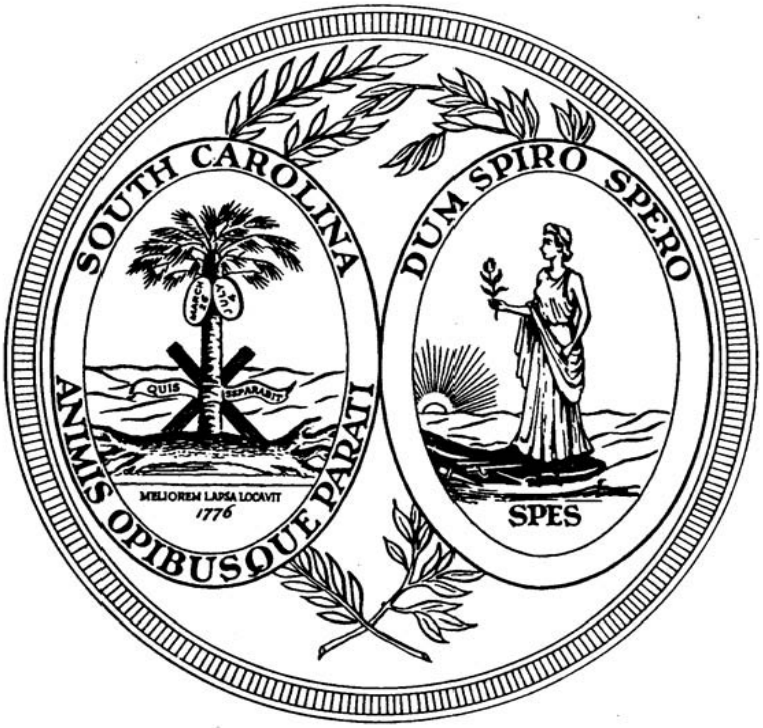
South Carolina Health & Human Services




# SOUTH CAROLINA HEALTHY CONNECTIONS (MEDICAID) PROVIDER MANUAL

## REHABILITATIVE BEHAVIORAL HEALTH SERVICES

July 1, 2010
Updated May 15, 2013

**South Carolina**
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**Post Office Box 8206**
**Columbia, South Carolina 29202-8206**
**www.scdhhs.gov**
June 8, 2010

MHRC

# MEDICAID BULLETIN

**TO:** **Medicaid Rehabilitative Behavioral Health Services Providers**

**SUBJECT:** **Medicaid Policy Manual for Rehabilitative Behavioral Health Services**

The South Carolina Department of Health and Human Services is pleased to announce the new Medicaid Rehabilitative Behavioral Health Services Provider Manual. This manual is effective July 1, 2010, and is to be used for program information and requirements, billing procedures, and provider services guidelines. **Providers are urged to carefully review this manual.**

The manual is organized 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 Rehabilitative Behavioral Health Services.

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 SCDHHS state and county offices, contacts for claim form suppliers and vendors, and information about obtaining forms and manuals.

The Forms section includes forms and form samples referenced throughout the manual, as well as some generic forms.

The **appendices** include the following:

- Appendix 1: Edit Codes, CARCs & RARCs, and Resolutions
- Appendix 2: Carrier Codes
- Appendix 3: Schedule of Copayments

The **Third-Party Liability Supplement** explains third-party liability requirements and recommended practices. It includes sample forms and resources.

The **Managed Care Supplement** contains information on the managed care program, including pictures of the cards issued by the various managed care plans.

The most current version of the provider manual is maintained on the SCDHHS Web site at **www.scdhhs.gov**. [On the SCDHHS home page, click on the Provider Manuals link listed under the heading "Providers."] The Web site is updated on the first of every month to reflect any minor non-policy changes to provider manuals (for example, corrections to addresses, etc.).

**Note**: **SCDHHS policy changes continue to be conveyed to providers as they occur via Medicaid bulletin; manuals are revised to reflect those changes as they occur. Providers with access to the Internet should check the SCDHHS Web site monthly to access information about any updates made to the provider manuals.**

Should you wish to order a printed copy of the provider manual, please call South Carolina Medicaid Provider Outreach at (803) 264-9609. Charges for printed manuals are based on actual costs of printing and mailing.

To order a compact disk (CD) of the provider manual, please call the Provider Outreach number listed above. There is no charge for a provider manual CD. To access the files on the CD, 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 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 Division of Family Services at 898-2564. Thank you for your continued support of the South Carolina Medicaid program.

/S/
Emma Forkner
Director

EF/mwcj

Enclosure

**NOTE: To receive Medicaid bulletins by e-mail, please register at http://bulletin@scdhhs.gov/**
**To sign up for Electronic Funds Transfer of your Medicaid payment, please go to http://www.dhhs.state.sc.us/dhhsnew/hippa/index.asp and select "Electronic Funds Transfer (EFT) for instructions.**

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## MANAGED CARE SUPPLEMENT

## THIRD-PARTY LIABILITY SUPPLEMENT

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 05-15-13 | 2 | 1<br>3<br>11<br>31<br>54<br>70<br><br>87<br>107 | Updated the following sections:<br>• Rehabilitative Services Overview<br>• Provider Qualifications<br>• Eligibility for Rehabilitative Services<br>• Documentation Requirements<br>• Core Rehabilitative Service Standards<br>• Core Treatment – Therapy and Counseling Services<br>• Community Support Services<br>Added Substance Abuse Treatment Services Section |
| 05-15-13 | 4 | 1-4<br><br>6-11 | • Updated Assessment, Therapy Service, and Support services procedure codes table<br>• Updated DAODAS only procedure codes table |
| 05-15-13 | Forms | - | Added Rehabilitative Behavioral Health Services(RBHS) Program Update Form |
| 05-01-13 | 3 | 6 | Deleted Place of Service Code 21 |
| 04-01-13 | 1 | 6 | Corrected the URL for MedicaideLearning.com |
| 04-01-13 | 4 | 1-4<br><br>5-10 | • Updated Assessment, Therapy Service, and Support services procedure codes table<br>• Added DAODAS procedure codes table |
| 04-01-13 | Appendix 1 | 2<br><br>20, 25, 28<br>4, 39, 52, 53, 57, 59 73<br>50, 51<br>67, 69 | • Changed edit code description reference DMR and MR/RD to ID/RD for edit code 052<br>• Updated CARCs for edit codes 460, 544, 569<br>• Updated resolutions for edit codes 079, 722, 837, 838, 855, 865, 960<br>• Added edit codes 820, 821<br>• Updated edit code 935, 938, 939 |
| 04-01-13 | Appendix 2 | - | Updated carrier code list |
| 03-01-13 | 2 | 7, 8 | • Changed mental retardation to intellectual disabilities or related disabilities |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 03-01-13 | 4 | 1-4<br><br>5-10 | • Updated Assessment, Therapy Service, and Support services procedure codes table<br>• Added DAODAS procedure codes table |
| 03-01-13 | 5 | 10 | Deleted Jasper County PO Box address |
| 03-01-13 | Appendix 1 | i<br>2, 38, 70<br><br>38, 54, 70 | Deleted Change Log<br>Changed edit code description reference to DMR and MR/RD to ID/RD for edit codes 052, 053, 712, and 953<br>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 | Forms | - | Revised DHHS Form 254 |
| 02-01-13 | 4 | - | • Updated RBHS procedure code table<br>• Added new table for DAODAS only procedure codes |
| 01-11-13 | Forms | - | Corrected procedure code for Diagnostic Assessment without medical- initial on Form 254 |
| 01-04-13 | Forms | - | Corrected procedure codes for Individual Psychotherapy on Form 254 |
| 01-01-13 | 2 | 39<br>41<br>42<br>43 | Updated the following sections:<br>• Diagnostic Assessment<br>• Initial Assessment<br>• Follow-up Assessment<br>• Billing/Frequency Limits |
| 01-01-13 | 4 | 1-8 | Updated procedure code table |
| 01-01-13 | 5 | 7<br>9 | • Added Chester county Zip+4 code<br>• Updated Greenville PO Box address |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 01-01-13 | Forms | - | Updated Form 254 |
| 01-01-13 | Appendix 1 | - | Added Change Log for section changes |
| 12-03-12 | 1 | 6<br>7-8<br>27-32<br>33-41 | • Updated web addresses for provider information and provider training<br>• Revised heading and language to reflect new provider enrollment requirements<br>• Updated Program Integrity language (entire section)<br>• Revised heading and language for Medicaid Anti-Fraud Provisions/Payment Suspension/Provider Exclusions/Terminations (entire section) |
| 12-03-12 | 3 | 6<br>10-11<br>19, 34, 37<br>25-26 | • Updated National Provider Identifier and Medicaid Provider Number<br>• Updated fields 17, 17b to add requirement for referring or ordering provider NPI<br>• Updated provider information web addresses<br>• Updated Electronic Funds Transfer (EFT) |
| 12-01-12 | 5 | Need page numbers | • Updated URL for provider information<br>• Updated McCormick county office telephone number |
| 12-01-12 | Appendix 1 | 24, 26, 27, 32, 33<br>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<br>• 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 | Page(s) | Change |
|---|---|---|---|
| 11-01-12 | 2 | 3-7<br>7<br>7<br>9<br>10<br>10<br>16 | Updated the following sections:<br>• Provider Qualifications (entire section)<br>• Eligibility for Rehabilitative Services<br>• Medical Necessity<br>• Services Directly Provided by State Agencies<br>• Referrals to Private Organizations<br>• State Agency Referrals<br>• Medicaid RBHS Staff Qualification for LISW-CP and SAP |
| 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 | 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 | 3 | 1, 26, 31, 34, 38<br>7, 19, 25 | • Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012<br>• Updated hyperlinks |
| 08-01-12 | 5 | 1<br>5<br>7 | • Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012<br>• Removed fax request information for SCDHHS forms<br>• Added SCDHHS forms online order information<br>• Updated telephone number for Greenville county office |
| 08-01-12 | Forms | - | • Deleted forms 140 and 142<br>• Updated Duplicate Remittance Advice Request Form |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 08-01-12 | Appendix 1 | -<br><br>1, 24, 60, 65, 66-67,70-72<br>15, 31, 69<br>8, 10, 29, 31<br>10, 11, 14, 34, 48 | • Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012<br>• 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<br>• Added edit codes 349, 590, 978, 990, 991-995<br>• Deleted edit codes 166, 205, 573, 574, 593, 596<br>• Updated resolution for edit codes 170-172, 171, 174, 210, 321, 711, 798 |
| 08-01-12 | Managed Care Supplement | 1-2<br>7<br>11<br>17<br>19 | • Changed Division of Care Management to Bureau of Managed Care<br>• Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012<br>• Removed language limiting enrollment to 2500 members<br>• Update contact information for Palmetto Physician Connections<br>• 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<br>45 | • Deleted edit codes 386 and 868<br>• Added edit codes 837, 838, 839 |
| 07-01-12 | Appendix 2 | - | Updated carrier codes |
| 05-01-12 | Appendix 1 | 62 | Updated edit code 975 |
| 04-01-12 | 1 | 4 | Replaced South Carolina Healthy Connections card |
| 04-01-12 | 5 | 11<br>12 | • Updated address for Marion County<br>• Updated phone number for Newberry County |
| 02-07-12 | Cover | - | Manual cover updated January 1, 2012 |
| 02-07-12 | Appendix 1 | 18<br>24<br>30 | • Updated edit code 402<br>• Updated edit code 544<br>• Updated edit code 636, 637, and 642 |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 02-01-12 | 2 | 3<br>6<br>9 | • Updated Private Organizations<br>• Deleted Provisional Enrollment section<br>• Updated Eligibility for Rehabilitative Services |
| 02-01-12 | 3 | 22<br>24 | • Added a note regarding The Web Tool<br>• Updated the Remittance Advice -835 Transaction |
| 02-01-12 | 5 | 9 | Updated the Fairfield county office number |
| 02-01-12 | Appendix 1 | 18<br>30<br>42<br>49 | • Updated edit code 402<br>• Updated edit code 636, 637, and 642<br>• Updated edit code 766<br>• 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 | 3 | -<br>25 | • Updated hyperlinks throughout section<br>• 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<br><br>- | • Deleted IVRS Information per “Retirement of Toll Free Eligibility Verification Line” bulletin released 11-18-11<br>• 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 |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 11-01-11 | 3 | 39, 43, 44 | Updated TPL contact information |
| 11-01-11 | TPL Supplement | 6, 15<br>12<br>3, 17, 19 | • Changed Medicare timely filing requirement to two years and six months<br>• Deleted policy to use Medicaid legacy provider number on the same line as the Medicaid carrier code<br>• Deleted sample legacy number from UB-04 TPL Fields table<br>• Updated TPL contact information |
| 10-01-11 | Appendix 1 | 14, 29<br>47 | • Added edit codes 334 and 584<br>• Updated edit code 845 |
| 09-01-11 | 1 | 19 | Deleted information regarding National Correct Coding Initiative |
| 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 | 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 |
| 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<br>43<br>56 | • Updated resolution for edit code 300<br>• Added edit codes 840 and 841<br>• Updated Provider Enrollment Contact information in edit codes 941 and 944 |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 07-01-11 | Appendix 3 | 1 | Updated the copayment schedule per the bulletin effective July 8, 2011 |
| 06-01-11 | 5 | 5 | Corrected Abbeville County PO Box Zip+4 Code |
| 06-01-11 | Forms | - | Removed Referral Request for Out of State Therapeutic Treatment Services form |
| 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 |
| 04-01-11 | 2 | 3<br>5& 6 | • Updated language for Private Organizations<br>• Updated policy and Web sites for New Provider Enrollment for Private Organizations |
| 04-01-11 | 5 | 6 | Updated telephone number for Beaufort County |
| 04-01-11 | Forms | - | Updated Electronic Funds Transfer Form |
| 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 | 5, 6 | Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center |
| 03-01-11 | 3 | 20, 21, 27, 28 | Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center |
| 03-01-11 | 5 | 4<br><br>5 | Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center<br>Added toll free number for Aiken County |
| 03-01-11 | Appendix 1 | -<br><br>67 | Added SCDHHS Medicaid Provider Service Center (PSC) information at top of each page in header section<br>Made change to Edit Code 990 description |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 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<br><br>24, 25 | • Changed the name of the Provider Outreach Web site to Provider Enrollment and Education<br>• Updated the descriptions for Form130s |
| 02-01-11 | 2 | - | Reformatted sections throughout document |
| 02-01-11 | Appendix 1 | 3 | Added edit codes 079 and 080 |
| 01-01-11 | 1 | 7<br><br>19-20 | • Updated the South Carolina Medicaid Web-based Claims Submission Tool section<br>• Updated to reflect Medicaid Bulletin dated December 8, 2010 – Information on NCCI Edits |
| 01-01-11 | 2 | 3-5<br>5-6<br><br>6-7<br>7<br>7<br>9<br>11<br>19<br>30<br>37<br>40<br>55<br><br><br><br>12<br>12-13<br><br>14<br><br><br>15 | • Updated the following sections:<br>o Private Organizations<br>o New Provider Enrollment for Private Organizations<br>o RBHS Enrollment Application<br>o Provisional Enrollment<br>o Reporting Changes<br>o Closure of a RBHS Provider<br>o Eligibility for Rehabilitative Services<br>o Maintenance of Staff Credentials<br>o Billable Code/Location of Service<br>o Addendum IPOC<br>o Progress Summaries<br>o Special Restrictions<br>• In the following sections, updated the medical necessity authorizing staff to include only the state referring LPHA:<br>o Medical Necessity<br>o Contents of the SCDHHS Medical Necessity Statement (MNS)<br>o Referrals to Private Organizations<br>o Referrals to Private Organizations, Medical Necessity<br>o Diagnostic Assessment Services |
| 01-01-11 | 3 | 21, 25, 26, 28 | • Updated electronic remittance package information |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| | | 18, 34<br><br>25 | • Updated to reflect Medicaid Bulletin dated December 10, 2010 – Reporting Patient Liability on Claims<br>• Updated to reflect Medicaid Bulletin dated December 10, 2010 – Requests for Duplicate Remittance Package |
| 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<br>8<br><br>10<br><br>13<br><br>15<br><br><br><br><br>15 | • Removed references to Dental claims<br>• Removed language to contact program areas for missing carrier codes<br>• Added reference to CMS-1500 for correcting edit code 151 on the ECF<br>• Added edit code 165 to other TPL-related insurance edit codes list<br>• Updated Retro Medicare section to include the following:<br>o Changed the timely filing requirement from 90 days of the invoice to 30 days<br>o Added SCDHHS TPL recovery language<br>• 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<br>16 | • Edit code 202: added information to Resolution section |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| | | 32<br><br>51<br>52 | • Edit codes 421 and 424 deleted<br>• Edit code 733 information updated in Resolution section: "Adjust the net charge in field" changed from 26 to 29<br>• Deleted edit code 959<br>• Deleted edit codes 962 and 963 |
| 11-01-10 | TPL Supplement | 3, 8, 13-14, 18-19<br><br>6, 15-17 | • Updated to reflect Medicaid Bulletin dated July 8, 2010 – Transfer of the Dental Program Administration to DentaQuest<br>• Updated to reflect Medicaid Bulletin dated September 13, 2010 – Changes to the Third Party Liability Medicare Recovery Cycle |
| 10-01-10 | 1 | -<br><br><br>1<br>7<br><br><br>10 | • Removed all reference to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program<br>• Updated Program Description section<br>• 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<br>• Updated Freedom of Choice section |
| 10-01-10 | 5 | 11 | Correct McCormick county office street address |
| 10-01-10 | Managed Care Supplement | -<br><br><br>1<br>2<br><br>3<br>4<br>5<br>6<br>13<br>17 | • Removed all references to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program<br>• Updated Managed Care Overview<br>• Updated Managed Care Organizations and Core Benefits paragraphs<br>• Updated MCO Program ID card paragraph<br>• Updated MHN Program ID card paragraph<br>• Updated Core Benefits<br>• Updated Exempt Services<br>• Updated Overview<br>• Deleted "Medicaid Managed" from "Current Medicaid Managed Care Organizations" heading and following paragraph |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 09-01-10 | 5 | 5<br>8<br>11 | • Removed County Commissioner's Building from the Aiken County address<br>• Deleted Dorchester County physical address telephone number<br>• Removed Highway 28 N from the McCormick County address |
| 09-01-10 | Appendix 1 | 9<br>- | • Added edit code 225<br>• Removed all references to the ADA Claim in the Resolution column |
| 09-01-10 | TPL Supplement | 12<br>13<br>18 | • Updated the Dental Paper Claims section to delete paper claims submission instructions and added the DentaQuest contact information<br>• Updated the Web-Submitted Claims section with the exception to Dental claims<br>• Updated the TPL Resources section to include the DentaQuest contact information for TPL questions |
| 08-01-10 | 2 | 2<br>3, 4<br>6<br>7<br>8<br>9<br>12<br>14<br>32<br>48 | • Updated the following sections:<br>o Rehabilitative Services Overview<br>o Private Organizations<br>o New Provider Enrollment for Private Organizations<br>o Private Organization Requirements<br>o Reporting Changes<br>o Closure for a RBHS Provider<br>o Contents of the SCDHHS Medical Necessity Statement (MNS)<br>o Medical Necessity<br>o Billable Code/Location of Service<br>• Updated the Billing/Frequency Limits for Diagnostic Assessment Services Chart |
| 08-01-10 | 3 | 7-8 | Updated modifiers |
| 08-01-10 | 4 | 1-8 | Updated modifiers |

# CHANGE CONTROL RECORD

| Date | Section | Page(s) | Change |
|---|---|---|---|
| 08-01-10 | 5 | 5, 9,<br>11-13<br>6 | • Updated the zip codes for Aiken, Edgefield, McCormick, Newberry, and Saluda counties<br>• Updated the address for Barnwell County<br>• Updated the telephone number for Beaufort County |
| 08-01-10 | Forms | - | Updated DHHS Form 254 |
| 08-01-10 | Appendix 1 | 20<br>51, 52<br><br>59 | • Deleted edit code 520<br>• Deleted Provider Enrollment e-mail address from codes 941 and 944<br>• Changed resolution for edit code 994 |
| 07-01-10 | 5 | - | Updated telephone numbers and zip codes for multiple county offices |
| 07-01-10 | Appendix 1 | 32<br>35 | • Updated edit code 714<br>• Updated edit code 738 |
| 07-01-10 | Appendix 2 | 21, 22,<br>25, 63,<br>89 | Changed First Health to Magellan Medicaid Administration |

# SECTION 1

# GENERAL INFORMATION AND ADMINISTRATION

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# SECTION 1

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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

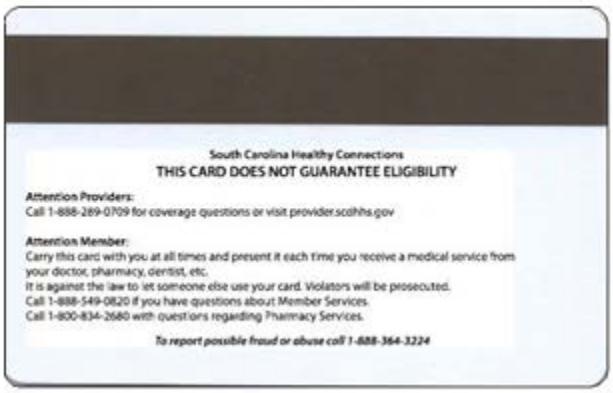
### MEDICARE / MEDICAID ELIGIBILITY (CONT'D.)

**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:

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## 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.

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## 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:

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## 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:

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## 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.

# SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

## APPEALS

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# SECTION 2 POLICIES AND PROCEDURES

## REHABILITATIVE SERVICES OVERVIEW

Effective July 1, 2010, the South Carolina State Medicaid Plan was amended to allow an array of behavioral health services under the Rehabilitative Services Option, 42 CFR 440.130(d). Rehabilitative Behavioral Health Services (RBHS) are medical or remedial services that have recommended by a physician or Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under South Carolina State Law and as further determined by the SCDHHS for maximum reduction of physical or mental disability and restoration of a beneficiary to their best possible functional level. This section describes these services, legal authorities, and the characteristics of the providers of services.

