELL COUNTY	-	-	-	-		
656	BEAUFORT COUNTY	-	-	-	-		

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
657	BERKELEY COUNTY	-	-	-	-		
658	CALHOUN COUNTY	-	-	-	-		
659	CHARLESTON COUNTY	-	-	-	-		
660	CHEROKEE COUNTY	-	-	-	-		
661	CHESTER COUNTY	-	-	-	-		
662	CHESTERFIELD COUNTY	-	-	-	-		
663	CLARENDON COUNTY	-	-	-	-		
664	COLLETON COUNTY	-	-	-	-		
665	DARLINGTON COUNTY	-	-	-	-		
666	DILLON COUNTY	-	-	-	-		
667	DORCHESTER COUNTY	-	-	-	-		
668	EDGEFIELD COUNTY	-	-	-	-		
669	FAIRFIELD COUNTY	-	-	-	-		
670	FLORENCE COUNTY	-	-	-	-		
671	GEORGETOWN COUNTY	-	-	-	-		
672	GREENVILLE COUNTY	-	-	-	-		
673	GREENWOOD COUNTY	-	-	-	-		
674	HAMPTON COUNTY	-	-	-	-		
675	HORRY COUNTY	-	-	-	-		
676	JASPER COUNTY	-	-	-	-		
677	KERSHAW COUNTY	-	-	-	-		
678	LANCASTER COUNTY	-	-	-	-		
679	LAURENS COUNTY	-	-	-	-		
680	LEE COUNTY	-	-	-	-		
681	LEXINGTON COUNTY	-	-	-	-		
682	MARION COUNTY	-	-	-	-		
683	MARLBORO COUNTY	-	-	-	-		
684	MCCORMICK COUNTY	-	-	-	-		
685	NEWBERRY COUNTY	-	-	-	-		
686	OCONEE COUNTY	-	-	-	-		
687	ORANGEBURG COUNTY	-	-	-	-		
688	PICKENS COUNTY	-	-	-	-		

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
689	RICHLAND COUNTY	-	-	-	-		
690	SALUDA COUNTY	-	-	-	-		
691	SPARTANBURG COUNTY	-	-	-	-		
692	SUMTER COUNTY	-	-	-	-		
693	UNION COUNTY	-	-	-	-		
694	WILLIAMSBURG COUNTY	-	-	-	-		
695	YORK COUNTY	-	-	-	-		
696	OUT-OF-STATE GA	-	-	-	-		
697	OUT-OF-STATE NC	-	-	-	-		
698	OUT-OF-STATE OTHER	-	-	-	-		
700		-	-	-	-	-	
701	UNI-CARE CHOICE HEALTH BENEFITS	PO BOX 51130	SPRINGFIELD	MA	01151	8002888630	
702	BOON CHAPMAN BENEFIT ADMINISTRATORS	PO BOX 9201	AUSTIN	TX	787669201	8002529653	CODE ASSIGNED BY SCHA
703	TUCKER COMPANY & ADMINISTRATORS	9140 ARROW POINT BLVD. #200	CHARLOTTE	NC	282738102	7045259666	
704	UNITED FOOD & COMMERCIAL WORKERS (UFCW)	1800 PHOENIX BLVD. STE. 310	ATLANTA	GA	30349	8002417701	
705	APS HEALTHCARE, INC.	PO BOX 1307	ROCKVILLE	MD	20849	8002218699	
706	PLUMBERS & PIPEFITTERS LOCAL NO. 421	PO BOX 840	MACON	GA	312020840	8887412673	
707	DILLON YARN MEDICAL BENEFITS	1019 TITAN RD	DILLON	SC	29536	8437747353	
708	PERFORMAX	PO BOX 61505	KING OF PRUSSIA	PA	19406	8885547629	CODE NOT REQUESTED BY MEDCAID. ASSIGNED BY SCHA
709	MERCER ADMINISTRATION	PO BOX 4546	IOWA CITY	IA	52244	8008687526	
710	21ST CENTURY HEALTH AND BENEFITS INC	PO BOX 5037	CHERRY HILL	NJ	08034	8003234890	
711	LABORERS DISTRICT COUNCIL OF GA AND SC	PO BOX 607	JONESBORO	GA	302370607	4044771888	
712	TDI MANAGED CARE SERVICES	620 EPSILON DR.	PITTSBURG	PA	15238	8005815300	CARRIER BOUGHT OUT BY PHARMACARE CC 740
713	HEALTH CARE CREDIT UNION ASSOC. HCCUA	PO BOX 260957	PLANT	TX	750260957	8663736366	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
714	STOWE ASSOCIATES	2872 WOODCOCK BLVD. #200	ATLANTA	GA	30341	8005337896	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
715	UNITED HEALTH & LIFE INSURANCE COMPANY	PO BOX 169050	DULUTH	MN	558168200	8005262414	USE CC113 UNITED HEALTHCARE

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
716	INDECS CORP	PO BOX 668	LYNDHURST	NJ	07071	8884463327	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
717	USA HEALTH CARE (MVP HEALTH CARE)	PO BOX 22920	ROCHESTER	NY	146922920	8009993920	CODE ASSIGNED BY SCHA
718	RX PRIME/CIGNA PHARMACY SERVICES	PO BOX 3598	SCRANTON	PA	185050598	8006225579	
719	FLORIDA HEALTH ALLIANCE	PO BOX 10269	JACKSONVILLE	FL	322470269	9043548335	
720	UNITED MINE WORKERS HEALTH & RETIREMENT FUND	RTE. 2 BOX 218A	BIG STONE GAP	VA	24219	8006549763	
721	EHD ADMINISTRATORS	PO BOX 83080	LANCASTER	PA	176083080		CODE ASSIGNED BY SCHA
722	AMERICAN REPUBLIC INSURANCE COMPANY	PO BOX 21670	EAGAN	MN	55121	8002472190	
723	CAROLINA CONTINENTAL INSURANCE	PO BOX 427	COLUMBIA	SC	29202	8032566265	
724	MUTUAL MEDICAL PLANS	PO BOX 689	PEORIA	IL	61652	8004484689	CODE ASSIGNED BY SCHA
725	DIALYSIS CLINIC, INC.	203 FREEMONT AVE.	SPARTANBURG	SC	29303	8645852046	
726	INSURANCE SERVICE AND BENEFITS	3218 HIGHWAY 67 STE. 218	MESQUITE	TX	75150	8008783157	
727	GUARANTEE MUTUAL LIFE CO.	8801 INDIAN HILLS DR.	OMAHA	NE	68114	8004624660	
728	GENERAL PRESCRIPTION PROGRAMS INC	305 MEDICINE BLVD.	NEW YORK	NY	10165	8003412234	
729	GROUP INSURANCE SERVICES (GIS)	PO BOX 2291	DURHAM	NC	27702	9194904391	CODE IN OPEN STATUS BY SCHA
730	GEORGIA HEALTHCARE PARTNERSHIP	PO BOX 16388	SAVANNAH	GA	314163088	8005666710	
731	ADOVA HEALTH	PO BOX 725549	ATLANTA	GA	31139	8664704959	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
732	HERTZ CLAIM MANAGEMENT	P.O BOX 726	PARK RIDGE	NJ	07656	2013072177	
733	MOUNTAIN CLAIMS MANAGEMENT	PO BOX 1008	FRUITLAND	ID	83619	2084527979	CODE IN OPEN STATUS BY SCHA
734	STRATEGIC OUTBURSTING INC.	PO BOX 241508	CHARLOTTE	NC	28224	8888367764	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA
735	EATON BENEFIT PAYMENT OFFICE	PO BOX 16691	COLUMBUS	OH	43214	8002216036	
736	SPECTERA	2811 LORD BALTIMORE DR.	BALTIMORE	MD	212442644	8006383120	
737	UNITED CONCORDIA	PO BOX 69421	HARRISBURG	PA	17106	8003320366	
738	FHA-TPA DIVISION	PO BOX 327810	FT LAUDERDALE	FL	333329711	8037988698	CODE IN OPEN STATUS BY SCHA
739	BOLLINGER INC	PO BOX 727	SHORT HILLS	NJ	07078	8662670092	
740	PHARMACARE	PO BOX 52188	PHOENIX	AZ	850722196	8002376184	AS OF 1/1/08 CO. MERGED WITH CAREMARK (471) ADD NEW POLICIES WITH 471

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
741	SPENCER & ASSOCIATES INS.	1 S. LIMESTONE ST STE 301	SPRINGFIELD	OH	45502	8667669016	CODE ASSIGNED BY SCHA
742	MIDA DENTAL PLAN	2000 TOWN CENTER, STE. 2200	SOUTHFIELD	MI	48075	8009376432	
743	EMPLOYEE PLANS, INC.	PO BOX 2362	FT WAYNE	IN	468012362	2606257500	
744	COLUMBIA PHARMACY SOLUTIONS	PO BOX 30 COLUMBIA PLAZA	GREENSBURG	PA	15601	8007131983	
745	GROUP BENEFIT SERVICES	1312 BELLONE AVE.	LUTHERVILLE	MD	21093	8006386085	
746	MED-TAC CLAIMS	PO BOX 9110	NEWTON	MA	02160	8003479355	
747	PACIFICARE	PO BOX 6099	CYPRESS	CA	90630	8663169776	CODE ASSIGNED BY SCHA
748	HEALTH CARE SAVINGS, INC.	4530 PARK RD	CHARLOTTE	NC	28209	-	CODE ASSIGNED BY SCHA
749	GERBER LIFE INSURANCE COMPANY	PO BOX 2088	GRAND RAPIDS	MI	49501	8002533074	
750	BENEFIT ADMINISTRATIVE SERVICES	PO BOX 4509	ROCKFORD	IL	61110	8159699663	
751	POLARIS BENEFIT ADMINISTRATORS	PO BOX 2010	WESTERVILLE	OH	43086-	8002340225	
752	HYGEIA CORPORATION	15500 NEW BARN RD.	MIAMI LAKES	FL	33014	8005912650	CODE ASSIGNED BY SCHA
753	HEALTHNET	PO BOXBXO 2226	AUGUSTA	GA	309032226	9009778221	
754	1199 SEIU NATIONAL BENEFIT FUND	PO BOX 1007	NEW YORK	NY	101081007	6464739200	
755	TOTAL BENEFIT SERVICES INC	PO BOX 30180	NEW ORLEANS	LA	70190	800596 315	
756	MANUS INSURANCE COMPANY	6350 W ANDREW JACKSON HWY	TALBOTT	TN	37877	8009933401	
757	J C PENNEY LIFE INSURANCE COMPANY	PO BOX 869090	PLANO	TX	750860909	9728816000	
758	HEALTHCHOICE	PO BOX 24870	OKLAHOMA	OK	731270870	8004892974	CODE ASSIGNED BY SCHA
759	MEDIPLUS	PO BOX 9126	DES MOINES	IA	50309	8002472192	AKA TROA
760	KEY BENEFIT ADMINISTRATORS	PO BOX55230	INDIANAPOLIS	IN	46205	8003314757	
761	EMPLOYEE BENEFIT STRATEGIES	229 EAST MICHIGAN AVE. STE. 235	KALAMAZOO	MI	49007	8003257477	
762	ROYAL NEIGHBORS OF AMERICA	PO BOX 10850	CLEARWATER	FL	337578850	8778158857	CODE ASSIGNED BY SCHA
763	THE PROVIDENT	PO BOX 31499	TAMPA	FL	33631	8005257268	
764	CARE LINK HEALTH PLAN	PO BOX 7373	LONDON	KY	407427373	8003482922	
765	DRIVERS CHOICE	PO BOX 25427	COLUMBIA	SC	29224	8777724642	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
766	PALMER & CAY/CARSWELL, INC.	PO BOX 1286	SAVANNAH	GA	31402	9122346621	
767	THIELE KAOLIN CO.	PO BOX 1868	STATESBORO	GA	30459	4785523951	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
768	WISCONSIN PHYSICIANS SERVICES	1717 WEST BROADWAY ST.	MADISON	WI	53708	8889154158	
769	FEDEX FREIGHTWAYS	PO BOX 840	HARRISON	AR	72602	8008744723	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
770	PEOPLES BENEFIT LIFE INSURANCE	PO BOX 484	VALLEY FORGE	PA	19493	8005237900	
771	PACIFIC FIDELITY LIFE INSURANCE CO (P.F.L.)	PO BOX 982009	N RICHLAND HILLS	TX	761828009	8176566040	USE CODE 477 MEGA LIFE
772	BENEFIT SYSTEMS INC	PO BOX 6001	INDIANAPOLIS	IN	462066001	8008243216	
773	PHYSICIANS MUTUAL INSURANCE COMPANY	PO BOX2018	OMAHA	NE	681032018	8002289100	DO NOT USE THIS CODE FOR MEDICARE ADVANTAGE PLANS OFFERED BY THIS CARRIER
774	DISNEY WORLDWIDE SERVICES	PO BOX 10130	LAKE BUENA VISTA	FL	33830	8003922978	
775	FIRST CHOICE BENEFITS MANAGEMENT	PO BOX 658	BELOIT	WI	535120658	8003035770	
776	GULF SOUTH ADMINISTRATORS	PO BOX 8570	METAIRIE	LA	700118570	8003662475	CODE IN OPEN STATUS BY SCHA
777	US HEALTH AND LIFE	PO BOX 37504	OAK PARK	MI	482370504	8002259674	THIS CODE NOT REQUESTED BY SCHA. ASSIGNED BY SCHA
778	DUKE BENEFIT SERVICES, INC.	3078 BRICKHOUSE CT.	VIRGINIA BEACH	VA	23452	757-485-25	CODE ASSIGNED BY SCHA
779	UNISYS	PO BOX 13500	TALLAHASEE	FL	32317	8007677829	DORMANT 8/06
780	CORPORATE SYSTEMS ADMINISTRATION INC	PO BOX 4985	JOHNSON CITY	TN	376024985	8002752847	
781	MEDICAL CLAIMS MANAGEMENT CORP	PO BOX 12995	CHARLOTTE	NC	282202995	8003340609	
782	HOUSING BENEFIT PLAN	PO BOX 542077	DALLAS	TX	753542077	8009372036	
784	PACIFIC HEALTH ADMINISTRATORS	PO BOX 620123	ORLANDO	FL	328620123	8007766070	CODE ASSIGNED BY SCHA
785	THE HARVEST INSURANCE CO.	PO BOX 956003	LAKE MARY	FL	327950856	8002530856	CODE ASSIGNED BY SCHA
786	E S BEVERIDGE & ASSO., CIN.	PO BOX 636	MANSFIELD	OH	44901	8004413961	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
787	PACIFICARE SENIOR SUPPLEMENT PLAN	PO BOX 6072	CYPRESS	CA	906300072	8008513802	
788	ERISA DESIGN SYSTEMS ADM.(EDSA)	PO BOX 1557	BALTIMORE	MD	21203	8008203372	DORMANT 8/06
789	NATIONAL CASUALTY COMPANY	PO BOX 1250	ROCKFORD	IL	611051250	8002751896	CODE IN OPEN STATUS BY SCHA
790	MHNET BEHAVIORAL HEALTH	PO BOX 7802	LONDON	KY	40742	8007527242	
791	UNITEDHEALTH INTEGRATED SERVICES	PO BOX 30783	SALT LAKE CITY	UT	841300786	8665968447	
792	PIONEER LIFE INSURANCE COMPANY OF ILLINOIS	PO BOX 1250	ROCKFORD	IL	611051250	8159875000	USE CODE 282 WASHINGTON NATIONAL
793	HUMANA GOLD PLUS	PO BOX 14601	LEXINGTON	KY	405124601	8004574708	MEDICARE ADVANTAGE PLAN
794	UNITED FAMILY LIFE INSURANCE COMPANY	PO BOX 2204	ATLANTA	GA	30371	4046593300	
795	REGIONAL MEDICAL ADMINISTRATORS INC.	PO BOX 4128	GLEN RAVEN	NC	272150901	3362267950	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
796	LINECO	2000 SPRINGER DR.	LOMBARD	IL	60148	8003237268	CODE ASSIGNED BY SCHA
797	TODAY'S OPTIONS UNIVERSAL AMERICAN	PO BOX 742528	HOUSTON	TX	77274	8664225009	MEDICARE ADVANTAGE PLAN
798	INCENTUS	1710 FIRMAN	RICHARDSON	TX	75081	8005591322	USE CODE B44 AMERICA CHOICE HEALTH PLAN
799	GENWORTH FINANCIAL	PO BOX 8021	SAN RAFAEL	CA	949129974	8008764582	WAS G E FINANCIAL SERVICES
800	NEBCO (TENNECO)	PO BOX 97	SCRATNON	PA	185040097	8007177562	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
801	IMERICA LIFE AND HEALTH INS. CO	PO BOX 3287	ENGLEWOOD	CO	80155	8882738020	
802	CONSTITUTION LIFE INSURANCE CO	PO BOX 130	PENSACOLA	FL	325910130	8007896364	
803	FIRST CONTINENTAL LIFE INSURANCE	PO BOX 1911	CARMEL	IN	46032	8005381235	
804	PIEDMONT COMMUNITY HEALTHCARE INC.	PO BOX 14408	CINCINNATI	OH	452500408	8004007247	
805	PENN TREATY NETWORK AMERICA (PTNA)	PO BOX 130	PENSACOLA	FL	325910130	8006357418	CODE ASSIGNED BY SCHA
806	NETWORK HEALTH PLAN	PO BOX 568	MENASHA	WI	54952	9207201300	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
807	OPTIMA HEALTH PLAN	PO BOX 5028	TROY	MI	460071199	8002291199	
808	NEW MARKET DIMENSION	PO BOX 1338	COCKEYVILLE	MD	21031	8005706745	
809	OHIP CARPENTERS HEALTH & WELFARE FUND	8281 YOUNGSTOWN WARREN RD #240	NILES	OH	44446	8003629354	CODE ASSIGNED BY SCHA
810	UNITED RESOURCE NETWORK	PO BOX 30758	SALT LAKE CITY	UT	84130	877-801-35	CODE ASSIGNED BY SCHA
811	SPARTANBURG REGIONAL HEALTHCARE SYSTEM	PO BOX 1000	LANCASTER	SC	29721	877-629-00	CODE ASSIGNED BY SCHA
812	MAJOR LEAGUE BASEBALL BENEFIT PLAN	PO BOX 7003	PARKERSBURG	WV	261027003	8006692255	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
813	CENTURY PLANNER	9201 WATSON RD, STE. 350	ST. LOUIS	MO	631261509	8007762453	
814	HEALTHCOMP ADMINISTRATORS	PO BOX 45018	FRESNO	CA	93718	8004427247	
815	BANKERS FIDELITY LIFE INSURANCE COMPANY	PO BOX 260040	PLANTO	TX	75026	8664587499	THID CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
816	ARCADIAN MEMBER CARE	PO BOX 4946	COVINA	CA	91723	8005738597	MEDICARE ADVANTAGE PLAN
817	PRIORITY HEALTH	1231 E BELTLINE NE	GRAND RAPIDS	MI	495254501	8004465674	
818	SEAFARERS HEALTH & BENEFIT PLAN (SHBP)	PO BOX 380	PINEY POINT	MD	20674	8002524674	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
819	TRICARE OVERSEAS PROGRAM	PO BOX 7985	MADISON	WI	537077985	8009826257	CODE ASSIGNED BY SCHA 6/07/10
820	MMSI MAYO MANAGEMENT SERVICES	4001 41ST ST. WEST	ROCHESTER	NM	41154	8006356671	CODE ASSIGNED BY SCHA SEE CARRIER CODE 536
821	ODS HEALTH PLAN ADVANTAGE	PO BOX 4030	PORTLAND	OR	972084030	8773370650	CODE ASSIGNED BY SCHA
822	MEDICAL MUTUAL	PO BOX 6018	CLEVELAND	OH	44101	8002582873	CODE ASSIGNED BY SCHA
823	HEALTH ALLIANCE PLAN	2850 W GRAND BLVD	DETROIT	MI	495254501	8004224641	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
824	ENVISION RX OPTIONS	2181 EAST AURORA RD STE 201	TWINSBURG	OH	44087	8003614542	
825	UNISON ADVANTAGE	PO BOX 1138	MONROEVILLE	PA	151465138	8002904009	MEDICARE ADVANTAGE PLAN
826	WILLSE & ASSOCIATES, INC.	PO BOX 1196	BALTIMORE	MD	21203	4105470454	
827	J. SMITH LANIER	PO BOX 72749	NEWNAN	GA	30271	8882954864	
828	NATIONAL PHARMACEUTICAL SERVICES	PO BOX 407	BOYSTOWN	NE	68017	8005465677	
829	ADMINISTRATIVE SOLUTIONS	PO BOX 2490	ALPHARETTA	GA	30023	6783390211	
830	CONTRACTORS EMPLOYEE BENEFIT ADM. (CEBA)	PO BOX 559017	AUSTIN	TX	78755	8002477724	
831	CORPORATE BENEFIT SOLUTIONS, INC.	PO BOX 8215	LITTLE ROCK	AR	72221	8886049397	
832	CAMERON AND ASSOCIATES	6100 LAKE FOREST DR.	ATLANTA	GA	30328	8003879919	
833	MERCY HEALTH PLANS	PO BOX 4568	SPRINGFIELD	MO	658084568	8006472240	
834	DEFINITY HEALTH	PO BOX 9525	AMHERST	NY	14226	8663334648	BROUGHT OUT BY UNITED HEALTCARE CARRIER 113
835	MANAGED PHARMACY BENEFITS	1100 NORTH LINDBERGH	ST. LOUIS	MO	63132	8006729540	THIS CARRIER BOUGHT OUT BY EXPRESS SCRIPTS.
836	HUMANA	1100 EMPLOYERS BLVD	GREEN BAY	WI	543440620	8005584444	
837	HEALTH ADMINISTRATION SERVICES	PO BOX 6724208	HOUSTON	TX	77267	8008655440	
838	SHESFIELD, OLSON & MCQUEEN	PO BOX 16608	ST PAUL	MN	55116	8883308408	
839	CITIZENS SECURITY LIFE INS.	PO BOX 436149	LOUISVILLE	KY	402536149	5022442420	
840	AMERICAN INCOME LIFE INSURANCE COMPANY	PO BOX 2608	WACO	TX	76797	8177723050	
841	WATKINS ASSOCIATED INDUSTRIES	PO BOX 1738	ATLANTA	GA	30301	8003333841	CODE ASSIGNED BY SCHA
842	GARDNER AND WHITE INC	PO BOX 40619	INDIANAPOLIS	IN	462400619	3172579131	
843	CORE MANAGEMENT RESOURCES GROUP	PO BOX 840	MACON	GA	31202	8887412673	
844	PRIME TIME HEALTH PLAN	PO BOX 6905	CANTON	OH	44706	8006177446	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
845	GEISINGER HEALTH PLAN GOLD	PO BOX 8200	DANVILLE	PA	178218200	8004989731	MEDICARE ADVANTAGE PLAN
846	SCRIPT CARE, INC.	6380 FOLSOM DR	BEAUMONT	TX	77706	8008809988	
847	MAHONEY BENEFIT ADMINISTRATORS	PO BOX 7260	FORT LAUDERDALE	FL	33338	8002807093	
848	HERITAGE	PO BOX 1730	AUBURNDALE	FL	33823	8002822460	
849	E.O.S. HEALTH	PO BOX 27088	TEMPE	AZ	85285	8884568417	
850	ONENET PPO	PO BOX 934	FREDERICK	MD	217050934	8003423289	CODE ASSIGNED BY SCHA
852	EMPLOYERS MUTUAL	1000 RIVERSIDE AVE, STE. 400	JACKSONVILLE	FL	32257	8006972235	
853	COMPSYCH CORP.	PO BOX 8379	CHICAGO	IL	60680	8775955282	
854	BOYD CARE (BOYD BROTHERS TRANSPORTATION)	PO BOX 70	CLAYTON	AL	36016	3347751284	
855	UNIVERSITY HEALTH PLANS	PO BOX 830926 DEPT 003	BIRMINGHAM	AL	35283	8778780914	
856	TRANSAMERICA OCCIDENTAL LIFE	PO BOX 2101 TERMINAL ANNEX	LOS ANGELES	CA	90051	2137422111	
857	CORPORATE BENEFIT SERVICES INC	PO BOX 981800	EL PASO	TX	79998	7043730447	
858	DENTAQUEST	PO BOX 2136	COLUMBIA	SC	29202	8003076553	NAIC 52040 MEDICAID DENTAL CLAIMS PROCESSOR
859	NEW ENGLAND GROUP TRUST	PO BOX 30466	TAMPA	FL	33630	8006541731	
860	MANAGED HEALTH NETWORK	PO BOX 209010	AUSTIN	TX	78720	8008352094	
861	SUPERIOR ESSEX	PO BOX 724907	ATLANTA	GA	31139	8772917920	
862	PERFORMAX	300 CORPORATE PARKWAY	AMHERST	NY	11226	8777776076	
863	INSURANCE ADMINISTRATION CORP.	PO BOX 39119	PHOENIX	AZ	85069	8008433106	
864	GE GROUP ADMINISTRATORS	PO BOX 150809	ARLINGTON	TX	76015	8882558961	
865	SECURIAN DENTAL PLANS	PO BOX 9385	MINNEAPOLIS	MN	554409385	8002349009	NAIC 93742
866	OLYMPIC HEALTH MANAGEMENT	PO BOX 5348	BELLINGHAM	WA	98227	3607349888	
867	STATE OF NC COMP. HEALTH BENEFIT	PO BOX 30025	DURHAM	NC	27702	9194897431	
868	KANSAS CITY LIFE	PO BOX 219325	KANSAS CITY	MO	64121	8008745254	
869	EMPLOYEE BENEFIT MANAGEMENT SERVICES	PO BOX 21367	BILLINGS	MT	59104	8007773575	
870	FOUNDATION HEALTH	PO BOX 453219	SUNRISE	FL	33345	8004415501	
871	UNITED BEHAVIORAL HEALTH	PO BOX 169053	DULUTH	MN	55816	8008776003	CODE ASSIGNED BY SCHA
872	UNITED HEALTHCARE PLAN OF RIVER VALLED	3800 23RD AVE. #200	MOLINE	IL	61215	8002246602	CODE ASSIGNED BY SCHA THESE COMPANY BOUGHT OUT JOHN DEERE INS. CO. THIS WAS THE HMO FOR JOHN DEERE 6/29/07