The purpose of this manual is to provide pertinent information to Rehabilitative Behavioral Health Services providers for successful participation in the South Carolina Medicaid Program. This manual provides a comprehensive overview of the program, standards, policies and procedures for Medicaid compliance. This provider manual only addresses the RBHS policy for state agencies and private organizations as service providers. All providers are required to meet all requirements as set forth in this policy manual for the delivery of Rehabilitative Behavioral Health Services and all applicable state and federal laws. Updates and revisions to this manual will be made by the South Carolina Department of Health and Human Services (SCDHHS) and will be made in writing to all providers.

SCDHHS encourages the use of “evidence-based” practices and “emerging best practices” that ensure thorough and appropriate screening, evaluation, diagnosis, and treatment planning, and fosters improvement in the delivery of mental health services to children and adults in the most effective and cost-efficient manner. Evidence-based practices are defined as preferential use of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems.

# SECTION 2 POLICIES AND PROCEDURES

## REHABILITATIVE SERVICES OVERVIEW

### REHABILITATIVE SERVICES OVERVIEW (CONT'D.)

The National Registry of Evidence-based Programs and Practices and other relevant specialty organizations publish lists of evidence-based practices that providers may reference.

Rehabilitative Behavioral Health Services are available to all Medicaid beneficiaries with a behavioral health disorder, as defined by the current edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM)* or the *International Classification of Diseases (ICD)* who meet medical necessity criteria. Rehabilitative services are provided to, or directed exclusively, toward the treatment of the Medicaid-eligible beneficiary for the purpose of ameliorating disabilities, improving the beneficiary's ability to function independently, and restoring maximum functioning through the use of diagnostic and restorative services.

Eligible beneficiaries may receive Rehabilitative Behavioral Health Services from a variety of qualified Medicaid providers. Public agencies that contract with the South Carolina Medicaid Program as qualified service providers may render Rehabilitative Behavioral Health Services directly to an eligible beneficiary. Private organizations may also render RBHS provided services have been prior authorized by a state referring agency.

# SECTION 2 POLICIES AND PROCEDURES

## PROVIDER QUALIFICATIONS

### RBHS ENROLLMENT APPLICATION

Potential applicants may access the online Medicaid enrollment application on the SCDHHS website. Once enrolled, providers are required to revalidate every five years.

Applicants must complete the online provider enrollment application. On the application, providers must select "New Enrollment" and the following options:

| FIELD | OPTION |
|---|---|
| Enrollment Type | Organization |
| Provider Type | Behavioral Health Services |
| Primary Specialty | Private Rehabilitative Behavioral Health Services |

Application submitted to SCDHHS with any options other than those specified in the table above will be denied.

If you have any questions, contact SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or you may submit an online inquiry at http://www.scdhhs.gov/contact-us.

To enroll as a RBHS Medicaid provider, please contact SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or you may submit an online inquiry at http://www.scdhhs.gov/contact-us.

Updates and changes will continue to be posted on the SCDHHS Web site at http://www.scdhhs.gov/.

Providers are encouraged to subscribe to SCDHHS Medicaid Bulletins located on our Web site under Providers, to receive bulletins and newsletters via email. You may review the RBHS manual for policy and procedures at the SCDHHS Web site at www.scdhhs.gov.

To participate in the South Carolina Medicaid Program, applicants must meet appropriate federal and state licensure, and all requirements outlined in the SCDHHS provider enrollment policy and this section including, but not limited to the following:

# SECTION 2 POLICIES AND PROCEDURES

## PROVIDER QUALIFICATIONS

### RBHS ENROLLMENT APPLICATION (CONT'D.)

- Complete the SCDHHS online Enrollment Application for RBHS and fee requirements
- New applicants and providers seeking revalidation shall be subject to a pre and post site visit.
- Providers must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or the Joint Commission in Behavioral Health Services
- LPHA or medical staff must be licensed or registered with the State where the business is located
- The applicant must have a business license from the state and/or municipality or county where the service will be provided
- Physical business site must be located in the SC Medicaid Service Area (SCMSA)
- Proof of General Liability insurance coverage worth at a minimum of $600,000
- Proof of Worker's Compensation insurance, if five or more personnel staff
- Accept the reimbursement rates established by Medicaid for RBHS

**Enrollment in the South Carolina Medicaid Program does not provide a guarantee of referrals or a certain funding level. Failure to comply with all Medicaid policy requirements may result in termination of Medicaid enrollment.**

**As a condition of participation in the Medicaid program, the provider must ensure that adequate and correct fiscal and medical records shall be kept to disclose the extent of services rendered and ensure that claims for funds are in accordance with all applicable laws, regulations, and policies.**

### ADDITIONAL REQUIREMENTS

Once enrolled, these additional requirements must be met:

- SCDHHS and USDHHS assume no responsibility with respect to accidents, illness or claims arising out of any activity performed by any State or private organization. The organization shall take necessary steps to insure or protect its recipient,

# SECTION 2 POLICIES AND PROCEDURES

## PROVIDER QUALIFICATIONS

### ADDITIONAL REQUIREMENTS (CONT'D.)

itself and its personnel. The provider agrees to comply with all applicable local, staff, and federal occupational and safety acts, rules and regulations.

- Providers must have cost information available for review by SCDHHS upon request.
- Providers must have a policy on file for the definition of confidentiality issues, record security and maintenance, consent for treatment, release of information, beneficiary's rights and responsibilities, retention procedures, and code of ethics.
- If the provider receives annual Medicaid payments of at least $5,000,000, the provider must comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005, Employee Education about False Claims Recovery.
- Providers must submit an attestation statement annually due July 1st of every year. Providers are subject to termination, if the attestation is not received by the annual due date. The attestation letter must be submitted to the Division of Behavioral Health Services. (See Sample Attestation Statement in the Forms section of this manual.)

  SC Department of Health and Human Services
  Behavioral Health Services
  Post Office Box 8206
  Columbia, SC 29202-8206
  Fax (803) 255-8402

### MAINTENANCE OF STAFF CREDENTIALS

Providers shall ensure that all staff, subcontractors, volunteers, interns, and other individuals under the authority of the provider who come into contact with beneficiaries are properly qualified, trained, and supervised. Providers must comply with all other applicable state and federal requirements.

# SECTION 2 POLICIES AND PROCEDURES

## PROVIDER QUALIFICATIONS

### MAINTENANCE OF STAFF CREDENTIALS (CONT'D.)

All RBHS providers must maintain and make available upon request, appropriate records and documentation of such qualifications, trainings and investigations. If these records are kept in a central "corporate office," the provider will be given five business days to retrieve the records for the agency that is requesting them.

All providers of RBHS shall maintain a file substantiating that each staff member meets staff qualifications. This shall include employer verification of staff certification, licensure, and work experience. The treatment provider must maintain a signature sheet that identifies all professionals providing services by name, signature, and initial.

All providers who enroll with South Carolina Medicaid to provide services in a category that require a professional license must be licensed to practice in the State of South Carolina and must not exceed their licensed scope of practice under state law. Providers rendering services outside of the South Carolina border must not exceed the licensed scope of practice granted under that state's laws. Providers who enroll as a physician or LPHA must be able to document experience working with the population to be served. Any services that are provided by staff who do not meet SCDHHS staff qualification requirements are subject to recoupment.

The following general training requirements apply:

- All providers must ensure treatment staff receives adequate orientation to RBHS.
- The content of the training must be directly related to the duties of the individual receiving the training.
- Individuals who are qualified to conduct such training shall carry out the instruction.
- Documentation of the training received and successfully completed shall be kept in the individual's personnel file.
- Documentation of the training shall consist of an outline of the training provided and the trainer's credentials.
- When required, document the completion of certification criteria.

# SECTION 2 POLICIES AND PROCEDURES

## PROVIDER QUALIFICATIONS

### MAINTENANCE OF STAFF CREDENTIALS (CONT'D.)

In addition to documentation of the training received by staff and documentation of staff credentials, the providers must keep the following specific documents on file for existing and new employees:

- A completed employment application form
- Copies of the official college diploma or high school diploma or GED, or transcripts with the official raised seal
- A copy of all applicable licenses
- Letters or other documentation to verify previous employment or volunteer work that documents work experience with the population to be served.
- A copy of the individual's criminal record check form from an appropriate law enforcement agency. Verification from the child abuse registry that there are no findings of abuse or neglect against the individual.
- Verification from the state and national sex offender registries that there are no findings of criminal charges against the individual. Sex offender and child abuse registries should be checked annually.
- Copies of all facility licenses
- The provider must identify a CEO or director responsible for the business operation of the entity. The provider must also identify a clinical director responsible for supervision of the RBHS program. The clinical director must be a licensed and/or master's level clinical professional. An organization must include a clinical director and two other professional or paraprofessional staff that provide RBHS. **It is the provider's responsibility to ensure staff operates within the scope of practice as required by South Carolina State law.**

# SECTION 2 POLICIES AND PROCEDURES

## PROVIDER QUALIFICATIONS

### Reporting Changes

Changes affecting business operations must be reported using the RBHS provider update form and submit to the Behavioral Health Division as soon as possible. Certain changes may impact your status as a Medicaid provider. The RBHS provider form can be found in the Form section of the manual.

The following changes must be reported by the director/Chief Executive Officer(CEO):

- Email addresses, or telephone numbers of the business office
- Clinical Director
- Staff Licensure
- Business Licenses
- Accreditation status
- DHEC Residential Facility licensure
- DSS licensure
- Other changes which affect compliance with Medicaid requirements

Exceptional circumstances may require that a new Enrollment Application for RBHS be completed prior to approval. Providers must use the online application process on our Web site, http://provider.scdhhs.gov, to add or change a location and business ownership to an existing enrollment.

Providers wishing to expand their RBHS must obtain approval from the Division of Behavioral Health Services program representative prior to expansion. Expansion is defined as adding a new population to be served, and adding an additional service.

### Closure of a RBHS Provider

In the event the provider is no longer operational and closes for business, the provider will adhere to all applicable federal and state laws, rules, and regulations, including but not limited to, the following requirements:

1. If the provider voluntarily terminates his or her agreement with Medicaid, a written notification must be received by SCDHHS and other appropriate agencies within 30 days of closing the facility. The notification shall include the location

# SECTION 2 POLICIES AND PROCEDURES

## PROVIDER QUALIFICATIONS

**Closure of a RBHS Provider (Cont'd.)**

where the beneficiary and administrative records will be stored.

2. If the provider is terminated involuntarily by Medicaid, the provider is responsible for all beneficiary and administrative records in the event of a post-payment review.

The owner(s) of the RBHS business entity provider is responsible for retaining administrative and beneficiary records for five years.

**RBHS Services**

The following services are in accordance with this policy manual:

- Behavioral Health Screening
- Diagnostic Assessment
- Psychological and Evaluation and Testing
- Individual Psychotherapy
- Group Therapy
- Family Therapy
- Service Plan Development
- Crisis Management
- Counseling Services
- Medication Management
- Psychosocial Rehabilitation Services
- Family Support
- Behavior Modification (children only)

**Managed Care Organization**

Some behavioral health services are covered for beneficiaries enrolled in Medicaid Managed Care Organizations (MCO). If the service is covered by the MCO, the provider must claim reimbursement from the MCO directly. Therefore, providers must have a relationship with the MCO in order to provide the services and receive reimbursement. Providers are encouraged to visit the SCDHHS Web site at https://msp.scdhhs.gov/managed care/ for additional information regarding MCO coverage.

# SECTION 2 POLICIES AND PROCEDURES

## PROVIDER QUALIFICATIONS

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# SECTION 2 POLICIES AND PROCEDURES

## ELIGIBILITY FOR REHABILITATIVE SERVICES

The determination of eligibility for Rehabilitative Behavioral Health Services (RBHS) should include a system-wide assessment and/or an intake process. This requires that specific information be gathered consistently regardless of the assessment tool being used. Medicaid-eligible beneficiaries may receive RBHS when there is a confirmed psychiatric diagnosis from the current edition of the DSM or the ICD. This excludes irreversible dementias, intellectual disabilities or related disabilities, and developmental disorders unless they co-occur with a serious mental disorder that meets current edition DSM criteria. Developmental disabilities should not be confused with mental disorders. Persons with a developmental disability should be carefully assessed to determine if there are co-occurring behavioral problems and if those problems could be addressed with RBHS. A determination should be made if the beneficiary is reasonably expected to improve in adaptive, social, and/or behavioral functioning from the delivery of RBHS.

The use of V-codes is allowed under certain circumstances, but in general is considered temporary. V-codes may not be used for longer than six-month duration for beneficiaries ages 7 and older. V-codes do not replace a psychiatric diagnosis from the current edition of the DSM or the ICD. After six months, if continued services are necessary, the treating clinician is expected to assess the beneficiary to determine an appropriate diagnosis code. The use of V-codes is not time limited for children ages 0 to 6 of age. Clinical documentation justifying the need for continued RBHS must be maintained in the child's clinical record.

### MEDICAL NECESSITY

In order to be covered under the Medicaid program, a service must be medically necessary. Medical Necessity means the need for treatment services is necessary to diagnose, treat, cure, or prevent an illness, or participation in services is reasonably expected to relieve pain, improve and preserve health, or be essential to life.

# SECTION 2 POLICIES AND PROCEDURES

## ELIGIBILITY FOR REHABILITATIVE SERVICES

### MEDICAL NECESSITY (CONT'D.)

All Medicaid beneficiaries must meet specific medical necessity criteria to be eligible for RBHS. A physician or LPHA must certify that the beneficiary meets the medical necessity criteria for services. LPHAs authorized to render services can be found under Licensed Practitioners of the Healing Arts (LPHAs).

The determination of medically necessary treatment must be:

- Based on information provided by the beneficiary, the beneficiary's family, and/or collaterals who are familiar with the beneficiary
- Based on current clinical information. (If the diagnosis has not been reviewed in a 12 or more months, the diagnosis should be confirmed immediately.)
- Made within SCDHHS standards for timeliness
- Made by a physician or LPHA employed by the state referring agency. **LPHAs employed by private organizations are not authorized to determine medical necessity.**

### Contents of the SCDHHS Medical Necessity Statement

If Medical Necessity is confirmed using the SCDHHS Medical Necessity Statement (MNS), it must include the following information to be valid:

- The beneficiary's name, date of birth, and Medicaid number or social security number. If the Medicaid number is not available at the time of the referral, the state agency must furnish the Medicaid number to the service provider when it becomes available. The Medicaid number must be added to the SCDHHS MNS.
- A psychiatric diagnosis from the current edition of the DSM or the ICD, excluding irreversible dementias, intellectual disabilities or related disabilities, and developmental disorders, unless they co-occur with a serious mental disorder that meets the current edition DSM criteria
- The specific rehabilitative service(s) recommended
- Identification of the beneficiary's problem areas

# SECTION 2 POLICIES AND PROCEDURES

## ELIGIBILITY FOR REHABILITATIVE SERVICES

### Contents of the SCDHHS Medical Necessity Statement (MNS) (Cont'd.)

- The physician's or LPHA's name, professional title, signature, and date (of the professional LPHA employed by the state referring agency)

The SCDHHS MNS must be maintained in the Medicaid beneficiary's clinical record and available during post-payment review.

### Duration of the SCDHHS Medical Necessity Statement

Medical Necessity must be confirmed within 365 calendar days, if the beneficiary needs continuing rehabilitative service(s). The signature date from the DHHS MNS stands as the date to be used for all subsequent annual confirmations.

If the beneficiary has not received RBHS for 45 consecutive calendar days, medical necessity must be re-established by completing a new MNS.

If SCDHHS or its designee determines that services were reimbursed when there was no valid medical necessity statement in the beneficiary's file, the provider payments will be subject to recoupment.

### SERVICES DIRECTLY PROVIDED BY STATE AGENCIES

State agencies are designated by State law as the authority to meet the physical and mental health needs of an identified population.

State agencies may either provide RBHS directly to South Carolina Medicaid beneficiaries or they may refer beneficiaries to qualified Medicaid-enrolled private providers. When state agencies refer beneficiaries to other qualified Medicaid-enrolled providers, agencies are responsible for ensuring that services are medically necessary and are provided in accordance with acceptable medical standards.

When services are provided directly by a state agency, the record must clearly document the date the beneficiary was determined to meet the eligibility requirements for RBHS. The beneficiary's eligibility for services must be documented on a diagnostic assessment, IPOC, or SCDHHS MNS. This must be completed prior to the delivery of services and be maintained in the beneficiary's clinical record.

Please refer to the IPOC section. Some RBHS are not required to be listed on the IPOC and may be rendered prior to completion of the IPOC.

# SECTION 2 POLICIES AND PROCEDURES

## ELIGIBILITY FOR REHABILITATIVE SERVICES

### SERVICES DIRECTLY PROVIDED BY STATE AGENCIES (CONT'D.)

The physician or LPHA must:

- Establish one or more diagnoses, including co-occurring substance abuse or dependence if present in accordance with the current edition of the DSM or ICD
- Determine the scope and appropriateness of treatment services—including the need for integrated treatment of co-occurring disorders
- Confirm medical and/or psychiatric necessity of treatment

The physician's or LPHA's signature on the diagnostic assessment, IPOC, or SCDHHS MNS serves as documentation of the medical necessity. Medical necessity must be confirmed within 365 calendar days if the beneficiary continues in treatment.

Services must be initiated within 45 days of the physician's or LPHA's signature on the document used to confirm medical necessity.

### REFERRALS TO PRIVATE ORGANIZATIONS

State agencies may also refer beneficiaries to "private organizations" enrolled with the Medicaid Program to render RBHS.

Private organizations will be offered the opportunity to render an array of services designed to provide the necessary treatment and support to beneficiaries. All services must be authorized by a state referring entity as designated by SCDHHS prior to service delivery and must be determined medically necessary to be eligible for Medicaid reimbursement. The private organization does not determine medical necessity.

The referring state agency is responsible for establishing the medical necessity for each service. The state referring agency's LPHA must sign the medical necessity.

#### State Agency Referrals

The following agencies are identified as a designated state referring agency and may refer Medicaid beneficiaries to Medicaid-enrolled RBHS providers for treatment:

- Division of the Continuum of Care for Emotionally Disturbed Children
- Department of Disabilities and Special Needs

# SECTION 2 POLICIES AND PROCEDURES

## ELIGIBILITY FOR REHABILITATIVE SERVICES

### State Agency Referrals (Cont'd.)

- Department of Education and Local Education Agencies
- Department of Juvenile Justice
- Department of Mental Health
- Department of Social Services

### Medical Necessity

Medical necessity must be confirmed and documented through the use of the SCDHHS MNS or the IPOC provided by the referring agency and made available to the treatment provider. This function is the responsibility of the state referring agency. Employees acting on behalf of enrolled private organizations shall not perform this function.

A properly completed SCDHHS MNS or IPOC should arrive with the beneficiary prior to or at the time of appointment. A faxed copy is acceptable. A copy of the SCDHHS MNS can be found in the Forms section of this manual.

The referring physician or LPHA assumes professional responsibility for all information contained in the SCDHHS MNS.

### Diagnostic Assessment Services

A state agency may authorize a private provider to render Diagnostic Assessment Services in order to confirm and/or substantiate the medical necessity. A MNS is not required for a Diagnostic Assessment. The only form required to authorize the Initial Diagnostic Assessment is the prior authorization form (DHHS Form 254). Once completed, the Diagnostic Assessment must be provided to the referring agency and should be used to develop the beneficiary's IPOC.

If the state agency provides the IPOC to an enrolled provider rather than a MNS, the IPOC must establish medical necessity and must be signed, titled and dated by a physician or LPHA from the referring state agency. (**The enrolled private organization shall not determine medical necessity.)**

### Licensed Practitioners of the Healing Arts (LPHAs)

The following professionals are considered Licensed Practitioners of the Healing Arts and must confirm medical necessity:

# SECTION 2 POLICIES AND PROCEDURES

## ELIGIBILITY FOR REHABILITATIVE SERVICES

### Licensed Practitioners of the Healing Arts (LPHAs) (Cont'd.)

- SC Licensed Psychiatrist
- SC Licensed Physician
- SC Licensed Ph.D. Psychologist
- Licensed Psycho-Educational Specialist
- SC Licensed Registered Nurse with a Master's Degree in Psychiatric Nursing
- SC Advanced Practice Registered Nurse
- SC Licensed Independent Social Worker-Clinical Practice
- SC Licensed Master Social Worker
- SC Licensed Physician's Assistant
- SC Licensed Professional Counselor
- SC Licensed Marriage and Family Therapist

### REFERRAL PROCESS/ PRIOR AUTHORIZATION (PA) — DHHS FORM 254

All Rehabilitative Behavioral Health Services provided by an enrolled private provider must be authorized by a designated state agency **prior** to the delivery of services.

When it is necessary to refer a beneficiary for services, the designated state agency will provide the qualified RBHS provider with a completed SCDHHS Referral/ Authorization for Rehabilitative Services form (DHHS Form 254) prior to the provision of services, or at the time the services are rendered. A faxed copy is acceptable. The form will provide all of the information necessary for service delivery and billing. DHHS Form 254 should accompany the MNS and/or IPOC. (DHHS Form 254 can be found in the Forms section of this manual.)

The DHHS Form 254 must be maintained in the clinical record and be available to confirm that the services have met the authorization requirements prior to billing Medicaid.

If SCDHHS or its designee determines that services were reimbursed when there was no valid DHHS Form 254 in the beneficiary's file, the provider payments will be subject to recoupment.

The DHHS Form 254 serves to:

- Establish the service(s) the beneficiary requires

# SECTION 2 POLICIES AND PROCEDURES

## ELIGIBILITY FOR REHABILITATIVE SERVICES

### REFERRAL PROCESS/ PRIOR AUTHORIZATION (PA) — DHHS FORM 254 (CONT'D.)

- Identify the treatment provider
- Authorize the service(s) and amount of services to be provided
- Identify the level of staff authorized to render services

The DHHS Form 254 must be completed prior to the delivery of services and placed in the beneficiary's clinical record within 10 business days of the signature date on the form. Faxed copies are acceptable.

The DHHS Form 254 must include the following:

- The beneficiary's Medicaid ID number
- The provider or entity's name and NPI number
- The Prior Authorization number assigned by the designated referring agency, which is mandatory for billing purposes
- The name of the designated referring state agency
- The authorization (beginning) date and the expiration (ending) date, which establishes the period during which services are authorized to be provided. Authorization periods must not exceed **six months** duration.
- The specific service(s) authorized to be provided (*i.e.,* Individual Therapy, Behavior Modification, etc.)
- The designated modifier of the staff level authorized to provide each service
- The maximum authorized amount number of units and frequency for RBHS
- Signature, title and date of a qualified state agency representative and phone or contact number

The DHHS Form 254 must be signed, titled and dated by a state agency representative authorized to make treatment referrals. A list of authorized state agency representatives must be provided to SCDHHS annually and updated as needed.

# SECTION 2 POLICIES AND PROCEDURES

## ELIGIBILITY FOR REHABILITATIVE SERVICES

### REFERRAL PROCESS/ PRIOR AUTHORIZATION (PA) — DHHS FORM 254 (CONT'D.)

When a beneficiary receives retroactive Medicaid coverage, DHHS Form 254 should be provided to the RBHS provider within 10 business days from the date of the Medicaid eligibility determination.

For beneficiaries receiving retroactive coverage, all other Medicaid service and documentation requirements must be met in order to receive Medicaid reimbursement for retroactively covered periods.

### UTILIZATION MANAGEMENT

Referral and prior authorization by a state agency is required for all services provided by private organizations.

RBHS providers will ensure that only authorized amounts of services are provided and submitted to SCDHHS for reimbursement. The RBHS provider will ensure that all services are provided in accordance with all SCDHHS policy requirements.

SCDHHS or its designee will conduct periodic utilization reviews. This does not replace state agency reviews of services. Reimbursement received in excess of authorized amount/duration is subject to recoupment.

### STAFF QUALIFICATIONS

The following professionals possessing the required education and experience are considered clinical professionals or paraprofessionals and may provide Medicaid Rehabilitative Behavioral Health Services in accordance with South Carolina State Law and the requirements set forth in this manual.

Medicaid RBHS Staff Qualifications

| Title of Professional | Level of Education/Degree/or Experience Required | License or Certification Required | State or Licensure Law | Services Able to Provide |
|---|---|---|---|---|
| **PROFESSIONALS** | | | | |
| Psychiatrist | Doctor of medicine or osteopathy and has completed a residency in psychiatry | Licensed by SC Board of Medical Examiners | 40-47-5 Et seq. | All Services, except PSS |
| Physician | Doctor of medicine or osteopathy | Licensed by SC Board of Medical Examiners | 40-47 | All Services, except PSS, PT |
| Psychologist | Doctoral degree in psychology | Licensed by SC Board of Psychology Examiners | 40-55-20 Et seq. | All Services except PSS |

# SECTION 2 POLICIES AND PROCEDURES

## ELIGIBILITY FOR REHABILITATIVE SERVICES

| Title of Professional | Level of Education/Degree/or Experience Required | License or Certification Required | State or Licensure Law | Services Able to Provide |
|---|---|---|---|---|
| **PROFESSIONALS** | | | | |
| Physician Assistant (PA) | Completion of an educational program for physician assistants approved by the Commission on Accredited Allied Health Education Programs | Licensed by SC Board of Medical Examiners | 40-47-905 | All Services, except PSS, PT |
| Pharmacist | Doctor of Pharmacy degree from an accredited school, college, or department of pharmacy as determined by the Board, or has received the Foreign Pharmacy Graduate Equivalency Certification issued by the National Association of Boards of Pharmacy (NABP) | Licensed by SC Board of Pharmacy | 40-43-10 Et seq. | MM |
| Advanced Practice Registered Nurse (APRN) | Doctoral, post-nursing master's certificate, or a minimum of a master's degree that includes advanced education composed of didactic and supervised clinical practice in a specific area of advanced practice registered nursing | Licensed by SC Board of Nursing; must achieve and maintain national certification, as recognized by the board, in an advanced practice registered nursing specialty | 40-33-10 Et seq. | All Services, except PSS, PT |
| Psycho-Educational Specialist | Hold a master's degree plus thirty hours of psychopathology class, successfully complete the ETS School Psychology exam (PRAXIS), and be licensed. | Licensed by SC Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists | 40-63-5 Et seq. | BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC,ST, PTR, ADA, ADS |
| Licensed Independent Social Worker – Clinical Practice (LISW-CP) | Master's or doctoral degree from a Board-approved social work program | Licensed by SC Board of Social Work Examiners | 40-63-5 Et seq. | BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC,ST, PTR, ADA, ADS |
| Licensed Masters Social Worker (LMSW) | Master's or a doctoral degree from a social work program, accredited by the Council on Social Work Education and one year of experience working with the population to be served | Licensed by SC Board of Social Work Examiners | 40-63-5 Et seq. | BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC, ST, PTR, ADA, ADS |
| Licensed Marriage and Family Therapist (LMFT) | A minimum of 48 graduate semester hours or 72 quarter hours in marriage and family therapy along with an earned master's degree, specialist's degree or doctoral degree. Each course must be a minimum of at least a 3 semester hour graduate level course with a minimum of 45 classroom hours or 4.5 quarter hours; one course cannot be used to satisfy two different categories. | Licensed by SC Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists | 40-75-5 Et seq. | BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC, ST, PTR, ADA, ADS |

# SECTION 2 POLICIES AND PROCEDURES

## ELIGIBILITY FOR REHABILITATIVE SERVICES

| Title of Professional | Level of Education/Degree/or Experience Required | License or Certification Required | State or Licensure Law | Services Able to Provide |
|---|---|---|---|---|
| **PROFESSIONALS** | | | | |
| Licensed Professional Counselor (LPC) | A minimum of 48 graduate semester hours during a master's degree or higher degree program and have been awarded a graduate degree as provided in the regulations. All coursework, including any additional core coursework, must be taken at a college or university accredited by the Commission on the Colleges of the Southern Association of Colleges and Schools, one of its transferring regional associations, the Association of Theological Schools in the United States and Canada, or a post-degree program accredited by the Commission on Accreditation for Marriage and Family Therapy Education or a regionally accredited institution of higher learning subsequent to receiving the graduate degree. | Licensed by SC Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists | 40-75-5 Et seq. | BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC,ST, PTR, ADA, ADS |
| Behavior Analyst | Must possess at least a master's degree, have 225 classroom hours of specific graduate-level coursework, meet experience requirements, and pass the Behavior Analysis Certification Examination. | Behavior Analyst Certification Board | N/A | BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC, ST, PTR, ADA, ADS |
| Certified Substance Abuse Professional | Master's degree in counseling, social work, family therapy, nursing, psychology, or other human services field, plus 250 hours of approved training related to the core functions and certification as an addictions specialist | SC Association of Alcoholism and Drug Abuse Counselors Certification Commission and/or NAADAC Association for Addiction Professionals | 40-75-300 | BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC, ST, PTR, ADA, ADS |
| Clinical Chaplain | Master of Divinity from an accredited theological seminary and have two years of pastoral experience as a priest, minister, or rabbi and one year of clinical pastoral education that includes a provision for supervised clinical services and one year of experience working with the population to be served | Documentation of training and experience | 40-75-290 | BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC, ST, PTR, ADA, ADS |
| Mental Health Professional (MHP) | Master's or doctoral degree from a program that is primarily psychological in nature (*e.g.*, counseling, guidance, or social science equivalent) from an accredited university or college and one year of experience working with the population to be served | DHHS-approved credentialing program | 40-75-290 | BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC, ST, PTR, ADA, ADS |
| Substance Abuse Professional (SAP) | Bachelor's degree in a health or human services related field and certification as a certified addiction counselor or in the process of becoming SCAADAC credentialed or be certified by SCAADAC | SC Association of Alcoholism and Drug Abuse Counselors Certification Commission | 40-75-300 | BMod, BHS, CM, FS, RPS, SAC, ST, ADA, ADS |

# SECTION 2 POLICIES AND PROCEDURES

## ELIGIBILITY FOR REHABILITATIVE SERVICES

| Title of Professional | Level of Education/Degree/or Experience Required | License or Certification Required | State or Licensure Law | Services Able to Provide |
|---|---|---|---|---|
| **PROFESSIONALS** | | | | |
| Licensed Bachelor of Social Work (LBSW) | Bachelor's degree in social work. (The practice of baccalaureate social work is a basic generalist practice that includes assessment, planning, intervention, evaluation, mediation, case management, information and referral, counseling, advocacy, supervision of employees, consultation, client education, research, community organization, and the development, implementation, and administration of policies, programs, and activities. Baccalaureate social workers are not qualified to diagnose and treat mental illness nor provide psychotherapy services. Baccalaureate social work is practiced only in organized settings such as social, medical, or governmental agencies and may not be practiced independently or privately.) | Licensed by SC Board of Social Work Examiners | 40-63-5 Et seq. | BMod, BHS, CM, FS, RPS, SAC, ST, ADA, ADS |
| Behavior Analyst | A board certified associate behavior analyst must have at least a bachelor's degree, have 135 classroom hours of specific coursework, meet experience requirements, and pass the Associate Behavior Analyst Certification Examination. | Behavior Analyst Certification Board | N/A | BMod, BHS, CM, FS, RPS, SAC, ST, ADA, ADS |
| Licensed Registered Nurse (RN) | At a minimum, an associate's degree in nursing from a Board- approved nursing education program and one year of experience working with the population to be served | Licensed by SC Board of Nursing | 40-33-10 Et seq. | BMod, FS, MM, RPS, MA, ST, ADA, ADS |
| Licensed Practical Nurse (LPN) | Completion of an accredited program of nursing approved by the Board of Nursing and one year of experience working with the population to be served High school diploma or GED equivalent. | Licensed by SC Board of Nursing | 40-33-10 Et seq. | BMod. FS, MM, RPS, MA, ADN, ADS |
| **PARAPROFESSIONALS** | | | | |
| Child Service Professional | Bachelor's degree from an accredited university or college in psychology, social work, early childhood education, child development or a related field or bachelor's degree in another filed and has a minimum of 45 documented training hours related to child development and children's mental health issues and treatment. | None required | N/A | BMod, BHS, FS, PRS, SAC, ST, ADA, ADS |
| Mental Health Specialist | At a minimum, a high school diploma or GED equivalent and have three years of documented direct care experience working with the identified target population or completion of an approved 30 hour training and certification program | DHHS-approved Certification program | N/A | RPS, BMod, FS, ST |
| Substance Abuse Specialist | At a minimum, a high school diploma or GED equivalent and have three years of documented direct care experience working with the identified target population or completion of an approved training and certification program | DHHS-approved Certification program | N/A | RPS, BMod, FS, ST |

# SECTION 2 POLICIES AND PROCEDURES

## ELIGIBILITY FOR REHABILITATIVE SERVICES

| Title of Professional | Level of Education/Degree/or Experience Required | License or Certification Required | State or Licensure Law | Services Able to Provide |
|---|---|---|---|---|
| **PARAPROFESSIONALS** | | | | |
| Peer Support Specialist | High school diploma or GED equivalent peer support providers must successfully complete a pre-certification program that consists of 40 hours of training. The curriculum must include the following topics: recovery goal setting; wellness recovery plans, problem solving; person centered services; and advocacy. Additionally, peer support providers must complete a minimum of 20 hours of continuing education training annually, of which at least 12 hours must be face-to-face training. | Certification as a Peer Support Specialist | N/A | PSS |

**Service Key**

| Service | Abbr. | Service | Abbr. | Service | Abbr. |
|---|---|---|---|---|---|
| Alcohol and Drug Assessment * | ADA | Family Therapy | FT | Psychosocial rehabilitative Service | PRS |
| Alcohol and Drug Nursing Assessment* | ADN | Group Therapy | GT | Psychological Testing and Evaluation | PT |
| Alcohol and Drug Screening * | ADS | Individual Psychotherapy | IT | Psychological Testing & reporting * | PTR |
| Behavior Modification | BMod | Injection Medication * | IJ | Service Plan Development | SPD |
| Behavioral Health Screening | BHS | Medication Administration * | MA | Skills Training and Development * | ST |
| Crisis Management | CM | Medication Management | MM | Substance Abuse Counseling * | SAC |
| Diagnostic Assessment | DA | Medical Evaluation and Management | EM | | |
| Family Support | FS | Peer Support Service ** | PSS | | |

***Service provided by DAODAS only.**

**** Services provided only by DMH and DAODAS providers.**

### MEDICAID RBHS STAFF QUALIFICATIONS (CONT'D.)

Please refer to the Core and Community Support Services section for specific service requirements. Providers are subject to termination or denial of services, if they are not in compliance with current policies and procedures.

### STAFF MONITORING/ SUPERVISION STAFF

Rehabilitative Behavioral Health Services provided by licensed or certified professionals must follow supervision requirements as required by South Carolina State Law for each respective profession. Rehabilitative Behavioral Health Services provided by any unlicensed/uncertified professional must be supervised by a master's level clinical professional or licensed practitioner of the healing arts (LPHA). Substance Abuse professionals who are in

# SECTION 2 POLICIES AND PROCEDURES

## ELIGIBILITY FOR REHABILITATIVE SERVICES

### STAFF MONITORING/ SUPERVISION STAFF (CONT'D.)

process of becoming credentialed must be supervised by a certified substance abuse professional or LPHA.

Licensed or master's level clinical professionals have the responsibility of planning and guiding the delivery of services provided by unlicensed or uncertified professionals. These clinical professionals will evaluate and assess the beneficiary as needed.

When services are provided by an unlicensed or uncertified professional, the state agency or private organization must ensure the following:

- The qualified licensed or master's level clinical professional who monitors the performance of the unlicensed professional must provide documented consultation, guidance, and education with respect to the clinical skills, competencies and treatment provided at least every 30 days.
- The supervising licensed or master's level clinical professional must maintain a log documenting supervision of the services provided by the unlicensed or uncertified professional to each beneficiary.
- Supervision may take place in either a group or individual setting. Supervision must include opportunities for discussion of the plan of care(s) and the individual beneficiary's progress. Issues relevant to an individual beneficiary will be documented in a service note in the clinical record.
- Case supervision and consultation does not supplant training requirements. The frequency of supervision should be evaluated on a case-by-case basis.

### STAFF-TO-BENEFICIARY RATIO

Staff-to-beneficiary ratios are established for safety and therapeutic efficacy concerns. Ratios must be met and maintained at all times during hours of operation. Ratios must be maintained in accordance with the requirements of each individual service standard. Staff involved in the treatment delivery must have direct contact with beneficiaries. Staff present, but not involved in the treatment delivery, cannot be included in the ratio. Staff shall be in direct contact and involved with the beneficiary's activities during service delivery.

# SECTION 2 POLICIES AND PROCEDURES

## ELIGIBILITY FOR REHABILITATIVE SERVICES

### STAFF-TO-BENEFICIARY RATIO (CONT'D.)

If at any time during the delivery of a service, the staff-to beneficiary ratio is not in accordance with the service standard, billing for beneficiaries in excess of the required ratio should be discontinued and subject to recoupment. The ratio count applies to all beneficiaries receiving services from the provider regardless of whether or not the beneficiary is Medicaid eligible.

Appropriately, credentialed staff must be substituted or group sizes must be adjusted to meet the service standard requirements before billing may resume.

When services are provided in a group setting, the provider must maintain a list of beneficiaries and individuals present in the group and the staff person(s) responsible for service delivery. This documentation must be available upon request.

### EMERGENCY SAFETY INTERVENTION (ESI)

The Emergency Safety Intervention (ESI) policy applies to any community-based provider that has policies prohibiting the use of seclusion and restraint, but who may have an emergency situation requiring staff intervention. Providers must have a written policy and procedure for emergency situations and must ensure that direct care staff are prepared and trained in the event of an emergency.

If the provider intends to use restraint and/or seclusion, the provider is responsible for adhering to the following requirements:

- Providers must ensure that all staff involved in the direct care of a beneficiary successfully complete a training program from a certified trainer in the use of restraints and seclusion prior to ordering or participating in any form of restraint.
- Training should be aimed at minimizing the use of such measures, as well as ensuring the beneficiary's safety. For more information on selecting training models, go to the *Project Rest Manual of Recommended Practice*, available at http://www.frcdsn.org/rest.html.
- Providers must have a comprehensive written policy that governs the circumstances in which seclusion and restraint are being used that adheres to all state licensing laws and regulations (including all reporting requirements)

# SECTION 2 POLICIES AND PROCEDURES

## ELIGIBILITY FOR REHABILITATIVE SERVICES

### EMERGENCY SAFETY INTERVENTION (ESI) (CONT'D.)

Failure to have these policies and staff training in place at the time services are rendered will result in termination from the Medicaid program and possible recovery of payments.

### COORDINATION OF CARE

It is the responsibility of the referring state agency to coordinate care among all service providers.

If a beneficiary is receiving treatment from multiple service providers, there should be evidence of care coordination in the beneficiary's clinical record.

### OUT-OF-HOME PLACEMENT

In accordance with the Code of Federal Regulations, 42 CFR § 435.1009-1011, Rehabilitative Behavioral Health Services are not available for beneficiaries residing in an institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. An institution may deemed as an Institution for Mental Diseases based on its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

Inpatient Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) receive a per diem payment that is considered all-inclusive. Rehabilitative Behavioral Health Services provided to beneficiaries in these settings are not Medicaid reimbursable.

# SECTION 2 POLICIES AND PROCEDURES

## ELIGIBILITY FOR REHABILITATIVE SERVICES

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# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

All Rehabilitative Behavioral Health Services providers shall maintain a clinical record for each Medicaid-eligible beneficiary that fully describes the extent of the treatment services provided. The clinical record must contain documentation sufficient to justify Medicaid participation, and should allow an individual not familiar with the beneficiary to evaluate the course of treatment. The absence of appropriate and complete records, as described below, may result in recoupment of payments by SCDHHS. An index as to how the clinical record is organized must be maintained and made available to Medicaid reviewers or auditors upon request.

Each provider shall have the responsibility of maintaining accurate, complete, and timely records and ensure the confidentiality of the beneficiary's clinical record.

The beneficiary's clinical record must include, at a minimum, the following:

- A comprehensive, diagnostic assessment, if applicable
- Referral Form/Authorization for Rehabilitative Services form (DHHS Form 254), if applicable
- Completed Medical Necessity Statement (MNS), if applicable
- Signed, titled and dated individual plan of care (IPOC) — initial, reviews, and reformulations
- Signed, titled and dated Clinical Service Notes (CSNs)
- Court orders, if applicable
- Copies of any evaluations and or tests, if applicable
- Signed releases, consents, and confidentiality assurances for treatment
- Physician's orders, laboratory results, lists of medications, and prescriptions (when performed or ordered)

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

### DOCUMENTATION REQUIREMENTS (CONT'D.)

- Copies of written reports (relevant to the beneficiary's treatment)
- Medicaid eligibility information, if applicable
- Other documents relevant to the care and treatment of the beneficiary

### CONSENT TO EXAMINATIONS AND TREATMENT

A consent form, dated and signed by the beneficiary, parent, legal guardian, or primary caregiver (in cases of a minor), or legal representative, must be obtained at the onset of treatment from all beneficiaries and for each treatment provider. If the beneficiary, parent, legal guardian, or legal representative cannot sign the consent form due to a crisis, and is accompanied by a next of kin or responsible party, that individual may sign the consent form. If the beneficiary is alone and unable to sign, a statement such as "beneficiary unable to sign and requires emergency treatment" must be noted on the consent form and must be signed by the physician or LPHA and one other staff member. The beneficiary, parent, legal guardian, or legal representative should sign the consent form as soon as circumstances permit. A new consent form should be signed and dated each time a beneficiary is readmitted to the system after discharge. Consent forms are not necessary to conduct court ordered examinations. However, a copy of the court order must be kept in the clinical record.

### CLINICAL SERVICE NOTES (CSNS)

All Rehabilitative Behavioral Health Services must be documented in clinical service notes (CSNs) upon the delivery of services. The purpose of the CSN is to record the nature of the beneficiary's treatment, any changes in treatment, discharge, crisis interventions, and any changes in medical, behavioral or psychiatric status.

The CSN must:

- Be completed each time a rehabilitative service is provided and/or whenever information is obtained that has bearing on the identified beneficiary's treatment
- Be individualized

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

### CLINICAL SERVICE NOTES (CSNS) (CONT'D.)

- Document that the rehabilitative service corresponds to billing by type of service, units of service, and dates of service (with month, day and year)
- Be typed or legibly handwritten using only black or blue ink
- Be kept in chronological order
- List the specific service that was rendered or its approved abbreviation
- Document the start and end time(s) for services delivered. **Please refer to each individual service description in this section for specific documentation requirements**.
- Reference individuals by full name, title and agency or provider affiliation at least once in each note
- Specify the place of service, as appropriate for the particular service provided
- Be signed, titled and signature dated (month/date/year) by the person responsible for the provision of services. The signature verifies that the services are provided in accordance with these standards.
- Be placed in the beneficiary's record as soon as possible but no later than 10 business days from the date of rendering the service

The CSN must also address the following items to provide a pertinent clinical description and to ensure that the rehabilitative behavioral health service conforms to the service description and authenticates the charges:

- The focus and/or reason for the session or interventions which should be related to a treatment objective or goal listed in the IPOC, unless there is an unexpected event that needs to be addressed
- The interventions and involvement of clinician and/or treatment staff in service provision
- The response of the beneficiary and his or her family (as applicable) to the interventions

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

### CLINICAL SERVICE NOTES (CSNS) (CONT'D.)

and/or treatment

- The general progress of the beneficiary to include observations of their conditions/mental status
- The future plan for working with the beneficiary

### BILLABLE CODE/LOCATION OF SERVICE

See the "Billable Place of Service" heading for each service under "Program Services" in this section. The following list provides the codes most commonly used:

03 — School

11 — Clinician or Doctor's Office

12 — Home

22 — Outpatient Hospital

23 — Emergency Room

53 — Community Mental Health Center

55 — Substance Abuse Residential Facility

57 — Non-Residential Substance Abuse Facility

99 — Other Unlisted Facility

### AVAILABILITY OF CLINICAL DOCUMENTATION

A CSN or other service documentation should be completed and placed in the clinical record immediately following the delivery of a service. If this is impossible due to the nature of the service, the documentation must be placed in the clinical record no later than 10 business days from the date of service.