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
873	MEDCO HEALTH	PO BOX 8190	MADISON	WI	537088190	8002217006	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY THE SCHA
874	HEALTH NET	PO BOX 14700	LEXINGTON	KY	40512	8887477823	THIS CODE NOT REQUESTED BY SCHA. ASSIGNED BY SCHA
875	AMERICAN SENTINEL	PO BOX 61140	HARRISBURG	PA	171061140	8006927338	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
876	HEALTHSOURCE OF NC INC	PO BOX 28087	RALEIGH	NC	27611	8008499000	USE CODE 134 CIGNA HEALTHCARE
877	CARTER-JONES LUMBER CO	WELFARE PLAN	FLORENCE	SC	295010659		CODE ASSIGBED BY SCHA
878	PENSION AND GROUP SERVICE/HRM CLAIM MANAGEMENT	PO BOX 4022	KALAMAZOO	MI	490034022	8002530966	
879	WELLPATH SELECT	PO BOX 7102	LONDON	KY	40742	8662083610	WELLPATH SELECT IS A PLAN UNDER THE PARENT CO. COVENTRY HEALTH CARE
880	OPTIMUM HEALTH PARTNERS	PO BOX 2243	GREENVILLE	SC	29602	8642134992	
881	UNITED HEALTHCARE OF NC	PO BOX 26303	GREENSBORO	NC	274386303	8009991147	CODE ASSIGNED BY SCHA
882	PRUDENTIAL HEALTHCARE SYSTEM OF NC	2701 COLTSGATE RD STE 100	CHARLOTTE	NC	28211		CODE ASSIGNED BY SCHA
883	SELECT HEALTH OF SOUTH CAROLINA INC	7410 NORTHSIDE DR. STE. 208	CHARLESTON	SC	29420	8435691759	CODE IN OPEN STATUS BY SCHA
884	HEALTH FIRST HEALTH PLANS	PO BOX 565001	ROCKLEDGE	FL	329565001	8007167737	CODE IN OPEN STATUS BY SCHA
885	JOHN ALDEN INSURANCE COMPANY	PO BOX 020270	MIAMI	FL	33102	8003284316	
886	PLANNED ADMINISTRATORS INC	PO BOX 6927	COLUMBIA	SC	29260	8037540041	
887	CNIC HEALTH SOLUTIONS	PO BOX 3559	ENGLEWOOD	CO	80155	8004267453	
888	SOUTHEASTERN BENEFIT PLANS INC.	335 ARCHDALE DR.	CHARLOTTE	NC	282174246	7045295400	
889	GROUP INSURANCE ADMINISTRATION INC	3350 PEACHTREE RD NE STE. 1040	ATLANTA	GA	30326	8006210683	
890	PARTNERS NATIONAL HEALTH PLANS OF NORTH CAROLINA	PO BOX 17368	WINSTON SALEM	NC	271167368	8009425695	
891	OPTIMUM CHOICE OF THE CAROLINAS INC	4 TAFT CT.	ROCKVILLE	MD	20850	8003438205	
892	INDEPENDENT HEALTH	PO BOX 9066	BUFFALO	NY	14231	8002471466	
893	KEYSTON HEALTH PLAN EAST	PO BOX 8339	PHILADELPHIA	PA	19101	8002273116	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
894	AMERIHEALTH MERCY HEALTH PLAN	PO BOX 7118	LONDON	KY	40742	8889917200	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
895	CONTINENTAL LIFE INS. OF TENNESSEE	PO BOX 1188	BRENTWOOD	TN	37024	6153771300	
896	OPTIMED HEALTH PLAN	4 TERRY DR., STE 1	NEWTOWN	PA	18940	8004828770	
897	SOUTHERN BENEFIT ADM.	5305 VIRGINIA BEACH BLVD	NORFOLK	VA	23502	7574618091	
898	ASSOCIATION & SOCIETY INS. CORP	PO BOX 2510	ROCKVILLE	MD	20847	8006382610	
899	AETNA HEALTH PLANS OF THE CAROLINAS INC	3 CENTERVIEW DR.	GREENSBORO	NC	27407	8004591466	HMO PLAN ONLY
900	KOHLER COMPANY	444 HIGHLAND DR.	KOHLER	WI	530441515	9204574441	
901	DENTAL CARE PLUS	100 CROWNE POINT PLACE	CINCINNATI	OH	45241	8003679466	
902	M CARE	PO BOX 130799	ANN ARBOR	MI	481130779	8006588878	CODE ASSIGNED BY SCHA. THIS IS THE HMO TO CC 504 WHICH IS THE POS
903	ACORDIA NATIONAL	PO BOX 11064	CHARLESTON	WV	253391064	8004354351	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
904	BEST CHOICE HEALTH PLAN	PO BOX 21128	FORT LAUDERDALE	FL	33335	8008674446	
905	BETTER BENEFITS	PO BOX 93929	SOUTHLAKE	TX	76092	8664163605	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
906	GROUP HEALTH ADMINISTRATOR INC	PO BOX 6244	CHARLOTTE	NC	282071018	8002225790	
907	CELTIC LIFE INSURANCE CO.	PO BOX 46337	MADISON	WI	53744	8007662525	
909	PREFERRED HEALTH ALLIANCE CORP.	PO BOX 382048	BIRMINGHAM	AL	35238	8007228477	
910	AMERICAN ADMINISTRATIVE GROUP	PO BOX 5227	LISLE	IL	605325227	8003545112	WAS GALLAGER & BASSETT SERVICES
911	COMMUNITY HEALTH PARTNERS	PO BOX 5787	SPARTANBURG	SC	29304	8889628437	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
912	WELLS FARGO TPA-NC OFFICES	PO BOX 2857	FAYETTEVILLE	NC	28302	8003376288	
913	FLORIDA HOSPITAL HEALTHCARE SYSTEM	PO BOX 536847	ORLANDO	FL	328536847	8007414810	
914	NATIONAL TEACHERS ASSO LIFE INSURANCE CO.	PO BOX 2369	ADDISON	TX	75001	8886716771	
915	MANAGED HEALTH RESOURCES	PO BOX 30742	CHARLOTTE	NC	28208	7043555200	
916	MHEALTH	PO BOX 742567	HOUSTON	TX	77274	8886425040	
919	AMERICAN HEALTH GROUP, INC.	PO BOX 1500	MAUMEE	OH	43537	8008728276	
920	HEALTHSMART PREFERRED CARE	PO BOX 53010	LUBBOCK	TX	794533010	8064732500	

APPENDIX 2 CARRIER CODES

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CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
922	BLUE CHOICE HEALTHPLAN	PO BOX 6170	COLUMBIA	SC	292606170	8037868466	WAS COMPANION HEALTHCARE NAME CHANGE EFFECTIVE 7/1/05
923	WJ JONES ADMINISTRATIVE SERVICES INC	1979 MARCUS AVE	LAKE SUCCESS	NY	11042	8008317783	DORMANT 8/06
927	UNITED HEALTHCARE HERITAGE PLUS	UHC OF RIVER VALLEY PO BOX 5230	KINGSTON	NY	102425230	8002246602	
928	COOK INSURANCE	PO BOX 1029	BLOOMINGTON	IN	47402	8005932080	
929	NATIONAL HEALTH INSURANCE COMPANY	PO BOX 619999	DALLAS/FORT WORTH AIRPORT	TX	752619999	8002371900	
930	SENTRY LIFE INSURANCE COMPANY	PO BOX 8025	STEVENS POINT	WI	54481	8004267234	
931	GOOD SAMARITAN PROGRAM	5151 WEST HWY 40	BEACHGROVE	IN	46140	3178942000	
932	MANHATTAN INSURANCE GROUP	PO BOX 925309	HOUSTON	TX	772925309	8006699030	CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
933	PREFERRED HEALTHCARE SYSTEMS	620 HOWARD AVE	ALTOONA	PA	166014899		CODE ASSIGNED BY SCHA
934	ASSOCIATION & SOCIETY INS. CORP.	PO BOX 2510	ROCKVILLE	MD	20847	8006382610	
936	KEY BENEFITS-TRANSCHOICE PLUS	PO BOX 1279	FORT MILL	SC	297161279	8005916764	CODE ASSIGNED BY SCHA
937	MVP HEALTH CARE	PO BOX 1434	SCHENECTADY	NY	12301	8002295851	NAME CHANGE ONLY 4/09. WAS PERFERRED CARE
939	PREMIER HEALTH SYSTEMS	PO BOX 1640	COLUMBIA	SC	292021640	8032968999	CODE ASSIGNED BY SCHA
940	PRIVATE HEALTH CARE SYSTEMS (PHCS)	PO BOX 2914	DES PLAINES	IL	600172914	8005317662	CODE ASSIGNED BY SCHA 6/18/07
941	FIDELITY SECURITY LIFE INSURANCE CO	419 E MAIN ST	MIDDLETOWN	NY	10940	8008267531	THE CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
942	PRINCIPAL FINANCIAL GROUP	PO BOX 10357	DES MOINES	IA	503060357	8002474695	
943	LIBERTY MUTUAL LIFE INSURANCE	5 HUTCHINSON DR	DANVERS	MA	01923	8889994767	CODE IN OPEN STATUS BY SCHA
945	CAROLINA ATLANTIC MEDICAL SERVICES ORGANIZATION	PO BOX 22528	CHARLESTON	SC	29413	8008100906	DORMANT 8/06
946	FIRST HEALTH	PO BOX 1377	THOMASVILLE	GA	31799	8668478235	
948	PHILADELPHIA AMERICAN LIFE INS. CO.	PO BOX 2465	HOUSTON	TX	77252	8005527879	
951	AMERICAN GROUP ADMINISTRATORS	101 CONVENTION CENTER DR. STE. 200	LAS VEGAS	NE	89109	8008424742	
952	STARK TRUSS CO., INC.	PO BOX 2080C	STOW	OH	44224	8004564002	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
953	USA HEALTHCARE ORGANIZATION	7301 N. 16TH ST STE 201	PHOENIX	AZ	85020	8008723860	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
954	MULTIPLAN	115 5TH AVE	NEW YORK	NY	100031004	8005463887	
955	DESIGN SAVERS PLAN	2814 SPRING RD. STE. 122	ATLANTA	GA	30339	8006165709	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
958	ITPE-NMU HEALTH AND WELFARE FUND	PO BOX 13817	SAVANNAH	GA	31416	9123527169	
960	HEALTH EOS	PO BOXBX 6090	DER PERE	WI	541156090	8004355694	CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
961	MHN (MANAGED HEALTH NETWORK)	PO BOX 27018	LAS VEGAS	NV	89126	8004584642	CODE ASSIGNED BY SCHA
962	VICARE PLUS	PO BOX 1710	SUFFOLK	VA	23439	8779344403	
963	OXFORD HEALTH PLANS	PO BOX 2083	NASHUA	NH	030612083	8882014111	
964	PHARMACEUTICAL CARE NETWORK	9343 TECH CENTER DR.	SACRAMENTO	CA	95826	8007770074	
965	PROFESSIONAL BENEFIT ADMINISTRATORS, INC. (PBA)	PO BOX 4687	OAKBROOK	IL	605223755	6306553755	
966	CAPITOL ADMINISTRATORS OF THE SOUTHEAST	PO BOX 346	ALPHARETTA	GA	30009	8886506566	
967	UNDERWRITERS SAFETY AND CLAIMS	PO BOX 23507	LOUISVILLE	KY	40223	8006781536	
968	AMERICAN BENEFIT ADMINISTRATIVE SERVICES	PO BOX 0928	BROOKFIELD	WI	53008	6304161111	
969	WHP HEALTH INITIATIVE	PO BOXBXO 545	DEERFIELD	IL	60015	8002072568	
970	CONSOLIDATED WORKERS ASSOCIATION (CWA)	PO BOX 2647	CHINO HILLS	CA	91709	8009195514	CODE ASSIGNED BY SCHA
971	ATLANTA ADMINISTRATIONS	135 BEAVER ST.	WALTHAM	MA	02452	8005481256	
972	ASR CORP (ADMINISTRATION SYSTEM RESEARCH)	PO BOX 6392	GRAND RAPIDS	MI	49512	8009682449	
973	CAMBRIDGE INTERGRATED SERVICES GROUP INC.	PO BOX 1687	GRAND RAPIDS	MI	49501	8007669780	USE CARRIER 171 AON
974	COMMERCE BENEFIT GROUP	PO BOX 900	ELYRIA	OH	44036	8002239941	
975	INFORMED RX	PO BOX 5206	LISLE	IL	60532	8006453332	WAS NATIONAL MEDICAL HEALTH CARD
976	PARAGON BENEFITS, INC.	PO BOX 12288	COLUMBUS	GA	31917	7062776710	
977	ZENITH ADMINISTRATION	PO BOX 91014	SEATTLE	WA	98111	8004265980	DORMANT 8/06
978	LEGGETT & PLATT	PO BOX 7687	HIGH POINT	NC	27264	8773112150	
979	MEDICAL REIMBURSEMENT OF AMERICA	113 SEABOARD LANE	FRANKLIN	TN	37067	6159633826	THIS CODE IS USED BY SCHA NOT AN ACTIVE MEDICAID CODE
980	BENEFIT SUPPORT, INC.	PO BOX 2977	GAINSVILLE	GA	30503	8007774752	
981	ARGUS HEALTH SYSTEMS	PO BOX 419019	KANSAS CITY	MO	64141	8005227487	
982	OFFICE OF GROUP BENEFITS STATE OF LOUISIANA	PO BOX 44036	BATON ROUGE	LA	708044036	8002728451	
983	INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS	3901 E. WINSLOW AVE	PHOENIX	AZ	85040	6022340497	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
984	HOMELAND HEALTHCARE	PO BOX 3726	SEATTLE	WA	98124	8004934240	
985	BENESIGHT	PO BOX 340	PUEBLO	CO	81002	8003621116	
986	COMMON WEALTH BENEFIT ADMINISTRATORS	115 HANOVER ST.	ASHLAND	VA	23005	8005261677	
987	BANKERS FIDELITY LIFE INS CO	PO BOX 190240	ATLANTA	GA	311190240	4042665500	
988	MID WEST NATIONAL LIFE INS. CO.	PO BOX 981606	EL PASO	TX	799981610	8007331110	
989	UNIVERA HEALTHCARE	PO BOX 23000	ROCHESTER	NY	14692	8772429464	
990	SOUTHERN GROUP ADMINISTRATORS, INC.	200 SOUTH MARSHALL ST.	WINSTON SALEM	NC	27101	8003348159	
991	WEST PORT BENEFITS	PO BOX 66743	ST. LOUIS	MO	63166	8883065299	
992	CHESTERFIELD RESOURCES, INC.	PO BOX 1884	AKRON	OH	44309	8003210935	
993	MPI INTERNATIONAL, INC.	PO BOX 81913	ROCHESTER	MI	483081913	2488539010	
994	UNITED PROVIDER SERVICES	PO BOX 820277	FORT WORTH	TX	76182	8005198374	CARRIER BOUGHT OUT BY CC 740 PHARMACARE
995	MEDIMPACT	10680 TREENA ST,STOP 5	SAN DIEGO	CA	92131	8007882949	
996	J.F. MOLLOY & ASSO.	PO BOX 68947	INDIANAPOLIS	IN	46268	8003313287	SEE CARRIER 942 PRINCIPAL FINANCIAL GROUP
997	GENWORTH FINANCIAL	PO BOX 10821	CLEARWATER	FL	33757	8778259337	CODE IN OPEN STATUS BY SCHA
998	CANADA LIFE ASSURANCE CO.	6201 POWERS FERRY RD. STE. 100	ATLANTA	GA	30348	8003332542	
999	CIGNA HEALTHCARE OF SC/HEALTHSOURCE SC	PO BOX 190024	CHARLESTON	SC	294199024	8007203150	BOUGHT BY CIGNA HEALTHCARE CC 134
100DN	AETNA US HEALTHCARE	PO BOX 14094	LEXINGTON	KY	40512	8004517715	
100RX	AETNA PHARMACY	PO BOX 14024	LEXINGTON	KY	40512	8002386279	
110RX	PROVIDENT/CAREMARK	PO BOX 686005	SAN ANTONIO	TX	78268	8008415550	USE CODE 280 CAREMARK
113DN	UNITED HEALTHCARE	PO BOX 30567	SALT LAKE CITY	UT	84130	8005215505	
134DN	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 188037	CHATTANOOGA	TN	37422	8002446224	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
134RX	CIGNA CONN GENERAL LIFE INSURANCE	PO BOX 42005	PHOENIX	AZ	850802005	8002510670	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE
139DN	UMR	PO BOX 188037	CHATTANOOGA	TN	374228037	8008269781	WAS WAUSAU INS. CO.
139RX	WAUSAU INSURANCE COMPANY	PO BOX 8013	WAUSAU,	WI	544028013	8008269781	
153DN	KANAWHA LIFE INSURANCE COMPANY	PO BOX 6000	LANCASTER	SC	29721	8032862440	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
160DN	UNICARE HEALTH AND LIFE INSURANCE	PO BOX 4059	SCHAUMBURG	IL	601684059	8772179677	
201DN	HCH ADMINISTRATORS	PO BOX 1986	PEORIA	IL	61656	8003221516	
237DN	GUARDIAN LIFE INSURANCE CO. OF AMERICA	PO BOX 2459	SPOKANE	WA	99210	8005417846	
245RX	FIRST HEALTH	PO BOX 23070	TUCSON	AZ	85734	8005544954	
300DN	BENEFIT ADMINISTRATORS INC	PO BOX 6279	ERIE	PA	16512	8007772524	
308DN	GREAT WEST LIFE	PO BOX 11111	FORT SCOTT	KS	66701	8776314227	
312DN	NATIONAL BENEFIT ADMINISTRATORS	PO BOX 690903	CHARLOTTE	NC	282277016	8004826736	
315DN	THOMAS COOPER AND COMPANY	PO BOX 22557	CHARLESTON	SC	29413	8437222115	
345DN	EMPLOYEE BENEFIT SERVICES INC	PO BOX 1929	FORT MILL	SC	29716	8002421510	
386DN	ASSURANT HEALTH	PO BOX 2940	CLINTON	IA	52733	8004427742	WAS FORTIS INSURANCE COMPANY
401DN	BLUE CROSS AND BLUE SHIELD OF SC	4101 PERCIVAL RD.	COLUMBIA	SC	29219	8037883860	THIS CODE USED ONLY FOR DENTAL CLAIMS WHERE BCBS IS THE INSURANCE CARRIER
415DN	WEYCO, INC.	PO BOX 30132	LANSING	MI	48909	5173497010	
476DN	CENTRAL STATES, SOUTHEAST & SOUTHWEST	PO BOX 5116	DEPLAINES	IL	60017	8003235000	
536DN	CLAIMSWARE MANAGEMED	PO BOX 6125	GREENVILLE	SC	29606	8642348200	
552DN	CORESOURCE INC	6100 FAIRVIEW RD.	CHARLOTTE	NC	28210	8003275462	
553DN	HEALTHSCOPE BENEFITS, INC.	PO BOX 8076	LITTLE ROCK	AR	72203	8008277026	
709DN	MARSH ADVANTAGE AMERICA	501 NORTH BROADWAY, STE. 500	ST LOUIS	MO	63102	8008687526	FORMERLY BENEFIT PLAN SERVICES
751DN	POLARIS BENEFIT ADMINISTRATORS	PO BOX 1008	DELAWARE	OH	43015-	8002340225	
751RX	POLARIS BENEFIT ADMINISTRATORS	PO BOX 1008	DELAWARE	OH	43015-	8002340225	
766DN	PALMER & CAY/CARSWELL, INC.	PO BOX 1286	SAVANNAH	GA	31402	9122346621	
781DN	MEDICAL CLAIMS MANAGEMENT CORP	PO BOX 12995	CHARLOTTE	NC	282202995	8003340609	
842DN	GARDNER AND WHITE INC	PO BOX 40619	INDIANAPOLIS	IN	462400619	3172579131	
857DN	CORPORATE BENEFIT SERVICES INC	PO BOX 12954	CHARLOTTE	NC	28220	7043730447	
885DN	JOHN ALDEN INSURANCE COMPANY	PO BOX 020270	MIAMI	FL	33102	8003284316	
886DN	PLANNED ADMINISTRATORS INC	PO BOX 6927	COLUMBIA	SC	29260	8037540041	
889DN	GROUP INSURANCE ADMINISTRATION INC	3350 PEACHTREE RD NE STE. 1040	ATLANTA	GA	30326	8006210683	
909DN	PREFERRED HEALTH ALLIANCE CORP.	300 CORPORATE PKWY. STE. 3	BIRMINGHAM	AL	35242	2059691155	
958DN	ITPE-NMU HEALTH AND WELFARE FUND	PO BOX 13817	SAVANNAH	GA	31416	9123527169	
A01	THRIVENT FINANCIAL FOR LUTHERANS	4341 N. BALLARD RD	APPLETON	WI	54919	8008474836	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A02	ALTERNATIVE BENEFITS PLANS, INC.	2920 BRANDYWINE RD. STE. 106	ATLANTA	GA	30341	8002417319	
A03	STARMARK	PO BOX 2942	CLINTON	IA	52733	8005221246	THIS CARRIER HANDLES GROUPS WITH LESS THAN 50 EMPLOYEES. SEE CC212 FFOR GROUPS OVER 50 EMPLOYEES.
A04	CONSULTEC PRESCRIPTION BENEFITS MANAGEMENT	9040 ROSWELL RD. STE. 700	ATLANTA	GA	303501853	8003654944	
A05	AMERICAN PUBLIC LIFE INSURANCE CO.	PO BOX 925	JACKSON	MS	39205	8002568606	
A06	COLONIAL PENN FRANKLIN LIFE INSURANCE COMPANY	1818 MARKET ST.	PHILADELPHIA	PA	191811250	8005234000	THIS CARRIER PART OF CONSECO INSURANCE GROUP
A07	CONTINENTAL LIFE INSURANCE CO. OF SOUTH CAROLINA	PO BOX 6138	COLUMBIA	SC	29260	8037824947	
A08	INDEPENDENCE AMERICAN INS. CO.(IHC HEALTH SOLUTION	PO BOX 21456	EAGON	MN	55121	8664290608	
A09	RX AMERICA	221 N CHARLES LINDBERG DR	SALT LAKE CITY	UT	84116	8007708014	
A10	AMERISCRIPT	4301 DARROW RD. STE. 4200	STOW	OH	44224	8006816912	
A11	PREFERRED ADMINISTRATORS	PO BOX 18263	TAMPA	FL	336798263	8772767198	
A12	MOUNTAIN CLAIMS MANAGEMENT	PO BOX 1008	FRUITLAND	ID	83616	8669527979	
A13	HOLDEN & COMPANY	PO BOX 10411	SAVANNAH	GA	31412	8004043344	
A14	EB RX	2045 MIDWAY DR	TWINSBURG	OH	44087	8008007153	
A15	MANAGED PRESCRIPTIONS SERVICES (MPS)	ONE CITY CENTRE STE. 1100	ST LOUIS	MO	631016922	8007596959	
A16	FCE BENEFIT ADMINISTRATOR	4615 WALZEM RD. STE 300	SAN ANTONIO	TX	782181610	8008999355	
A17	NOVA HEALTHCARE ADMINISTRATORS	2680 GRAND ISLAND BLVD	GRAND ISLAND	NY	140720308	8003333195	
A18	MSH MOBILITY BENEFITS	PO BOX 77	BEEBE PLAIN	VT	05823	8888421530	CODE ASSIGNED BY SCHA
A19	ISLAND GROUP ADMINISTRATION, INC.	3 TOILSOME LANE	EAST HAMPTON	NY	11937	8009262306	CODE ASSIGNED BY SCHA
A20	PROFESSIONAL CLAIMS MANAGEMENT	PO BOX 35276	CANTON	OH	443155276	8003258424	
A20DN	PROFESSIONAL CLAIMS MANAGEMENT	PO BOX 35276	CANTON	OH	443155276	8003258424	
A21	PC HEALTH PLAN ADMINISTRATION	P.O BOX 1377	THOMASVILLE	GA	31799	8884261937	CODE ASSIGNED BY SCHA
A22	PIEDMONT ADMINISTRATORS	PO BOX 78030	GREENSBORO	NC	274270830	8008527040	
A23	SERV U PRESCRIPTION	PO BOX 23237	MILWAUKEE	WI	532230237	8007593203	
A24	WELLPOINT NEXT RX	PO BOX 145433	CINCINNATI	OH	45250	8009627378	USE CARRIER 333 EXPRESS SCRIPTS
A25	BENESCRIPT	8300 E. MAPLEWOOD AVE	GREENWOOD VILLAGE	CO	80111	8003453189	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A26	MARKEL SMART STM	PO BOX 15953	LUBBOCK	TX	79490	8002792290	
A27	HEALTHCARE SUPPORT	25 COLUMBIA HEIGHTS	BROOKLYN HEIGHTS	NY	112012482	8005544022	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A28	SHENANDOAH LIFE INSURANCE CO	PO BOX 12847	ROANOKE	VA	24029	8008485433	
A29	MERITAN HEALTH	PO BOX 80884	INDIANAPOLIS	IN	46280	8006064841	
A30	RMSCO, INC.	PO BOX 678	LIVERPOOL	NY	130880678	8772047086	
A30DN	RMSCO, INC.	PO BOX 678	LIVERPOOL	NY	130880678	8772047086	
A31	UNITY HEALTH INSURANCE	PO BOX 610	SAUK CITY	WI	535831374	8003623308	
A32	MAGELLEN BEHAVIORAL HEALTH	PO BOX 1659	MARYLAND HEIGHTS	MO	63043	8003592422	
A33	ALLIANT HEALTH PLANS, INC.	PO BOX 21109	ROANOKE	VA	24108	8002834927	
A34	WOODS & GROOM	2549 17TH ST.	COLUMBUS	IN	47202	8003683429	DORMANT 8/06
A35	FABRI-KAL CORPORATION	PO DRAWER C	PIEDMONT	SC	29773	8642991720	CODE IN OPEN STATUS BY SCHA
A36	FIELDCREST CANNON (CANNON MILLS)	PO BOX 5000	EDEN	NC	272895000	8002223693	
A37	UNITED BEHAVIORAL/DENTAL SYSTEMS	PO BOX 30755	SALT LAKE CITY	UT	84130	8005575745	
A38	UNITED HEALTHCARE OF NC	PO BOX 2604	GREENSBORO	NC	274386304	8009991147	
A39	COMPLETE BENEFITS SOLUTIONS	PO BOX 3649	GREENVILLE	SC	29603	8662702316	
A40	STRATEGIC RESOURCE COMPANY	PO BOX 14079	LEXINGTON	KY	40512	8887729682	
A41	CLAIMS MANAGEMENT SERVICES	PO BOX 10888	GREENBAY	WI	54307	8004727130	
A42	PRIMERICA LIFE INSURANCE COMPANY	3120 BRECKINRIDGE BLVD.	DULUTH	GA	30199	4043811000	
A43	PREMIER BENEFIT MANAGEMENT, INC.	7070-A KAIGHN AVE	PENSAUKEN	NJ	08109	800-966-01	CODE ASSIGNED BY SCHA
A44	GLOBAL MEDICAL MANAGEMENT, INC	7901 SW 36TH ST. STE 100	DAVIE	FL	33328	9543706404	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A45	INTEQ GROUP	5445 LASIERRA DR STE. 400	DALLAS	TX	75231	8009593953	
A46	STANDARD INSURANCE COMPANY	PO BOX 209	PORTLAND	OR	972070209	5033217000	
A47	STATESMAN NATIONAL LIFE INSURANCE COMPANY	3815 MONTROSE BLVD.	HOUSTON	TX	77006	7135266000	
A48	QUALMED OF OREGON	PO BOX 286	CLACKMAS	OR	970150286	8005685628	DORMANT 8/06
A49	ARIZONA FOUNDATION FOR MEDICAL CARE	PO BOX 2909	PHONEIX	AZ	850622909	6022318855	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A50	FEDERAL EMPLOYEES COMPENSATION ACT	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A51	COAL MINE WORKERS COMP PROGRAM	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A52	NATIONWIDE SPECIALITY HEALTH CLAIMS	PO BOX 420	SPRINGFIELD	MA	01101	8005174791	
A53	LONGSHORE & HARBOR WORKERS COMP PROGRAM	PO BOX 8300	LONDON	KY	407428300	8663358319	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A54	CENTURY HEALTHCARE	PO BOX 2256	GRAPEVINE	TX	76099	8884441995	NEIC 30018
A55	AETNA LIFE AND CASUALTY	PO BOX 36890	LOUISVILLE	KY	40232	8004233289	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A56	VULCAN MATERIALS COMPANY	PO BOX 530187	BIRMINGHAM	AL	352530187	8642772371	DORMANT 8/06
A57	AMERICAN GROUP ADMINISTRATORS, INC.	101 CONVENTION CENTER DR. STE 200	LAS VEGAS	NV	89109	8008424742	CODE ASSIGNED BY SCHA
A58	COMPREHENSIVE BENEFITS	PO BOX 8955	MELVILLE	NY	11747	8008283605	
A60							
A62	AMERICAN MEDICAL AND LIFE INSURANCE (AMLI)	PO BOX 1353	CHICAGO	IL	60690	8882641512	
A63	CITIZENS INSURANCE	PO BOX 1627	ANDERSON	SC	29622	8643340090	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A64	NTCA (NAT'L TELECOMMUNICATIONS COOPERATIVE ASSO.)	ONE WEST PACK SQUARE STE 600	ASHEVILLE	NC	288013459	8282819000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A65	DATARX	5920 ODELLE ST	CUMMINGS	GA	30040	8778231273	
A66	SOUTHERN BENEFIT ADMINISTRATORS, INC.	PO BOX 1449	GOODLETTSVILLE	TN	37070	8008310420	
A67	HEALTHSCOPE BENEFITS	PO BOX 99005	LUBBOCK	TX	794906831	8009676831	
A68	HOLLINGSWORTH SACO LOWELL CORP.	P O DRAWER 2327	GREENVILLE	SC	29602	8648593211	DORMANT 8/06
A69	KAISER FOUNDATION HEALTH PLAN OF SOUTHERN CA	PO BOX 7004	DOWNEY	CA	902427004	8003310420	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A70	NATIONAL EMPLOYEE BENEFIT ADMINISTRATORS	1920 N. FLORIDA MANGO RD	WEST PALM BEACH	FL	33409	8008225899	
A71	CAROLINA BEHAVIORAL HEALTH ALLIANCE	PO BOX 571137	WINSTON SALEM	NC	271571137	8004757900	
A72	BABB, INC.	850 RIDGE AVE	PITTSBURGH	PA	15212	8002456102	
A73	CLAIMS TECHNOLOGY, INC.	100 CT. AVE. STE. 306	DES MOINES	IA	50309	8002458813	
A74	FIRST CAROLINA CARE, INC.	PO BOX 381686	BIRMINGHAM	AL	35238	8008113298	
A75	HEALTH COST SOLUTIONS	PO BOX 1439	HENDERSONVILLE	TN	37077	8882295020	WAS LIFECARE CENTERS OF AMERICA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
A76	TOWER LIFE INS. CO.	310 S. MARY ST	SAN ANTONIO	TX	78205	8006606077	
A77	SISCO	PO BOX 389	DUDUQUE	IA	52004	8004574725	
A78	HIGHWAY TO HEALTH (HTH)	PO BOX 968	HORSHAM	PA	19044	8883502002	THIS CODE ASSIGNED BY SCHA. NOT REQUESTED BY MEDICAID
A79	HEALTH SPECIAL RISK	4001 N. JOSEY LANE	CARROLLTON	TX	75007	9724926474	
A80	TOTAL SCRIPT	10901 WEST 120TH AVE. STE 110	BROOMFIELD	CO	80021	8007522211	
A81	BENESYS	PO BOX 90082	LUBBOCK	TX	79402	3372341789	
A82	UNITED HEALTHCARE INDEMNITY	PO BOX 740801	ATLANTA	GA	303740801	8008488406	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A83	GROUP RESOURCES INC	PO BOX 100043	DULUTH	GA	300969343	7706238383	
A84	HCC LIFE INSURANCE COMPANY	PO BOX 863	INDIANAPOLIS	IN	46206	8664007102	
A85	QUALCHOICE	PO BOX 25610	LITTLE ROCK	AR	722219914	8002357111	
A86	BENEFIT MANAGEMENT CO	PO BOX 269000	WESTON	FL	333269000	8002629175	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A87	SOUTHEAST COMMUNITY CARE (ARCADIAN HEALTH)	PO BOX 4946	COVINA	CA	91723	8005738597	
A88	WINDSOR STERLING	PO BOX 269003	PLANO	TX	750269003	8888588551	
A89	SPECIAL INSURANCE SERVICES (SIS)	PO BOX 250349	PLANO	TX	750250349	8007676811	CODE ASSIGNED BY SCHA
A90	EMPLOYEE BENEFIT CLAIMS INC	9501 WEST DEVON	ROSEMONT	IL	60018	3126963660	
A91	STATES GENERAL LIFE INS. CO	115 WEST 7TH ST. STE. 1200	FORT WORTH	TX	761027012	8007828375	
A92	PROVIDENT AMERICAN LIFE & HEALTH INS.	PO BOX 29158	SHAWNEE MISSION	KS	66201915	8007535133	
A93	AMERICAN COLLEGE OF SURGEONS	PO BOX 2522	FORT WORTH	TX	761132522	8004331672	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A94	FORETHOUGHT LIFE INSURANCE COMPANY	PO BOX 981721	EL PASO	TX	79998	8774925870	
A95	REYNOLDS & REYNOLDS	PO BOX 1272	DAYTON	OH	45401	8007363539	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
A96	HAMRICKS INC	742 PEACHOID RD.	GAFFNEY	SC	29340	8644877505	
A97	EMPLOYER PLAN SERVICES, INC.	2180 NORTH LOOP WEST, STE. 400	HOUSTON	TX	77018	8004476588	
A98	CORPORATE BENEFIT SERVICES OF AMERICA INC	PO BOX 738	HOPKINS	MN	55343	8007654224	
A99	CHEROKEE INSURANCE	PO BOX 853925	RICHARDSON	TX	750853925	8002010450	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B01	HEALTH PARTNERS	PO BOX 1289	MINNEAPOLIS	MN	554401289	8889222313	
B02	LIFE INSURANCE CO. OF ALABAMA	PO BOX 349	GADSDEN	AL	35902	8002262371	
B03	CHESAPEAKE LIFE INS. CO.	PO BOX 809025	DALLAS	TX	753809025	8887563534	
B04	CARITEN HEALTHCARE	PO BOX 22987	KNOXVILLE	TN	37933	8002840042	CODE IN OPEN STATUS BY SCHA
B05	FOCUS HEALTHCARE MANAGEMENT, INC.	720 COOL SPRINGS BLVD	FRANKLIN	TN	37067	6157784000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B06	SOUTHCARE HEALTHCARE PREFERRED	1100 CIRCLE 75 PARKWAY, STE 1400	ATLANTA	GA	30339	8004702004	
B07	MAGNACARE	PO BOX 1001	GARDEN CITY	NY	11530	8666246259	
B08	AMFIRST INSURANCE CO	PO BOX 16708	JACKSON	MS	93236	8888882519	
B09	DEARBORN NATIONAL	PO BOX 23060	BELLEVILLE	IL	62223	8003484512	
B10	PILGRIM HEALTH & LIFE INSURANCE	PO BOX 897	ATLANTA	GA	30303	4046592100	CODE IN OPEN STATUS BY SCHA
B11	CBCA ADMINISTRATORS, INC.	PO BOX 1272	MINNEAPOLIS	MN	554400535	8884465710	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B12	JOHN HANCOCK LIFE AND HEALTH INSURANCE	JOHN HANCOCK B5-03 200 BERKELEY STEET	BOSTON	MA	02116	8003777311	
B13	WEB TPA	PO BOX 99906	GRAPEVINE	TX	760999706	8007582851	
B14	A.C.S. CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON SALEM	NC	271022000	3367592013	
B14DN	A.C.S. CONSULTING SERVICES, INC.	PO BOX 2000	WINSTON SALEM	NC	271022000	3367592013	
B15	HILLCREST BENEFIT ADMINISTRATORS	PO BOX 1516	MT. DORA	FL	32756	8007439264	
B16	PARTNER RX MANAGEMENT	PO BOX 12119	SCOTTSDALE	AZ	85260	8006594112	
B17	ULTRA BENEFITS	PO BOX 763	WESTBORO	MA	01581	8668587223	
B18	LUMENOS	PO BOX 69309	HARRISBURG	PA	17106	8774957223	
B19	RENAISSANCE DENTAL	PO BOX 17250	INDIANAPOLIS	IN	46217	8883589484	
B20	FMH BENEFIT SERVICES, INC.	PO BOX 25946	OVERLAND PARK	KS	66225	8009909058	
B21	PIONEER HEALTH	PO BOX 6600	HOLYOKE	MA	01041	8004234586	
B22	SOUTHERN HEALTH SERVICES	PO BOX 7704	LONDON	KY	40742	8006274872	
B23	LINCOLN FINANCIAL GROUP	PO BOX 614008	ORLANDO	FL	32861	8004232765	
B24	EMBLEM HEALTH CARE CO.	PO BOX 3000	NEW YORK	NY	10116	2125014444	
B25	HEALTH AND WELFARE FUND LOCAL 218	PO BOX 115027	ATLANTA	GA	30310	4047555665	
B26	IMSCO HEALTH PLAN	PO BOX 697	BUCKEYSTOWN	MD	217170697	8009442833	IMSCO - INTERNATIONAL MANAGEMENT SERVICE CO.