RBHS must be documented in the clinical record and the documentation must justify the amount of reimbursement claimed to Medicaid.

### ABBREVIATIONS AND SYMBOLS

Abbreviations may be used in the IPOC or the CSN. Service providers shall maintain a list of abbreviations and symbols used in clinical documentation, which leaves no doubt as to the meaning of the documentation. An abbreviation key must be maintained to support the use of abbreviations and symbols in entries. Providers must furnish the list and abbreviation key upon request of SCDHHS and/or its designee.

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

### LEGIBILITY

All clinical documentation must be typed or handwritten using only black or blue ink, legible, and filed in chronological order. All clinical records must be current, consistently organized, and meet documentation requirements. Records must be arranged in a logical order so they can be easily and clearly reviewed, copied, and audited.

Original legible signature and credentials (*e.g.*, registered nurse) or functional title (*e.g.*, SAP, MHP) of the person rendering the service must be present in all clinical documentation. Photocopied signatures, stamped signatures, or signatures of anyone other than the person rendering the service or co-signature, when required, are not acceptable. (See Section 1 of this manual for the use of electronic signatures and/or exceptions.)

### ERROR CORRECTION

Clinical records are legal documents. Staff should be extremely cautious in making alterations to the records. In the event that errors are made, adhere to the following guidelines:

- Draw one line through the error, and write “error,” “ER,” “mistaken entry,” or “ME” to the side of the error in parenthesis. Enter the correction, sign or initial, and date it.
- Errors cannot be totally marked through. The information in error must remain legible.
- No correction fluid may be used. If an explanation is necessary to explain the corrections, they must be entered in a separate CSN.

### LATE ENTRIES

Late entries (entries to provide additional documentation to supplement entries previously written) may be necessary at times to handle omissions in documentation. Late entries should rarely be used, and then only to correct a genuine error of omission or to add new information that was not discovered until a later time. When late entries are made, adhere to the following guidelines:

- Identify the new entry as a “late entry.”
- Enter the current date and time.

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

### LATE ENTRIES (CONT'D.)

- Identify or refer to the date and incident for which the late entry is written.
- If the late entry is used to document an omission, validate the source of additional information as much as possible.
- When using late entries, document as soon as possible.

### RECORD RETENTION

Clinical records shall be retained for a period of five years. If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the five-year period, the records shall be retained until completion of the action and resolution of all issues that arise from it or until the end of the five-year period, whichever is later. In the event of an entity's closure, providers must notify SCDHHS regarding medical records.

Clinical records must be arranged in a logical order to facilitate the review, copy, and audit of the clinical information and course of treatment. Clinical records will be kept confidential in conformance with the Health Insurance Portability and Accountability Act (HIPAA) regulations and safeguarded as outlined in Section 1 of this manual.

### COMPONENTS OF THE INDIVIDUAL PLAN OF CARE (IPOC)

#### Definition

The individual plan of care (IPOC) is an individualized comprehensive plan of care to improve the beneficiary's condition. The IPOC is developed in collaboration with a beneficiary, which may include an interdisciplinary team of the following; significant other(s), parent, guardian, primary caregiver, other state agencies, staff, or service providers. Multiple staff or members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the IPOC. While there may be certain treatment methodologies commonly utilized within a particular service, providers must ensure that services are tailored to the beneficiary's individual needs and

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

**Definition (Cont'd.)**

the service delivery reflects knowledge of the particular treatment issues involved.

The assessment of the beneficiary is used to identify problems and needs, develop goals and objectives, and determine appropriate Rehabilitative Behavioral Health Services and methods of intervention should be completed to develop the IPOC. The IPOC confirms the appropriateness of services for the beneficiary, and outlines the service delivery needed to meet the identified needs and improve overall functioning.

The IPOC utilizes information gathered during the evaluation, screening and assessment process. The IPOC must be written to provide a beneficiary and family-centered plan. The beneficiary must be given the opportunity to determine the direction of his or her IPOC. If family reunification or avoiding removal of the child from the home is a goal for the beneficiary, the family, legal guardian, legal representative, or primary caregiver must be encouraged to participate in the treatment planning process. Documentation of compliance with this requirement must be located in the beneficiary's record. If the family, legal guardian, legal representative, or primary caregiver is not involved in the treatment planning process, the reason must be documented in the beneficiary's clinical record. For adults, the family or a legal representative should be included as appropriate.

For beneficiaries receiving retroactive coverage, all other Medicaid service and documentation requirements must be met to receive Medicaid reimbursement for retroactively covered periods.

**IPOC Documentation**

IPOC documentation must meet all SCDHHS requirements and the following components listed below. . If these components are also listed on the assessment, the assessment must be attached to the IPOC.

**Beneficiary Identification:** Name and Medicaid ID number.

**Presenting Problem(s):** Statements that outline the specific needs that require treatment (validate the need for and appropriateness of treatment).

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

IPOC Documentation (Cont'd.)

**Justification for Treatment:** The primary diagnosis that is the basis for the treatment planned, as well as the code and description according to the current edition of the DSM or the ICD.

For individuals who have more than one diagnosis regarding mental health, substance use, and/or medical conditions, all diagnoses should be recorded.

**Goals and Objectives:** A list of specific short-and long-term goals and objectives addressing the expected outcome of treatment. Goals should include input from the beneficiary and objectives should be written so that they are observable, measurable, individualized (specific to the beneficiary's problems and/or needs), and realistic.

**Specific interventions:** A list of therapeutic interventions used to meet the stated goals and objectives must be included.

**Frequency of Services:** The frequency must be listed on the IPOC for each service. Each service should be listed by its name or approved abbreviation with a planned frequency.

**Criteria for Achievement:** Outline how success for each goal and objective will be demonstrated. Criteria must be reasonable, attainable, and measurable, must include target dates, and must indicate a desired outcome to the treatment process.

**Target Dates:** A timeline that is individualized to the beneficiary and their goals and objectives.

**Medical or Health History:** A brief medical history and summary to include all medication, medical issues and any safety services and supports systems (a safety net). It is important for overall health care and wellness issues to be addressed.

**Family or Social Support:** A brief family or social summary of the beneficiary is included in the IPOC. It is necessary to identify supports systems to aid the beneficiary in achieving goals

**Contact Information:** A list of all emergency contacts must be listed.

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

### IPOC Documentation (Cont'd.)

**Beneficiary Signature:** The beneficiary or their guardian must sign the IPOC indicating they have been involved in the planning process and have been offered a copy of the IPOC. If the beneficiary does not sign the plan of care or if it is not considered appropriate for the beneficiary to sign the plan of care, the reason must be documented on the IPOC.

**Authorized Signature(s):** An LPHA or master's level staff, the beneficiary, the clinician and/or interdisciplinary team which may include: significant other(s); parent, guardian, or primary caregiver; and/or other state agencies, staff, or service providers must sign and date a signature sheet or the IPOC which identifies who is present during the IPOC meeting. If a separate signature sheet is completed, it must be kept with the IPOC.

The dated signature of the physician, LPHA or master's level clinical professional is required to confirm the appropriateness of care. Each page of the IPOC must be signed, titled and signature dated by the physician, LPHA, or master's level qualified clinical professional. The IPOC must be filed in the beneficiary's clinical record with any supporting documentation such as the diagnostic assessment.

### Services Not Required on the IPOC

The following services are not required to be listed on the IPOC:

- Diagnostic Assessment
- Crisis Management
- Service Plan Development
- Behavioral Health Screening

### Duration of the IPOC

The initial IPOC must be finalized, signed, titled and signature dated by the physician, LPHA, or master's level qualified clinical professional within 45 calendar days from the signature date of the document used to confirm medical necessity. If the IPOC is not developed within 45 days, services rendered from the 46th day until the date of completion of the IPOC are not Medicaid reimbursable.

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

### Addendum to the IPOC

When services are added or frequencies of services changed in an existing IPOC, the addendum must include the signature and titles of the clinician, who formulated the addendum and the date it was formulated. All service change must be medically necessary. The original IPOC signature date stands as the date to use for all subsequent progress summaries and review.

Beneficiaries do not have to be present when changes are made to the IPOC. All additions to the IPOC should be listed in chronological order. The IPOC must be signed or initialed and dated by the reviewing physician, LPHA, or master's level qualified clinical professional to confirm changes. The addendum is added to the existing IPOC, when space is unavailable on the current IPOC, a separate sheet must be added and labeled as "Addendum IPOC" and the addendum must accompany the existing IPOC.

If changes and updates are made to the original IPOC, an updated copy must be provided to the beneficiary and other involved parties within 10 calendar days.

### IPOC REFORMULATION

The maximum duration of the IPOC is 365 calendar days from the date of the signature of the physician, LPHA, or master's level qualified clinical professional on the IPOC. Prior to termination or expiration of the treatment period, the physician, LPHA, or master's level qualified clinical professional must review the IPOC, preferably with the beneficiary, and evaluate the beneficiary's progress in reference to each of the treatment objectives. Multiple staff members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the IPOC. The signature of the physician, LPHA, or master's level qualified clinical professional responsible for the treatment is required. The professional should also assess the need for continued services and specify services needed based on the progress of the beneficiary.

The IPOC must include the date when the reformulation was completed, the signature and title of the physician, LPHA, or master's level qualified clinical professional authorizing services, and the

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

### IPOC REFORMULATION (CONT'D.)

signature date. There should be evidence in the clinical record regarding the involvement of the beneficiary in the reformulation of the IPOC. Copies of the reformulated IPOC must be distributed to all involved participants within 10 business days.

### IPOC DEVELOPMENT – PRIVATE RBHS PROVIDERS

A state agency may authorize a private RBHS organization to develop the IPOC. The state agency must have a completed assessment to determine medical necessity.

When the private RBHS provider is authorized to develop the IPOC, the state agency must furnish the private RBHS provider the assessment, all clinical documentation on the beneficiary, the DHHS MNS, and DHHS 254 Form.

Once these steps are completed, the private RBHS provider may develop the IPOC. The private provider must submit the IPOC to the state agency within 30 working days from the initial authorization date.

The state agency is responsible for ensuring the required components listed in the above section are documented in the IPOC.

After an assessment is completed, IPOC must be developed within 45 days. If the IPOC is not completed, services rendered on or after the 46$^{th}$ day is not Medicaid reimbursable.

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

### IPOC Additions or Changes — Private RBHS Providers

Additions or changes to the IPOC must be coordinated between the private RBHS provider and the referring state agency. Any changes and/or additions to services needed must be authorized to the private RBHS provider via the prior authorization form (DHHS Form 254).

If changes and updates are made to the original IPOC, an updated copy must be provided to the referring state agency and to the beneficiary and other involved parties within 10 calendar days.

## SERVICE PLAN DEVELOPMENT (SPD) OF THE IPOC

### Purpose

The purpose of this service is to allow the interdisciplinary team to discuss the beneficiaries' needs and development a plan of care. The interdisciplinary team will establish the beneficiary's needs, goals, and objectives and identify appropriate treatment or services needed by the beneficiary to meet those goals. Service Plan Development (SPD) assists beneficiaries and their families in planning, developing, and choosing needed services.

### Service Description

Service Plan Development is interaction between the beneficiary and a qualified clinical professional or a team of professionals to develop a plan of care based on the assessed needs, physical health, personal strengths, weaknesses, social history, and support systems of the beneficiary and to establish treatment goals and treatment services to reach those goals.

The planning process should focus on the identification of the beneficiary's and his/or her family's needs and desired goals and objectives. The beneficiary and clinical professional(s) or interdisciplinary team should identify the skills and abilities of the beneficiary that can help achieve their goals, identify areas in which the beneficiary needs assistance and support, and decide how the team of professionals can help meet those needs.

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

Service Description (Cont'd.)

An interdisciplinary team is typically composed of the beneficiary, his or her family and/or other individuals significant to the beneficiary, treatment providers, and care coordinators.

An interdisciplinary team may be responsible for periodically reviewing progress made toward goals and modifying the IPOC as needed.

When there are multiple agencies or providers involved in serving the beneficiary, Service Plan Development should be conducted as a team process with the beneficiary. This treatment planning process requires meeting with at least two other health and human service agencies or providers to develop an individualized, multi-agency service plan that describes corresponding needs of the beneficiary and identifies the primary or lead provider for accessing and/or coordinating needed service provision.

Multi-agency meetings may be face-to face or telephonic and only billable when the discussion focuses on planning and coordinating service provision for the identified beneficiary.

*SPD-Interdisciplinary Team — Conference with Client/Family -*

The purpose of this service is to allow the Physician, LPHA or master's level staff to review with other entities or support teams, and the opportunity to discuss issues that are relevant to the needs of the beneficiary with the beneficiary or family member being present. Effective service planning should include representation from all systems of support in which the beneficiary is engaged.

When the IPOC has been developed, a qualified clinical professional must review the IPOC with the beneficiary and/or family member or legal representation. The beneficiary must sign the IPOC. If the beneficiary cannot sign the IPOC, the reason must be documented on the IPOC.

SPD-Interdisciplinary Team — Conference without Client/Family

The purpose of this service is to allow the Physician, LPHA or master's level staff to review with other entities or support teams, and the opportunity to discuss issues that are relevant to the needs of the beneficiary without the beneficiary or family member being present. The components of the interdisciplinary team

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

**SPD-Interdisciplinary Team — Conference without Client/Family (Cont'd.)**

conference must be followed for this service.

Effective service planning should include representation from all systems of support in which the beneficiary is engaged.

When the IPOC has been developed, a qualified clinical professional must review the IPOC with the beneficiary and/or family member or legal representation. The beneficiary must sign the IPOC. If the beneficiary cannot sign the IPOC, the reason must be documented on the IPOC.

**Service Plan Development By Non-Physicians**

The purpose of this service is to allow a non-physician to review, with other entities or support teams, the issues that are relevant to the needs of the beneficiary with the beneficiary or family member.

Effective service planning should include representation from all systems of support in which the beneficiary is engaged

When the IPOC has been developed, a qualified clinical professional must review the IPOC with the beneficiary and/or family member or legal representation. The beneficiary must sign the IPOC. If the beneficiary cannot sign the IPOC, the reason must be documented on the IPOC.

**Service Documentation**

Documentation should include the involvement of the clinical professional and/or team of professionals in the following:

- The development, staffing, review and monitoring of the plan of care
- Discharge criteria and/or achievement of goals
- Confirmation of medical necessity for state agencies providing services
- Establishment of one or more diagnoses, including co-occurring substance use or dependence, if present ("N/A" for private organizations when documented on MNS)
- Recommended treatment
- Copy of the Assessment summary

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

**Service Documentation (Cont'd.)**

The IPOC must include the date it was completed, the signature and title of the physician, LPHA, or master's level qualified clinical professional signing the IPOC to authorize services,

While attendance of multiple provider representatives may be necessary, only one professional that is actively involved in the planning process from each provider office may receive reimbursement. The provider representative must have documentation of the invitation to the IPOC meeting in the clinical record.

**Medical Necessity Criteria**

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorders. The results of the assessment and/or screening tool that would support the need for services.

**Staff Qualifications**

SPD is provided by, or under the supervision of, qualified professionals as specified under the "Staff Qualifications" section and in accordance with the South Carolina State Law. A physician, LPHA or master's level qualified clinical professional staff must sign the finalized IPOC.

**Staff-to-Beneficiary Ratio**

SPD requires at least one professional for each beneficiary. An interdisciplinary team requires participation from at least two qualified health professional from any agency.

Participants are actively involved in the development, revision, coordination, and implementation of the services needed by the beneficiary.

**Billing Frequency**

SPD-Interdisciplinary Team Confrere with and without Client/Family is billed as an encounter.

SPD by a non-physician is billed in a 15 minute unit.

**Special Restrictions Related to Other Services**

State agencies that refer SPD to qualified RBHS providers may designate and authorize the provider to develop the plan of care. Providers must ensure state agencies receive a copy of the IPOC within 30 days of the authorization date. The state agency must approve the IPOC and ensure all of the components of the IPOC are completed.

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

### Special Restrictions Related to Other Services (Cont'd.)

SPD codes 99366, 99367, and H0032 cannot be billed on the same date of service. Codes 99366 and 99367 cannot be billed on the same date of services with the assessment codes.

### PROGRESS SUMMARIES

The 90-day progress summary is a periodic evaluation and review of a beneficiary's progress toward the treatment objectives, the appropriateness of services rendered, and the need for the beneficiary's continued participation in the treatment.

The review of the beneficiary's participation in RBHS will be conducted at least every 90 calendar days from the signature date on the initial IPOC and each 90 days thereafter.

The review must be summarized in the IPOC by the physician, LPHA, or other qualified clinical professional. The 90-day progress summary must be clearly documented on the IPOC or on a separate sheet attached to the IPOC.

The physician, LPHA, or other qualified clinical professional will review the following areas:

- The beneficiary's progress toward treatment goals and objectives
- The appropriateness and frequency of the services provided
- The need for continued treatment
- Recommendations for continued services

### DISCHARGE/TRANSITION CRITERIA

State agencies are responsible for determining the duration of treatment based on the individual needs of the beneficiary.

Beneficiaries should be considered for discharge from treatment or transferred to another level when they meet any of the following criteria:

- Level of functioning has significantly improved
- The beneficiary has made limited or no progress with respect to the goals outlined in the IPOC
- Achieved the goals as outlined in the IPOC or reached maximum benefit

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

### DISCHARGE/TRANSITION CRITERIA (CONT'.D)

- Developed the skills and resources needed to transition to a lower level of care
- The beneficiary requested to be discharge from treatment (and is not imminently dangerous to self or others)
- The beneficiary requires a higher level of care (*i.e.*, inpatient hospitalization or PRTF)
- The beneficiary displays the inability to actively participate in the program or no longer is working or participating toward their goals.
- The beneficiary should be re-evaluated for services before discharged from that particular service level of care

# SECTION 2 POLICIES AND PROCEDURES

## DOCUMENTATION REQUIREMENTS

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# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICE STANDARDS

Core Rehabilitative Services may be provided by a qualified state agency or services may be authorized to enrolled private organizations.

### SCREENING SERVICES

#### Behavioral Health Screening (BHS)

*Purpose*

The purpose of this service is to provide early identification of behavioral health issues and to facilitate appropriate referral for a focused assessment and/or treatment. Behavioral Health Screening (BHS) is designed to identify behavioral health issues and/or the risk of development of behavioral health problems and/or substance abuse.

*Service Description*

This service requires completion of a brief questionnaire to examine the nature and context of the problem and identify patterns of behavior. Screenings are conducted using a standardized or SCDHHS-approved tool, through interviews or self-report. Some of the common tools used for screenings are:

GAIN — Global Appraisal of Individual Needs — Short Screener

DAST — Drug Abuse Screening Test

ECBI — Eyberg Child Behavior Inventory

SESBI — Sutter Eyberg Student Behavior Inventory

CIDI — Composite International Diagnostic Interview

Screenings should be scored utilizing the tool's scoring methodology and referrals made based on the interpretation of the results.

Screenings should focus on patterns of behavior and associated factors such as legal problems, mental health status, educational functioning, and living situation.

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

*Service Description (Cont'd.)*

The beneficiary's awareness of the problem, feelings about his or her behavior, mental health or substance use and motivation for changing behaviors may also be integral parts of the screen.

Prior to conducting the screening, attempts should be made to determine whether another screening had been conducted in the last 90 days. If a recent screening has been conducted, efforts should be made to access the record. A screening may be repeated as clinically appropriate or if a significant change in behavior or functioning has been noted.

Reimbursement for this service is only available for the interpretation and/or scoring of the screening tool and does not include time spent administering the tool.

*Medical Necessity Criteria*

All Medicaid-eligible beneficiaries who have been identified as having or at risk of a substance abuse and/or mental health disorder are eligible for this service.

*Staff Qualifications*

BHS may be provided by qualified clinical professionals as defined in the "Staff Qualifications" section of this manual, who have been specifically trained to review the screening tool and make a clinically appropriate referral.

*Service Documentation*

BHS results should be documented during the screening session with the beneficiary. The completed screening tool and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date of service.

Documentation must:

- Include the outcome of the screening
- Identify any referrals resulting from the screening
- Support the number of units billed

*Staff-to-Beneficiary Ratio*

BHS requires one staff member for each beneficiary. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

*Billing Frequency*

BHS is billed in 15-minute units for a maximum of two units per day. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

*Billable Place of Service*

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

*Special Restrictions Related to Other Services*

No restrictions

### Diagnostic Assessment (DA) Services

*Purpose*

The purpose of this initial face-to-face assessment is to determine the need for rehabilitative services, to establish or confirm a diagnosis, to provide the basis for development of an effective, comprehensive individual plan of care based upon the beneficiary's strengths and deficits, or to assess progress in and the need for continued treatment. This assessment includes a comprehensive bio-psychosocial interview and review of relevant psychological, medical, and education records.

Information obtained during the assessment must lead to a diagnosis that identifies the beneficiary's current symptoms or disorder by using the current edition of the DSM or the ICD.

Information gathered during the assessment process may be obtained from diagnostic interviews with the beneficiary and/or others familiar with the beneficiary's functioning, psychological testing, interpretation, and questionnaires, review of written reports or medical records and observation of the beneficiary.

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

*Purpose (Cont'd.)*

Only diagnostic codes that are clearly and consistently supported by the documentation should be reported in the record. Diagnoses should be updated as the condition of the beneficiary changes. Information relating to a diagnosis that has not been reviewed in a 12-month or more periods should be confirmed immediately.

*Service Description*

Psychiatric Diagnostic Assessment without medical services identifies the beneficiary's needs, concerns, strengths and deficits and allows the beneficiary and his or her family to make informed decisions about the treatment. Patient condition, characteristics, or situational factors may require services described as being with interactive complexity. The assessment includes a bio-psychosocial assessment to gather information that establishes or supports a diagnosis, provides the basis for the development or modification of the treatment plan, and development of discharge criteria.

Components of a Diagnostic Assessment Service include:

- Beneficiary demographic information
- Presenting complaint, source of distress
- Medical history and medications
- Family history
- Psychological and/or psychiatric treatment history for beneficiary and family
- Substance use history for beneficiary and family
- Mental status
- Current edition DSM or ICD diagnosis
- Functional assessment (with age-appropriate expectations)
- Exposure to physical abuse, sexual abuse, anti-social behavior, or other traumatic events

Psychiatric Diagnostic Assessment with medical services includes those same components listed in the assessment, but will include the medical components.