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B27	HEALTH FIRST (PPO)	PO BOX 17709	GREENVILLE	SC	29606	8642893000	
B28	THE STANDARD	PO BOX 82622	LINCOLN	NE	68501	8005479515	
B29	PANAMERICAN BENEFIT SOLUTIONS	PO BOX 619008	DALLAS	TX	75261	8006949888	WAS US NOW INSURANCE GROUP
B30	SOUTHERN BENEFITS, SOUTHEASTERN PIPE TRADERS	PO BOX 1449	GOODLETTSVILLE	TN	370701449	8008314914	
B31	GREAT AMERICAN LIFE INS. CO (GALIC)	PO BOX 559002	AUSTIN	TX	787553010	8008802745	
B32	MAXCARE	PO BOX 18024	OKLAHOMA CITY	OK	73154	8002597765	
B33	PHARMAVAIL DRUG COMPANY	3380 TRICKHUM RD. BLDG 400, UNIT 100	WOODSTOCK	GA	30188	8009333734	
B34	ATLANTA LIFE INSURANCE COMPANY	100 AUBURN AVE., NE	ATLANTA	GA	30303	4046592100	
B35	PROCARE RX PBM	3090 PREMIERE PARKWAY, STE 100	DULUTH	GA	30097	8006993542	
B36	COMMONWEALTH INDEMITY PLAN	PO BOX 9016	ANDOVER	MA	01810	8004429033	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B37	BENEFIT ADMINISTRATORS	PO BOX 21308	COLUMBIA	SC	29221	8778400936	
B37DN	BENEFIT ADMINISTRATORS	PO BOX 1957	BEATTYVILLE	KY	41311	8003258424	
B38	MEDBEN	PO BOX 1009	NEWARK	OH	43058	8006868425	
B39	MEDICAL SAVINGS INSURANCE CO.	5835 WEST 74TH ST	INDIANAPOLIS	IN	462781758	3173298222	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B40	TOTAL CLAIMS SOLUTION (TCS)	PO BOX 10888	GREEN BAY	WI	543070888	8003760110	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B41	VYTRA HEALTHCARE	PO BOX 9091	MELVILLE	NY	11747	8668089399	
B42	UMR	PO BOX 266	ONALASKA	WI	546568764	8002368672	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B43	AFFINITY HEALTH PLAN	PO BOX 981726	EL PASO	TX	799981726	8662475678	
B44	AMERICAN CHOICE HEALTH PLAN, LLC	PO BOX 922043	HOUSTON	TX	77292	8006334226	
B44DN	AMERICAN CHOICE HEALTH PLAN, LLC	PO BOX 922009	HOUSTON	TX	77292	8005989799	
B45	ATLANTICARE	PO BOX 613	HAMMONTON	NJ	08037	8883282287	
B46	TOTAL CLAIMS SOLUTION (TCS)	PO BOX 10888	GREEN BAY	WI	54307	8003760110	
B47	PHARMACY DATA MANAGEMENT, INC	1170 E WESTERN RESERVE RD	POLAND	OH	44514	8007740890	
B48	SELECT HEALTH	PO BOX 30192	SALT LAKE CITY	UT	84123	8005385038	
B49	FALLON COMMUNITY HEALTH PLAN	PO BOX 15121	WORCHESTER	MA	01615	8008685200	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B50	MEMBER HEALTH	PO BOX 391180	CLEVELAND	OH	44139	8888685854	
B51	INNOVIANT	PO BOX 8082	WAUSAU	WI	54402	8775592955	
B52	SOUTHERN PLANNED ADMINISTRATORS	PO BOX 218180	HOUSTON	TX	77218	2818291033	
B53	NATIONAL FOUNDATION LIFE INSURANCE COMPANY	110 WEST 7TH ST. STE. 300	FORT WORTH	TX	76102	8002219039	
B54	NGS AMERICAN INC	PO BOX 7676	ST. CLAIR SHORES	MI	48080	8107797676	
B55	US SCRIPTS	2425 WEST SHAW AVE	FRESNO	CA	93711	8004608988	
B56	MEDSAVE USA	3035 LAKELAND HILLS BLVD	LAKELAND	FL	33805	8002263155	
B57	SOUTHERN FARM BUREAU LIFE INS. CO.	PO BOX 78	JACKSON	MS	39205	8004579611	
B58	AVMED HEALTH	PO BOX 569000	MIAMI	FL	332569000	8004528633	
B59	LDI INTEGRATED PHARMACY SERVICES	701 EMERSON RD. STE. 301	CREVE COEUR	MO	63141	8665163121	
B60	STATE MUTUAL LIFE ASSURANCE COMPANY OF AMERICA	1100 31ST ST.	DOWNERS GROVE	IL	60515	8003233359	CODE IN OPEN STATUS BY SCHA
B61	STOWE-PHARR MILLS	100 MAIN ST.	MCADENVILLE	NC	28101	7048243551	CODE IN OPEN STATUS BY SCHA
B62	COX HEALTH SYSTEMS INS. CO	PO BOX 5750	SPRINGFIELD	MO	658015750	8005613265	
B63	GE PENSIONER HEALTH BENEFITS	PO BOX 740801	ATLANTA	GA	303740801	8008488406	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B64	UNITED MEDICAL RESOURCES INC.	PO BOX 145804	CINCINNATI	OH	45214	5136193000	
B65	CHRISTIAN CARE MEDI SHARE	PO BOX 674	STERLING	IL	61081	8156258595	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B66	KIRKE-VAN ORSDEL, INC.	PO BOX 9126	DES MOINES	IA	503069126	8002472192	USE CODE 759 MEDIPLUS PER SCHA
B67	BENISTAR TRUST AKA MARSH AFFINITY GROUP SERVICES	PO BOX 10432	DES MOINES	IA	50306	8668109452	
B68	HUMANA GOLD CHOICE	PO BOX 202047	FLORENCE	SC	295022047	8775115000	THIS CODE INCORRECTLY ASSIGNED BY HOSP. ASSO. USE CODE 648 FOR THE MEDICARE ADVANTAGE PLAN 648
B69	AMERICAN INSURANCE ADMINISTRATORS	PO BOX 2348	COLUMBUS	OH	432162348	8009221245	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA.
B70	ELECTRICAL WELFARE TRUST FUND	4601 PRESIDENTS DR, #300	LANHAM	MD	20706	3017311050	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA.

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B71	CHCS SERVICES, INC.	PO BOX 12467	PENSACOLA	FL	325912457	8888031780	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B72	INTEGRITY NATIONAL LIFE INS.	PO BOX 32350	LOUISVILLE	KY	40232	5024261843	CODE ASSIGNED BY SCHA
B73	SOUTHERN CALIFORNIA PIPE TRADES TRUST FUND	501 SHATTO PLACE, 5TH FLOOR	LOS ANGELES	CA	90020	2133856161	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B74	STAR HRG	PO BOX 54150	PHOENIX	AZ	850784150	8002881474	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B75	HEALTH DESIGN PLUS	PO BOX 2584	HUDSON	OH	442362584	8008930777	
B76	INTERNATIONAL ASSO. BENEFITS	1747 PENNSYLVANIA AVE NORTH WEST	WASHINGTON	DC	20006	8002751171	
B77	UNITED HEALTHCARE PLAN ADMINISTRATORS	PO BOX 121212	MARIETTA	GA	300670092	8005627079	USE CODE 985 BENESIGHT
B78	ARKANSAS BEST CORP. CHOICE BENEFITS	PO BOX 10048	FT SMITH	AR	72917	4797856178	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B79	SHASTA ADMINISTRATIVE SERVICES	PO BOX 5735	CINCINNATI	OH	45201	5136291800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B80	IMB-SBC MEDICAL PLAN	PO BOX 1746	INDIANAPOLIS	IN	462061746		THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B81	HM BENEFITS ADMINISTRATORS, INC.	PO BOX 535078	PITTSBURGH	PA	152535078	8002792624	
B82	LIFEGUARD BENEFITS	PO BOX 93929	SOUTHLAKE	TX	76092	8664163617	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
B83	STATE OF LOUISIANA EMPLOYEES	PO BOX 44036	BATON ROUGE	LA	70804	8002728451	THIS CODE NOT REQUESTED BY MEDICAID. ASSSIGNED BY SCHA
B84	HEALTH CARE CORPORATION	203 JANDERS RD.	CARY	IL	60013		CODE IN OPEN STATUS BY SCHA
B85	TUFTS HEALTHCARE	PO BOX 9185	WATERTOWN	MA	02471	8004238080	
B86	PREFERRED ONE ADMINISTRATIVE SERVICES	PO BOX 59212	MINNEAPOLIS	MN	55459	8009971750	
B87	HEALTH ALLIANCE	PO BOX 6003	URBANA	IL	616036003	8003227451	
B88	GETTYSBURG HEALTH ADMINISTRATORS	PO BOX 1169	FREDERICK	MD	21702	8004974474	
B89	WESTERN & SOUTHERN FINANCIAL GROUP	PO BOX 5735	CINCINNATI	OH	45201	5136291800	
B90	WESTERN FIDELITY INSURANCE	PO BOX 901010	FORT WORTH	TX	76101	8174517200	
B91	CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST	1205 WINDHAM PARKWAY	ROMEOVILLE	IL	60446	8008070400	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
B92	CARE SOURCE	ONE SOUTH MAIN	DAYTON	OH	45402	8004880134	
B93	WESTERN STATES ADMINISTRATION	PO BOX 8082	FRESNO	CA	937478082	2092514891	CODE ASSIGNED BY SCHA
B94	THE CAPELLA GROUP	PO BOX 200368	ARLINGTON	TX	76006	8884113888	
B95	HDR EMPLOYEE BENEFITS ADMINISTRATORS	PO BOX 5150	GREENVILLE	SC	29606	8004765150	CODE IN OPEN STATUS BY SCHA
B96	PENN TREATY & AMERICAN NETWORK	PO BOX 130	PENSACOLA	FL	32591	8006357418	
B97	NIPPON LIFE INSURANCE CO.	PO BOX 25951	SHAWNEE MISSION	KS	662255951	8003741835	
B98	AMERICAN PIONEER LIFE INSURANCE COMPANY	PO BOX 130	PENSACOLA	FL	32591	8005381053	
B99	GROUP & PENSION ADMINISTRATORS, INC.	PO BOX 749075	DALLAS	TX	75374	8662063224	
C01	TERMINIX SERVICE	PO BOX 2627	COLUMBIA	SC	29202	8037721783	CODE ASSIGNED BY SCHA
C02	FOUNDATION BENEFITS ADMINISTRATORS	6300 BRIDGEPOINT PKWAY, BLDG 3 #400	AUSTIN	TX	78730	8883687910	
C03	TOTAL PLAN SERVICES, INC.	PO BOX 251369	PLANO	TX	75025	8009695238	
C04	MOTOR CITY WELFARE FUND	2075 W BIG BEAVER STE 700	TROY	MI	48084	2488227044	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C05	STRATEGIC OUTSOURCING, INC. (SOI)	PO BOX 241508	CHARLOTTE	NC	28224	8888367764	
C06	MISSIONARY MEDICAL	PO BOX 45730	SALT LAKE CITY	UT	84145	8007771647	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C07	AMERIBEN SOLUTIONS	PO BOX 7186	BOISE	ID	83707	8007867930	
C08	MEDICAL DEVELOPMENT INTERNATION	19450 DEERFIELD AVE. STE. 400	LANSTOWNE	VA	20176	8008416188	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C09	HEALTH PLAN ADMINISTRATORS	PO BOX 2638	ROCKFORD	IL	61132	8156335800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C10	ZAVATA	PO BOX 1208	AMERICUS	GA	31709	8008417735	WAS PARADIGM CARE PLAN
C11	BENEFIT MANAGEMENT SERVICES INC	PO BOX 1178	MATTHEWS	NC	28106	7048455608	
C11DN	BENEFIT MANAGEMENT SERVICES INC	PO BOX 1317	MATTHEWS	NC	28106	7048455608	
C12	BENICOMP, INC.	8310 CLINTON PARK DR	FT WAYNE	IN	46825	8008377400	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C13	CENTRAL RESERVE LIFE OF NORTH AMERICA INSURANCE CO	17800 ROYALTON RD.	STRONGSVILLE	OH	441365197	8003213997	
C14	COASTAL LUMBER CO	PO BOX 1576	WALTERBORO	SC	29488	8435382876	CODE IN OPEN STATUS BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C15	ADVANCE PCS	PO BOX 52188	PHOENIX	AZ	850722196	4803914600	SEE CARRIER 471
C16	CONSOLIDATED BENEFITS, INC	PO BOX 23686	COLUMBIA	SC	29224	8037365088	
C17	NATIONAL BENEFITS	110 GIBRALTAR RD.	HORSHAM	PA	19044	2154430404	
C18	EVOLUTIONS HEALTHCARE SYSTEMS	PO BOX 5001	NEW PORT RICHEY,	FL	34656	8008814474	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C19	TAYLOR BENEFIT RESOURCES, INC.	PO BOX 6580	THOMASVILLE	GA	31758	8883525246	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C20	SCREEN ACTORS GUILD-PRODUCERS HEALTH PLAN	PO BOX 7830	BURBANK	CA	915107830	8007774013	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C22	BOSTON MUTUAL LIFE INSURANCE COMPANY	120 ROYALL ST.	CANTON	MA	02021	6178287000	
C23							
C24	ENCOMPASS HEALTH MANAGMENT SYSTEM	6000 WEST TOWN PARKWAY STE 350	DES MOINES	IA	50266	8005113389	
C25	MEDICAL CLAIMS SERVICES	1 WALL ST. STE 2A	RAVENSWOOD	WV	26164	8882250522	
C26	INTERACTIVE MEDICAL SYSTEMS, INC.	PO BOX 19108	RALEIGH	NC	27619	9198468400	
C27	SELECT BENEFIT ADMINISTRATORS	PO BOX 440	ASHLAND	WI	54806	8004973699	
C27DN	SELECT BENEFIT ADMINISTRATORS	PO BOX 440	ASHLAND	WI	54806	8004973699	
C28	BENEFIT PLAN MANAGEMENT	PO BOX 536	ROCKLYN	MA	02370	8776427500	
C29	TRUE CHOICE USA	PO BOX 251369	PLANO	TX	75025	8002519665	THIS CODE NOT REQUESTED BY MEDCAID. ASSIGNED BY SCHA
C30	KEENAN AND COMPANY	PO BOX 11431	TORRANCE	CA	90510	8006533626	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C31	CONSUMER HEALTH SOLUTIONS	PO BOX 3492	SPARTANBURG	SC	29304	8645739541	THE CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C32	WELL FARGO INSURANCE	PO BOX 2801	CHARLESTON	WV	253302801	8004354351	
C32DN	WELLS FARGO	PO BOX 11064	CHARLESTON	WV	253321064	8004354351	
C33	THE DESTINY HEALTH PLAN	PO BOX 4628	OAKBROOK	IL	60522	8668269345	
C34	HTH WORLDWIDE INSURANCE SERVICES	PO BOX 39	MINNEAPOLIS	MN	554400039	8665108780	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C35	MUTUAL PROTECTIVE MEDICO LIFE INSURANCE COMPANIES	1515 S 75TH ST.	OMAHA	NE	68124	8002286080	SEE CODE C99

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C36	NORTH AMERICAN INSURANCE COMPANY	PO BOX 44160	MADISON	WI	53744	6086621232	
C37	OLD SURETY LIFE INSURANCE CO	PO BOX 54407	OKLAHOMA CITY	OK	731541407	8002725466	
C38	STANDARD LIFE & ACCIDENT INSURANCE COMPANY	PO BOX 1800	GALVESTON	TX	775531800	8883501488	
C39	CONTINENTAL GENERAL INSURANCE COMPANY	PO BOX 247007	OMAHA	NE	681247007	4023973200	
C40	AVERA HEALTH PLANS	PO BOX 381506	BIRMINGHAM	AL	35238	8883222115	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C41	INSUREX BENEFITS ADMINISTRATORS, INC.	PO BOX 41779	MEMPHIS	TN	381741799	9017256435	
C41DN	INSUREX BENEFITS ADMINISTRATORS, INC.	PO BOX 41779	MEMPHIS	TN	381741799	9017256435	
C42	STANDARD CORPORATION	1400 MAIN ST. STE 1300	COLUMBIA	SC	29201	8037716785	
C43	EMPLOYEE BENEFIT ADMINISTRATORS	PO BOX 5150	GREENVILLE	SC	29606	8642356474	
C44	S C MEDICAL ASSOCIATION-MEMBERS INSURANCE TRUST	PO BOX 11188	COLUMBIA	SC	29211	8037986207	
C45	TALL TREE ADMINISTRATORS	PO BOX 71747	SALT LAKE CITY	UT	841710747	8774534201	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C46	MEDCO HEALTH SOLUTIONS	PO BOX 14713	LEXINGTON	KY	40512	8002727243	AS OF 8/1/02 MERCK-MEDCO AND THEIR SUBSIDIARY PAID PRESCRIPTIONS IS NOW MEDCO HEALTH.
C47	KANAWHA BENEFIT SERVICES	PO BOX 50098	KNOXVILLE	TN	379500098	8008221274	
C47DN	KANAWHA BENEFIT SERVICES	PO BOX 50098	KNOXVILLE	TN	379500098	8008221274	
C48	SOUTHERN ADMINISTRATIVE SERVICES	PO BOX 8069	COLUMBUS	GA	31908	8004268803	
C49	PENN WESTERN BENEFITS, INC	PO BOX 7834	GREENSBORO	NC	27417	3366659400	
C49DN	PENN WESTERN BENEFITS, INC	PO BOX 7834	GREENSBORO	NC	27417	3366659400	
C50	TENNESSEE BENEFIT ADMINISTATORS	PO BOX 3257	SPARTANBURG	SC	29304	901-685-89	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C51	YALE HEALTH PLAN	PO BOX 208217	NEW HAVEN	CT	065208217	2034320250	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C52	TPA OF GEORGIA	4574 LAWRENCEVILLE HWY, STE 201	LILBURN	GA	30047	7704517550	
C53	-	-	-	-	-	-	NOT ASSIGNED

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C54	INTER-AMERICAS INS. CORP. (OOIDA)	PO BOX 9510	WICHITA	KS	672770510		THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C55	PLAN ADMINISTRATORS (MATURE AMERICAN)	734 15TH ST. NW STE. 500	WASHINGTON	DC	20005	2023936600	
C56	COMPDENT	1930 BISHOP LANE SUIT 132	LOUISVILLE	KY	40218	8006331262	
C57	WORLD TRAVEL PROTECTION	4600 WITMER INDUSTRIAL ESTATES #2	NIAGARA FALLS	NY	14305	8004564553	THIS CODE NOT REQUESTED BY MEDCAID. ASSIGNED BY SCHA
C59	HUMANA CHOICE (PPO)	P.O .BOX 14605	LEXINGTON	KY	405784602	8004574708	MEDICARE ADVANTAGE PLAN
C60	INSTILL HEALTH SYSTEMS (FFS)	PO BOX 7061	CAMDEN	SC	290207845	8774467845	MEDICARE ADVANTAGE PLAN
C61	INSTILL HEALTH SYSTEMS (PPO)	PO BOX 7061	CAMDEN	SC	290207845	8774467845	MEDICARE ADVANTAGE PLAN
C62	BCBS OF SC MEDICARE BLUE PRIVATE (PFFS)	PO BOX 100133	COLUMBIA	SC	29202	8006053256	MEDICARE ADVANTAGE PLAN
C63	BCBS OF SC MEDICARE BLUE&MEDICARE BLUE PLUS (PPO)	PO BOX 100133	COLUMBIA	SC	29202	8006053256	MEDICARE ADVANTAGE PLAN
C64	BLUE CHOICE HEALTH PLAN (PPO)	PO BOX 6170	COLUMBIA	SC	29260	8772753256	MEDICARE ADVANTAGE (PPO)
C65	-	-	-	-	-	-	NOT ASSIGNED
C66	CATERPILLAR, INC.	PO BOX 62920	COLORADO SPRINGS	CO	809622920	3094942363	
C67					-----		
C68	DENTAL BENEFIT PROVIDERS	PO BOX 389	ROCKVILLE	MD	20848	8004459090	
C69							
C71	JOHNS HOPKINS HEALTHCARE	6704 CURTIS CT.	GLEN BURNIE	MD	21060	8002612393	
C72	ADVANCED INSURANCE ADMINISTRATION	125 MERRILL DR. STE. 2000	LITTLE ROCK	AR	72211	8882424800	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C73	UNION PACIFIC RAILROAD EMPLOYEES HEALTH	795 NORTH 400 WEST	SALT LAKE	UT	84103	8005470421	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C74	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 981610	EL PASO	TX	799981610	7043643865	
C74DN	NATIONAL CLAIMS ADMINISTRATIVE SERVICES	PO BOX 220887	CHARLOTTE	NC	28222	7043643865	
C75	FLORIDA 1ST SERVICE ADMINISTRATORS, INC.	PO BOX 3607	WINTER HAVEN	FL	338853067	8002263155	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C76	SELF FUNDING ADMINISTRATORS	PO BOX 6596	ANNAPOLIS	MD	21401	8004248622	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
C77	CARPENTERS HOSPITALIZATION PLAN	3611 CHESTER AVE	CLEVELAND	OH	44114	8004213959	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C78	KAISER PERMANENTE	PO BOX 190849	ATLANTA	GA	31119	4042612590	
C79	BENEFIT ADMINISTRATIVE SYSTEM, LTD	PO BOX 17475 JOVANNA DR. STE. 1B	HOMEWOOD	IL	60430	7087997400	
C80	ELDER HEALTH (MHN/HMC)	PO BOX 4433	BALTIMORE	MD	21223	8887768851	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C81	UNITED PAYORS & UNITED PROVIDERS	2273 RESEARCH BLVD	ROCKVILLE	MD	20850	8002474144	
C82	AMERICAN STANDARD LIFE & ACCIDENT INS. CO.	P O DRAWER 3248, 224 NORTH INDEPENDENT	ENID	OK	73701	4052334000	CODE IN OPEN STATUS BY SCHA
C83	FREEDOM LIFE INSURANCE CO. OF AMERICA	PO BOX 24294	LOUISVILLE	KY	40224	8005281057	
C84	CENTRAL UNITED & CHRISTIAN MUTUAL LIFE INS. CO.	2727 ALLEN PARKWAY	HOUSTON	TX	770192115	7135290045	
C85	LOYAL AMERICAN LIFE INSURANCE COMPANY	PO BOX 559004	AUSTIN	TX	78755	8006336752	
C86	NATIONAL STATES INSURANCE COMPANY	PO BOX 27321, 1830 CRAIG PARK CT.	ST LOUIS	MO	63141	3148780101	
C87	SIHO INSURANCE SERVICES	PO BOX 1787	COLUMBUS	IN	47202	8008732022	
C88	ADVENTIST RISK MANAGEMENT	PO BOX 1928	GRAPEVINE	TX	76099	8006380589	
C89	NEW SOURCES BENEFITS	PO BOX 6305	SPARTANBURG	SC	29304	8004761555	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
C92	AMERICAN HEALTH CARE	2217 PLAZA DR STE. 100	ROCKLIN	CA	95765	8008728276	
C92DN	AMERICAN HEALTH CARE	3001 DOUGLAS ST	ROSEVILLE	CA	95661	8008728276	
C93	STUDENT ASSURANCE INSURANCE SERVICES	PO BOX 196	STILL WATER	MN	55085	8003282739	
C94	ERIN GROUP ADMINISTRATORS	PO BOX 7777	LANCASTER	PA	17604	8004333746	ANOTHER PHONE NUMBER 717-581-1300
C94DN	ERIN GROUP ADMINISTRATORS	PO BOX 7777	LANCASTER	PA	17604	8004333746	ANOTHER PHONE NUMBER 717-581-1300
C95	MIDWEST SECURITY	2700 MIDWEST DR	ONALASKA	WI	54650	8002368672	
C96	MEDTRACK SERVICES	6310 LAMAR AVE. STE 230	OVERLAND PARK	KS	66202	8007714648	
C97	GEM GROUP	1200 THREE GATEWAY CENTER	PITTSBURGH	PA	15222	8002428923	
C98	MEDICAL BENEFIT ADM. OF MARYLAND, INC.	P.O .BOX 950	FORREST HILL	MA	60631	8885323467	
C99	MUTUAL PROTECTIVE MEDICO LIFE INS. CO.	1515 S. 75TH ST	OMAHA	NE	68124	8002286080	CARRIER WAS PREVIOUSLY C35.
CAS	CASUALTY CASE	-	-	-	-		

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
CO5	-	-	-	-	-	-	NOT ASSIGNED
CO9	EMPLOYEE BENEFITS TRUST	PO BOX 1431	WICHITA FALLS	TX	76307	8177617611	CODE ASSIGNED WITH LETTER O INSTEAD OF NUMERIC ZERO.
D01	INTERLINK HEALTH SERVICES	4950 NE BELNAP CT #205	HILLSBORO	OR	97124	5036402000	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D02	INSURANCE ADMINISTRATOR OF AMERICA	PO BOX 5082	MT. LAUREL	NJ	08054	8009896739	
D03	PACIFIC SOURCE	PO BOX 7068	EUGENE	OR	97401	8006246052	
D04	LBA HEALTH PLANS, INC./PRIMARY SELECT	PO BOX 17098	OWINGS MILL	MD	211177098	8008158240	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D05	UPMC HEALTH BENEFITS, INC.	PO BOX 2999	PITTSBURGH	PA	15230	8773813764	MEDICARE ADVANTAGE PLAN
D06	SOUTHERN CALIFORNIA BAKERY & CONFECTIONARY	PO BOX 22041	COMMERCE	CA	90022	3237227171	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D08	BIG LOTS ASSOCIATE BENEFIT PLAN	PO BOX 9071	DUBLIN	OH	430170971	8772542363	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D09	JM FAMILY ENTERPRISES	8019 BAYBERRY RD	JACKSONVILLE	FL	32256	8008920059	THIS CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D10	SEVEN CORNERS INC	PO BOX 3430	CARMEL	IN	46082	8666994186	
D11	ADVANCED BENEFIT SOLUTIONS	PO BOX 71490	PHOENIX	AZ	85050	8884191094	CODE NOT REQUESTED BY MEDICAID ASSIGNED BY SCHA MEDICARE SUPPLEMENTAL PLAN
D12	SECUREHORIZONS DIRECT PFFS	PO BOX 12466	PENSACOLA	FL	325912466	8882024340	MEDICARE ADVANTAGE PLAN
D13	ARCADIAN	PO BOX 4946	COVINA	CA	91723	8007756490	CODE ORIGINALLY ASSIGNED AS MA IN ERROR USE CODE 816 FOR MA PLAN
D14	MEDICARE PLUS BLUE (BCBS OF MICHIGAN)	27000 ELEVEN MILE RD	SOUTHFIELD	MI	48034	8002495103	MEDICARE ADVANTAGE PLAN
D15	SECURITYCHOICE ENHANCED PLUS	PO BOX 795180	SAN ANTONIO	TX	78279	8884458916	MEDICARE ADVANTAGE PLAN
D16	AETNA MEDICARE OPEN PLAN	PO BOX 14079	LEXINGTON	KY	405124079	8006240756	MEDICARE ADVANTAGE PLAN

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D17	WELLCARE	PO BOX 795184	SAN ANTONIO	TX	78279	8662352770	MEDICARE ADVANTAGE PLAN
D18	COMMUNITY CARE SENIOR HEALTH PLAN	PO BOX 3249	TULSA	OK	741013249	8006428065	MEDICARE ADVANTAGE PLAN
D19	HEALTHFIRST 65 PLUS	PO BOX 5196	NEW YORK	NY	10274	8882601010	MEDICARE ADVANTAGE PLAN
D20	EXCELLUS MEDICARE BLUE CHOICE OPTIMUM	PO BOX 41915	ROCHESTER	NY	14604	8778839577	MEDICARE ADVANTAGE PLAN
D21	CARITEN SENIOR HEALTH	PO BOX 22885	KNOXVILLE	TN	37933	8656707790	MEDICARE ADVANTAGE PLAN
D22	SMART VALUE (BC OF GA) (PFFS)	PO BOX 3897	SCRANTON	PA	18505	8668659329	MEDICARE ADVANTAGE PLAN
D23	AMERICA'S HEALTH CHOICE MEDICAL PLANS,(HMO)	762 SOUTH US HWY. ONE PMB 224	VERO BEACH	FL	32962	8003089823	MEDICARE ADVANTAGE PLAN
D24	MOUNT CARMEL HEALTH PLAN (MCHP) MEDIGOLD (HMO)	PO BOX 6111	WESTERVILLE	OH	43086	8002403870	
D25	ELDER PLAN, INC. (HMO)	PO BOX 199100	BROOKLYN	NY	11219	7189218818	MEDICARE ADVANTAGE
D26	OXFORD MEDICARE ADVANTAGE (HMO)	PO BOX 7082	BRIDGEPORT	CT	06601	8002341228	MEDICARE ADVANTAGE PLAN
D27	SECURE HORIZONS PACIFICARE	PO BOX 25032	SANTA ANA	CA	927995032	7148253828	MEDICARE ADVANTAGE PLAN
D28	PYRAMID LIFE INSURANCE CO (PFFS)	PO BOX 958465	LAKE MARY	FL	327958465	4076281776	MEDICARE ADVANTAGE PLAN
D29	UNICARE LIFE & HEALTH INS. CO (PFFS)	233 S WACKER DR. STE. 3900	CHICAGO	IL	68606	3123247000	MEDICARE ADVANTAGE PLAN
D30	UNITED HEALTHCARE INS. CO (PPO)	PO BOX 150450	HARTFORD	CT	061150450	8607025000	MEDICARE ADVANTAGE PLAN
D31	LEON MEDICAL CENTER HEALTH PLAN	PO BOX 65-9006	MIAMI	FL	33265	3055595366	MEDICARE ADVANTAGE PLAN
D32	MEDICARE COMPLETE (UNITED HEALTH CARE)	PO BOX 659735	SAN ANTONIO	TX	782659735	8778423210	MEDICARE ADVANTAGE PLAN
D33	ADVANTRA FREEDOM	PO BOX 7154	LONDON	KY	407427154	8007135095	MEDICARE ADVANTAGE PLAN
D34	UNIVERSAL HEALTH CARE	PO BOX 3211	ST PETERSBURG	FL	33731	8666904842	MEDICARE ADVANTAGE PLAN
D36	HOP/PSERS HEALTH ADMINISTRATION UNIT	PO BOX 2921	CLINTON	IA	52733	8007737725	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D37	WEST VIRGINIA LOCAL 152 HEALTH & WELFARE	5 HOT METAL ST. STE. 200	PITTSBURGH	PA	15203	8668258152	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D38	AMERICAN INSURANCE ADMINISTRATORS	PO BOX 2348	COLUMBUS	OH	43216	8009221245	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D39	NEW YORK WELFARE FUND	101-49 WOOKHAVEN BLVD	OZONE PARK	NY	11416	7188455800	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D40	MINNESOTA POWER HEALTH PLANS	30 W SUPERIOR ST	DULUTH	MN	55802	8888128800	CODE NOT REQUESTED BY MEDICAID. ASSIGNED BY SCHA
D41	BLUEGRASS FAMILY HEALTH	PO BOX 22738	LEXINGTON	KY	40522	8007872680	
D42	CARE IMPROVEMENT PLUS	PO BOX 4347	SCRANTON	PA	18505	8666862506	MEDICARE ADVANTAGE PLAN
D43	SOUTHEAST COMMUNITY CARE BY ARCADIAN HEALTH	PO BOX 4946	COVINA	CA	91723	8005738597	MEDICARE ADVANTAGE PLAN
D44	INDEPENDENT HEALTH	PO BOX 9066	BUFFALO	NY	14231	8666178585	MEDICARE ADVANTAGE PLAN
D45	HIGHMARK SECURITY BLUE	120 5TH AVE	PITTSBURGH	PA	15222309	8005473627	MEDICARE ADVANTAGE PLAN
D46	GROUPHEALTH OPTIONS, INC	PO BOX 34585	SEATTLE	WA	98124	8887674670	MEDICARE ADVANTAGE PLAN
D47	TOUCHSTONE HEALTH PSO	PO BOX 33519	INDIANAPOLIS	IN	462030519	8887770204	MEDICARE ADVANTAGE PLAN
D48	AMERICAN CONTINENTAL INSURANCE CO	PO BOX 2368	BRENTWOOD	TN	37024	6153371300	MEDICARE ADVANTAGE PLAN
D51	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	8006004441	MEDICAID HMO
D52	WELLCARE OF GEORGIA	PO BOX 31224	TAMPA	FL	33531	8662311821	MEDICARE ADVANTAGE PLAN
D53	SIERRA OPTIMA PLUS CLAIMS	PO BOX 15645	LAS VEGAS	NV	891145645	8882742207	MEDICARE ADVANTAGE PLAN
D54	GATEWAY HEALTH PLAN MEDICARE ASSURED	PO BOX 11560	ALBANY	NY	122110655	8006855209	MEDICARE ADVANTAGE PLAN
D55	TOTAL CAROLINA CARE, INC	1441 MAIN ST	COLUMBIA	SC	29210	8664336031	MEDICAID HMO
D56	CITRUS HEALTH CARE, INC.	PO BOX 20547	TAMPA	FL	33622	8667691157	MEDICARE ADVANTAGE PLAN
D57	CIGNA MEDICARE ACCESS	PO BOX 22174	TEMPE	AZ	852852174	8005779410	MEDICARE ADVANTAGE PLAN
D58	BRAVO HEALTH MEDICARE ADVANTAGE	P.O, BOX 4433	BALTIMORE	MD	21223	8005561570	MEDICARE ADVANTAGE PLAN
D60	AMERIGROUP COMMUNITY CARE OF SC	PO BOX 31789	VIRGINIA BEACH	VA	234661789	8006004441	CODE ASSIGNED BY SCHA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
D61	AMERICA'S 1ST CHOICE	PO BOX 210769	COLUMBIA	SC	29210	8663213947	MEDICARE ADVANTAGE PLAN
D62	SECURE HORIZONS DIRECT (UNITED HEALTHCARE)	PO BOX 31353	SALT LAKE CITY	UT	84131	8665798774	MEDICARE ADVANTAGE PLAN
D63	UNIVERA SENIOR CHOICE SECURE	PO BOX 23000	ROCHESTER	NY	15692	8006171114	MEDICARE ADVANTAGE PLAN
D64	EMPIRE HEALTHCHOICE ASSURANCE, INC.	PO BOX 100300 CLAIMS PROCESSING	COLUMBIA	SC	29204	8037888562	MEDICARE ADVANTAGE PLAN
D65	ANTHEM SENIOR ADVANTAGE	PO BOX 37690	LOUISVILLE	KY	402337180	8882909160	MEDICARE ADVANTAGE PLAN
D66	CHCCARES OF SOUTH CAROLINA	140 STONE RIDGE DR	COLUMBIA	SC	29210	8668022474	MEDICAID HMO
D67	BLUE CROSS OF FLORIDA HEALTH OPTIONS	PO BOX 1798	JACKSONVILLE	FL	32231	8773522583	MEDICARE ADVANTAGE PLAN
D69	TOTAL CARE/HEALTHSPRING	PO BOX 20000	NASHVILLE	TN	372024070	8007437141	MEDICARE ADVANTAGE PLAN
D71	KEYSTONE 65	PO BOX 7799	PHILADELPHIA	PA	191017799	8002273116	MEDICARE ADVANTAGE PLAN
D74	DART MANAGEMENT CORP	PO BOX 318	MASON	MI	488540318	8002480457	
D75	WINDSOR MEDICARE EXTRA	PO BOX 269025	PLANTO	TX	750269025	8662705223	MEDICARE ADVANTAGE PLAN
D94	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	8006004441	MEDICAID HMO
D99	MEDICARE ADVANTAGE						MEDICARE ADVANTAGE PLAN GENERIC CODE
E12	CAROLINA CRESCENT	1201 MAIN ST. STE 970	COLUMBIA	SC	29201	8032516630	HEALTHY KIDS CONNECTION
E37	SELECT HEALTH	PO BOX 7120	LONDON	KY	40742	8882762020	HEALTHY KIDS CONNECTION
E38	UNISON HEALTH PLAN	250 BERRYHILL RD	COLUMBIA	SC	29210	8037985852	HEALTHY KIDS CONNECTION
E51	AMERIGROUP COMMUNITY CARE	PO BOX 61010	VIRGINIA BEACH	VA	234661010	8006004441	
E55	TOTAL CAROLINA CARE INC.	1441 MAIN ST	COLUMBIA	SC	29210	8664336041	
E66	CHCCARE OF SOUTH CAROLINA	140 STONE RIDGE DR	COLUMBIA	SC	29210	8668022474	
X01	BLUE CROSS & BLUE SHIELD OF MARYLAND, INC.	PO BOX 14115	LEXINGTON	KY	405124115	8005244555	
X0A	BLUE CROSS OF GEORGIA/COLUMBUS INC	PO BOX 9907	COLUMBUS	GA	319089907	8004412273	POLICIES SHOULD BE ADDED WITH XOB. BCBS OF GA