Components of a Diagnostic Assessment Service include:

- Medical history and medications

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

*Service Description (Cont'd.)*

- Assess the appropriateness of initiating or continuing the use of medications, including medications treating concurrent substance use disorders
- Diagnose, treat, and monitor chronic and acute health problems
- This may include completing annual physicals and other health maintenance care activities such as ordering, performing, and interpreting diagnostic studies such as lab work and x-rays.

Comprehensive Diagnostic Assessment Services identifies the beneficiary's needs, concerns, strengths and deficits and allows the beneficiary and his or her family to make informed decisions about the treatment. The assessment includes a bio-psychosocial assessment to gather information that establishes or supports a diagnosis, provides the basis for the development or modification of the treatment plan, and development of discharge criteria.

Components of a Diagnostic Assessment Service include:

- Beneficiary demographic information
- Presenting complaint, source of distress
- Medical history and medications
- Family history
- Psychological and/or psychiatric treatment history for beneficiary and family
- Substance use history for beneficiary and family
- Mental status
- Current edition DSM or ICD diagnosis
- Functional assessment (with age-appropriate expectations)
- Exposure to physical abuse, sexual abuse, anti-social behavior, or other traumatic events

*Initial Assessment*

Use of a standardized diagnostic tool is strongly recommended. Initial assessments must be completed within the first three non-emergency visits to the provider.

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

*Initial Assessment (Cont'd.)*

The initial assessment evaluates the beneficiary for the presence of a behavioral health disorder and is conducted face-to-face. The initial assessment is used to determine the beneficiary's mental status and social functioning and to identify any physical or medical conditions. Each beneficiary considered for initial entry into Rehabilitative Behavioral Health Services should receive an individualized, comprehensive assessment that includes a diagnosis, prior to the development of the individual plan of care.

Initial assessments may include a clinical face-to-face interview with the beneficiary and/or family members or guardians as appropriate, review of the presenting problems, symptoms and functional deficits and history. This may include contact with service providers to gather beneficiary data. The initial assessment process leads to the development of the individual plan of care (provided the beneficiary meets medical necessity).

*Mental Health - Comprehensive Assessment - Follow-up*

A follow-up assessment occurs after an initial assessment to re-evaluate the status of the beneficiary, identify any significant changes in behavior and/or condition, and to monitor and ensure appropriateness of treatment. .

When significant changes occur in behaviors and/or conditions, changes must be documented separately on the CSN and comply with the service documentation requirements. The course of treatment and documentation in the IPOC must reflect these changes.

Medical Necessity Criteria

All Medicaid-eligible beneficiaries who have been identified as having or at risk of a behavioral health and/or substance use disorder are eligible for this service.

Staff Qualifications

DA may be provided by a qualified clinical professional operating within their scope of practice. The professional must be specifically trained to render and review the assessment tool to make a clinically appropriate referral.

Service Documentation

The completed assessment tool and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date of service.

Documentation must:

- Include the outcome of the assessment

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

- Identify any referrals resulting from the assessment
- Support the number of units billed

**Staff-to-Beneficiary Ratio**

DA and follow-up assessment require one staff member for each beneficiary. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

**Billing Frequency**

DA is billed as an encounter. The initial session should last at least an hour. One encounter can be done every six months and coordination care should occur between providers. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Comprehensive Diagnostic Assessment follow-up is billed as an encounter. Services must be documented on the CSN with a start time and end time

**Billable Place of Service**

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

**Special Restrictions Related to Other Services**

The Diagnostic Assessment and Comprehensive Assessment can only be rendered every six months per beneficiary. These assessments cannot be rendered or billed on the same day.

The follow-up assessment should only be utilized when documented behavioral changes have occurred and the beneficiary needs to be re-assessed.

**PSYCHOLOGICAL TESTING AND EVALUATION**

Psychological Testing and Evaluation services include psycho-diagnostic assessment of personality, psycho-pathology, emotionality, and intellectual abilities (*e.g.*, WAIS-R, Rorschach, and MMPI).

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

### PSYCHOLOGICAL TESTING AND EVALUATION (CONT'D.)

Testing and evaluation must involve face-to-face interaction between a licensed psychologist and the beneficiary for the purpose of evaluating the beneficiary's intellectual, emotional, and behavioral status. Testing may include measures of intellectual and cognitive abilities, neuropsychological status, attitudes, emotions, motivations, and personality characteristics, as well as use of other non-experimental methods of evaluation.

When necessary or appropriate, consultation shall only include telephone or face-to-face contact by a psychologist to the family, school, or another health care provider to interpret or explain the results of psychological testing and/or evaluations related to the care and treatment of the beneficiary. The psychologist is expected to render an opinion or receive an opinion and/or advice. The psychologist must document the recommended course of action.

### Medical Necessity Criteria

All Medicaid-eligible beneficiaries who have been identified as having or at risk of a behavioral health and/or substance use disorder are eligible for this service.

### Staff Qualifications

Psychological Testing and Evaluation must be provided by qualified clinical professional operating within their scope of practice, as allowed by state law and who have been specifically trained to provide and review the assessment tool and make a clinically appropriate referral.

When the administration and interpretation of psychological tests is required to aid in the determination of diagnoses and the level of impairment, a psychologist must provide the diagnosis. .

### Service Documentation

The CSN must include the purpose of the assessment, the results of diagnostic assessment, or make reference to the completed assessment tool.

### Staff-to-Beneficiary Ratio

Psychological Testing and Evaluation Services require one professional for each beneficiary. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider regardless of whether or not the beneficiary is Medicaid eligible.

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

### Billing Frequency

Psychological Testing and Evaluation is billed as a 60 minute unit. . The session should last, at a minimum, one hour. The provider can bill up to six units per day, but only 20 units are allowed in a year. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

### Billable Place of Service

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality

### Special Restrictions Related to Other Services

Efforts should be made to determine whether another psychological testing has been conducted in the last 90 days and the information should be updated as needed. If an assessment has been conducted within the last 90 days, efforts should be made to access those records. An assessment should be repeated only if a significant change in behavior or functioning has been noted. A repeated assessment must be added to the clinical records.

Delivery of this service should include contacts with family and/or guardians of children for the purpose of securing pertinent information necessary to complete an evaluation of the beneficiary.

The Psychological Testing and Evaluation, Diagnostic and Comprehensive assessment can be billed on the same day. The assessments must be billed separately and provide different outcomes.

| Code | Assessment | Description | Modifier | Frequency |
|---|---|---|---|---|
| 90791 | Psychiatric Diagnostic Assessment without medical services–Initial | Clinical Psychologist<br>Master's level staff | AH<br>HO | 1 encounter per 6 months |
| 90792 | Psychiatric Diagnostic Assessment with medical services - Initial | Specialty physician (Psychiatrist)<br>Physician team member svc (PA)<br>Nurse practitioner (APRN) | AF<br>AM<br>SA | 1 encounter per 6 months |
| H2000 | Comprehensive Diagnostic Assessment - Initial | Clinical Psychologist<br>Master's level | AH<br>HO | 1 encounter per 6 months |

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

| Code | Assessment | Description | Modifier | Frequency |
|---|---|---|---|---|
| 96101 | Psychological Testing (hour) | Clinical Psychologist | AH | 6 per day; 20 units per year |
| H0031 | Mental Health Comprehensive Assessment –Follow-up | Clinical Psychologist<br>Master's level | AH<br>HO | 1 encounter per day<br>12 encounters per year |

# SECTION 2 POLICIES AND PROCEDURES

## CORE TREATMENT — THERAPY AND COUNSELING SERVICES

### THERAPY

Therapy Services are provided within the context of the goals identified in the beneficiary's plan of care. An Assessment must be completed to determine the need for therapy services. The nature of the beneficiary's needs and diagnosis including substance abuse, strengths, and resources, determine the extent of the issues addressed in treatment, the psychotherapeutic modalities used by the clinical professional and its duration.

Therapy Services are based on an empirically valid body of knowledge about human behavior. Therapy Services do not include educational interventions without therapeutic process interaction or any experimental therapy not generally recognized by the profession. These services do not include drug therapy or other physiological treatment methods.

Therapy Services are planned face-to-face interventions intended to help the beneficiary achieve and maintain stability; improve their physical, mental, and emotional health; and cope with or gain control over the symptoms of their illness(es) and the effects of their disabilities. Therapy Service should be used to assist beneficiaries with problem solving, achieving goals, and managing their lives by treating a variety of behavioral health issues. Therapy Services may be provided in an individual, group, or family setting. The assessments, plans of care, and progress notes in the beneficiary's records must justify, specify, and document the initiation, frequency, duration and progress of the therapeutic modality.

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

### Individual Psychotherapy (IT)

*Purpose*

The purpose of this face-to-face intervention is to assist the beneficiary in improving his or her emotional and behavioral functioning. The clinical professional assists the individual in identifying maladaptive behaviors and cognitions, identifying more adaptive alternatives, and learning to utilize those more adaptive behaviors and cognitions.

*Service Description*

Individual Psychotherapy (IT) is an interpersonal, relational intervention directed towards increasing an individual's sense of well-being and reducing subjective discomforting experience. IT may be psychotherapeutic and/or therapeutically supportive in nature.

IT involves planned therapeutic interventions that focus on the enhancement of a beneficiary's capacity to manage his or her emotions and behaviors through effective decision making, developing and acquiring coping skills, making better choices and decisions regarding co-occurring substance abuse, achievement of personal goals, and development of self-confidence and self-esteem.

Treatment should be designed to maximize strengths and to reduce problems and/or functional deficits that interfere with a beneficiary's personal, family, and/or community adjustment. Interventions should also be designed to achieve specific behavioral targets, such as improving medication adherence or reducing substance abuse.

*Medical Necessity Criteria*

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorders. The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.

*Staff Qualifications*

Therapy Services must be provided by clinical professionals operating within their scope of practice, as allowed by state law

*Staff-to-Beneficiary Ratio*

IT is one professional to one beneficiary.

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

*Service Documentation*

The CSN must document how the therapy session applied to the identified beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes. Services must be documented on the CSN with a start time and end time.

*Billing Frequency*

IT is billed as an encounter. Each encounter has a set time limit. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

*Billable Place of Service*

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

*Special Restrictions Related to Other Service*

IT encounter sessions can only be rendered one time daily. Services can be rendered in a variety of combinations, but only eight sessions per month are billable. Only one Individual Psychotherapy session can be billed per day.

### Group Therapy (GT)

*Purpose*

The purpose of this face-to-face intervention is to assist a group of beneficiaries, who are addressing similar issues, in improving their functioning. The group process allows members to offer each other support, share common experiences, identify strategies that have been successful for them, and to challenge each other's behaviors and cognitions. The therapist guides the group to ensure that the process is productive for all members and focuses on identified therapeutic issues.

*Service Description*

Group Therapy (GT) is a method of treatment in which several beneficiaries with similar problems meet face-to-face in a group with a clinician to improve and manage their emotions and behaviors. The goal of GT is to help beneficiaries with solving emotional difficulties and to encourage the personal development of beneficiaries in the group.

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

*Service Description (Cont'd.)*

GT involves a small therapeutic group that is designed to produce behavior change. The group must be a part of an active treatment plan and the goals of GT must match the overall treatment plan for the individual beneficiary. GT requires a relationship and interaction among group members and a stated common goal. The focus of the therapy sessions must not be exclusively educational or supportive in nature. The intended outcome of such group oriented, psychotherapeutic services is the management, reduction, or resolution of the identified behavioral health problems, thereby allowing the beneficiary to function more independently and competently in daily life.

Beneficiaries who meet the following criteria may benefit from GT:

- Beneficiaries with interpersonal problems related to their diagnoses and functional impairments. Interaction with peers in a group setting will allow the beneficiary to develop and practice new skills and focus on the factors that impact the beneficiary's symptoms.
- Beneficiaries with the same type of problem that may gain insight by being in a group with others
- Beneficiaries who have a similar experience and all beneficiaries demonstrate a level of competency to function in GT

**Caregiver Groups** are direct services provided to persons serving in primary caregiver roles for beneficiaries. Caregiver groups are intended to promote effective support from the caregivers to facilitate the improvement and/or recovery of the beneficiary. These groups are psych-educational in nature. They provide information and education to the participants about the nature of the severe mental illness, serious emotional disturbance, or substance abuse that the beneficiary experience. They allow and promote the participants to process the information and share feelings and experiences in caring for the beneficiary, and receive support from the group.

**Multiple Family/Group Therapy** is directed toward the restoration, enhancement, or prevention of the deterioration of role performance of families. Multiple Family/Group Therapy allows the therapist to address the needs of several

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

*Service Description (Cont'd.)*

families at the same time and mobilizes group support between families. The Multiple Family/Group Therapy process provides commonality of the FT experience, including experiences with co-occurring substance use disorders, and utilizes a complex blend of family interactions and therapeutic techniques, under the guidance of a therapist. The intended outcome of such family-oriented, psychotherapeutic services is the management, reduction, or resolution of the identified mental health problems, thereby allowing the beneficiary and family units to function more independently and competently in daily life.

*Medical Necessity Criteria*

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorders. The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.

*Staff Qualifications*

Therapy Services must be provided by clinical professionals operating within their scope of practice, as allowed by state law.

*Service Documentation*

The CSN must document how the group and/or family therapy session applied to the identified beneficiary's treatment goals. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

*Staff-to-Beneficiary Ratio*

GT requires one professional and no more than eight beneficiaries, or groups of up to six family units, but no more than 12 members per group.

Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider regardless of whether or not the beneficiary is Medicaid eligible.

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

*Billing Frequency*

GT is billed as an encounter. A session must last a minimum of 75-90 minutes. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes. More than one session can be billed per day.

*Billable Place of Service*

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

*Special Restrictions Related to Other Services*

GT is an encounter session. Each session must be documented separately.

### Family Therapy (FT)

*Purpose*

The purpose of this face-to-face intervention is to address the interrelation of the beneficiary's functioning with the functioning of his or her family unit. The therapist assists family members in developing a greater understanding of the beneficiary's psychiatric and/or behavioral disorder and the appropriate treatment for this disorder, identifying maladaptive interaction patterns between family members and how they contribute to the beneficiary's impaired functioning, and identifying and developing competence in utilizing more adaptive patterns of interaction.

*Service Description*

Family Therapy (FT) involves interventions with members of the beneficiary's family unit *(i.e.,* immediate or extended family or significant others) with or on behalf of a beneficiary to restore, enhance, or maintain the family unit.

FT may be rendered with or without the beneficiary to family members of the identified beneficiary as long as the identified beneficiary is the focus of the sessions. The identified beneficiary is the family member with the symptom that has brought the family into treatment. Only issues pertinent to the identified beneficiary may be addressed under this service.

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

*Service Description (Cont'd.)*

FT tends to be short-term treatment, with a focus on resolving specific problems such as eating disorders, difficulties with school, or adjustments to bereavement or geographical relocation. Treatment should be focused on changing the family dynamics and attempting to reduce and manage conflict. The family's strengths should be used to help them handle their problems.

FT helps families and individuals within that family understand and improve the way they interact and communicate with each other (*i.e.*, transmission of attitudes problems and behaviors) and promote and encourage family support to help facilitate the beneficiary's improvement. The goal of FT is to get family members to recognize and address the problem by establishing roles that promote individuality and autonomy, while maintaining a sense of family cohesion.

Interventions include the identification and the resolution of conflicts arising in the family environment — including conflicts that may relate to substance use or abuse on the part of the beneficiary or family members; and the promotion of the family understanding of the beneficiary's mental disorder, its dynamics, and treatment. Services may also include addressing ways in which the family can promote recovery for the beneficiary from mental illness and/or co-occurring substance use disorders.

*Medical Necessity Criteria*

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance abuse disorders. The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.

*Staff Qualifications*

Therapy Services must be provided by clinical professionals operating within their scope of practice, as allowed by state law.

*Service Documentation*

The CSN must document how the FT session applied to the identified beneficiary's treatment goals. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

*Staff-to-Beneficiary Ratio*

FT is one professional for each family unit.

*Billing Frequency*

FT is billed as an encounter and can only be rendered once per day. FT with the beneficiary can be rendered four sessions per month and FT without the beneficiary can be rendered four times a month. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

*Billable Place of Service*

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

*Special Restrictions Related to Other Services*

No restrictions.

## CRISIS MANAGEMENT (CM)

### Purpose

The purpose of this face-to-face or telephonic short-term service is to assist a beneficiary who is experiencing a marked deterioration of functioning related to a specific precipitant, in restoring his or her level of functioning. The goal of this service is to maintain the beneficiary in the least restrictive, clinically appropriate level of care.

### Service Description

The clinician must assist the beneficiary in identifying the precipitating event, in identifying personal and/or community resources that he or she can rely on to cope with this crisis, and in developing specific strategies to be used to mitigate this crisis and prevent similar incidents.

A crisis can be defined as an event that places a beneficiary in a situation that was not planned or expected. Sometimes, these unexpected events can hinder the beneficiary's capacity to function. Clinical professionals should provide an objective frame of reference within which to consider the crisis, discuss possible alternatives, and promote healthy functioning. All activities must occur within the context of a potential or actual psychiatric crisis.

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

Service Description (Cont'd.)

Crisis Management (CM) should therefore be immediate methods of intervention that can include stabilization of the person in crisis, counseling and advocacy, and information and referral, depending on the assessed needs of the individual.

Face-to-face inventions require immediate response by a clinical professional and include:

- A preliminary evaluation of the beneficiary's specific crisis
- Intervention and stabilization of the beneficiary
- Reduction of the immediate personal distress experienced by the beneficiary
- Development of an action plan that reduces the chance of future crises through the implementation of preventative strategies
- Referrals to appropriate resources
- Follow up with each beneficiary within 24 hours, when appropriate
- Telephonic interventions are provided either to the beneficiary or on behalf of the beneficiary to collect an adequate amount of information to provide appropriate and safe services, stabilize the beneficiary, and prevent a negative outcome.

An evaluation of the beneficiary should be conducted promptly to identify presenting concerns, issues since last stabilization (when applicable), current living situation, availability of supports, potential risk for harm to self or others, current medications and medication compliance, current use of alcohol or drugs, medical conditions, and when applicable, history of previous crises including response and results.

Individuals in crisis who require this service may be using substances during the crisis. Substance use should be recognized and addressed in an integrated fashion, as it may add to risk, increasing the need for engagement in care. This coordination must be documented in the individual's plan of care.

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

### Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance abuse disorder, experiencing seriously acute psychiatric symptoms, or psychological and/or emotional changes that result in increased personal distress and who would without intervention be at risk for a higher level of care, such as hospitalization or other out-of-home placement.

Beneficiaries in crisis may be represented by a family member or other individuals who have extensive knowledge of the beneficiary's capabilities and functioning.

### Staff Qualifications

CM must be provided by qualified clinical professionals as defined in the "Staff Qualifications" in this section.

Bachelor's level staff providing this service must have documented intensive training in Crisis Management.

### Service Documentation

CM is not required to be listed on the plan of care. A CSN must be completed upon contact with the beneficiary and should include the following:

- Start time and duration
- All participants during the service
- Summary of the crisis or the symptoms that indicate the beneficiary is in a crisis
- Content of the session
- Active participation and intervention of the staff
- Response of the beneficiary to the treatment
- Beneficiary's status at the end of the session
- A plan for what will be worked on with the beneficiary

Resolution of the crisis must be clearly documented in the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

### Staff-to-Beneficiary Ratio

CM requires at least one professional for each beneficiary.

### Billing Frequency

CM is billed in 15-minute units. Services must be documented on the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

**Billable Place of Service**

Services can be rendered in a community mental health center, substance abuse facility, or setting that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

**Special Restrictions Related to Other Services**

Services provided to children must include coordination with family or guardians and other systems of care as appropriate.

## MEDICATION MANAGEMENT (MM)

**Purpose**

The purpose of this face-to-face service is to train and educate the beneficiary about his or her medication, to determine any physiological and/or psychological effects of medication(s) on the beneficiary, administer necessary medications, and to monitor the beneficiary's compliance with his or her medication regime.

**Service Description**

Medication Management (MM) is focused on topics such as possible side effects of medications, possible drug interactions, and the importance of compliance with medication. During assessments, attempts should be made to obtain necessary information regarding the beneficiary's health status and use of medications.

MM encompasses those processes through which medicines are selected, procured, delivered, prescribed, administered, and reviewed to optimize the contribution that medicines make to producing informed and desired outcomes of the beneficiary's care.

MM includes two or more of the following services:

- Management, which involves prescribing and then reviewing medications for their side effects
- Monitoring, which involves observing and encouraging people to take their medications as prescribed (frequently used with people with a poor compliance history)
- Administration, which is the actual giving of an oral medication by a licensed professional

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

Service Description (Cont'd.)

- Training, which educates beneficiaries and their families on how to follow the medication regime and the importance of doing so
- Assess the need for beneficiaries to see the physician

MM may provide the following:

- Determine the overt physiological effects related to any medication(s)
- Determine psychological effects of medications
- Monitor beneficiaries' compliance to prescription directions
- Educate beneficiaries as to the dosage, type, benefits, actions, and potential adverse effects of the prescribed medications
- Educate beneficiaries about psychiatric medications and substance abuse in accordance with nationally accepted practice guidelines
- Monitor and evaluate the beneficiary's response to medication(s)
- Perform a medication review to identify, resolve, and prevent medication-related problems, including adverse drug events
- Document the care delivered and communicate essential information to the beneficiary and/or other service providers, if appropriate. When the service is provided to children, the service should include communication and coordination with the family and/or legal guardian.
- Provide verbal education and training designed to enhance the beneficiary understanding and appropriate use of the medications
- Provide information, support services, and resources designed to enhance beneficiary's adherence to medication regiment
- Coordinate and integrate MM services within the broader health care management services being provided to the beneficiary

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

**Medical Necessity Criteria**

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorder. The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services. The beneficiary must be on medication prescribed by a physician or being educated on how to take their medication appropriately.

**Staff Qualifications**

MM services must be provided by a qualified clinical professional operating within their scope of practice as allowed by state law.

A physician must be available in the event of an emergency.