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X0ARX	BLUE CROSS OF GEORGIA/COLUMBUS INC	PO BOX 9907	COLUMBUS	GA	319089907	8004412273	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
X0B	BLUE CROSS & BLUE SHIELD OF GEORGIA/ATLANTA INC	PO BOX 9907	COLUMBUS	GA	319086007	4048428000	FOR GEORGIA STATE EMPLOYEES USE CARRIER 419 GEORGIA STATE HEALTH BENEFIT PLAN
X0BDN	BCBS OF GEORGIA DENTAL	PO BOX 9201	OXNARD	CA	930319201	4048428000	
X0C	BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA	PO BOX 35	DURHAM	NC	27702	8002144844	
X0CDN	BLUE CROSS & BLUE SHIELD OF NORTH CAROLINA	PO BOX 2100	WINSTON SALEM	NC	271022100	9194897431	
X0D	BLUE CROSS AND BLUE SHIELD OF FLORIDA	PO BOX 1798	JACKSONVILLE	FL	322310014	8007272227	
X0E	EMPIRE BLUE CROSS AND BLUE SHIELD	PO BOX 1407 CHURCH ST. STATION	NEW YORK	NY	10008	8003429816	
X0F	BLUE CROSS & BLUE SHIELD OF VIRGINIA	PO BOX 27401	RICHMOND	VA	23279	8009916061	
X0G							
X0H	BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN	PO BOX 2025	MILWAUKEE	WI	53201	4142246100	
X0I	BLUE CROSS & BLUE SHIELD OF MARYLAND, INC.	PO BOX 9836	BALTIMORE	MD	21204	8005244555	USE CARRIER X01
X0J	PENNSYLVANIA BLUE SHIELD	PO BOX 890089	CAMP HILL	PA	17089	8006373493	
X0K	REGENCE BLUE CROSS BLUE SHIELD OF OREGON	PO BOX 1271	PORTLAND	OR	97207	5032255221	
X0KRS	REGENCE BCBS OF OREGON	PO BOX 12625 MAILSTOP S4P	SALEM OREGON	OR	97309	8884371508	RX PLAN ONLY MM CODE X0K
X0KRX	REGENCE BCBS OF OREGON	P.O .BOX 12625 MAILSTOP S4P	SALEM	OR	97309	8884371508	RX PLAN ONLY X0K IS MM PLAN
X0L	BLUE CROSS & BLUE SHIELD OF DELAWARE INC	PO BOX 1991	WILMINGTON	DE	19899	3024210260	
X0M	BLUE CROSS OF MASSACHUSETTS INC	PO BOX 986020	BOSTON	MA	022986020	8002535210	
X0MDN	BCBS OF MASSACHUSETTS	PO BOX 986005	BOSTON	MA	02298	800253521-	DENTAL ONLY
X0N	BLUE CROSS AND BLUE SHIELD OF TEXAS	PO BOX 660044	DALLAS	TX	752660044	8004510287	
X0NDN	BLUE CROSS AND BLUE SHIELD OF TEXAS	PO BOX 660247	DALLAS	TX	75266	8004947218	
X0O	BLUE CROSS AND BLUE SHIELD OF ALABAMA	PO BOX 2294	BIRMINGHAM	AL	35298	8005176425	DO NOT USE FOR MEDICARE.THIS CODE IS ONLY USED FOR HEALTH RELATED COVERAGE.
X0ODN	BLUE CROSS AND BLUE SHIELD OF ALABAMA	PO BOX 995	BIRMINGHAM	AL	35298	8005176425	
X0P	BLUE CROSS & BLUE SHIELD OF TENNESSEE	1 CAMERON HILL CIRCLE	CHATTANOOGA	TN	374020002	8004689736	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X0PDN	BLUE CROSS & BLUE SHIELD OF TENNESSEE	1 CAMERON HILL CIRCLE STE. 0002	CHATTANOOGA	TN	374020002	8005659140	
X0Q	BLUE CROSS & BLUE SHIELD OF MICHIGAN	600 LAFAYETTE EAST	DETROIT	MI	482262998	8004820898	
X0QDN	BLUE CROSS & BLUE SHIELD OF MICHIGAN	PO BOX 49	DETROIT	MI	48231	8888268152	
X0R	MEDICAL MUTUAL OF OHIO	2060 EAST 9TH ST.	CLEVELAND	OH	441151355	2166877000	
X0S	BLUE CROSS & BLUE SHIELD OF NEW JERSEY, INC.	PO BOX 1938	NEWARK	NJ	07102	8003552583	AKA HORIZON BCBS OF NEW JERSEY
X0SDN	BLUE CROSS & BLUE SHIELD OF NEW JERSEY, INC.	PO BOX 420	NEWARK	NJ	07102	8003552583	AKA HORIZON BCBS OF NEW JERSEY
X0T	BLUE CROSS OF ILLINOIS	PO BOX 805107	CHICAGO	IL	60680	8006348644	
X0TDN	BLUE CROSS OF ILLINOIS	PO BOX 23059	BELLEVILLE	IL	62223	8668260914	
X0U	BLUE CROSS & BLUE SHIELD OF KENTUCKY INC	9901 LINN STATION RD.	LOUISVILLE	KY	40223	5024232011	
X0V	BLUE SHIELD OF NORTHEASTERN NEW YORK	PO BOX 15013	ALBANY	NY	12212	5184534600	
X0W	BLUE CROSS OF CALIFORNIA	PO BOX 60007	LOS ANGELES	CA	90060	8888878969	
X0X	CENTRAL BENEFITS MUTUAL INSURANCE COMPANY	PO BOX 16526	COLUMBUS	OH	43216	6144645870	
X0Y	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 105187	ATLANTA	GA	30348	8006224822	
X0YDN	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 659444	SAN ANTONIO	TX	78265	8006224822	
X0YRX	ANTHEM BLUE CROSS AND BLUE SHIELD	PO BOX 37010	LOUISVILLE	KY	40233	8006224822	
X0Z	BLUE CROSS & BLUE SHIELD OF MISSISSIPPI INC	PO BOX 1043	JACKSON	MS	39208	6019323800	
X1A	BLUE CROSS BLUE SHIELD OF NEW MEXICO	PO BOX 27630	ALBUQUERQUE	NM	87125	8007113795	
X1D	BLUE CROSS /BLUE SHIELD OF NATIONAL CAPITAL AREA	550 12TH ST. SW	WASHINGTON	DC	20024	2024798000	
X1E	BLUE CROSS OF PUERTO RICO	PO BOX 366068	SAN JUAN	PR	009366068	8097599898	
X1F	BLUE CROSS & BLUE SHIELD OF RHODE ISLAND	500 EXCHANGE ST.	PROVIDENCE	RI	02903	4018317300	
X1G	INDEPENDENCE BLUE CROSS	PO BOX 69352	HARRISBURG	PA	171069352	8002752583	
X1H	BLUE CROSS & BLUE SHIELD OF CONNECTICUT INC	PO BOX 504	NEW HAVEN	CT	06473	2032394961	
X1I	ARKANSAS BLUE CROSS AND BLUE SHIELD, INC	PO BOX 2181	LITTLE ROCK	AR	72203	5013782010	
X1J	BLUE CROSS & BLUE SHIELD OF WESTERN NEW YORK, INC.	PO BOX 80	BUFFALO	NY	142400080	8008880757	
X1K	BLUE CROSS & BLUE SHIELD OF MEMPHIS	85 NORTH DANNY THOMAS BLVD	MEMPHIS	TN	38103	9015293111	
X1L	BLUE CROSS & BLUE SHIELD OF LOUISIANA	PO BOX 98029	BATON ROUGE	LA	708989029	5042915370	
X1M	BLUE CROSS & BLUE SHIELD OF KANSAS	1133 SOUTHWEST TOPEKA BLVD.	TOPEKA	KS	66629	7852914180	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X1N	MEDICAL SERVICE CORPORATION OF EASTERN WASHINGTON	PO BOX 3048	SPOKANE	WA	99220	5095364900	
X1O	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 5023	SIOUX FALLS	SD	57104	5152454500	USE CARRIER CODE X2A
X1P	BLUE CROSS & BLUE SHIELD OF MINNESOTA	PO BOX 64338	ST PAUL	MN	55164	8003822000	
X1Q	BLUE CROSS & BLUE SHIELD OF MAINE	2 GANNETT DR.	SOUTH PORTLAND	ME	041066911	2077751550	
X1R	HIGHMARK BLUE CROSS BLUE SHIELD	PO BOX 535053	PITTSBURGH	PA	152535053	4125447000	
X1S	COMMUNITY MUTUAL INSURANCE COMPANY	1351 WILLIAM HOWARD TAFT RD.	CINCINNATI	OH	45206	5132821016	CODE IN OPEN STATUS BY SCHA
X1T	-	-	-	-	-	-	NOT ASSIGNED
X1U	BLUE CROSS & BLUE SHIELD OF NEBRASKA	PO BOX 3248, MAIN PO BOXSTATION	OMAHA	NE	681800001	4023901820	
X1V	BLUE CROSS & BLUE SHIELD OF COLORADO	700 BROADWAY	DENVER	CO	80273	3038312131	
X1W	BLUE CROSS & BLUE SHIELD OF UTAH	PO BOX 30270	SALT LAKE CITY	UT	841300270	8013332100	
X1X	BLUE CROSS OF OHIO	PO BOX 956	TOLEDO	OH	43696	8003621279	
X1Y	BLUE SHIELD OF CALIFORNIA	PO BOX 272540	CHICO	CA	959272590	8882351765	
X1YDN	BLUE SHEILD OF CALIFORNIA	PO BOX 272590	CHICO	CA	959272590	8887024171	
X1Z	-	-	-	-	-	-	NOT ASSIGNED
X20	-	-	-	-	-	-	NOT ASSIGNED
X21	-	-	-	-	-	-	NOT ASSIGNED
X25	-	-	-	-	-	-	NOT ASSIGNED
X2A	WELLMARK BLUE CROSS BLUE SHIELD OF IOWA	PO BOX 5023	SIOUX FALLS	SD	571175023	8005268995	
X2B	BLUE CROSS & BLUE SHIELD OF KANSAS CITY	PO BOX 419169	KANSAS CITY	MO	641416169	8008926048	
X2C	-	-	-	-	-	-	NOT ASSIGNED
X2D	-	-	-	-	-	-	NOT ASSIGNED
X2E	-	-	-	-	-	-	NOT ASSIGNED
X2F	BLUE CROSS AND BLUE SHIELD OF THE ROCHESTER AREA	PO BOX 22999	ROCHESTER	NY	14692	7163253630	
X2G	BLUE CROSS & BLUE SHIELD CENTRAL NEW YORK, INC.	PO BOX 4809	SYRACUSE	NY	132214809	3154483801	
X2H	BLUE CROSS & BLUE SHIELD OF UTICA-WATERTOWN, INC.	12 RHOADS DR., UTICA BUSINESS DISTRICT	UTICA	NY	13501	3157984238	
X2I	-	-	-	-	-	-	NOT ASSIGNED
X2J	BLUE CROSS & BLUE SHIELD OF NORTH DAKOTA	4510 13TH AVE. SW	FARGO	ND	581210001	8003682312	
X2K	CAPITAL BLUE CROSS	PO BOX 779503	HARRISBURG	PA	171779503	8009622242	
X2L	BLUE CROSS OF NORTHEASTERN PENNSYLVANIA	70 NORTH MAIN ST.	WILKES-BARRE	PA	18711	8008298599	

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

CARR	TPL NAME	ADDRESS LINE	CITY	ST	ZIP	PHONE NUM	CARRIER COMMENT
X2M	BLUE CROSS OF WASHINGTON AND ALASKA	PO BOX 91059	SEATTLE	WA	981119159	8007221471	
X2N	-	-	-	-	-	-	NOT ASSIGNED
X2O	BLUE CROSS & BLUE SHIELD OF WEST VIRGINIA INC	PO BOX 1353	CHARLESTON	WV	25325	3043477709	
X2P	MOUNTAIN STATE BLUE CROSS & BLUE SHIELD, INC.	PO BOX 1948	PARKERSBERG	WV	26102	3044247700	
X2Q	-	-	-	-	-	-	NOT ASSIGNED
X2R	-	-	-	-	-	-	NOT ASSIGNED
X2S	BLUE CROSS & BLUE SHIELD OF VERMONT	PO BOX 186	MONTPELIER	VT	05602	8022472583	
X2T	BLUE CROSS & BLUE SHIELD OF OKLAHOMA	PO BOX 3283	TULSA	OK	74102	9185603535	
X2U	BLUE CROSS & BLUE SHIELD OF MISSOURI	1831 CHESTNUT ST.	ST LOUIS	MO	63103	3149234444	AKA ALLIANCE BLUE CROSS BLUE SHIELD
X2V	BLUE CROSS OF IDAHO HEALTH SERVICE, INC.	PO BOX 7408	BOISE	ID	83707	2083447411	
X2W	BLUE CROSS & BLUE SHIELD OF ARIZONA, INC.	PO BOX 13466	PHOENIX	AZ	850023466	6028644100	
X2X	BLUE CROSS BLUE SHIELD OF HAWAII	PO BOX 44500	HONOLULU	HI	96801	8007764672	
X2Y	BLUE CROSS BLUE SHIELD OF MONTANA	PO BOX 5004	GREAT FALLS	MT	59403	4067914000	
X3A	UNITED TEACHERS ASSO. INS. CO.	PO BOX 30010	AUSTIN	TX	78755	8008808824	
X3B	TPA EXCHANGE	PO BOX 4363	ST AUGUSTINE	FL	32085	8885022789	
XOKRX	REGENCE BCBS OF OREGON RX PLAN	PO BOX 12625 MAILSTOP S4P	SALEM	OR	97309	8884371508	RX PLAN ONLY MM PLAN IS X0K
XOV	BLUE CROSS OF NORTHEASTERN NEW YORK INC	PO BOX 15013	ALBANY	NY	12212	5184385500	
XYZ	OPTUM RX	PO BOX 29044	HOT SPRINGS	AR	71903	8007887871	FORMERLY PRESCRIPTION SOLUTIONS

APPENDIX 2 CARRIER CODES

CARRIER CODES: ARRANGED NUMERICALLY

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APPENDIX 3 COPAYMENT SCHEDULE

SCHEDULE OF COPAYMENTS

NOTE: Copayment schedule revised to reflect new copay amounts effective for dates of service on and after July 11, 2011 per Medicaid bulletin.

Amount	Type of Services
$1.15 per date of service	
	Chiropractor
	Podiatrist
$3.30 per date of service	
	Ambulatory Surgical Center
	Federally Qualified Health Center (FQHC)
	Home Health
	Optometrist
	Physician Office Visits - (Physician/Nurse Practitioner)
	Rural Health Clinic (RHC)
$3.40 per date of service	
	*Durable Medical Equipment and Supplies
	Dental
	Pharmacy (per prescription /refill) (Copay will apply to ages 19 and above only)
$3.40 per claim	
	Outpatient Hospital **(non-emergency)**
$25.00 per admission	
	Inpatient Hospital

***NOTE**: Durable Medical Equipment that is under a rent to purchase payment plan will have the $3.40 co-pay split evenly among the 10-month rental payment schedule.

APPENDIX 3 COPAYMENT SCHEDULE

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MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

Managed Care is a health care delivery model implemented by the South Carolina Department of Health and Human Services (SCDHHS) to establish a medical home for all Medicaid Managed Care eligible beneficiaries. The goals of a medical home include:

- Provide accessible, comprehensive, family-centered coordinated care
- Manage the beneficiary's health care, perform primary and preventive care services, and arrange for any additional needed care
- Provide beneficiaries access to a "live voice" 24 hours a day, 7 days a week, to ensure access to appropriate care
- Provide beneficiary education about preventive and primary health care, utilization of the medical home, and the appropriate use of the emergency room

Enrolling in a managed care plan does not limit benefits. Benefits offered under fee for service (FFS) Medicaid, as well as additional or enhanced benefits are provided by all health plans. These additional benefits vary from plan to plan according to the contracted terms and conditions between SCDHHS and the managed care entity. Beneficiaries and providers should contact the health plan with questions concerning additional benefits.

Examples of additional benefits include:

- 24-hour nurse advice line
- Care coordination
- Health management programs (asthma, diabetes, pregnancy, etc.)
- Unlimited office visits
- Adult dental services

The Bureau of Managed Care administers the program for Medicaid-eligible beneficiaries by contracting with Managed Care Organizations (MCOs) and Care Services Organizations (CSOs) to offer health care services (*CSOs support the Medical Homes Network (MHN) managed care health delivery model*). An MCO must receive a Certificate of Authority from the SC Department of Insurance and must be licensed as a domestic insurer by the State to render Medicaid managed care services. MCO model contracts are approved by the Centers for Medicare and Medicaid Services (CMS) and Medicaid.

This Managed Care supplement is intended to provide an overview of the Managed Care program. Providers should review the MCO and MHN Policy and Procedure Guides for detailed program-specific requirements. Both guides are located on the SCDHHS Web site (www.scdhhs.gov) within the Managed Care section.

The Exhibits section of this supplement provides contact information for MCOs and MHNs currently participating in the Medicaid Managed Care program as MCOs and MHNs are subject to change at any time. Providers are encouraged to visit the SCDHHS website

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

(www.scdhhs.gov) for the most current listing of health plans, the counties in which they are authorized to operate, and the number of managed care enrollees within a county.

SC MEDICAID MANAGED CARE CONTACT INFORMATION

For additional information, contact the Bureau of Managed Care at the following address:

South Carolina Department of Health and Human Services
Bureau of Managed Care
Post Office Box 8206
Columbia, SC 29202-8206
Phone: (803) 898-4614
Fax: (803) 255-8232

PROGRAM DESCRIPTIONS

Managed Care Organizations (MCOs)

A Managed Care Organization (MCO) is commonly referred to as an HMO (Health Maintenance Organization) in the private sector. MCOs are required to operate under a contract with SCDHHS to provide healthcare services to beneficiaries through a network of healthcare professionals, both primary and specialty care, as well as hospitals, pharmacies, etc. This network is developed by contracting with the various healthcare professionals.

Primary care providers (PCP) must be accessible within a 30-mile radius, while specialty care providers, to include hospitals, must be accessible within a 50-mile radius. While MCOs will contract with providers within a specific county, enrolled members may seek treatment, or be referred to in-network providers in neighboring counties.

MCOs are responsible for providing core services to Medicaid-eligible individuals as specified in their contract with SCDHHS. The health care providers within the MCO network are not required to accept FFS Medicaid as most claims are filed to and processed by the MCO. Only services rendered on a fee-for-service (FFS) basis require providers be enrolled in SC Medicaid, as those claims are paid by SCDHHS. (Core services are discussed further in the **Core Benefits** section of this supplement.)

Core Benefits

Managed Care Organizations are fully capitated plans that provide a core benefits package similar to the current FFS Medicaid plan. MCO plans are required to provide beneficiaries with "medically necessary" care at current limitations for all contracted services. Unless otherwise specified, service limitations are based on the State fiscal year (July 1 through June 30). While appropriate and necessary care must be provided, MCOs are not bound by the current variety of service settings. For example, a service may only be covered FFS when performed in an inpatient hospital setting, while the MCO may authorize the same service to be performed both in an inpatient and an outpatient hospital setting.

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

MCOs may offer SCDHHS-approved additional benefits. These are benefits that go beyond the core package. Additions, deletions, or modifications to additional benefits made during the contract year must be approved by SCDHHS. These benefits may include medical services which are currently non-covered by FFS and/or which are above current Medicaid limitations.

Providers should refer to the **Core Benefits** section of the MCO Policy and Procedures Guide on the SCDHHS website (www.scdhhs.gov) for a detailed explanation of core benefits and service limitations.

Services Outside of the Core Benefits

The South Carolina Healthy Connections (Medicaid) program continues to provide and/or reimburse certain FFS benefits. Providers rendering services that are not included in the MCO's benefits package, but are covered under FFS Medicaid receive payment in accordance with the current Medicaid fee schedule. These services are filed to SC Medicaid for processing and payment. MCOs are responsible for the beneficiaries' continuity of care by ensuring appropriate referrals and linkages to the Medicaid FFS providers. For specifics concerning services outside of the core benefits, please see the MCO Policy and Procedures Guide on www.scdhhs.gov.

MCO Program Identification (ID) Card

Managed Care Organizations issue an identification card to beneficiaries within 14 calendar days of the selection of a primary care provider, or the date of receipt of the beneficiary's enrollment data from SCDHHS, whichever is later.

To ensure immediate access to services, the provider should verify eligibility and enrollment regardless of a beneficiary's ability to supply a SC Medicaid or MCO card. The MCO ID card must include at least the following information:

- The MCO name
- The 24-hour telephone number for the beneficiary to use in urgent or emergency situations and to obtain any additional information
- The name of the primary care physician
- The beneficiary's name and Medicaid ID number
- The MCO's plan expiration date (optional)
- The Member Services toll-free telephone number
- The MCO and SC Medicaid logos

Claims Filing

Providers should file claims with the MCO for beneficiaries participating in a managed care program, unless the service rendered is not covered by the MCO and is, instead, paid on a FFS basis by SC Medicaid. Providers should contact the MCO for managed care billing requirements. Non-contracted providers should contact the MCO for billing and prior authorization requirements prior to rendering services to MCO enrolled beneficiaries. An exception is services

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

rendered in an emergency room. Even if the physician is not in-network with the MCO, the MCO cannot refuse to reimburse for covered emergency services. Specifics concerning emergency coverage are contained in Section 4, **Emergency Medical Services**, of the MCO contract.

Prior Authorizations and Referrals

Providers, both in and out of network, should contact the beneficiary's MCO for assistance with prior authorization (PA) requirements before administering services. Each MCO may have different prior authorization requirements and services requiring PA may differ according to the terms of a provider's contract with an MCO.

Admission to a hospital through the emergency department **may** require authorization. Hospitals should always check with the beneficiary's MCO plan for their requirements. The physician component for inpatient services **always** requires prior authorization. Specialist referrals for follow-up care after a hospital discharge also require prior authorization.

Medical Homes Networks (MHNs)

Medical Homes Networks (MHNs) are Medicaid's Primary Care Case Management (PCCM) programs that link beneficiaries with a primary care provider (PCP). An MHN is a group of physicians who have agreed to serve as PCCM providers. They work in partnership with the beneficiary to provide and arrange for most of the beneficiary's health care needs, including authorizing services provided by other health care providers. They also partner with a Care Coordination Services Organization (CSO) to accept the responsibility for providing medical homes for beneficiaries and for managing beneficiaries' care. The CSO supports the physicians and enrolled beneficiaries by providing care coordination, disease management, and data management. All providers participating in an MHN must be enrolled SC Medicaid providers, as all services are paid on a fee-for-service (FFS) basis.

The outcomes of the medical home initiative are a healthier, better educated Medicaid beneficiary, and cost savings for South Carolina through a reduction of acute medical care and disease-related conditions. The MHN provides case managers, who assist in developing, implementing, and evaluating the predetermined care management strategies of the network.

MHNs are under contract with the CSO, who, in turn, contracts with SCDHHS. Providers must be in good financial standing with SCDHHS. MHN contracts with SCDHHS must receive CMS approval. A sample of an MHN contract can be reviewed on the SCDHHS website.

MHN Program Identification (ID) Card

Medicaid Homes Networks do not issue a separate identification card. Beneficiaries enrolled in an MHN will have only one identification card, the one issued by SC Medicaid. This card does not contain the name or phone number of the assigned PCP. Such information can only be obtained by checking eligibility.

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

Core Benefits

Services provided under the MHN program are all paid on a FFS basis. As such, all claims are submitted to and processed by SCDHHS. Benefits offered in the MHN program mirror those offered in FFS with the following exceptions:

- All beneficiaries, regardless of age, receive unlimited ambulatory visits

For additional information concerning core services and limitations, please refer to the MHN Policy and Procedures manual, or program specific provider manuals for the applicable area (Physicians, Hospitals, etc.). Manuals are located on the agency website at www.scdhhs.gov

Prior Authorizations and Referrals

The PCP is contractually required to either provide medically necessary services or authorize another provider to treat the beneficiary via a referral. Even if a physician in the same practice, but at a different practice location with a different Medicaid "pay-to or group" provider ID, treats a beneficiary, the services rendered still need a referral from the PCP. If a beneficiary has failed to establish a medical record with the PCP, the CSO, in conjunction with the PCP, shall arrange for the prior authorization (PA) on any existing referral. For a list of services that do not require authorization, refer to the **Exempt Services** section later in this supplement.

In some cases, the PCP may choose to authorize a service retroactively. All authorizations and consultations, including services authorized retroactively, are at the discretion of the PCP. The process for referring a beneficiary to a specialist can be made by telephone or in writing. The referral should include the number of visits being authorized and the extent of the diagnostic evaluation.

A PCP may authorize multiple visits for a specific course of treatment or a particular diagnosis. This prevents a provider to whom the beneficiary was referred from having to obtain a referral number for each visit so long as the course of treatment or diagnosis has not changed. The provider simply files the claims referencing the same referral number. It is the PCP's responsibility to authorize additional referrals for any further diagnosis, evaluation, or treatment not identified in the scope of the original referral. If a specialist needs to refer the beneficiary to a second specialist for the same diagnosis, the beneficiary's PCP must be contacted for a referral number.

A referral number is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the physician component for inpatient hospital services does require a referral number. The hospital should contact the PCP for a referral number within 48 hours of the beneficiary's admission. Specialist referrals for follow-up care after discharge from a hospital also require a referral from the PCP. In addition to the MHN's authorization, prior approval may be required by SCDHHS to verify medical necessity before rendering some services. Prior authorizations are for medical approval only. Obtaining a prior authorization does not guarantee payment or ensure the beneficiary's eligibility on the date of service.

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For a list of services requiring a referral number from the PCP, along with noted exceptions, please refer to the MHN Policy and Procedures Guide. Claims submitted for reimbursement must include the PCP's referral number.

Specific services sponsored by state agencies require a referral from that agency's case manager. The state agency's case manager should coordinate with the PCP and the MHN Care Coordinator to ensure the continuity of care. These services include, but are not limited to, the following:

- Audiologist Services
- High/Moderate Management Group Homes Services
- Occupational Therapist Services
- Physical Therapist Services
- Psychologist Services
- Speech Therapist Services
- Therapeutic Foster Care Services

Referrals for a Second Opinion

PCPs are required to refer a beneficiary for a second opinion at his or her request when surgery is recommended.

Referral Documentation

All referrals must be documented in the beneficiary's medical record. The CSO and the PCP shall review the monthly referral data to ensure that services rendered to the beneficiary were authorized and recorded accurately in the medical record. It is the PCP's responsibility to review the referral data for validity and accuracy, and to report inappropriate and/or unauthorized referrals to the CSO. The CSO is responsible for investigating these incidents and notifying SCDHHS if Medicaid fraud or abuse is suspected.

Exempt Services

Beneficiaries can obtain the following services from Medicaid providers without obtaining a prior authorization from their PCP:

- Ambulance Services
- Dental Services
- Dialysis/End Stage Renal Disease Services
- Emergency Room Services (billed by the hospital)
- Family Planning Services
- Home- and Community-Based Waiver Services
- Independent Laboratory and X-ray [1] Services

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- Medical Transportation Services
- Nursing Home Services
- Obstetrician and Gynecologist Services
- Optician Services
- Optometrist Services
- Pharmacy Services
- State Agency Services[2]

[1] FQHCs/RHCs that provide laboratory and x-ray services under a separate provider number (not the FQHC/RHC number) must enter a prior authorization number on the claim form or the claim will be rejected.

[2] Agencies exempt from prior authorization are the Department of Mental Health, the Continuum of Care, the Department of Alcohol and Other Drug Abuse, the Department of Disabilities and Special Needs, the Department of Juvenile Justice, and the Department of Social Services.

The above list is not all-inclusive. For a complete list of exempt services, refer to the MHN Policy and Procedures Guide on the SCDHHS website (www.scdhhs.gov). Some services still require a prescription or a physician's order. Physicians should refer to the appropriate Medicaid Provider Manual for more detailed information and/or requirements, or contact the SCDHHS Provider Service Center (PSC) by calling 888-289-0709. Providers can also submit an online inquiry at http://scdhhs.gov/contact-us and a provider service representative will respond to you directly.

Primary Care Provider Requirements

The primary care provider is required to either provide services or authorize another provider to treat the beneficiary. The following Medicaid provider types may enroll as a primary care provider:

- Family Medicine
- General Practitioners
- Pediatricians
- Internal Medicine
- Obstetrics and Gynecology
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Nurse Practitioners (see the MHN Policy and Procedure Guide on the SCDHHS Web site (www.scdhhs.gov) for guidelines)

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

24-Hour Coverage Requirements

The MHN requires PCPs to provide access to medical advice and care for enrolled beneficiaries 24 hours per day, 7 days per week. A qualified medical practitioner must provide medical advice, consultation, and/or authorization or referral for services when appropriate within one hour of the beneficiary's presentation or notification. PCPs must have at least one telephone line that is answered by office staff during regular office hours.

Women, Infants, and Children (WIC) Program Referrals

Federal law mandates coordination between Medicaid Managed Care programs and the WIC program. PCPs are required to refer potentially eligible beneficiaries to the local WIC program agency. The beneficiary must sign a WIC Referral Form and a Medical Records Release Form. Both forms are submitted to the local WIC agency for follow up.

For more information, providers should contact the local WIC agency at their county health department.

MANAGED CARE SUPPLEMENT

MANAGED CARE ELIGIBILITY

Individuals must apply for SC Medicaid as outlined in Section 1 of this manual. If the applicant meets the established eligibility requirements, he or she may be eligible for participation in the Managed Care program. Not all Medicaid beneficiaries are eligible to participate in the Managed Care program.

The following Medicaid beneficiaries are **not eligible** to participate in a **Managed Care Organization**:

- Dually eligible beneficiaries (Medicare and Medicaid)
- Beneficiaries age 65 or older
- Residents of a nursing home
- Participants in limited benefits programs such as Family Planning, Specified Low Income Beneficiaries, Emergency Service Only, etc.
- Home- and Community-Based Waiver participants
- PACE participants
- Medically Complex Children's Waiver Program participants
- Hospice participants
- Beneficiaries covered by an MCO/HMO through third-party coverage
- Beneficiaries enrolled in another Medicaid managed care plan

The following Medicaid beneficiaries are **not eligible** to participate in a **Medical Homes Network**:

- PACE participants
- Individuals institutionalized in a public facility
- Beneficiaries in a nursing home payment category (Residents of a nursing home)
- Participants in limited benefits programs such as Family Planning, Specified Low Income Beneficiaries, Emergency Services Only, etc.
- Beneficiaries enrolled in another Medicaid managed care program
- Beneficiaries covered by an MCO/HMO through third-party coverage

Providers should verify beneficiaries' eligibility through the Web Tool or a point-of-service (POS) terminal prior to delivering services.

MANAGED CARE SUPPLEMENT

MANAGED CARE ELIGIBILITY

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MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

OVERVIEW

All managed care enrollment and disenrollment activities are handled through one single point of contact, South Carolina Healthy Connections Choices (SCHCC). SCHCC is responsible for processing the enrollment and disenrollment of Medicaid-eligible beneficiaries into a managed care plan. Beneficiaries may enroll online, by telephone, by mail, or by fax. Managed Care eligible Medicaid beneficiaries are encouraged to actively enroll with a managed care plan. Medicaid beneficiaries may currently select among the following Medicaid service delivery options:

- Managed Care Organization
- Medical Homes Network

SCHCC may be reached by calling (877) 552-4642, or via the SCHCC website: www.SCchoices.com. SCHCC should be contacted for assistance with enrollment, as well as transferring to, or disenrolling from, a health plan regardless of how long a beneficiary has been enrolled in their current health plan.

Not all Medicaid beneficiaries are eligible to participate in managed care. Beneficiaries who are eligible for participation are made aware of their eligibility via an outreach or enrollment mailing from SCHCC.

An **enrollment packet** is mailed to beneficiaries who are required to make a managed care plan choice. Failure to do so will result in managed care plan assignment by SCHCC.

An **outreach packet** is mailed to beneficiaries who are eligible, but not required, to participate in a managed care plan. Managed care participation is on a voluntary basis for this population. (See **Enrollment Counselor Services** later in this supplement.)

Outreach and assignment is based on the beneficiary's payment category or Recipient Special Program (RSP) indicator, and is effective according to the published cut-off schedule.

If a Medicaid beneficiary enrolled in a managed care plan looses Medicaid eligibility, but regains it within 60-days, he or she will be automatically reassigned to the same plan and will forego a new 90-day choice period.

Beneficiaries cannot enroll directly with the MCO or the MHN. Beneficiaries must contact SCHCC to enroll in a managed care plan, or to change or discontinue their plan. A member can only change or disenroll without cause within the first 90 days of enrollment. If the beneficiary is approved to enroll in a managed care plan, or changes his or her plan, and is entered into the system before the established cut-off date, the beneficiary appears on the plan's member listing for the next month. If the beneficiary is approved, and entered into the system after the established cut-off date, the beneficiary will appear on the plan's member listing for the following month.

MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

ENROLLMENT PROCESS

Medicaid beneficiaries receive a managed care enrollment packet or an outreach packet by mail within two days of first becoming eligible for Medicaid, or 30 to 60 days prior to their annual Medicaid review. Beneficiaries enrolled in a managed care plan will also receive a reminder letter from their health plan prior to their annual review date.

Beneficiaries are always encouraged to open, read, and respond to the enrollment packets to avoid plan assignment. While managed care enrollment is encouraged during annual review, FFS Medicaid beneficiaries may contact SCHCC to enroll at anytime. They do not need to wait to receive enrollment information. Beneficiaries enrolled in a managed care plan at the time of their annual review will remain in their health plan unless they contact SCHCC during their open enrollment (90-day choice period) to request a change.

When enrollment packets are mailed, beneficiaries have at least 30 days from the mail date to choose a health plan. If a beneficiary fails to act on the initial enrollment packet, outbound calls are placed in an effort to encourage plan selection. If, after the multiple outreach efforts, a beneficiary still fails to respond, he or she will be assigned to a managed care plan.

The assignment process places beneficiaries into health plans available in the county where the beneficiary resides based on the following criteria:

- The health plan, if any, in which the beneficiary was previously enrolled
- The health plan, if any, in which family members are enrolled
- The health plan selected by a random assignment process if no health plan was identified

There are three easy ways for beneficiaries to enroll:

- Call SCHCC at (877) 552-4642
- Mail or fax the completed enrollment form contained in the enrollment packet
- Online at www.SCchoices.com

A beneficiary is enrolled in a Managed Care plan for a period of 12 months. The beneficiary shall remain enrolled in the plan unless one of the following occurs:

- The beneficiary becomes ineligible for Medicaid and/or Managed Care enrollment
- The beneficiary forwards a written request to transfer plans for cause
- The beneficiary initiates the transfer process during the annual re-enrollment period
- The beneficiary requests transfer within the first 90 days of enrollment

Enrollment of Newborns

Babies born to Medicaid-eligible mothers are automatically deemed Medicaid eligible. As such, they are subject to being enrolled into a managed care plan. If, at the time of delivery, the mother is enrolled with an MCO, the baby will be automatically enrolled into the same MCO. If, however, the mother is enrolled with an MHN, or is FFS, the baby will revert to FFS Medicaid

for the first year of life. If the mother was enrolled in an MHN at the time of delivery, the CSO overseeing the MHN will outreach to encourage enrollment into the MHN. Newborns in FFS are still eligible to enroll in managed care and may be enrolled at anytime by contacting SCHCC.

Babies automatically enrolled into the mother's MCO have a 90-day choice period following birth during which a change to their health plan may be made. Following the 90-day choice period, the newborn enters into his or her lock-in period and may not change health plans for the first year of life without "just cause." The newborn's effective date of enrollment into a managed care plan is the first day of the month of birth.

Providers should refer to the appropriate Medicaid provider manual for additional limitations when providing services to newborns.

Primary Care Provider Selection and Assignment

Upon enrolling into a managed care plan, all beneficiaries are "assigned" to a primary care provider (PCP). If the beneficiary calls SCHCC and chooses a health plan, he or she is asked to select a PCP at that time. If, however, SCHCC assigns the beneficiary to a health plan, the PCP "selection" is handled differently.

For beneficiaries assigned to an MCO, the MCO is responsible for assigning the PCP. For beneficiaries assigned to an MHN, SCHCC is responsible for assigning the PCP. After assignment, beneficiaries may elect to change their PCP. **There is no lock-in period with respect to changing PCPs.** Enrolled beneficiaries may change their PCP at any time and as often as necessary.

MCO members must call their designated Member Services area to change their PCP. MHN members may call either their Member Services area or speak with their current PCP to enact a change.

The name of the designated PCP will appear on all MCO cards. Should an MCO member change his PCP, he will be issued a new health plan card from the MCO reflecting the new PCP.

MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

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MANAGED CARE SUPPLEMENT

MANAGED CARE DISENROLLMENT PROCESS

OVERVIEW

Beneficiaries not required to participate in managed care may request to disenroll and return to fee-for-service Medicaid. Beneficiaries required to participate in managed care may only request to transfer to another health plan as fee-for-service Medicaid is no longer an option for this population.

Disenrollment/transfer requests are processed through the enrollment counselor, SCHCC. The beneficiary, the MCO, the MHN, or SCDHHS may initiate the process. During the 90 days following the date of initial enrollment with the managed care plan, beneficiaries may change plans without cause. Only one change may be requested during this period. Once a change has been requested, or the 90 days following the date of initial enrollment has expired, beneficiaries move into their "lock-in" period. Requests to change health plans made during the lock-in period are processed only for "just cause." Please refer to the MCO or MHN Policy and Procedures Guide for additional information concerning just cause.

Transfer requests made during the lock-in period require the completion of a Health Plan Change form, which may only be obtained by contacting SCHCC. The form requires the beneficiary to provide information confirming his or her attempt to resolve any issues necessitating disenrollment. That information includes documenting the date and time of the call to the health plan to discuss his or her issues, as well as the person with whom the beneficiary spoke. Failure to provide all required information results in denial of the disenrollment request as all such requests must be reviewed by the SCDHHS Managed Care staff.

Upon review by Managed Care staff, the managed care plan is notified of the request to disenroll so that a plan representative may follow up with the beneficiary in an effort to address the concerns raised. Managed care plans are required to notify SCDHHS within 10 days of the follow-up results for all complaints or disenrollment requests forwarded to the plan. If just cause is not validated, disenrollment is denied and the beneficiary remains in the managed care plan. A beneficiary's request to transfer is honored if a decision has not been reached within 60 days of the initial request. The final decision to accept the beneficiary's request is made by SCDHHS.

If the beneficiary believes he or she was disenrolled/transferred in error, it is the beneficiary's responsibility to contact SCHCC or the managed care plan for resolution. The beneficiary may be required to complete and submit a new enrollment form to SCHCC.

INVOLUNTARY BENEFICIARY DISENROLLMENT

A beneficiary may be involuntarily disenrolled from a managed care plan at any time deemed necessary by SCDHHS or the plan, with SCDHHS approval.

The plan's request for beneficiary disenrollment must be made in writing to SCHCC using the applicable form, and the request must state in detail the reason for the disenrollment. The request must also include documentation verifying any change in the beneficiary's status. SCDHHS determines if the plan has shown good cause to disenroll the beneficiary and informs SCHCC of

MANAGED CARE SUPPLEMENT

MANAGED CARE DISENROLLMENT PROCESS

their decision. SCHCC notifies both the plan and the beneficiary of the decision in writing. The plan and the beneficiary have the right to appeal any adverse decision. Managed care plans are required to inform providers of those beneficiaries disenrolling from their programs. Providers should always check the Medicaid eligibility status of beneficiaries before rendering service.

The plan may not terminate a beneficiary's enrollment because of any adverse change in the beneficiary's health. An exception would be when the beneficiary's continued enrollment in the plan would seriously impair the plan's ability to furnish services to either this particular beneficiary or other beneficiaries.

For additional information, please review the involuntary disenrollment guidelines used by SCDHHS and the Managed Care plans in the **Disenrollment Process** section in the MCO or MHN Policy and Procedures Guide.

MANAGED CARE SUPPLEMENT

EXHIBITS

MANAGED CARE PLANS BY COUNTY

A map of the Managed Care plans by county is available on the SCDHHS website at www.scdhhs.gov. Not all MCOs are authorized to operate in every county within the state. Providers should refer to the map for SCDHHS-approved MCOs operating within their service area.

The **Exhibits** section provides the contact information and a card sample for each MCO currently operating in South Carolina.

CURRENT MEDICAID MEDICAL HOMES NETWORK (MHNS)

The following MHNs are participants in the South Carolina Healthy Connections (Medicaid) Managed Care program. MHN beneficiaries should present their South Carolina Healthy Connections Medicaid Insurance card in order to receive health care services. No additional card is necessary.

Carolina Medical Homes

250 Berryhill Road, Suite 202
Columbia, SC 29210
(803) 509-5377 or (800) 733-1108
www.carolinamedicalhomes.com

Palmetto Physician Connections

531 South Main Street, Suite 307
Greenville, SC 29601
(888) 781-4371
www.palmettophysicianconnections.com

South Carolina Solutions

132 Westpark Blvd
Columbia, South Carolina 29210
(803) 612-4120 or (866) 793-0006
(803) 612-4152 or (888) 893-0018
www.sc-solutions.org

MANAGED CARE SUPPLEMENT

CURRENT MEDICAID MANAGED CARE ORGANIZATIONS

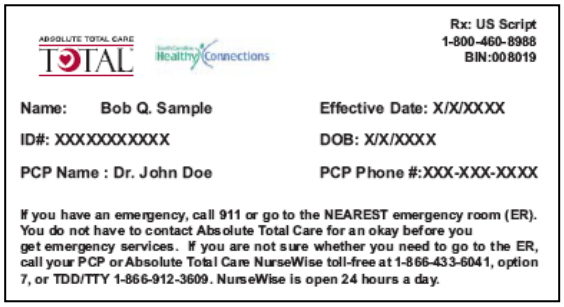
South Carolina Healthy Connections (Medicaid) Managed Care Organizations are required to issue a plan identification card to enrolled beneficiaries. Beneficiaries should present both the MCO-issued identification card and the Healthy Connections Medicaid card. MCO cards contain important information on the beneficiary (name, plan number), the MCO (toll-free contact numbers), and the PCP.

SAMPLE MEDICAID MCO CARDS

The following card samples are used by MCOs that are currently authorized to operate in South Carolina. Not all MCOs are authorized to operate in every county of the state. Please consult the SCDHHS website at www.scdhhs.gov for the current list of authorized plans and counties.

Absolute Total Care

Centene Corporation
(866) 433-6041
www.absolutetotalcare.com

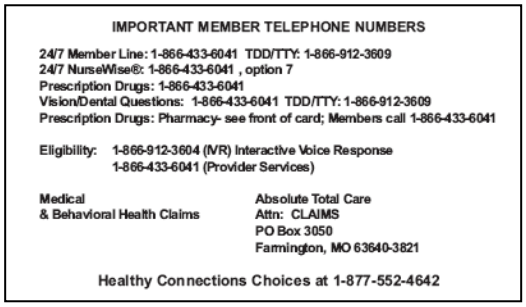

ABSOLUTE TOTAL CARE TOTAL
Healthy Connections

Rx: US Script
1-800-460-8988
BIN:008019

Name: Bob Q. Sample
Effective Date: X/X/XXXX
ID#: XXXXXXXXXXX
DOB: X/X/XXXX
PCP Name : Dr. John Doe
PCP Phone #:XXX-XXX-XXXX

If you have an emergency, call 911 or go to the NEAREST emergency room (ER). You do not have to contact Absolute Total Care for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or Absolute Total Care NurseWise toll-free at 1-866-433-6041, option 7, or TDD/TTY 1-866-912-3609. NurseWise is open 24 hours a day.

(front)


IMPORTANT MEMBER TELEPHONE NUMBERS

24/7 Member Line: 1-866-433-6041 TDD/TTY: 1-866-912-3609
24/7 NurseWise®: 1-866-433-6041 , option 7
Prescription Drugs: 1-866-433-6041
Vision/Dental Questions: 1-866-433-6041 TDD/TTY: 1-866-912-3609
Prescription Drugs: Pharmacy- see front of card; Members call 1-866-433-6041

Eligibility: 1-866-912-3604 (IVR) Interactive Voice Response
1-866-433-6041 (Provider Services)

Medical
& Behavioral Health Claims

Absolute Total Care
Attn: CLAIMS
PO Box 3050
Farmington, MO 63640-3821

Healthy Connections Choices at 1-877-552-4642

(back)

MANAGED CARE SUPPLEMENT

BlueChoice

BlueChoice HealthPlan of South Carolina Medicaid
(866) 781-5094
www.bluechoicesc.com

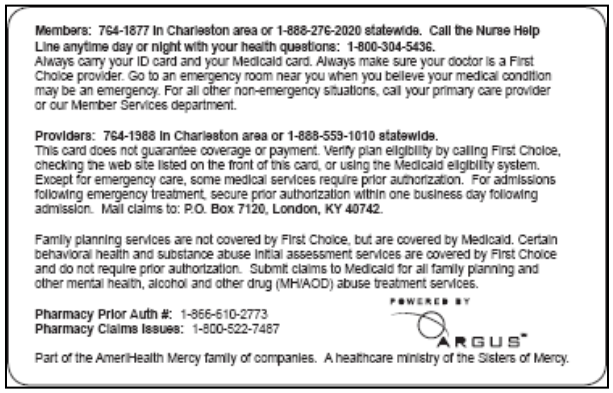
(front)

(back)

First Choice by Select Health

Select Health of South Carolina, Inc.
(888) 276-2020
www.selecthealthofsc.com

(front)



(back)

MANAGED CARE SUPPLEMENT

UnitedHealthcare Community Plan

UnitedHealthcare Community Plan
(800) 414-9025
www.uhccommunityplan.com

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PROVIDER MANUAL SUPPLEMENT

THIRD-PARTY LIABILITY

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THIRD-PARTY LIABILITY SUPPLEMENT

INTRODUCTION

"Third-party liability" (TPL) refers to the responsibility of parties other than Medicaid to pay for health insurance costs. Medicaid is always the payer of last resort, which means that Medicaid will not pay a claim for which someone else may be responsible until the party liable before Medicaid has been billed. For the most part, this means providers are responsible for billing third parties before billing Medicaid.

Third parties can include:

- Private health insurance
- Medicare
- Employment-related health insurance
- Medical support from non-custodial parents
- Long-term care insurance
- Other federal programs
- Court judgments or settlements from a liability insurer
- State workers' compensation
- First party probate-estate recoveries

Private health insurers and Medicare are the most common types of third party that providers are required to bill. For information on casualty cases and estate recovery, see Section 1 of your provider manual.

HEALTH INSURANCE RECORDS

Medicaid Insurance Verification Services (MIVS), Medicaid's TPL contractor, researches third-party insurance information. Sources of information include providers, eligibility offices, long-term care workers, private insurers, other government agencies, and beneficiaries themselves.

It can take up to 25 days for a new policy record to be added to a beneficiary's eligibility file and five days for corrections and updates of an existing record. New policy information and updates are added to the Medicaid Management Information System (MMIS) every working day.

ACCESS TO CARE

As a provider, your role in the TPL process begins as soon as you agree to treat a Medicaid-eligible patient. You should ask every patient and/or the patient's responsible party about other insurance coverage.

According to 42 CFR 447.20(b), **you cannot refuse to treat a Medicaid patient simply because he or she has other health insurance**. You and the patient should work together to decide whether you will consider the individual a Medicaid patient or a private-pay patient. If you accept the individual as a Medicaid patient, you are obligated to follow Medicaid's third-party liability guidelines and other policies. Remember, you agree to treat a patient as a Medicaid

patient for an entire spell of illness; you cannot change a beneficiary's status in the midst of a course of treatment.

When you first accept a Medicaid beneficiary, and at every service encounter thereafter, you will check to see whether the patient is eligible for Medicaid. At the same time, you will check for any other insurers you may need to bill. You should also perform a Medicaid eligibility check again when entering a claim, as eligibility and TPL information are constantly being updated.

South Carolina Healthy Connections (Medicaid) does not require you to obtain copies of other insurance cards from the beneficiary. You can obtain from South Carolina Healthy Connections (Medicaid) all the information you need to file with another insurer or to code TPL information on a Medicaid claim, including policy numbers, policy types, and contact information for the insurer, as long as Medicaid has that information on file.

Health Insurance Premium Payment Project

The Health Insurance Premium Payment (HIPP) project allows SCDHHS to pay private health insurance premiums for Medicaid beneficiaries who may be at risk of losing the private insurance coverage. SCDHHS will pay such premiums if the payment is deemed cost effective; see Section 1 of your provider manual for more information on qualifying situations. Maintaining good communication with your patients will help you identify candidates for referral to the HIPP program.