**Service Documentation**

MM must be listed in the plan of care. Medication Monitoring requires that the following items be documented in the CSN:

- Medications the beneficiary is currently taking, or reference to the physician's order or other document in the medical record that lists all the medications prescribed to the beneficiary
- All benefits and side effects of new medications being prescribed or for medications that is potentially dangerous
- Any change in medications and/or doses and rationale for any change, if applicable
- Documentation of any medications being prescribed
- Follow-up instructions for the next visit
- Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

**Staff-to-Beneficiary Ratio**

MM requires at least one professional for each beneficiary.

**Billing Frequency**

MM is billed in 15-minute units. Services must be documented on the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

# SECTION 2 POLICIES AND PROCEDURES

## CORE REHABILITATIVE SERVICES STANDARDS

| | |
|---|---|
| Billable Place of Service | The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that the beneficiary and the professional will have adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality. |
| Special Restrictions Related to Other Services | MM cannot be billed with Individual Psychotherapy with the E&M codes. |

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

Community Support Services can only be provided by state agencies or enrolled private RBHS organizations.

### PSYCHOSOCIAL REHABILITATIVE SERVICES (PRS)

#### Purpose

The purpose of the face-to-face service is to assist beneficiaries with behavioral health and/or substance abuse disorders to enhance the restoration or strengthening of skills needed to promote and sustain independence and stability in their living, learning, social, and working environments. Psychosocial Rehabilitative Services are a form of skill building support, not a form of therapy or counseling. This service includes activities that are necessary to achieve goals in the plan of care in the following areas:

- Skills development related to life in the community and to increasing the beneficiary's ability to manage their illness, to improve their quality of life and to live as actively and independently in the community as possible
- Basic living skills development in understanding and practice of daily and healthy living habits and self-care skills
- Interpersonal skills training that enhances the beneficiary's self-management and communication skills, cognitive functioning, and ability to develop and maintain environmental supports
- Consumer empowerment that improves the beneficiary's basic decision making and problem solving skills

#### Service Description

PRS is designed to improve the quality of life for beneficiaries by assisting them to assume responsibility over their lives, strengthen skills, and develop environmental supports necessary to enable them to function as actively and independently in the community, as possible.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

### Service Description (Cont'd.)

PRS should be provided in a supportive community environment. Each beneficiary should be offered PRS in a manner that maximizes the beneficiary's responsibility, control, and feelings of self-worth, and encourages ownership in the rehabilitation process.

The goals of PRS are to:

- Effectively manage the illness
- Reduce problem areas that prevent successful independent living
- Develop or increase basic life skills that contribute to successful independent living

PRS includes services provided individually or in small groups based on the assessed needs and level of functioning of the beneficiary and includes activities that foster growth in the following areas:

- Basic Living Skills Development — Coaching and encouraging the beneficiary to participate in activities that enhance their basic living skills
- Interpersonal Skills Training — Directing and promoting the beneficiary's self-management, socialization, communication skills, and cognitive functioning
- Therapeutic Socialization — Teaching the beneficiary the necessary skills to appropriately perform activities that sustain independence
- Consumer Empowerment — Promoting and enhancing the beneficiary's development of basic decision-making and problem-solving skills

PRS activities that are directed to promote recovery, restore skills, and develop adaptive behaviors may include the following:

- Promoting the understanding and the practice of healthy living habits
- Promoting the enhancement of self-care, personal hygiene, selection of nutritional food, and appropriate eating habits
- Assisting with maintaining adequate relationships with others

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

**Service Description (Cont'd.)**

- Promoting the expression of his or her needs, feelings, and thoughts in a supportive and safe environment
- Promoting the safe use of community resources
- Assisting with issues of personal safety
- Promoting hope through understanding of his or her illness, its effect on their lives, social adaptation, and alternatives to improve their quality of life
- Assisting to restore basic functional abilities he or she may have lost because of the illness
- Assisting to develop abilities to maintain his or her personal belonging and living space
- Identifying and managing symptoms, attitudes, and behaviors that interfere with seeking a job or obtaining an education
- Improving concentration and attention, problem-solving skills, ethics development, and time management
- Directing interventions to identify and reduce stressors, develop coping skills and prevent decompensation
- Enabling to verbalize thoughts, feelings, and ideas in a supportive environment
- Helping to reduce distraction or preoccupation with disturbing thoughts and withdrawal

**Medical Necessity Criteria**

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance abuse disorders. The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.

**Staff Qualifications**

PRS is provided by qualified staff, under the supervision, of qualified clinical professionals as specified under the "Staff Qualifications" section. Staff providing the service must have, at a minimum, a high school diploma or GED, or higher educational level.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

### Service Documentation

PRS must be listed on the IPOC with a planned frequency and should be documented upon contact with the beneficiary. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

The staff providing the service is responsible for completing and signing the documentation. Documentation should clearly identify the specific goal from the IPOC for which the delivery of this service addresses.

The professional providing the service should record the specific deficit of the beneficiary and the therapeutic intervention that was used to address the deficit when the service is provided.

### Staff-to-Beneficiary Ratio

PRS is provided individually, face-to-face with the beneficiary or in small groups of one staff to 12 beneficiaries, as determined appropriate based on the needs of the beneficiary. The ratio count applies to all beneficiaries receiving services by a provider regardless of whether the beneficiary is Medicaid eligible or non-Medicaid.

### Billing Frequency

PRS is billed in 15-minute unit. Services must be documented on the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

### Billable Place of Service

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

### Special Restrictions Related to Other Services

For services rendered to beneficiaries that are residing in a Community Residential Care Facility or Substance Abuse Facility, activities must be above and beyond structured activities required daily by the DHEC licensure requirements. This delineation must be clearly defined, documented, and accessible in the beneficiary record.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

### BEHAVIOR MODIFICATION (B-MOD)

**Purpose**

The purpose of this service is provided to children ages 0 to 21. The purpose of this face-to-face service is to provide the beneficiary with in vivo redirection and modeling of appropriate behaviors in order to enhance his or her functioning within their home or community. The beneficiary's plan of care should determine the focus of this service.

**Service Description**

The goal of Behavior Modification (BMod) is to alter behavior that is inappropriate or undesirable of the child or the adolescent. Behavior Modification involves regularly scheduled interventions designed to optimize emotional and behavioral functioning in the natural environment through the application of clinically planned techniques that promote the development of healthy coping skills, adaptive interactions with others, and appropriate responses to environmental stimuli.

BMod provides the beneficiary the opportunity to alter existing behaviors, acquire new behaviors, and function more effectively within his or her environment. Interventions are planned in such a way that they are constantly supporting, guiding, and reinforcing the beneficiary's ability to learn life skills.

Inappropriate and/or undesirable behaviors are identified, targeted, stopped and/or redirected. BMod involves the observation of the beneficiary's behaviors and events that occur before an inappropriate and/or undesirable behavior is exhibited by the beneficiary and identification of precipitating factors that cause a behavior to occur. New, more appropriate behaviors are identified, developed, and strengthened through modeling and shaping. Intervention strategies that require direct involvement with the beneficiary should be used to develop, shape, model, reinforce and strengthen the new behaviors.

BMod techniques allow professionals to build the desired behavior in steps and reward those behaviors that come progressively closer to the goal and allow the beneficiary the opportunity to observe the professional performing the desired behavior.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

**Service Description (Cont'd.)**

Successful delivery of BMod should result in the display of certain desirable behavior that has been infrequently or never displayed by the beneficiary.

**Medical Necessity Criteria**

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance abuse disorders and must be between the ages of 0 and 21. The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school, recreational settings and behaviors that present risk of harm to self or others.

**Staff Qualifications**

BMod services are provided by qualified staff, under the supervision, of qualified clinical staff as defined in the "Staff Qualifications" section. Staff providing the service must have, at a minimum, a high school diploma or GED, or be a higher educational level.

**Service Documentation**

BMod must be listed on the IPOC with a planned frequency and should be documented upon contact with the beneficiary.

The physician, or LPHA or other qualified clinical professional is responsible for developing the IPOC that includes strategies for eliminating and managing behavior.

The staff providing the service is responsible for completing and signing the documentation. Documentation should clearly identify the specific goal from the IPOC for which the delivery of this service addresses.

In addition to general documentation requirements, the documentation of this service must include the inappropriate and/or undesirable behavior of the beneficiary and how the behavior was redirected.

**Staff-to-Beneficiary Ratio**

BMod is provided individually, face-to-face with the beneficiary and a qualified professional or paraprofessional.

**Billing Frequency**

B-Mod is billed in 15-minute unit. Services must be documented on the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

**Billable Place of Service**

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

**Special Restrictions Related to Other Services**

Services cannot be billed for group activities.

### FAMILY SUPPORT (FS)

**Purpose**

The purpose of this face-to-face or telephonic service is to enable the family or caregiver (parent, guardian, custodian or persons serving in a caregiver role) to serve as a knowledgeable member of the beneficiary's treatment team and to develop and/or improve the ability of families or caregivers to appropriately care for the beneficiary.

**Service Description**

Family Support (FS) is a medical supportive service with the primary purpose of treatment of the beneficiary's condition. The intent of this service is face-to-face contact, but services may also include telephonic contact with the identified beneficiary and collateral contact with persons who assist the beneficiary in meeting their goal as specified in the Individual Plan of Care. The documentation must support the circumstances that warrant services provided by telephone. FS is the process of family participation with the services provider in the treatment process of the Medicaid beneficiary. FS should result in an intervention that changes or modifies the structure, dynamics and interactions that act on the beneficiary's emotions and behavior.

FS does not treat the family or family members other than the identified beneficiary. FS is not for the purpose of history taking or coordination of care. This service includes the following discrete services when they are relevant to the goal in the individual plan of care: providing guidance to the family or caregiver on navigating systems that support individuals with behavioral health needs, such as behavioral health advocacy groups and support networks; fostering empowerment of family or caregiver by offering supportive guidance for families with behavioral health

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

**Service Description (Cont'd.)**

needs and encouraging participation in peer or parent support and self-help groups; and modeling these skills for parents, guardians, or caregivers. Family Support does not include respite care or child care services.

Training and education are provided to the family or caregiver for the purpose of enabling the family or caregiver to better understand and care for the needs of the beneficiary and participate in the treatment process by coaching and redirecting activities that support therapy interventions.

Services may only be provided to the family or caregiver and directed exclusively to the effective treatment of the beneficiary.

FS is intended to:

- Equip families with coping skills to counteract the stress of dealing with the beneficiary's behavioral health needs
- Alleviate the burden of stigma that families carry
- Teach families to deal with the crisis and to coordinate effectively with service provider
- Reduce families isolation by connecting them with behavioral health advocacy and support network
- Educate families to advocate effectively for their relatives
- Provide families with information and skills necessary to allow them to be an integral and active part of the beneficiary's treatment team

**Medical Necessity Criteria**

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance abuse disorder. The results of the assessment and/or screening tool must indicate a need for support and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work environment, school and recreational settings.

**Staff Qualifications**

FS is provided by, or under the supervision of, qualified professionals as specified under the "Staff Qualifications" section and in accordance with the South Carolina State Law.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

### Service Documentation

FS must be listed on the IPOC with a planned frequency and should be documented upon contact with the beneficiary.

The staff providing the service is responsible for completing and signing the documentation. Documentation should clearly identify the specific goal from the IPOC for which the delivery of this service addresses.

### Staff-to-Beneficiary Ratio

FS requires one professional for each family unit.

### Billing Frequency

FS is billed in 15-minute units. Services must be documented on the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

### Billable Place of Service

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

### Special Restrictions Related to Other Services

Services provided on the behalf of children must include coordination with family or guardians and other systems of care as appropriate.

## PEER SUPPORT SERVICES (PSS)

### Purpose

The purpose of this service is to allow Medicaid beneficiaries over the age of 18 with similar life experiences to share their understanding with other beneficiaries to assist-in their recovery from mental health and/or substance use disorders. The peer support specialist gives advice and guidance, provides insight, shares information on services and empowers the beneficiary to make healthy decisions. The unique relationship between the peer support specialist and the beneficiary fosters understanding and trust in beneficiaries who otherwise would be alienated from treatment. The beneficiary's plan of care determines the focus of Peer Support Services (PSS).

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

### Purpose (Cont'd.)

This service is person centered with a recovery focus and allows beneficiaries the opportunity to direct their own recovery and advocacy process. The service promotes skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills.

The peer support specialist will utilize their own experience and training to assist the beneficiary in understanding how to manage their illness in their daily lives by helping them to identify key resources, listening and encouraging beneficiaries to cope with barriers and work towards their goals. The peer support specialist will also provide ongoing support to keep beneficiaries engaged in proactive and continual follow up treatment.

The peer support specialist actively engages the beneficiary to lead and direct the design of the plan of care and empowers the beneficiary to achieve their specific individualized goals. Beneficiaries are empowered to make changes to enhance their lives and make decisions about the activities and services they receive. The peer support specialist guides the beneficiary through self-help and self-improvement activities that cultivate the beneficiary's ability to make informed independent choices and facilitates specific, realistic activities that lead to increased self-worth and improved self-concepts.

### Service Description

Services are multi-faceted and emphasize the following:

- Personal safety
- Self-worth
- Introspection
- Choice
- Confidence
- Growth
- Connection
- Boundary setting
- Planning
- Self-advocacy
- Personal fulfillment

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

- The Helper Principle
- Crisis management
- Education
- Meaningful activity and work
- Effective communications skills

Due to the high prevalence of beneficiaries with mental health and/or substance use disorders and the value of peer support in promoting dual recovery, identifying individuals co-occurring disorders who require a dual treatment is a priority.

The availability of services is a vital part of PSS to reinforce and enhance the beneficiary's ability to cope and function in the community and develop natural supports. Services must be rendered face to- face. The beneficiary must be willing to participate in the service delivery. Services are structured or planned one-to-one or group activities that promote socialization, recovery, self-advocacy, and preservation.

PSS must be coordinated within the context of a comprehensive, individualized POC that includes specific individualized goals. Providers should use a person-centered planning process to help promote beneficiary ownership of the POC.

Such methods actively engage and empower the beneficiary and individuals selected by the beneficiary, in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the beneficiary in achieving the specific, individualized goals that have measurable results and are specified in the service plan.

Service interventions include the following:

- Self-help activities that cultivate the beneficiary's ability to make informed and independent choices. Activities help the beneficiary develop a network for information and support from others who have been through similar experiences.
- Self-improvement includes planning and facilitating specific, realistic activities leading to increased self-worth and improved self-concepts.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

- Assistance with substance use reduction or elimination provides support for self-help, self-improvement, skill development, and social networking to promote healthy choices, decisions, and skills regarding substance use disorders or mental illness and recovery.
- System advocacy assists beneficiaries in making telephone calls and composing letters about issues related to substance use disorders, or mental illness or recovery.
- Individual advocacy discusses concerns about medications or diagnoses with a physician or nurse at the beneficiary's requests. Further, it helps beneficiaries arrange the necessary treatment when requested, guiding them toward a proactive role in their own treatment.
- Crisis support assists beneficiaries with the development of a crisis plan. It teaches beneficiaries:
  - How to recognize the early signs of a relapse
  - How to request help to prevent a crisis
  - How to use a crisis plan
  - How to use less restrictive, hospital alternatives
  - How to divert from using the emergency room
  - How to make choices about alternative crisis support
  - Housing interventions instruct beneficiaries in learning how to maintain stable housing or learning how to change an inadequate housing situation.
- Social network interventions assist beneficiaries with learning about the need to end unhealthy personal relationships, how to start a new relationship, and how to improve communication with family members.
- Education and/or employment interventions assist beneficiaries in obtaining information about going back to school or getting job training. Interventions give beneficiaries an opportunity to acquire

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

**Service Description (Cont'd.)**

knowledge about mainstreaming back into full-time or part-time work. Additionally, they are taught how to obtain reasonable accommodations under the Americans with Disabilities Acts (ADA).

**Services Evaluation and Outcome Criteria**

To the extent measurable, the service will be evaluated on the effectiveness of developing rehabilitative skills and diminishing the effects of mental illness, substance use, or co-occurring disorders. Particular attention will be given to measuring outcomes for individuals who identify as having concurrent mental illness and substance use disorders, as well as those who may have greater difficulties with access to the appropriate services.

PSS should be monitored and reviewed quarterly using the following measures:

- A client advisory group that consists of the peer support specialist, the clinical supervisor, and other clinical staff shall meet quarterly to discuss the services and provide guidance as needed.
- The focus group consists of the beneficiaries, clinical staff, and the peer support specialist. The group will meet to discuss comments from the suggestion box and any other issues.
- Service satisfaction surveys and system-wide surveys must provide outcome measures in the following areas for PSS:
  - **Satisfaction with Services** — Beneficiaries will rate their satisfaction of PSS as evidenced by a survey that measures their own perception of care. Service satisfaction surveys and system-wide surveys will be used to improve access to treatment, and to improve the quality of treatment.
  - **Access to Services** — Beneficiaries will rate the accessibility of the services and how much assistance the program provided. The survey should be given at the beginning of the service and at the end of the service. The survey will assist in providing a guide to help determine treatment intensity for mental health and/or substance use disorders.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

### Services Evaluation and Outcome Criteria (Cont'd.)

- **Clinical Outcomes** — Beneficiaries receiving PSS will maintain or improve their functioning as evidenced by a combination of the beneficiary's self-report measure of outcome (*e.g.*, MHSIP); and a clinical measure, such as the Global Assessment of Functioning (GAF).

### Medical Necessity Criteria

Medicaid beneficiaries over the age of 18 and diagnosed with a behavioral health and/or substance abuse disorders are eligible for services. The results of the screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.

PPS facilitate the need to build community supports to increase recovery time and provides support and encouragement to beneficiaries and their families. Services should begin following the development of the IPOC and authorization as required, throughout treatment, adjustments to new medications, relapse, and discharge planning.

### Staff Qualifications

*Peer Support Specialist*

The peer support specialist must possess, at a minimum, a high school diploma or GED, and he or she must have successfully completed and passed a certification training program, and he/she must be a current or former beneficiary of services as defined by SCDHHS.

The criteria for meeting the consumer of services qualification are:

- Have had a diagnosis of behavioral health or substance use disorder, as defined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and received treatment for the disorder
- Self-identify as having had a behavioral health and/or substance use disorder
- Be in a recovery program

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Peer Support Specialist (Cont'd.)*

Peer support specialists must have the following experience:

- The ability to demonstrate recovery expertise including knowledge of approaches to support others in recovery and dual recovery, as well as the ability to demonstrate his or her own efforts at self-directed recovery
- One year of active participation in a local or a national mental health and/or substance use consumer movement, which is evidenced by previous volunteer service or work experience
- Peer support providers **must** successfully complete a precertification program that consists of:
  - Forty hours of training including recovery goal setting, wellness recovery plans and problem solving, person-centered services, and advocacy
  - A minimum of 20 hours of continuing education training annually, of which at least 12 hours must be face-to-face training. All trainings must be approved by SCDHHS or other authorized entity.

Supervision

Supervision must be provided by a master's level staff or higher or a bachelor's level staff with a CAC II certification.

The supervisor must be available to supervise the peer support specialist and ensure that he or she provides services in a safe, efficient manner in accordance with accepted standards of clinical practice and certification and/or training standards as approved by SCDHHS.

The supervisor is required to chair regularly scheduled staff meetings with the peer support specialists to discuss administrative and individual treatment issues. At a minimum, staff meetings shall occur monthly. Staff meetings are not separately billable under another clinical service, unless the staffing includes a physician consultation. The supervisor shall review services that address specific program content and assess the beneficiary's needs. Issues relevant to the individual beneficiary will be documented in a staff note and noted in the beneficiary's medical record.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

### Supervision (Cont'd.)

The supervisor is also required to perform at least one evaluation of the beneficiary no later than six months after admission to the program. The evaluation shall be repeated annually to:

- Monitor the recovery process of the beneficiary
- Monitor the focus of the services provided
- Ensure that the beneficiary continues to meet the Peer Support criteria

The evaluation must be kept in the beneficiary's file and may be billed separately as a follow-up assessment.

### Service Documentation

PSS must be documented in the IPOC with a planned frequency and should be documented upon contact with the beneficiary. The staff providing the service is responsible for completing and signing the documentation. Documentation should clearly identify the specific goals from the IPOC for which the delivery of this service addresses.

Billable services must be documented in units on the beneficiary's CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Providers shall submit an annual report to the SCDHHS program manager within 60 calendar days after the close of the state fiscal year. This report should include summaries of the service provision and the service evaluation and outcome criteria, and the number of beneficiaries participating in the service.

### Staff-to-Beneficiary Ratio

PSS is provided one-to-one or in a group setting. When rendered in groups, PSS shall not exceed one professional per eight beneficiaries.

### Billing Frequency

PSS is billed in 15-minute units with 16 units billed per day. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

### Billable Place of Service

The only excluded settings are acute care hospitals. PSS can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

**Billable Place of Service (Cont'd.)**

beneficiary's rights to privacy and confidentiality.

As a group service, PSS may operate in the same building as other day services. However, with regard to staffing, content, and physical space; a clear distinction must exist between day services during the hours the PSS is in operation. PSS do not operate in isolation from the rest of the programs in the facility.

**Special Restrictions Related to Other Services**

PSS cannot be billed for Medicaid beneficiaries that reside in an acute care hospital facility.

PSS can only be provided by DMH and DAODAS.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

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# SECTION 2 POLICIES AND PROCEDURES

## SUBSTANCE ABUSE TREATMENT SERVICES

### PROGRAM DESCRIPTION

SCDHHS and the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) have implemented a statewide system to coordinate alcohol and other drug (AOD) services that are critical to serving eligible Medicaid beneficiaries. AOD services are rendered by Alcohol and Drug Commission providers through outpatient and residential treatment programs.

SCDHHS has adopted the American Society of Addiction Medicine's Patient Placement Criteria (ASAM-PPC) for the Treatment of Substance-Related Disorders as the basis for the beneficiary's placement in the appropriate levels of care. This manual specifies the policies that SCDHHS requires providers to meet in addition to the ASAM criteria

Beneficiaries must have a diagnosis of behavioral health and/or substance use disorder from the most recent DSM or ICD manual and meet medical necessity requirements before being placed in an AOD outpatient and or residential treatment program. Services must be authorized by a physician or Licensed Practitioner of the Healing Arts (LPHA).