Eligibility Verification

- **Medicaid Card:** Possession of a Medicaid card means only that a beneficiary was eligible for Medicaid when the card was issued. You must use other eligibility resources for up-to-date eligibility and TPL information.
- **Point-of-Sale Devices and Eligibility Verification Vendors:** Check with your vendor to see how TPL information is reported.
- **Web Tool:** The Eligibility Verification function of the South Carolina Healthy Connections (Medicaid) Web-based Claims Submission Tool provides information about third-party coverage. See the Web Tool User Guide for instructions on checking eligibility.

REPORTING TPL INFORMATION TO MEDICAID

Providers are an important source of information from beneficiaries about third-party insurers. You can report this information to Medicaid in two ways: enter the information on claims submitted to Medicaid, or submit Health Insurance Information Referral Forms to Medicaid. When primary health insurance information appears on a claim form, the insurance information is passed to MIVS electronically for verification. This referral process is conducted weekly and contributes to timely additions and updates to the policy file.

THIRD-PARTY LIABILITY SUPPLEMENT

Health Insurance Information Referral Forms

The SCDHHS Health Insurance Information Referral Form is used to document third-party insurance coverage, policy changes, beneficiary coverage changes, carrier changes, and policy lapse information. You should fill out this form when you discover third-party coverage information that Medicaid does not know about, or when you have insurance documentation that indicates the TPL health insurance record needs an update.

A copy of the form is included in the Forms section of your provider manual, and samples appear at the end of this supplement. Send or fax the completed forms to:

South Carolina Healthy Connections
PO Box 101110
Columbia, SC 29211-9804
Fax: (803) 252-0870

COORDINATION OF BENEFITS

Health insurers adhere to "coordination of benefits" provisions to avoid duplicating payments. The health plan or payer obligated to pay a claim first is called the "primary" payer, the next is termed "secondary," and the third is called "tertiary." Together, the payers coordinate payments for services up to 100% of the covered charges at a rate consistent with the benefits.

Medicaid does not participate in coordination of benefits in the same way as other insurers. Medicaid is never primary, and it will only make payments up to the Medicaid allowable. However, you should understand how other companies coordinate payments.

COST AVOIDANCE VS. PAY & CHASE

South Carolina Healthy Connections (Medicaid) is required by the federal government to reject claims for which another party might be liable; this policy is known as "cost avoidance." Providers must report primary payments and denials to Medicaid to avoid rejected claims. The majority of services covered by Medicaid are subject to cost avoidance.

For certain services, Medicaid does not cost-avoid claims and will pursue recovery under a policy known as "Pay & Chase." Medicaid remains the payer of last resort in all cases; however, under Pay & Chase it temporarily behaves like a primary payer.

Services that fall under Pay & Chase are:

- Preventive pediatric services
- Dental EPSDT services
- Maternal health services
- Title IV – Child Support Enforcement insurance records
- Certain Department of Health and Environmental Control (DHEC) services under Title V

While providers of such services are encouraged to file with any liable third party before Medicaid, if they choose not to do so, SCDHHS will pay the claims and bill liable third parties directly through the Benefit Recovery program. More information on recovery appears later in

this supplement. If you choose to bill both a third party and Medicaid, you must enter the TPL filing information on your Medicaid claim as outlined in this supplement – rendering Pay & Chase-eligible services does not exempt you from the requirement to correctly code for TPL.

Resources Secondary to Medicaid

Certain programs funded only by the state of South Carolina (*i.e.*, without matching federal funds) should be billed secondary to Medicaid. The TPL claim processing subsystem does not reject claims for resources that may pay after Medicaid. These resources are:

- BabyNet
- Best Chance Network
- Black Lung
- Commission for the Blind
- Community Health
- Crime Victims Compensation Fund
- CRS (Children's Rehabilitative Services)
- Department of Corrections
- DHEC Cancer
- DHEC Family Planning (DHEC Maternal Child Health)
- DHEC Heart
- DHEC Hemophilia
- DHEC Migrant Health
- DHEC Sickle Cell
- DHEC TB
- Indian Health
- Other Indigent (hospital charity)
- Other Sponsor
- Ryan White Program
- State Aid Cancer Program
- Vaccine Injury Compensation
- Veterans Administration
- Vocational Rehabilitation Services

COPAYMENTS AND TPL

For certain services, Medicaid beneficiaries must make a Medicaid copayment. SCDHHS deducts this amount from what Medicaid pays the provider. Copayments are described in detail in Section 3 of your provider manual (if they apply to the services you provide).

Remember, as a Medicaid provider you have agreed to accept Medicaid's payment as payment in full. You can never balance bill a beneficiary receiving Medicaid-covered services for anything other than the Medicaid copayment. (You may, however, bill a beneficiary for services that Medicaid does not cover.)

When a beneficiary has Medicare or private insurance, he or she is still responsible for the Medicaid copayment. However, if the sum of the copayment and the Medicare/third-party payment would exceed the Medicaid-allowed amount, you must adjust or eliminate the copayment. In other words, though you may accept a primary insurance payment higher than what Medicaid would pay, the beneficiary's copayment cannot contribute to the excess revenue.

Medicaid beneficiaries with private insurance are **not** charged the copayment amount of the primary plan(s). When you accept a patient as a Medicaid patient, all Medicaid rules, including the Medicaid copayment rules, apply to that individual. These rules are federal law; they protect the Medicaid beneficiary by limiting his or her liability for payment for medical services.

THIRD-PARTY LIABILITY SUPPLEMENT

Medicaid determines payment in full and the patient's liability. Therefore, when you file a secondary claim with Medicaid, you can only apply the Medicaid copayment and cannot require the primary plan copayment as you would for a private pay patient.

DENIALS AND EOBS

When you bill a primary health insurer, you should obtain either a payment or a denial. You should also receive an Explanation of Benefits (EOB) that explains how the payment was calculated and any reasons for non-payment. Once you have received a reply from all potentially liable parties, if there are still charges that are not paid in full that might be covered by Medicaid, you may then bill Medicaid. This process is known as sequential billing.

Note that you must receive a *valid* denial before billing Medicaid. A request for more information or corrected information does not count as a valid denial.

POLICY TYPES

Each private policy listed in a patient's insurance record has an entry for "policy type," the most common of which is Health No Restrictions (HN). Another policy type you may encounter is HI, Health Indemnity; such policies pay per diem for hospital stays, surgeries, anesthesia, etc. HS, Health Supplemental, refers to policies that cover Medicare coinsurance and deductibles. Other policy types include Accident (HA) and Cancer (HC).

The policy type HN may be applied to a pharmacy carve-out, a mental health claim administrator, or a dental policy. The policy type does not provide specific information about the types of services covered, so you may have to take extra steps to determine whether to bill a particular carrier:

1. Ask the beneficiary. He or she should be able to tell you what kind of policy it is.
2. Look at the name of the carrier in the full list of carrier codes. The name may help you figure out the type of coverage (*e.g.*, ABC Dental Insurers).
3. Call SCDHHS Provider Service Center (PSC). Providers can also submit an online inquiry at http://scdhhs.gov/contact-us and a provider support representative will respond to you directly. He or she can look up more details of the plan in the TPL policy file.

TIMELY FILING REQUIREMENTS

Providers must file claims with Medicaid within a year of the date of service. If a claim is rejected, you must resubmit the Edit Correction Form (ECF) within that year, and Void/Replacement adjustments must be made within that year as well – all activity related to the claim must occur within a year of the date of service in order for you to be paid.

Because of this timely filing requirement, you should bill third parties as soon as possible after service delivery. SCDHHS recommends that you file a claim with the primary insurer within 30 days of the date of service.

THIRD-PARTY LIABILITY SUPPLEMENT

Regardless of how long the third party takes to reply, providers must still meet Medicaid's timeliness requirements. Delays by other insurers are not a sufficient excuse for timeliness extensions.

Timely Filing	
Medicaid claims	One year
Medicare-primary claims to Medicaid	Two years or within six months from Medicare adjudication
Primary health insurance	30 days recommended

Late claim filing to the primary insurer and gaps in activity related to obtaining payment from a primary carrier are not reasonable practices. SCDHHS will not consider payment if a claim is not successfully adjudicated by the MMIS within the time frames above.

REASONABLE EFFORT

Providers occasionally encounter difficulties in obtaining documentation and payment from third parties and beneficiaries. For example, the third-party insurer may refuse to send a written denial or explanation of benefits, or a beneficiary may be missing or uncooperative. It is your responsibility as a provider to seek a solution to such problems.

"Reasonable effort" consists of taking logical, timely steps at each stage of the billing process. Such steps may include resubmitting claims, making follow-up phone calls, and sending additional requested information. Many resources are available to help you pursue third-party payments. The PSC can work with you to explore these options.

Reasonable Effort and Insurance Companies

Below is a suggested process for filing to insurance companies. A flowchart based on this process can be found at the end of this supplement.

A. Send a claim to the insurance company.

If after **thirty days** you have received no response:

B. Call the company's customer service department to determine the status of the claim.

- **If the company has not received the claim:**
  1. Refile the claim. Stamp the claim as a repeat submission or send a cover note.
  2. Repeat follow-up steps as needed.
- **If the company has received the claim but considers the billing insufficient:**
  1. Supply all additional information requested by the company.

THIRD-PARTY LIABILITY SUPPLEMENT

2. Confirm that all requested information has been submitted.
3. Allow thirty more days for the claim to be processed.
4. If there is no response within thirty days and all information has been supplied as requested, proceed as instructed below.

- **If the company has received the claim, considers the billing valid, and has not suspended the claim:**
  1. Make a note in your files.
  2. Follow up with a written request for a response.

C. If after two more weeks you have still received no response:

1. Write to the company citing this history of difficulties. Copy the South Carolina Department of Insurance Consumer Division on your letter.

Remember, difficulties with insurance companies do not exempt you from timely filing requirements. It is important that you file a claim as soon as possible after providing a service so that, should you encounter any difficulty, you have time to pursue the steps described above.

Once the Department of Insurance has resolved an issue (which usually takes about 90 days), you should have adequate information to bill Medicaid correctly. Following all the steps above should take no more than 180 days, well within the Medicaid timely filing limit of one year.

Reasonable Effort and Beneficiaries

Difficulties can arise when a beneficiary does not cooperate with an insurer's request for information. For example, U.S. military beneficiaries must report changes in their status and eligibility to the Defense Eligibility and Enrollment Reporting System (DEERS); a delay by a beneficiary may delay a provider's response from the insurer. An insurer may also need a beneficiary to send in subrogation forms related to a hospitalization.

It is in your interest to contact the beneficiary, whether by phone, certified letter, or otherwise. You may offer to help the beneficiary understand and fill out forms. Be sure to document all your attempts at contact and inform the insurer of such actions.

Occasionally insurers will pay a beneficiary instead of a provider. If you know an insurance payment will be made to a patient, you should consider having the patient sign an agreement indicating that the total payment will be turned over to the provider, and that failure to cooperate with the agreement will result in the beneficiary no longer being accepted as a Medicaid patient.

Reasonable Effort Documentation Form

In cases where you have made all reasonable efforts to resolve a situation, you can submit a Reasonable Effort Documentation form. The form must demonstrate that you have made sustained efforts to contact the insurance company or beneficiary. This document is used only as a last resort, when all other attempts at contact and payment collection have failed.

THIRD-PARTY LIABILITY SUPPLEMENT

Attach the form either to a claim filed as a denial or to an ECF. Attach copies of all documents that demonstrate your efforts (correspondence with the insurer and the Department of Insurance, notes from your files, etc.). If you are filing electronically, you must keep the Reasonable Effort Documentation form and all supporting documentation on file. A blank Reasonable Effort Documentation form can be found in the Forms section of your provider manual, and examples appear at the end of this supplement.

REPORTING TPL INFORMATION ON CLAIMS

When you file a claim that includes TPL information, you will report up to five pieces of TPL information, depending on the type of claim:

For each insurer:

1. The carrier code
2. The insured's policy number
3. A payment amount or "0.00"

For the whole claim:

4. A denial indicator when at least one payer has not made payment
5. The total of all payments by other insurers

Carrier Codes

Medicaid, in conjunction with the South Carolina Hospital Association (SCHA), assigns every third-party insurer a unique three-digit alphanumeric code. Among the SCHA carrier codes are a few five-digit codes created by SCDHHS to satisfy carrier-specific claim filing requirements; these are identified by the suffix RX (pharmacy plans). SCHA carrier codes are used to identify insurers and other payers (including the Medicare Advantage plans) on dental, professional, and institutional claims. A complete list of carrier codes can be found in Appendix 2 of those provider manuals.

SCDHHS maintains an entirely separate list of five-digit carrier codes for pharmacy claims submission. Providers should visit http://southcarolina.fhsc.com or the SCDHHS Provider Information page at http://provider.scdhhs.gov/ to view the pharmacy carrier codes list.

With very few exceptions, the alphanumeric carrier codes assigned by the SCHA are three digits, alpha-numeric-alpha. However, if you file hard copy, you may want to indicate a zero as Ø to ensure it is keyed correctly.

If you cannot find a particular carrier or carrier code in your manual, please visit the SCDHHS Provider Information page at http://provider.scdhhs.gov/ to view the most current carrier codes list.

If you are billing a company for which you cannot find a code, you may use 199, the generic carrier code. MIVS will then call you to ask about the new insurer. You may prefer to submit a Health Insurance Information Referral Form to MIVS while you have the carrier information easily accessible, as MIVS may call you up to one month after the claim has been processed.

THIRD-PARTY LIABILITY SUPPLEMENT

You may encounter the "CAS" carrier code when checking a beneficiary's eligibility. This code represents an open casualty case. Medicaid does not cost avoid claims with casualty coverage. You may decide to bill Medicaid directly and forgo participation in the case, or you may take action with the liable party and not bill Medicaid. Timely filing requirements still apply even where there is a possible casualty settlement, so you must make your decision prior to the one-year Medicaid timely filing deadline.

Policy Numbers

Many insurance companies use Social Security numbers (SSNs) as policy numbers, but some are transitioning to policy numbers that do not rely on confidential information. You should use the number that appears on the beneficiary's health insurance card.

SCDHHS has begun adding these new policy numbers to beneficiary records. If one of your claims is rejected for failure to file to a private insurer (edit 150) and you have already filed to that insurer, there may be a policy number discrepancy; you should code the claim with the beneficiary's SSN. Edit codes and rejected claims are discussed in more detail below.

PHARMACY CLAIMS

TPL policies apply to all Medicaid services. Like other providers, pharmacists must bill all other potentially liable parties, including Medicare, before billing Medicaid. However, pharmacists' billing procedures differ from those of other providers. Pharmacists do not use the carrier codes assigned by the SCHA; South Carolina Healthy Connections (Medicaid) maintains separate carrier codes for pharmacy claims submission. Providers should visit the SCDHHS Provider Information page at http://provider.scdhhs.gov for pharmacy carrier codes. These unique codes may also be found at http://southcarolina.fhsc.com.

Pharmacists receive two-character NCPDP edit codes rather than South Carolina Healthy Connections (Medicaid) edit codes. Code 41 indicates that you need to file to a third-party payer, to include Medicare Parts B and D, if applicable.

Pharmacy services are generally cost-avoided; however, SCDHHS performs Pay & Chase billing for insurance resources that are Child Support Enforcement-ordered and in situations where the insurance company will not pay the Medicaid-assigned claim and instead makes payment to the subscriber. Pharmacists who file to primary plans but do not receive the insurance payment should report that fact to MIVS or SCDHHS so that Pay & Chase may be implemented instead of cost avoidance.

The point-of-sale contractor's Pharmacy Provider Manual contains complete instructions on how to submit TPL information on Medicaid claims.

NURSING FACILITY CLAIMS

Nursing facilities are required to follow Medicaid's TPL policies by billing other liable parties before billing Medicaid. The nursing facility claim form, the Turn Around Document, does not provide fields for coding TPL information. In order to have TPL payments calculated, you will report TPL payments and denials on a Health Insurance Information Referral Form and/or send the insurance EOB with an ECF.

THIRD-PARTY LIABILITY SUPPLEMENT

If you discover third-party coverage that Medicaid does not yet have on file, bill the third party and send a Health Insurance Information Referral Form to MIVS so that the insurance record may be put online. If Medicaid has already paid, you are responsible for refunding the insurance payment. Failure to report insurance that will likely be subsequently discovered may result in the claim being put into benefit recovery and recouped in a recovery cycle (see the section on recovery for more information).

To initiate Medicaid billing for a resident also covered by a third party payer, submit a claim to Medicaid and receive a rejection (edit code 156 for commercial insurance) for having failed to file with the other liable third parties. This establishes your willingness to accept a resident as a Medicaid beneficiary. It also shows that you intend to adhere to Medicaid's timely filing requirements.

When you receive an ECF for the claim, attach all EOBs and return the ECF to the Medicaid Claims Control System (MCCS); they will route it to the Medicaid TPL department for processing. If you are subsequently paid by a third party, use Form 205 to refund part or all of your Medicaid payment. Mark "health insurance" as the reason for the refund, supply the insurance information, and attach a check for the amount being refunded.

Remember that claims in recovery have timely filing requirements. SCDHHS suggests that as soon as you receive a 156 edit and/or discover that a resident has third-party coverage, you check your records and bill the third party for previous claims for the current calendar year and for one year prior for which Medicaid should not have paid primary. If you wait for the next recovery cycle, you may run into timely filing deadlines. All previously paid claims that were not filed with the insurance company or third parties are subject to recovery by Medicaid.

Should MIVS mail you a letter of recovery, make sure you follow all procedures and timelines as required. The PSC will be able to assist you in completing all requirements from MIVS in order to avoid a take-back or to reverse a previous take-back.

If you have any other questions or concerns about third-party liability issues, call the PSC. Because nursing home billing cycles are often longer than those of other providers, it is essential that you contact SCDHHS early in the TPL billing process, before timely filing requirements become a concern.

The Nursing Facility Services Provider Manual contains complete billing instructions for nursing facilities. Please see also the following sections of this supplement: Eligibility Verification, Reporting TPL Information to Medicaid, Cost Avoidance vs. Pay & Chase, Timely Filing Requirements, and Reasonable Effort.

PROFESSIONAL, INSTITUTIONAL, AND DENTAL CLAIMS

The CMS-1500 and UB-04 claim forms have space to report two payers other than Medicaid. If there are three or more insurers, you will need to code your claim with the payers listed that pay primary and secondary. When your claim receives edit 151, you may write in the carrier code, policy number, and amount paid in the third occurrences of fields 24, 25, and 26 of the CMS-1500 ECF, and submit the ECF to MCCS. Claims submitted electronically will be processed automatically with up to ten primary payers. You may also submit the ECF and all the EOBs to

the Division of Third-Party Liability; however, that is no longer required and may slightly delay claim payment.

Professional Paper Claims

The CMS-1500 has two areas for entering other insurers: block 9 (fields 9a, 9c, and 9d) and block 11 (fields 11, 11b, and 11c). If there is only one primary insurer, you can use either block. If there are two insurers, use both blocks.

CMS-1500 TPL Fields

9a Other Insured's Policy or Group Number Enter the policy number.	**11 Insured's Policy Group or FECA Number** Enter the policy number.
9c Employer's Name or School Name If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.	**11b Employer's Name or School Name** If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.
9d Insurance Plan Name or Program Name Enter the three-digit carrier code.	**11c Insurance Plan Name or Program Name** Enter the three-digit carrier code.

10d Reserved for Local Use Enter the appropriate TPL indicator for this claim.

The valid TPL indicators are:

1 Insurance denied

6 Crime victim

8 Uncooperative beneficiary

If either insurer denied payment, you will put the TPL indicator "1" in field 10d. "6" is used to alert SCDHHS to potential criminal proceedings and restitution. "8" is used in conjunction with the Reasonable Effort Documentation form to show that you have been unable to contact a beneficiary from whom you need information and/or payment.

29 Amount Paid Enter the total amount paid from all insurance sources. This amount is the sum of 9c and 11b.

Complete instructions for filling out CMS-1500 claim forms can be found in Section 3 of provider manuals for professional services. Sample CMS-1500s with TPL information appear at the end of this supplement.

THIRD-PARTY LIABILITY SUPPLEMENT

Institutional Paper Claims

Unlike other claim types, the UB claim form has a section for listing all parties being billed, **including Medicaid**. Medicaid's carrier code, 619, must be entered on all UB claims submitted to Medicaid.

Fields 50, 54, and 60 are the main fields for coding TPL information.

- Identify all other payers, with the primary payer on line A.
- For each payer other than Medicaid, enter the three-digit carrier code in field 50 and the corresponding payment in field 54.
- For denials, enter the carrier code in field 50 and "0.00" in field 54. Then, enter occurrence code 24 and the date of denial in item 31, 32, 33, or 34.
- You are not required to enter a provider number for payers other than Medicaid, though doing so will not affect your claim.
- Enter Medicaid (619) on line B or C. Leave field 54 of the Medicaid line blank; there will never be a prior payment.
- Enter the patient's 10-digit Medicaid ID number on the lettered line (A, B, or C) that corresponds to the Medicaid line in fields 50 – 54. Enter the other policy numbers on the same lettered line as the code and payment for that carrier.

UB-04 TPL Fields

	50 PAYER	51 PROVIDER NO	54 PRIOR PAYMENTS
A	618/620 (Medicare carrier code)		$33.01
B	401 (BCBS carrier code)		$255.39
C	619 (Medicaid carrier code)		

60 CERT.-SSN-HIC.-ID NO.
ABQ1111222
123456789-1212
1234567890

If one claim spans multiple claim forms, fields 50, 51, and 54 must be completed in exactly the same way on each page of the claim.

Complete instructions for filling out UB claim forms can be found in the Hospital Services and Psychiatric Hospital Services provider manuals, and a sample UB-04 with TPL information appears at the end of this supplement.

Dental Paper Claims

For samples and complete instructions for filling out the ADA and CMS-1500 claim forms, refer to the DentaQuest Dental Office Reference Manual (ORM) at http://www.DentaQuest.com

THIRD-PARTY LIABILITY SUPPLEMENT

Web-Submitted Claims

The Web Tool User Guide contains instructions for entering TPL information for all claim types except Dental using the Web Tool. The basic steps are the same as for paper claims.

REJECTED CLAIMS

If you file a claim to Medicaid for which you should have first billed a third-party insurer, your claim will be rejected unless 1) the policy has not yet been uploaded to the MMIS, or 2) the service is in Pay & Chase. The Edit Correction Form will supply information you need to file with the third-party payer.

Insurance Edits

There are six edit codes indicating that a claim has not been filed to other insurers:

- 150: TPL coverage verified/filing not indicated on claim
- 151: Multiple insurance policies/not all filed – call TPL
- 155: Possible, not positive, insurance match/other errors
- 156: TPL verified/filing not indicated on claim
- 157: TPL coverage; no amount other sources on claim
- 953: Buy-in indicated – possible Medicare payer

If you receive one of these edit codes and have not filed a claim with all third parties listed on the ECF, you must do so. **Whenever you receive one of these edits, your subsequent attempts to obtain Medicaid payment must have at least one TPL carrier code and policy number even when there is no primary payment.** If a policy has lapsed by the time a claim is processed, SCDHHS will be unable to correctly identify the claim as TPL-related unless you enter the TPL information.

TPL information appears on the ECF to the right of the Medicaid claims receipt address under the heading "INSURANCE POLICY INFORMATION." The insurance carrier code, the policy number, and the name of the policyholder are all listed on the ECF, while the carrier's address and telephone number may be found in Appendix 2 of your provider manual or on the SCDHHS Web site.

Because of timely filing requirements, you should file with the primary insurer as soon as possible.

If you have already filed a claim with all third parties listed on the ECF, check to see that all the information you entered is correct. Compare the carrier code and policy number you entered on the claim to what appears on the ECF. Enter the correct information on the ECF.

You can also refile a claim instead of returning an ECF. If you choose to refile a claim that was rejected for any reason, you must re-enter all TPL information.

Other TPL-related edit codes include:

165: TPL balance due/patient responsibility must be present and numeric

THIRD-PARTY LIABILITY SUPPLEMENT

316: Third party code invalid

317: Invalid injury code

390: TPL payment amount not numeric

400: TPL carrier and policy number must both be present

401: Amount in other sources, but no TPL carrier code

555: TPL payment is greater than payment due from Medicaid

557: Carrier payments must equal payments from other sources

565: Third-party payment, but no third-party ID

690: Amount from other sources more than Medicaid amount

732: Payer ID number not on file

733: Insurance information coded, but payment or denial indicator missing

953: Buy-in indicated on CIS – possible Medicare

Resolution instructions for these edit codes can be found in Appendix 1 of your provider manual. Sample corrected ECFs appear at the end of this supplement.

CLAIM ADJUSTMENTS AND REFUNDS

If you are paid by a third-party insurer after you have been paid by Medicaid, you should initiate a claim adjustment if you wish to refund the original paid claim in full. You must use the Void/Replacement rather than the Void Only option. Unless there is a replacement claim, new TPL information will not be available to MIVS for investigation and addition to the policy file in the MMIS.

If the refund is for an amount less than the original Medicaid payment, contact MIVS for a manual TPL debit or send a refund check for the appropriate amount. Complete instructions for filing adjustments are in Section 3 of your provider manual, and sample Adjustment Form 130s appear at the end of this supplement. Please remember that hospital providers, pharmacists, and nursing facilities do not use the Form 130.