Outpatient and residential services may require a physical examination to be completed within a specified time frame by a qualified health care professional.

Coordination of care must occur when a beneficiary is being served by multiple agencies and/or providers. Each provider is responsible for making the effort to identify during the intake process whether a beneficiary is already receiving treatment from another Medicaid provider and notifying any other involved Medicaid providers of the beneficiary's need for services. Medically necessary services should never be denied to a beneficiary because another provider has been identified as the service provider. Additionally, each provider should also notify other involved agencies or providers immediately if a beneficiary in an overlapping situation discontinues their services.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

### PROGRAM DESCRIPTION (CONT'D.)

Providers must ensure that staff responsible for the provision of services meets the appropriate licensing, credentialing, certification, or privileging standards required for each service or level of care.

DADOAS providers may render specific services listed in the Core Rehabilitative section, the Core Treatment section, and the Community Support section listed above. In order to be reimbursed for these services, DAODAS providers must follow the guidelines listed under "DAODAS Providers Only Procedure Codes" in Section 4 of this manual.

### PROGRAM SERVICES

Services listed below are rendered only by DAODAS providers. See the criteria listed below for policy guidelines and see Section 4 for frequency limitations and modifiers.

### Alcohol and Drug Screening (ADS) and Brief Intervention Services

*Purpose*

The purpose of this service is to provide early identification of behavioral health and/or substance use issues and to facilitate appropriate referral for a focused assessment and/or treatment. Alcohol and Drug Screening (ADS) is designed to identify beneficiaries who are at risk of development of behavioral health and/or substance use problems.

*Service Description*

This service requires completion of a brief questionnaire to examine the nature and context of the problem and identify patterns of behavior. Screenings are conducted using a standardized or SCDHHS-approved tool, through interviews or self-report. Some of the common tools used for screenings are:

GAIN — Global Appraisal of Individual Needs — Short Screener

DAST — Drug Abuse Screening Test

ECBI — Eyberg Child Behavior Inventory

SESBI — Sutter Eyberg Student Behavior Inventory

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Service Description (Cont'd.)*

CIDI — Composite International Diagnostic Interview

Screenings should be scored utilizing the tool's scoring methodology and referrals made based on the interpretation of the results.

Screenings should focus on patterns of behavioral health and/or substance use disorder and associated factors such as legal problems, mental health status, educational functioning, and living situation.

The beneficiary's awareness of the problem, feelings about his or her behavioral health and/or substance use disorders and motivation for changing behaviors may also be integral parts of the screening.

Prior to conducting the screening, attempts should be made to determine whether another screening had been conducted in the last 30 days. If a recent screening has been conducted, efforts should be made to access the record. A screening may be repeated as clinically appropriate or if a significant change in behavior or functioning has been noted.

*Medical Necessity Criteria*

All Medicaid-eligible beneficiaries who have been identified as having or at risk of a behavioral health and/or substance use disorder are eligible for this service.

*Staff Qualifications*

ADS may be provided by qualified clinical professionals as defined in the "Staff Qualifications" section of this manual, who have been specifically trained to review the screening tool and make a clinically appropriate referral.

*Service Documentation*

Services must be documented on the CSN with a start time and ending time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes ADS results should be documented during or immediately following the screening session with the beneficiary. The completed screening tool and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date of service.

Documentation must contain the following:

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Service Documentation (Cont'd.)*

- The outcome of the screening
- Identify any referrals resulting from the screening
- Support the number of units billed

*Staff-to-Beneficiary Ratio*

ADS require one staff member for each beneficiary. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

*Billing Frequency*

BHS is billed as an encounter. Twelve (12) encounters are allowed in a year. Only one encounter code is allowed per day.

*Billable Place of Service*

The only exclude settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

*Special Restrictions*

An AOD initial assessment without a physical examination cannot be billed on the same date of services as an AOD structured screening and brief intervention service.

### Alcohol and Drug Assessment (ADA) w/o Physical

*Purpose*

The purpose of this face-to-face assessment is to determine the need for rehabilitative services and substance abuse services, to establish or confirm a diagnosis, to provide the basis for development of an effective, comprehensive individual plan of care based upon the beneficiary's strengths and deficits, or to assess progress in and the need for continued treatment. This assessment includes a comprehensive bio-psychosocial interview and review of relevant psychological, medical, and education records.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Service Description*

Information obtained during the assessment must lead to a diagnosis that identifies the beneficiary's current symptoms or disorder by using the current edition of the DSM or the ICD.

Information gathered during the assessment process may be obtained from diagnostic interviews with the beneficiary and/or others familiar with the beneficiary's functioning, psychological testing, interpretation, and questionnaires, review of written reports or medical records, and observation of the beneficiary.

Only diagnostic codes that are clearly and consistently supported by the documentation should be reported. Diagnoses should be updated as the condition of the beneficiary changes.

Components of the assessment service include:

- Beneficiary demographic information
- Presenting complaint or source of distress
- Medical history and medications
- Family history
- Psychological and/or psychiatric treatment history for beneficiary and family
- Substance use history for beneficiary and family
- Mental status
- Current edition DSM or ICD diagnosis
- Functional assessment (with age-appropriate expectations)
- Exposure to physical abuse, sexual abuse, anti-social behavior, or other traumatic events

**Follow-up Assessment**

A follow-up assessment occurs after an initial assessment to reevaluate the status of the beneficiary, identify any changes in behavior and/or condition, and to monitor and ensure appropriateness of the treatment. Follow-up assessments may also be rendered to assess

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Service Description (Cont'd.)*

the beneficiary's progress, response to treatment, and the need for continued treatment.

A follow-up assessment should occur before the review of the IPOC, response to treatment, and need for continued participation in treatment. When changes in behavior and/or other related conditions occur or when a reassessment is completed, it must be documented separately on the CSN and comply with the service documentation requirements.

*Medical Necessity Criteria*

All Medicaid-eligible beneficiaries who have been identified as having or at risk of a behavioral health and/or substance use disorder are eligible for this service.

*Staff Qualification*

ADA must be provided by qualified clinical professionals as defined in the "Staff Qualifications" section of this manual, who have been specifically trained to provide and review the assessment tool and make a clinically appropriate referral.

*Service Documentation*

Services must be documented on the CSN with a start time and end time Additionally; the documentation must meet all SCDHHS requirements for clinical service notes. The completed assessment tool and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date of service.

The documentation must include the outcome of the assessment, identify any referrals resulting from the assessment and support the number of units billed.

*Staff to Beneficiary Ratio*

ADA requires one staff member for each beneficiary. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

*Billing Frequency*

ADA is billed as an encounter. A session should last a minimum of 60 minutes. One encounter is allowed every six months and coordination care should occur between providers.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Billable Place of Service*

The only exclude settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

*Special Restriction in Relationship to Other Services*

The assessment can only be rendered every six months per beneficiary. Services are rendered by the staff listed in Section 4 of this manual.

### Alcohol and Drug/Substance Abuse Counseling (SAC)

*Purpose*

The purpose of this face-to-face intervention is to assist beneficiaries in their recovery process. Alcohol and Drug/Substance Abuse Counseling (SAC) is focused on exploring and identifying the consequences of continued substance abuse, identifying triggers for substance abuse, and developing alternative coping strategies.

This service provides reinforcement of the beneficiary's ability to function within the confines of society without having to rely on addictive substances. SAC addresses goals identified in the plan of care that involves the beneficiary relearning basic coping strategies, understanding related psychological problems that trigger addictive behavior, and encouraging the beneficiary to recognize opportunities to change their behavior and how to achieve their goals.

*Service Description*

SAC requires face-to-face and goal-oriented interactions between a beneficiary and a clinical professional. The interactions provide the beneficiary with the skills and supports needed to reduce the use of substances, obtain abstinence, and successfully manage their illness. This service supports the beneficiary in achieving and maintaining improved ability to function in his or her daily living.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Service Description (Cont'd.)*

The goal of SAC is to aid beneficiaries in recovery from substance use disorders. SAC serves to educate beneficiaries about substance abuse and cultivate the skills needed to attain and sustain progress on identified goals; such as skills needed to manger anger or to cope with urges to use substances by altering thoughts and actions that lead to substance abuse. Interventions should focus on helping the beneficiary to develop the motivation to change substance-abusing behaviors and pursue life goals. Interventions should also focus on improving communication and conflict resolution skills and developing healthy boundaries.

SAC allows the clinical professional to listen to, interpret, and respond to the beneficiary's expression of physical, emotional, and/or cognitive problems and helps them to develop the skills and supports needed to live a satisfying life without substance abuse. SAC explores issues coexisting with and contributing to substance use or abuse, such as, delinquent behavior and/or mental health concerns (*e.g.*, depression, anger, anxiety, interpersonal conflicts, poor self-esteem, and anger management).

**Substance Abuse Group - Counseling**

Groups serve as a forum to share information about managing day-to-day without using illicit substances and may address major developmental issues that contribute to addiction, interfere with recovery, or contribute to relapse.

A qualified clinical professional may meet with the beneficiary and one or more family members to identify and address substance abuse issues in a family setting. SAC should actively involve members of the beneficiary's immediate family, extended family, or significant others as determined appropriate. In a group setting, SAC allows the clinical professional to meet the needs of several beneficiaries at the same time and mobilize group support.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

| | |
|---|---|
| *Medical Necessity Criteria* | Beneficiaries eligible for this service must have a diagnosis of a behavioral health and/or substance use disorder. The results of the screening and/or assessment tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings. |
| *Staff Qualifications* | SAC services must be provided by a qualified clinical professional or under the supervision of a qualified clinical professional as defined in the "Staff Qualifications" section. |
| *Service Documentation* | Documentation must indicate how the counseling session applies to the identified beneficiary's treatment goals. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes. |
| *Staff-to-Beneficiary Ratio* | SAC requires at least one professional for each beneficiary or group of up to 16 beneficiaries. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible. |
| *Billing Frequency* | Individual counseling is billed in a 15-minute unit. Group counseling is billed as an encounter. A group session should last at a minimum of 60 minutes. If the session last longer than 60 minutes, this time is not billable. Only one encounter code is allowed per day |
| *Billable Place of Service* | The only exclude settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality. |
| *Special Restrictions in Relationship to Other Services* | None |

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

### Skills Training (ST) and Development Services for Children (0 to 6 years)

*Purpose*

The purpose of this service is provided skills training and development to children 0 to 6 years of age. This face-to-face service provides activities that will restore or enhance targeted behaviors and improve the child's ability to function in his or her living, learning, and social environments. Skills Training and Development is a form of skills building support. It is not a form of therapy or counseling. Interventions are planned in such a way that they are constantly supporting, guiding, and reinforcing the beneficiary's ability to learn needed life skills.

*Service Description*

Skills Training and Development is a means to alter behavior that is inappropriate or undesirable of the child. Services involve regularly scheduled interventions designed to optimize emotional and behavioral functioning in the natural environment through the application of clinically planned activities that promote the development of healthy coping skills, adaptive interactions with others, and appropriate responses to environmental stimuli.

Through interaction with appropriately trained and qualified staff, activities will focus on skill deficits and provide the beneficiary the opportunity to alter existing behaviors, acquire new behaviors, and function more effectively within his or her environment.

This service includes activities that are identified during the assessment and are necessary to achieve goals in the plan of care.

Skills Training and Development interactions include the following:

- Skills activities designed to promote age-appropriate behavior and to improve the beneficiary's functioning within the home or social environments

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Service Description (Cont'd.)*

- Basic living skills development designed to help the beneficiary learn and practice daily, healthy living habits, and age-appropriate self-care skills
- Interpersonal skills training designed for age-appropriate and normal development of the beneficiary to will improve communication, problem solving, and self-management

Successful delivery of Skills Training and Development should result in the display of age-appropriate and desirable behavior that has been infrequent or never displayed.

Skills Training include services provided in a small group based on the assessed needs and level of functioning of the beneficiary.

*Medical Necessity Criteria*

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorders and must be 0 to 6 years of age. The results of the screening and/or assessment tool must indicate a functioning level that supports the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.

*Staff Qualifications*

Skills Training and Development services are provided by qualified staff, under the supervision, of qualified clinical staff as defined in the "Staff Qualifications" section. Staff providing the service must have, at a minimum, a high school diploma or GED, or higher educational level.

*Service Documentation*

The CSN must document how Skills Training and Development applies to the beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes. The service must be listed on the IPOC with a planned frequency and should be documented upon contact with the beneficiary or immediately afterwards.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Service Documentation (Cont'd.)*

The physician, LPHA, or other qualified clinical professional is responsible for developing the IPOC that includes strategies for eliminating and managing behaviors.

The staff providing the service is responsible for completing and signing the documentation.

In addition to general documentation requirements, the documentation of this service must include the inappropriate or undesirable behavior of the beneficiary and how the behavior was redirected.

*Staff-to-Beneficiary Ratio*

Skills Training and Development is provided face-to-face with the beneficiary. The service can be rendered in groups of one staff to 12 beneficiaries, as appropriate, based on the needs of the beneficiary. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the individual is Medicaid eligible.

*Billing Frequency*

Skills training and development is billed in a 15-minute unit.

*Billable Place of Service*

The only exclude settings are acute care hospitals Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

*Special Restrictions in Relationship to Other Services*

Services provided to children must include coordination with family or guardians and other systems of care as appropriate.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

### Psychological Testing and Reporting

*Purpose*

The purpose of the test is to evaluate the beneficiary's intellectual, emotional, and behavioral status. Testing may include measures of intellectual and cognitive abilities, neuropsychological status, attitudes, emotions, motivations, and personality characteristics, as well as the use of other non-experimental methods of evaluation.

Psychological Testing services are provided by a qualified clinical professional. The professional provides the administering of the test and technical aspects of the test. This service is rendered face-to-face with the Medicaid-eligible beneficiary.

*Service Description*

When necessary or appropriate, a consultation shall only include telephone or face-to-face contact by a qualified clinical professional to the family, school, or another health care provider to interpret or explain the results of psychological testing and/or evaluations related to the care and treatment of the beneficiary.

The psychologist is expected to review the report and render the diagnoses. The psychologist must document the recommended course of action.

*Medical Necessity Criteria*

All Medicaid-eligible beneficiaries who have been identified as having or at risk of a behavioral health and/or substance use disorder are eligible for this service.

*Staff Qualifications*

Psychological Testing must be provided by a qualified clinical professional operating within their scope of practice, as allowed by state law, and who is specifically trained to provide and review the assessment tool and make a clinically appropriate referral.

When the administration and interpretation of psychological tests is required to aid in the determination of diagnoses and the level of impairment, a psychologist must provide the diagnoses.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Service Documentation*

The documentation must include the purpose of the assessment, the results of diagnostic assessment, and the name of the assessment tool utilized.

*Staff-to-Beneficiary Ratio*

Psychological Testing and Reporting requires one professional for each beneficiary. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider regardless of whether or not the beneficiary is Medicaid eligible.

*Billing Frequency*

Psychological Testing is billed as an encounter. The session should last, at a minimum, one hour. Six units can be billed per day, but only 20 units are allowed in a year. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

*Billable Place of Service*

The only excluded settings are acute care hospitals Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

*Special Restrictions in Relationship to Other Services*

Efforts should be made to determine whether another psychological testing has been conducted within the last 90 days and information should be updated as needed. If an assessment has been conducted within the last 90 days, efforts should be made to access those records. An assessment should be repeated only if a significant change in behavior or functioning has been noted.

This service cannot be utilized when a determination of the appropriateness of initiating or continuing the use of psychotropic medication is required.

Delivery of this service should include contacts with family and/or guardians of children for the purpose of securing pertinent information necessary to complete an evaluation of the beneficiary.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

### MEDICAL SERVICES

#### Evaluation and Management of Medical Services

The purpose of the service is to make medical decisions for treatment and/or referral for services after a medical assessment. The service is delivered face to face, which includes time spent performing an examination to obtain the beneficiary's medical history.

#### *Description of the Physical Examination*

A physical examination is a face-to-face interaction between a qualified medical health care professional and the beneficiary. The professional must assess the beneficiary's status and provide diagnostic evaluation and screening. The physical examination is one mechanism used to provide referrals for AOD rehabilitative services. The physical examination may include a tuberculosis test, as deemed necessary by the health care professional.

The examination may also be used to determine the following:

- Medical necessity for initiating AOD rehabilitative services
- The need for specialized medical assessment
- The need for a referral to other health care providers

Physical examinations must include the following:

- A brief medical history of the beneficiary to include hospital admissions and surgeries; allergies; present medication information about shared needles, sexual activity, sexual orientation; and history of hepatitis, cirrhosis, or liver diseases
- A history of the beneficiary's and their family's involvement with alcohol and/or other drugs
- An assessment of the beneficiary's nutritional status
- An examination including, but not limited to, vital signs; inspection of the ears, nose, mouth, teeth and gums; inspection of the skin for recent or old needle marks and tracking; and abscesses or scarring from healed abscesses

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Description of the Physical Examination (Cont'd.)*

- A general assessment of the beneficiary's cardiovascular system, respiratory system, gastrointestinal system, and neurological status
- A screening for anemia (Hematocrit or hemoglobin may be used when the physician has access to the equipment.)

*Evaluation for New Patients*

A new patient is one who has not received any professional services from the health care professional or another qualified health care professional of the exact same specialty and sub-specialty who belongs to the same group practice, within the past three years.

The evaluation of a new patient requires the following three components:

- A detailed history
- A detailed examination
- A ,medical decision

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem and includes the beneficiary's and/or their family. The encounter should last at least 30 minutes.

*Evaluation for Established Patients*

An established patient is one who has received professional services from a qualified health professional or another qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

The evaluation of an established patient, requires two of the three key components below:

- An expanded problem focused history
- An expanded problem focused examination
- A medical decision making of low complexity

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem and includes the beneficiary and/or their family. The encounter should last at least 15 minutes.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Medical Necessity Criteria*

All Medicaid-eligible beneficiaries who have been identified as having or at risk of a behavior health and/or substance use disorder are eligible for this service.

*Staff Qualifications*

Services are provided by qualified professionals operating within their scope of practice, as allowed by state law.

Qualified health care professionals include physicians, physician assistants (PA) and advanced practical registered nurse (APRN) practitioners.

A physician must be available in the event of an emergency.

*Service Documentation*

The appropriate medical documentation must appear in the beneficiary's medical record to justify medical necessity for the level of service reimbursed, including the illness, history, physical findings, diagnosis, and prescribed treatment. The record must reflect the level of service billed.

Services must be documented on the CSN and signed by a qualified professional within the appropriate time frame for the beneficiary's level of care. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

*Staff-to-Beneficiary Ratio*

Services require at least one professional for each beneficiary.

*Billing Frequency*

Services are billed as an encounter. Only one encounter code is allowed per day.

*Billable Place of Service*

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting where the beneficiary and the professional will have adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Special Restrictions in Relationship to Other Services*

New Patient (99203) and Established Patient (99213) services are allowed one per day per service.

When a beneficiary receives a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same medical professional, report both the E/M and psychotherapy codes. The difference in the services must be significant and documented separately on the CSN.

Only one EM encounter is allowed per day when the Individual Psychotherapy codes (90833 and 90836) are used.

### Alcohol and Drug Assessment Nursing Services

A nurse is responsible for overseeing the monitoring of the beneficiary's medical treatment and medication administration.

*Service Description*

Alcohol and Drug Assessment Nursing Services are provided as a face-to-face interaction between a qualified health care professional and the beneficiary.

Services may be rendered to beneficiaries as a discrete service. This service is also included in the bundled service packages.

Alcohol and Drug Nursing Services include, but are not limited to, the following:

- Providing medical assessment(s)
- Assessing and/or monitoring the beneficiary's physical status
- Assessing and/or monitoring the beneficiary's response to treatment
- Providing medication management
- Assessing the need for referrals to other health care systems
- Monitoring the beneficiary's mental behaviors
- Verifying the beneficiary's medications, which may have been prescribed as oral or injection
- Assessing the need for beneficiaries to see the physician

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Service Description (Cont'd.)*

- Monitoring for overt side effects related to any medication
- Monitoring for psychological effects of the medications
- Monitoring for interactions of psychiatric medications, prescribe medications and substance abuse.

*Medical Necessity Criteria*

All Medicaid-eligible beneficiaries who have been identified as having or at risk of a behavior health and/or substance use disorder are eligible for this service.

*Staff Qualifications*

Services must be provided by qualified health care professionals operating within their scope of practice, as allowed by state law.

*Service Documentation*

The appropriate medical documentation must appear in the beneficiary's medical record to justify medical necessity for the level of service reimbursed, including the illness, history, physical findings, diagnosis, and prescribed treatment.

Services must be documented on the CSN/Nursing progress form and signed by a qualified health care professional within the appropriate time frame for the beneficiary's level of care. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes. A nursing discharge form must be completed when the beneficiary moves to another level of service.

*Staff-to-Beneficiary Ratio*

Services require at least one professional for each beneficiary.

*Billing Frequency*

When billed as a discrete service, Alcohol and Drug Nursing Services are billed in a 15-minute unit.

*Billable Place of Service*

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that the beneficiary and the professional will have adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Special Restrictions in Relationship to Other Services*

Nursing Services may be billed when providing discrete services, IOP, or Day treatment/Partial Hospital services.

### Medication Administration (MA)

The purpose of this service is to allow a heath care professional to administer an injection to the beneficiary. The medical record must substantiate the medical necessity for this treatment.

*Service Description*

Medication Administration is rendered in response to a physician, PA, or APRN order documented on a Physician Medical Order (PMO). The qualified health care professional must ensure the form is properly completed and included in the medical record to confirm the initial and any subsequent contacts with the beneficiary.

*Medical Necessity Criteria*

Beneficiaries eligible for this service must have a diagnosis of a behavioral health and/or substance use disorder. Providers must have a prescription or medical order from a qualified health care profession to administer the prescription drug Vivitrol.

*Staff Qualifications*

Services must be provided by qualified health care professionals operating within their scope of practice, as allowed by state law.

*Service Documentation*

Medication Administration must be listed in the plan of care and PMO and be documented on a CSN as the service to be rendered.