If you submit a refund to SCDHHS and subsequently discover that it was in error, SCDHHS must receive your credit adjustment request within 90 days of the refund.

Remember: you should not send a check when you make a claim-level adjustment. However, if you need to send a reimbursement check for any reason, fill out the Form for Medicaid Refunds (Form 205 – see the Forms section of your provider manual) and send it with the check to the following address:

South Carolina Healthy Connections
Cash Receipts
PO Box 8355
Columbia, SC 29202

THIRD-PARTY LIABILITY SUPPLEMENT

RECOVERY

"Recovery" refers to all situations where Medicaid or the provider pursues third parties who are liable for claims that Medicaid has already paid. Recovery categories include Retro Medicare, Retro Health, and Pay & Chase.

MIVS is responsible for mailing recovery invoices and posting benefit recovery responses. If you have questions about recovery, please contact them directly. See the contact list at the end of the supplement.

Retro Medicare

SCDHHS invoices institutional and professional medical providers at the beginning of each month for retroactive Medicare coverage (Retro Medicare). You will receive a letter indicating that your account will be debited. The letter identifies Medicare-eligible beneficiaries, claim control numbers, and dates of service, as well as the check date of the automated adjustment and an "own reference number" to identify the debit(s).

You are expected to file the affected claims to Medicare within 30 days of the invoice. After filing to Medicare, you have the option of filing a claim to Medicaid for consideration of an additional payment toward the coinsurance and deductible. Requests for reconsideration of the debit must be received within 90 days of the debit.

If Medicare has denied, you may submit a claim to Medicaid. Provider adjustments will not be submitted for payment in order to eliminate the possibility of duplicate payments. Certain claims for patients with Medicare Part B only, when it is impossible to file them within the one-year timely filing limit, may be an exception.

Despite the extended timely filing deadlines for Medicare-primary claims (six months from Medicare payment or two years from the date of service), you may encounter difficulties with timely filing when Medicare does not make a payment and a claim is in Retro Medicare. If a claim sent to Medicaid is denied with edit 510 for being more than one year after the date of service or six months after the Medicare remittance date, mail, or fax the ECF to MIVS. If the patient is Part B-only and a UB claim form has received edit 510, the ECF should be forwarded or faxed to MIVS. If MIVS determines that the late filing is valid, they will make a credit adjustment.

Claims pulled into Retro Medicare, when filed within 30 days should meet Medicare one year timely filing rule.

Please note that the computer logic also reviews the procedures on the claims and does not pull into recovery procedure codes that are not Medicare covered.

South Carolina Healthy Connections (Medicaid) is responsible for attempting to recover all claims that can be filed within timely filing limits.

Retro Health and Pay & Chase

SCDHHS invoices institutional providers each quarter for Retro Health and Pay & Chase claims. Providers are expected to file the claims to the primary medical plan within the quarter of the invoice and to respond to the recovery letter upon receiving the primary adjudication.

THIRD-PARTY LIABILITY SUPPLEMENT

Approximately four months after the recovery letter, providers are notified of any claims for which there has been no response. Six months after the initial invoice, claims for which there was no response are automatically debited. Requests for reconsideration of the debit must be received within 90 days of the debit. SCDHHS will not reconsider requests after the nine-month cycle.

Retro Health Example

January 2011	Initial invoice
May 2011	Second letter
June 2011	Notification: Automated debit on last check date of the month
September 2011	Deadline for reconsideration

You should submit claims promptly to the primary carriers to avoid receiving timely filing denials from the primary health plans for cost avoidance and for recovery. If you fail to meet timely filing requirements and thus fail to meet a primary carrier's deadline, this is not an acceptable denial; however, when an insurer's timely filing deadline for a date of service is within approximately six weeks of an invoice in Retro Health or possibly before the Medicaid invoice, SCDHHS will accept the insurer's denial and stop a subsequent debit of the Medicaid paid claim from your account.

Insurers occasionally recoup payments made to providers who have put the insurance payment on a Medicaid secondary claim or who have refunded the Medicaid primary payment under Retro Health or Pay & Chase. When the provider submits proof of return of the primary payment, SCDHHS will consider reinstating payment by manual adjustment when the request is received within 90 days of the primary plan request to the provider.

CONCLUSION

Medicaid's ability to fund health care for low-income people relies in part on the success of its cost avoidance measures. For providers, third-party liability responsibilities can be summarized as follows:

- Bill all other liable parties before billing Medicaid.
- Make reasonable, good-faith efforts to get responses from insurers and beneficiaries.
- Code TPL information correctly on claims and ECFs.

THIRD-PARTY LIABILITY SUPPLEMENT

TPL RESOURCES

The PSC is your first source for questions about third-party liability. Listed below are some other resources.

Dental Claims: Provider questions about third party liability should be directed to the DentaQuest Call Center at 1-888-307-6553 or via e-mail at denclaims@dentaquest.com.

SCDHHS Web site: http://www.scdhhs.gov

- Carrier codes
- Provider manuals
- Edit codes and resolutions

Provider Enrollment and Education Web site: http://MedicaideLearning.com

- Web Tool User Guide and Addenda

Medicaid Insurance Verification Services

South Carolina Healthy Connections
PO Box 101110
Columbia, SC 29211-9804

Main Number	1-888-289-0709 option 5
Health Insurance Premium Payment Project	(803) 264-6847 (803) 462-2580 Fax
Benefit Recovery	(803) 462-2582 Fax
Casualty and Estate Recovery	(803) 462-2579 Fax
General Correspondence	(803) 462-2583 Fax

South Carolina Department of Insurance

300 Arbor Lake Drive, Suite 1200
PO Box 100105
Columbia, SC 29223
http://www.doi.sc.gov/

SCDHHS Division of Third-Party Liability

(803) 898-2630

SCDHHS Casualty Department

(803) 898-2977

SCDHHS Health Insurance Department

(803) 898-2907

THIRD-PARTY LIABILITY SUPPLEMENT

SCDHHS Estate Recovery Department

South Carolina Healthy Connections
PO Box 100127
Columbia, SC 29202
(803) 898-2932

THIRD-PARTY LIABILITY SUPPLEMENT

SAMPLE FORMS

Form
Health Insurance Information Referral Form: Carrier change Health Insurance Information Referral Form: Coverage ended Reasonable Effort Documentation Form: Failure to respond – beneficiary Reasonable Effort Documentation Form: Failure to respond – insurer Reasonable Effort Flowchart Adjustment Form 130: Primary insurer paid after the appeal process Adjustment Form 130: Primary insurer payment received after Medicaid payment UB-04: Medicare paid; private insurer denied CMS-1500: Two private insurers; one paid, one denied CMS-1500: Medicare and private insurer paid ECF: Correction to add carrier payment ECF: Correction to add carrier denial and note about policy lapse

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: Acme Dental Clinic Provider ID or NPI: 1234560000

Contact Person: Richard Roe Phone #: 803-555-5555 Date: 03/01/10

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: Jim Smith Date Referral Completed: 02/29/2010

Medicaid ID#: 2222222222 Policy Number: AZ99999999999

Insurance Company Name: OmniCorp Insurers Group Number: 390-OP-777777

Insured's Name: N/A Insured SSN: 777-77-0000

Employer's Name/Address: Retired

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.

__X__ b. beneficiary coverage ended - terminate coverage (date) 12/31/2009

_____ 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) _____

Sample Only

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

DHHS 931 – Updated January 2008

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: Acme Dental Clinic Provider ID or NPI: 1234560000

Contact Person: Richard Roe Phone #: 803-555-5555 Date: 03/01/2010

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: John Doe Date Referral Completed: 02/28/2010

Medicaid ID#: 9999999999 Policy Number: DH123456

Insurance Company Name: National Dental Insurance Group Number: QWE1234

Insured's Name: Jane Doe Insured SSN: 123-45-6789

Employer's Name/Address: South Carolina State Library, 1500 Senate Street, Columbia, SC 29201

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) _____

__X__ d. subscriber changed plans under employer - new carrier is GloboChem

- new policy number is A1111111110

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

Sample Only

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax: 803-252-0870 **or** **Mail:** 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: 803-255-8225 **or** **Mail:** Post Office Box 8206, Attention TPL, Columbia, SC 29202-8206

DHHS 931 – Updated January 2008

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER Acme Orthopedic **DOS** 01/01/10

NPI or MEDICAID PROVIDER ID 1234567890

MEDICAID BENEFICIARY NAME Jane Doe

MEDICAID BENEFICIARY ID# 1111111111

INSURANCE COMPANY NAME Jones Health Insurance

POLICYHOLDER Jane Doe

POLICY NUMBER 987654321J

ORIGINAL DATE FILED TO INSURANCE COMPANY 01/15/10

DATE OF FOLLOW UP ACTIVITY 02/16/10

RESULT:
Called insurer to check claim status. Insurer needs bene to fill out subrogation forms

Sample Only

FURTHER ACTION TAKEN:

Called beneficiary on 02/16/10, 02/18/10, and 02/28/10. No answer and no answering machine. No other contact info on file w/ Medicaid or insurer.

DATE OF SECOND FOLLOW UP 03/05/10

RESULT:

Sent certified letter offering to help bene fill out forms. Bene refused letter. Called insurer 8/10/08; they will not act without forms.

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

Mary Orthoped 03/12/10
(SIGNATURE AND DATE)

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

Revised 06/2007

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER Dr. Betty Smith **DOS** 03/05/10

NPI or MEDICAID PROVIDER ID 1231231230

MEDICAID BENEFICIARY NAME John Jones

MEDICAID BENEFICIARY ID# 9999999999

INSURANCE COMPANY NAME Global Health

POLICYHOLDER John Jones

POLICY NUMBER 8888888888

ORIGINAL DATE FILED TO INSURANCE COMPANY 03/07/10

DATE OF FOLLOW UP ACTIVITY 04/06/10

RESULT:
Called insurer. They received claim and have not suspended it. Sent follow-up letter requesting a response on 04/10/10.

Sample Only

FURTHER ACTION TAKEN:

04/27/10: No response from insurer. Called again; they could not find claim. Resubmitted on 04/29/10.

DATE OF SECOND FOLLOW UP 05/30/10

RESULT:

Called insurer; no action on claim. Notified Dept. of Insurance 05/31/10. Case is still open; Dept. of Ins. advised that we file with Medicaid now, as decision may take some time.

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

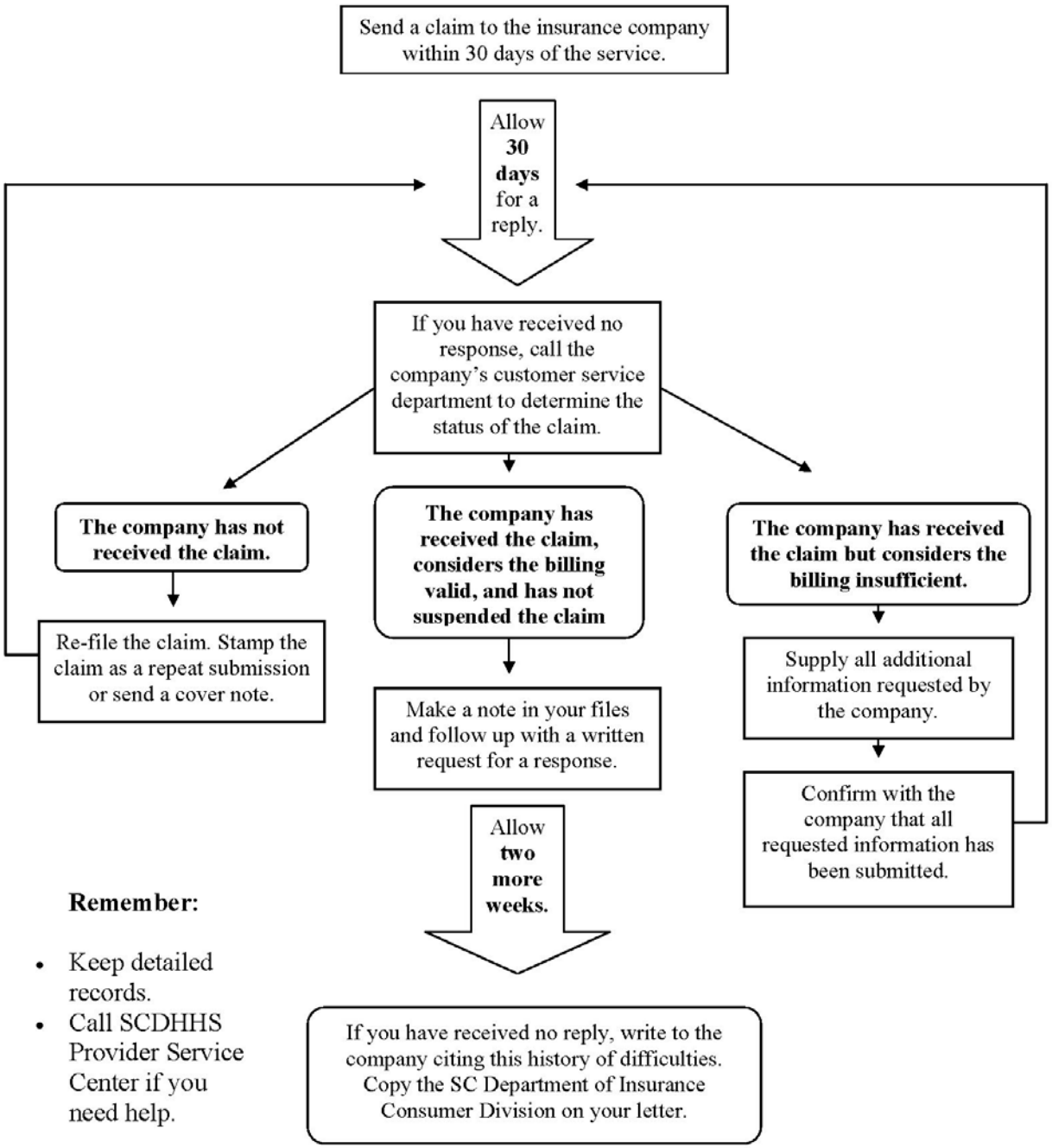
Betty Smith 06/03/10
(SIGNATURE AND DATE)

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

Revised 06/2007

THIRD-PARTY LIABILITY SUPPLEMENT

How to Obtain a Response from Insurance Company
A Suggested Third-Party Filing Process



Remember:

- Keep detailed records.
- Call SCDHHS Provider Service Center if you need help.

THIRD-PARTY LIABILITY SUPPLEMENT

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

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

Provider Address :
111 Oak Lane

Provider City , State, Zip:
Anywhere, SC 22222-2222

Total paid amount on the original claim:
$1244.00

Original CCN: 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 A

Provider ID: A B C 1 2 3

NPI: 1 2 3 4 5 6 7 8 9 0

Recipient ID: 2 2 2 2 2 2 2 2 2 2

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

Sample Only

For Agency Use Only

Analyst ID:

- ○ 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:
Primary insurer paid after the appeal process.

Signature: Jane Doe

Date: 04/01/10

Phone: (555) 555-5555

DHHS Form 130 Revision date: 03-13-2007

THIRD-PARTY LIABILITY SUPPLEMENT

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)
Dr. Joe Jones

Provider Address :
123 Main Street

Provider City , State, Zip:
Somewhere, SC 22222-0000

Total paid amount on the original claim:
$230

Original CCN: 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 A

Provider ID:

NPI: 9 8 7 6 5 4 3 2 1 0

Recipient ID: 7 7 7 7 7 7 7 7 7 7

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:

- ○ 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:

Primary insurance payment received after Medicaid payment.

Signature: *Mary Smith*

Date: 04/01/10

Phone: (803) 555-5555

DHHS Form 130 Revision date: 03-13-2007

THIRD-PARTY LIABILITY SUPPLEMENT

1 ABC MEDICAL CENTER
111 OAK LANE
ANYWHERE SC 22222-0000

2

3a PAT. CNTL # DOE1234
b. MED. REC. # 654321-654321
4 TYPE OF BILL 111
5 FED. TAX NO. 00-0000000
6 STATEMENT COVERS PERIOD FROM 030910 THROUGH 031010
7

8 PATIENT NAME a b JANE DOE
9 PATIENT ADDRESS a 222 MAPLE STREET b COLUMBIA c SC d 22222-2222 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
01011960	F	030910		2	7		01							80	C5					

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a	24	033110													
b															

38
MEDICAID
PO BOX 1458
COLUMBIA SC 29202-1458

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	02	00 00				
b						
c						
d						

	42 REV CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	206	ICU/INTERMEDIATE	975.00	031010	5	4875 00		
2	270	MED/SURG SUPPLY		031010	104	1636 23		
3	350	CT SCAN		031010	2	1821 00		
4	450	EMERG ROOM		030910	1	591 00		
23	0001	PAGE 1 OF 1	CREATION DATE	042910	TOTALS	8923 00	0	

Sample Only

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 9876543210
A	618 MEDICARE				6000 00		57
B	199 ACME HEALTH				0 00		OTHER
C	619 MEDICAID						PRV ID

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A			12345678999		
B			99911111111AZX		
C			1234567890		

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX 288.8 67 A B C D E F G H 68
I J K L M N O P Q

69 ADMIT DX 70 PATIENT REASON DX a b c 71 PPS CODE 72 ECI a b c 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
4131	031010					
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

	76 ATTENDING	NPI	QUAL	
	LAST		FIRST	
	77 OPERATING	NPI	QUAL	
	LAST		FIRST	
	78 OTHER	NPI	QUAL	
	LAST		FIRST	
	79 OTHER	NPI	QUAL	
	LAST		FIRST	

80 REMARKS
81CC a B3 1212121212
b
c
d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

THIRD-PARTY LIABILITY SUPPLEMENT

1500

One Carrier Paid; One Carrier Denied

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) [x] GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): $1244.00

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Johnson DME Supply

3. PATIENT'S BIRTH DATE MM DD YY SEX: Anywhere, SC 22222-2222 M [x] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 A

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: A B C 1 2 3 STATE

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 2 2 2 2 2 2 2 2 2 2 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:

11. INSURED'S POLICY GROUP OR FECA NUMBER: We filed to Medicaid, but then appealed to primary insurer. We won the appeal.

a. OTHER INSURED'S POLICY OR GROUP NUMBER (Insurer denied claim – decided equipment wasn't medically necessary)

a. EMPLOYMENT? (Current or Previous): YES [x] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M F

b. AUTO ACCIDENT? YES [x] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME: (555) 555-5555

c. OTHER ACCIDENT? YES [x] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: Jane Doe

d. INSURANCE PLAN NAME OR PROGRAM NAME: 134

10d. RESERVED FOR LOCAL USE: 1

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [x] YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [x] YES 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 3.

2. 4.

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	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 31 10 01 31 10	11		99999			20 00	1		ZZ / NPI	1212121212 / 1234567890
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 SSN EIN [x]

26. PATIENT'S ACCOUNT NO.: DOE1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [x] YES NO

28. TOTAL CHARGE $ 20 00

29. AMOUNT PAID $ 10 00

30. BALANCE DUE $ 10 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

ABC Clinic

111 Main Street

Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Only

THIRD-PARTY LIABILITY SUPPLEMENT

1500

Medicare Paid; Private Carrier Paid

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [x] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [x] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): $1244.00

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Johnson DME Supply

3. PATIENT'S BIRTH DATE MM DD YY SEX: Anywhere, SC 22222-2222 M [x] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 A

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: A B C 1 2 3 STATE

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 2 2 2 2 2 2 2 2 2 2 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

c. EMPLOYER'S NAME OR SCHOOL NAME: (555) 555-5555

d. INSURANCE PLAN NAME OR PROGRAM NAME: 134

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [x]

b. AUTO ACCIDENT? YES [ ] NO [x] PLACE (State)

c. OTHER ACCIDENT? YES [ ] NO [x]

10d. RESERVED FOR LOCAL USE: 1

11. INSURED'S POLICY GROUP OR FECA NUMBER: We filed to Medicaid, but then appealed to primary insurer. We won the appeal.

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME: Jane Doe

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] 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 3.

2. 4.

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	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	31	10	01	31	10	11		99999			20 00	1		ZZ NPI	1212121212 1234567890
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [x]: 555555555

26. PATIENT'S ACCOUNT NO.: DOE1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [x] NO [ ]

28. TOTAL CHARGE $ 20 00

29. AMOUNT PAID $ 10 00

30. BALANCE DUE $ 10 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

ABC Clinic
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Only

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

THIRD-PARTY LIABILITY SUPPLEMENT

```
RUN DATE 06/01/2010 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
 PROVIDER   RECIPIENT    P AUTH  TPL  INJURY  EMERG  PC COORD    ---- DIAGNOSIS ----          INSURANCE EDITS
    ID         ID        NUMBER        CODE                     PRIMARY   SECONDARY          00-150

  ABC123    1111111111                                            485       787.91           CLAIM EDITS
  NPI: 1234567890
                                                                                             LINE EDITS

 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    **    AGENCY USE ONLY       **
   RES    ALLOWED    LN    DATE OF   PLACE   PROC   MOD             INDIVIDUAL CHARGE  PAY  UNITS **     APPROVED EDITS       **
                     NO    SERVICE          CODE                    PROVIDER     IND            **                          **
                                                          23                                     **   REJECTED LINE EDITS    **
                                                          NDC                                    **                          **
                                                                                                 ******************************
              .00     1    05/07/10    11   85025    000              ABC123     29.50       1.000
          NPI: 1234567890     TAXONOMY: 1212121212                                               !!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
                      2      /  /                                                                !  CLAIMS/LINE PAYMENT INFO  !
          NPI:                TAXONOMY:                                                          !                            !
                      3      /  /                                                                !  EDIT        PAYMENT DATE  !
          NPI:                TAXONOMY:                                                          !!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
                      4      /  /
          NPI:                TAXONOMY:
                      5      /  /
          NPI:                TAXONOMY:
                      6      /  /
          NPI:                TAXONOMY:

    24                25                  26
 INS CARR            POLICY              INS CARR
  NUMBER             NUMBER               PAID                    27  TOTAL CHARGE       29.50

01                                                                 28  AMT REC'D INS       .00   5.00
   401               1231231230           5.00
02                                                                 29  BALANCE DUE        29.50  24.50

03                                                                 30     OWN REF #   DOE12345

RESOLUTION DECISION _R_

  ADDITIONAL DIAG CODES:       .        .        .        .        .        .

                        RETURN TO:                          INSURANCE POLICY INFORMATION
                        MEDICAID CLAIMS RECEIPT
                        P. O. BOX 1412                      401     1231231230
                        COLUMBIA, S.C. 29202-1412           DOE    JOHN

                        PROVIDER:
                        ABC HEALTH PROVIDER
                        PO BOX 00000
                        ANYWHERE,SC 00000-0000
```

Sample Only

THIRD-PARTY LIABILITY SUPPLEMENT

```
RUN DATE 06/01/2010 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
 PROVIDER   RECIPIENT    P AUTH  TPL  INJURY  EMERG  PC COORD    ---- DIAGNOSIS ----          INSURANCE EDITS
    ID         ID        NUMBER        CODE                     PRIMARY   SECONDARY          00-150

  ABC123    1111111111          1                                 485       787.91            CLAIM EDITS
  NPI: 1234567890

                                                                                             LINE EDITS

 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  **    AGENCY USE ONLY       **
   RES    ALLOWED    LN    DATE OF   PLACE   PROC   MOD             INDIVIDUAL CHARGE  PAY  UNITS **     APPROVED EDITS       **
                     NO    SERVICE           CODE                   PROVIDER     IND            **                           **
                                                          23                                     **   REJECTED LINE EDITS     **
                                                          NDC                                    **                           **
                                                                                                 ******************************
              .00     1    05/07/10    11   85025    000              ABC123     29.50       1.000
          NPI: 1234567890     TAXONOMY: 1212121212                                               !!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
                      2      /  /                                                                !  CLAIMS/LINE PAYMENT INFO  !
          NPI:                TAXONOMY:                                                          !                            !
                      3      /  /                                                                !  EDIT        PAYMENT DATE  !
          NPI:                TAXONOMY:                                                          !!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
                      4      /  /
          NPI:                TAXONOMY:
                      5      /  /
          NPI:                TAXONOMY:
                      6      /  /
          NPI:                TAXONOMY:

    24                25                  26
 INS CARR           POLICY              INS CARR
  NUMBER            NUMBER               PAID                    27  TOTAL CHARGE       29.50

01                                                                28  AMT REC'D INS        .00
    401          9999999999          0.00
02                                                                29  BALANCE DUE        29.50

03                                                                30     OWN REF #   DOE12345

RESOLUTION DECISION _R_

  ADDITIONAL DIAG CODES:       .        .        .        .        .        .

                        RETURN TO:                          INSURANCE POLICY INFORMATION
                        MEDICAID CLAIMS RECEIPT
                        P. O. BOX 1412                      401     9999999999
                        COLUMBIA, S.C. 29202-1412           DOE    JOHN
                        PROVIDER:
                        ABC HEALTH PROVIDER
                        PO BOX 00000
                        ANYWHERE,SC 00000-0000
```

(No longer covered by this insurance.)

Sample Only

THIRD-PARTY LIABILITY SUPPLEMENT

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