The provider of the service must include the following items in order to provide a relevant clinical description, ensure the service conforms to the service description, and authenticate the charges:

- Medications the beneficiary is currently taking, or a reference to the physician's order, or other documentation, in the medical record that lists all the medications prescribed to the beneficiary
- The dosage given (quantity and strength)
- The route (I.M., I.D., I.V.)
- The injection site
- The side effects or adverse reactions noted

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Service Documentation (Cont'd.)*

- All benefits of the medications being prescribed
- Any change in medications and/or doses and the rationale for any change, if applicable
- Follow-up instructions for the next visit

*Staff-to-Beneficiary Ratio*

Medication Administration requires at least one qualified health care professional for each beneficiary.

*Billing Frequency*

Medication Administration is billed as an encounter and must be billed with the injection code. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

*Billable Place of Service*

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that the beneficiary and the professional will have adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

*Special Restrictions in Relationship to Other Services*

Medication Administration is billed in conjunction with injection code J2315.

### Injectable Medication

*Purpose*

This code is the specific Injectable Medication, provided by a qualified health care professional with a medical prescription or order.
The purpose of the treatment is to restore, maintain, or improve a beneficiary's behavior or substance use disorder.

*Service Description*

The qualified health care professional must ensure the injection medication order is properly completed and included in the medical record to confirm the initial and any subsequent administration to the beneficiary. The procedure code for the injection is billed in conjunction with procedure code 96372.

*Medical Necessity Criteria*

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorders by a qualified health care professional

# SECTION 2 POLICIES AND PROCEDURES

## COMMUNITY SUPPORT SERVICES

*Staff Qualifications*

A qualified health care professional who is authorized in the state of South Carolina to give an injectable medication.

*Service Documentation*

Injectable Medication is required to be listed on the PMO. The injection must be documented on the CSN as the service. The documentation should include the following items in order to provide a relevant clinical description, ensure the service conforms to the service description, and authenticate the charges:

- The medication administered
- The dosage given (quantity and strength)
- The route (I.M., I.D., I.V.)
- The injection site
- The side effects or adverse reactions noted

*Billing Frequency*

The injectable procedure code is billed as an encounter and it is rendered only one time a month to the beneficiary.

*Billable Places of Service*

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

*Special Restriction in Relationship to Other Services*

A qualified health care professional must provide a prescription for the injection.

The medication administration code is billed in conjunction with the injection code. Both services are documented on the same CSN, but must be billed separately.

# 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.

### 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.

# SECTION 3 BILLING PROCEDURES

## GENERAL INFORMATION

### 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 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.

# 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 PROCESSING

*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

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

*Diagnostic Codes (Cont'd.)*

use 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 |
|---|---|
| AF | Specialty physician (psychiatrist) |
| HP | Doctoral level (MD) |
| UB | Pharmacist |
| AM | Physician team member svc (PA) |
| SA | Nurse practitioner (APRN) |
| AH | Clinical psychologist |
| HO | Master's level |
| TD | Registered nurse (RN) |
| TE | Licensed practical nurse (LPN) |

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

*Modifiers (Cont'd.)*

| Modifier | Description |
|---|---|
| HN | Bachelor's level |
| HM | Less than bachelor's level |

*Place of Service Key*

**Place of Service Codes**

| Code | Description |
|---|---|
| 03 | School |
| 11 | Office |
| 12 | Home |
| 22 | Outpatient Hospital |
| 23 | Emergency Room - Hospital |
| 53 | Community Mental Health Center |
| 55 | Residential Substance Abuse Treatment Facility |
| 57 | Non-Residential Substance Abuse Treatment Facility |
| 99 | Other Place of Service |

*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.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

*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.

| 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.

**Sex**

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

**4 Insured's Name**

Not applicable

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

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

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

**5 Patient's Address**

Enter the full address and telephone number of the patient.

**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.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

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

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

**10a Is Patient's Condition Related to Employment?**

Check "YES" or "NO."

**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

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

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

**Field** **Description**

* Required for claim to process

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

health insurance has denied payment, enter "0.00" in this field.

**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.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

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

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

**17a ID Number of Referring Physician**

Not applicable

**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

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

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

**Field** **Description**

* Required for claim to process

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

**23** Prior Authorization Number**

A valid Prior Authorization number must be entered in this field, if applicable. This Prior Authorization is not applicable for providers who are rendering services directly.

**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**

If applicable, enter an “E” in this field to indicate that the service rendered was on an emergency basis.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

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

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

**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.

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.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

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

**Field** **Description**

* Required for claim to process

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

**24H Unshaded****

**EPSDT/Family Planning**

If applicable, if this claim is for EPSDT services or a referral from an EPSDT Screening, enter a "Y."

This field should be coded as follows:

**N =** No problems found during visit

**1 =** Well child care with treatment of an identified problem treated by the physician

**2.=** Well child care with a referral made for an identified problem to another provider

**24I Shaded***

**ID Qualifier**

**Typical Providers:**

Enter ZZ for the taxonomy qualifier.

**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.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

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

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

**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 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.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

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

**Field** **Description**

* Required for claim to process

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

**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 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

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

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

**Field** **Description**

* Required for claim to process

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

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

**Atypical Providers:**

Not applicable

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

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

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

**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).

### 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.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

### Trading Partner Agreement (Cont'd.)

**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 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 also to submit claims electronically:

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

*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, 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:

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

*SC Medicaid Web-based Claims Submission Tool (Cont'd.)*

- 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

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# 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.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

### Duplicate Remittance Package (Cont'd.)

Providers will have the option of requesting the 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 are suspended pending further action. 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

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

*EDI Remittance Advice – 835 Transaction (Cont'd.)*

reasons for why claims did not pay as billed. (See 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

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

*Electronic Funds Transfer (EFT) (Cont'd.)*

financial institution before any SC Medicaid direct deposits are made.

During the pre-certification period, the provider will receive reimbursement via hard copy checks.

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.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

### Edit Correction Form (ECF) (Cont'd.)

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.**

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.

As stated earlier, SCDHHS only distributes ECFs electronically through the Web Tool.

**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

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

*Edit Types (Cont'd.)*

"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).

**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:

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

*Description of Fields (Cont'd.)*

**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

**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

**Field Description**

**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)**

If applicable, enter the referral number received from the primary care provider.

**8 Primary Diagnosis**

The foremost reason for medical attention should be indicated with an ICD-9 code. To find the

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

*Description of Fields (Cont'd.)*

correct diagnosis code, always use Volume I of the current year's edition for 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 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.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

*Description of Fields (Cont'd.)*

**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.

**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**

11-digit National Drug Code (NDC)

**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)

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

*Description of Fields (Cont'd.)*

**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).

**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.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

### Resolution Instructions (Cont'd.)

**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.

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

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

### THIRD-PARTY LIABILITY (TPL) (CONT'D.)

forms should be mailed or faxed directly to Medicaid Insurance Verification Services at the following address:

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

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

### Reporting Third-Party Insurance On a CMS-1500 Claim Form (Cont'd.)

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:

| 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 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.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

*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 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 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.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

### 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 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.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

### CLAIM ADJUSTMENTS (CONT'D.)

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.

### Claim-Level Adjustments

All Medicaid providers are able to initiate claim-level adjustments. Please note: gross-level adjustments may still be used as discussed later in this section. 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

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

Claim-Level Adjustments (Cont'd.)

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 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

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

*Void Only and Void/Replacement Claims (Cont'd.)*

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 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 17$^{th}$ is alpha, indicating the claim type.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

*Form 130 Instructions (Cont'd.)*

**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.

**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.

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

*Form 130 Instructions (Cont'd.)*

**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.

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

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

### Gross-Level Adjustments (Cont'd.)

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:

South Carolina Healthy Connections
Post Office Box 101110
Columbia, SC 29211-9804

Fax: (803) 462-2582
Phone: 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,

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

### Gross-Level Adjustments (Cont'd.)

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 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

# SECTION 3 BILLING PROCEDURES

## CLAIM PROCESSING

### Refund Checks (Cont'd.)

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 3 BILLING PROCEDURES

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# SECTION 4

# PROCEDURE CODES

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# SECTION 4 PROCEDURE CODES

## PROCEDURE CODES

### UNITS OF SERVICE

Rehabilitative Behavioral Health Services are billed using frequency limits, procedure codes, and modifier combinations. Each service has its own maximum number of units billable per beneficiary per day.

**SCDHHS will continue to monitor all utilization for outliers.** **Effective February 1, 2013**

| SERVICE NAME | PROC CODE | MODIFIER / DESCRIPTION | | UNIT FREQ | FREQ. LIMITS DAILY |
|---|---|---|---|---|---|
| **Assessment Services** | | | | | |
| Psychiatric Diagnostic Evaluation without Medical Services | 90791 | AH<br>HO | Clinical psychologist<br>Master's level | Encounter | 1 Encounter per 6 months |
| Psychiatric Diagnostic Evaluation with Medical Services | 90792 | AF<br>AM<br>SA | Specialty physician (psychiatrist)<br>Physician team member svc (PA)<br>Nurse practitioner (APRN) | Encounter | 1 Encounter per 6 months |
| Psychological Testing Diagnostic Assessment | 96101 | AH | Clinical psychologist | 60 minutes | 6 per day<br>20 units per year |
| Behavioral Health Screening | H0002 | AF<br>HP<br>AM<br>SA<br>AH<br>HO<br>HN | Specialty physician (psychiatrist)<br>Doctoral level (MD)<br>Physician team member svc (PA)<br>Nurse practitioner (APRN)<br>Clinical psychologist<br>Master's level<br>Bachelor's level | 15 minutes = 1 unit | 2 units per day |
| Mental Health Comprehensive Diagnostic Assessment – **Follow–up** | H0031 | AH<br>HO | Clinical psychologist<br>Master's level | Encounter | 12 Encounters per year |
| Comprehensive Diagnostic Assessment **– Initial** | H2000 | AH<br>HO | Clinical psychologist<br>Master's level | Encounter | 1 Encounter per 6 months |

When billing for beneficiaries in an MCO, the provider must follow the MCO contract guidelines.

# SECTION 4 PROCEDURE CODES

## PROCEDURE CODES

**SCDHHS will continue to monitor all utilization for outliers.** **Effective February 1, 2013**

| SERVICE NAME | PROC CODE | MODIFIER / DESCRIPTION | | UNIT FREQ | FREQ. LIMITS DAILY |
|---|---|---|---|---|---|
| Service Plan Development – **Team Conference w/Client/Family** | 99366 | | | Encounter | 6 Encounters per rolling 12 months |
| Service Plan Development – **Team Conference w/o Client** | 99367 | | | Encounter | 6 Encounters per rolling 12 months |
| Mental Health Service Plan Development – **Non–Physician** | H0032 | AH<br>HO<br>HN | Clinical psychologist<br>Master's level<br>Bachelor's level | 15 minutes = 1 unit | 10 – units per week |
| **Therapy Services** | | | | | |
| Individual Psychotherapy – **Face to Face** | 90832 | AF<br>AM<br>SA<br>AH<br>HO | Specialty physician (psychiatrist)<br>Physician team member svc (PA)<br>Nurse practitioner (APRN)<br>Clinical psychologist<br>Master's level | 30 minutes | 1 per date of service<br>IT can be rendered in a variety of combinations, - **6** sessions per month. |
| Individual Psychotherapy – **Face to Face** | 90834 | AF<br>AM<br>SA<br>AH<br>HO | Specialty physician (psychiatrist)<br>Physician team member svc (PA)<br>Nurse practitioner (APRN)<br>Clinical psychologist<br>Master's level | 45 minutes | 1 per date of service<br>IT can be rendered in a variety of combinations, - **6** sessions per month. |
| Individual Psychotherapy – **Face to Face** | 90837 | AF<br>AM<br>SA<br>AH<br>HO | Specialty physician (psychiatrist)<br>Physician team member svc (PA)<br>Nurse practitioner (APRN)<br>Clinical psychologist<br>Master's level | 60 minutes | 1 per date of service<br>IT can be rendered in a variety of combinations, - 6 sessions per month. |
| Family Psychotherapy – **w/o Client** | 90846 | HP<br>AH<br>HO | Doctoral level (MD)<br>Clinical psychologist<br>Master's level | Encounter | 1 per date of service<br>4 sessions per month |

When billing for beneficiaries in an MCO, the provider must follow the MCO contract guidelines.

# SECTION 4 PROCEDURE CODES

## PROCEDURE CODES

**SCDHHS will continue to monitor all utilization for outliers.** **Effective February 1, 2013**

| SERVICE NAME | PROC CODE | MODIFIER / DESCRIPTION | | UNIT FREQ | FREQ. LIMITS DAILY |
|---|---|---|---|---|---|
| Family Psychotherapy – **w/Client** | 90847 | HP<br>AH<br>HO | Doctoral level (MD)<br>Clinical psychologist<br>Master's level | Encounter | 1 per date of service<br>4 sessions per month |
| Group Psychotherapy<br>75 to 90 minutes per session | 90853 | AH<br>HO | Clinical psychologist<br>Master's level | Encounter | 8 session per month |
| **Support Services** | | | | | |
| Medication Management | H0034 | AF<br>HP<br>AM<br>SA<br>TD<br>TE | Specialty physician (psychiatrist)<br>Doctoral level (MD) (Pharm)<br>Physician team member svc (PA)<br>Nurse practitioner (APRN)<br>Registered nurse (RN)<br>Licensed Practical Nurse (LPN) | 15 minutes = 1 unit | 8 units per day |
| Peer Support Service – **Provided by DMH and DAODAS only** | H0038 | | | 15 minutes = 1 unit | 16 units per day |
| Crisis Management | H2011 | AF<br>HP<br>AM<br>SA<br>AH<br>HO<br>TD<br>HN | Specialty physician (psychiatrist)<br>Doctoral level (MD)<br>Physician team member svc (PA)<br>Nurse practitioner (APRN)<br>Clinical psychologist<br>Master's level<br>Registered nurse (RN)<br>Bachelor's level | 15 minutes = 1 unit | 16 units per day |

When billing for beneficiaries in an MCO, the provider must follow the MCO contract guidelines.

# SECTION 4 PROCEDURE CODES

## PROCEDURE CODES

**SCDHHS will continue to monitor all utilization for outliers.** **Effective February 1, 2013**

| SERVICE NAME | PROC CODE | MODIFIER / DESCRIPTION | | UNIT FREQ | FREQ. LIMITS DAILY |
|---|---|---|---|---|---|
| Behavior Modification | H2014 | AF | Specialty physician (psychiatrist) | 15 minutes = 1 unit | 32 units per day |
| | | HP | Doctoral level (MD) | | |
| | | AM | Physician team member svc (PA) | | |
| | | SA | Nurse practitioner (APRN) | | |
| | | AH | Clinical psychologist | | |
| | | HO | Master's level | | |
| | | TD | Registered nurse (RN) | | |
| | | HN | Bachelor's level | | |
| | | HM | Less than bachelor's degree | | |
| | | TE | Licensed Practical Nurse (LPN) | | |
| Psychosocial Rehabilitation Service | H2017 | AF | Specialty physician (psychiatrist) | 15 minutes = 1 unit | 64 units per day |
| | | HP | Doctoral level (MD) | | |
| | | AM | Physician team member svc (PA) | | |
| | | SA | Nurse practitioner (APRN) | | |
| | | AH | Clinical psychologist | | |
| | | HO | Master's level | | |
| | | TD | Registered nurse (RN) | | |
| | | HN | Bachelor's level | | |
| | | HM | Less than bachelor's degree | | |
| | | TE | Licensed Practical Nurse (LPN) | | |
| Family Support | S9482 | AF | Specialty physician (psychiatrist) | 15 minutes = 1 unit | 32 units per day |
| | | HP | Doctoral level (MD) | | |
| | | AM | Physician team member svc (PA) | | |
| | | SA | Nurse practitioner (APRN) | | |
| | | AH | Clinical psychologist | | |
| | | HO | Master's level | | |
| | | TD | Registered nurse (RN) | | |
| | | HN | Bachelor's level | | |
| | | HM | Less than bachelor's degree | | |
| | | TE | Licensed Practical Nurse (LPN) | | |

When billing for beneficiaries in an MCO, the provider must follow the MCO contract guidelines.

# SECTION 4 PROCEDURE CODES

## DAODAS ONLY PROCEDURE CODES

# DAODAS ONLY PROCEDURE CODES

### UNITS OF SERVICE

The South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) are billing codes combinations for Rehabilitative Behavioral Health Services. These services are rendered by SC Alcohol and Drug Abuse Commissions and are billed using frequency limits, procedure codes, and modifiers. Each service has its own maximum number of units billable per beneficiary per day.

**Assessment, Therapy, and Support Services** **Effective February 1, 2013**

| SERVICE NAME | PROC CODE | MODIFIER / DESCRIPTION | | UNIT FREQ | FREQ. LIMITS DAILY | BRIEF DESCRIPTION |
|---|---|---|---|---|---|---|
| Psychiatric Diagnostic Evaluation with Medical Services **1.5 hour session** | 90792 | AF<br>AM<br>SA | Physician/psychiatrist<br>Physician team member (PA)<br>Nurse practitioner (APRN) | Encounter = 1 unit | 1 per every 6 months | Outside of Bundle package |
| Psychological Testing Diagnostic Assessment **Face to Face** | 96101 | AH | Clinical psychologist | Encounter = 1 unit – one hour session | 20 units per year | Outside of Bundle package |
| Psychological Testing Diagnostic Assessment **Face to Face – Administering test and preparing report** | 96102 | HO | Master's level | Encounter = 1 unit – one hour session | 20 units per year | Outside of Bundle package |
| Alcohol and Drug Assessment – Initial **w/o Physical** | H0001 | AH<br>HO<br>HN | Clinical psychologist<br>Master's level<br>Bachelor's level | Encounter = 1 unit – 1.5 hour session | 1 per every 6 months | Outside of Bundle package |
| Alcohol and Drug Assessment **Follow-up w/o Physical** | H0001 | TS | Follow-up | Encounter = 1 unit – one hour session | 1 per every 6 months | Provided by the staff listed for initial assessment<br>Outside of Bundle package |
| Alcohol and Drug Assessment **Nursing Services** | H0001 | U2 | Performed by a LPN or higher medical staff | 15 minutes = 1 unit | 22 units per rolling 12 months | Outside of Bundle package |

# SECTION 4 PROCEDURE CODES

## PROCEDURE CODES

**Assessment, Therapy, and Support Services** **Effective February 1, 2013**

| SERVICE NAME | PROC CODE | MODIFIER / DESCRIPTION | | UNIT FREQ | FREQ. LIMITS DAILY | BRIEF DESCRIPTION |
|---|---|---|---|---|---|---|
| Alcohol and Drug<br>**Structured screening and brief intervention services** | 99408 | AF<br>AM<br>AH<br>SA<br>HO<br>HN<br>TD<br>TE | Physician/psychiatrist<br>Physician team member (PA)<br>Clinical psychologist<br>Nurse practitioner (APRN)<br>Master's level<br>Bachelor's level<br>Registered nurse (RN)<br>Licensed practical nurse (LPN) | Encounter = 1 unit – one hour session | 12 units per rolling 12 months | H0001 and 99408 cannot be billed on the same date of services.<br>Outside of Bundle package |
| Service Plan Development<br>**Interdisciplinary Team w/Client** | 99366 | | | Encounter = 1 unit – one hour session | 6 – units per rolling 12 months | Master's level staff and above must sign the IPOC |
| Service Plan Development<br>**Interdisciplinary Team w/o Client** | 99367 | | | Encounter = 1 unit – one hour session | 6 – units per rolling 12 months | Master's level staff and above must sign the IPOC |
| Mental Health Service Plan Development –<br>Non–Physician w/ Client | H0032 | | | Encounter = 1 – unit – one hour session | 6 - units per rolling 12 months | Master's level staff and above must sign the IPOC |
| Mental Health Service Plan Development –<br>Non–Physician w/out client | H0032 | HF | | Encounter = 1 – unit – one hour session | 6 - units per rolling 12 months | Master's level staff and above must sign the IPOC |
| Individual Psychotherapy<br>**Face to Face**<br>**30 minute session** | 90832 | AF<br>AM<br>AH<br>SA<br>HO | Physician/psychiatrist<br>Physician team member (PA)<br>Clinical psychologist<br>Nurse practitioner (APRN)<br>Master's level | Encounter = 1 unit | 12 units per rolling 12 months | 30 - minute session |
| Individual Psychotherapy<br>**Face to Face**<br>**45 minute session** | 90834 | AF<br>AM<br>AH<br>SA<br>HO | Physician/psychiatrist<br>Physician team member (PA)<br>Clinical psychologist<br>Nurse practitioner (APRN)<br>Master's level | Encounter = 1 unit | 12 units per rolling 12 months | 45 - minute session |

When billing for beneficiaries in an MCO, the provider must follow the MCO contract guidelines.

# SECTION 4 PROCEDURE CODES

## PROCEDURE CODES

**Assessment, Therapy, and Support Services** **Effective February 1, 2013**

| SERVICE NAME | PROC CODE | MODIFIER / DESCRIPTION | | UNIT FREQ | FREQ. LIMITS DAILY | BRIEF DESCRIPTION |
|---|---|---|---|---|---|---|
| Individual Psychotherapy<br>**Face to Face**<br>**30 minutes session with Medical Evaluation and Management services** | 90833 | AF<br>AM<br>SA | Physician/psychiatrist<br>Physician team member svc (PA)<br>Nurse practitioner (APRN) | Encounter = 1 unit | 18 units per rolling 12 months | Must use as a add on code when a Medical evaluation is provided – 99203 and 99213 |
| Individual Psychotherapy<br>**Face to Face**<br>**45 minute session with Medical Evaluation and Management services** | 90836 | AF<br>AM<br>SA | Physician/psychiatrist<br>Physician team member svc (PA)<br>Nurse practitioner (APRN) | Encounter = 1 unit | 18 – units per rolling 12 months | Must use as a add on code when a Medical evaluation is provided – 99203 and 99213 |
| Medical evaluation and Management<br>**New Patient**<br>**30 minute session** | 99203 | AF<br>AM<br>SA | Physician/psychiatrist<br>Physician team member svc (PA)<br>Nurse practitioner (APRN) | Encounter = 1 unit | Per date of service | This code is outside of the bundle package |
| Medical evaluation and Management<br>**Established Patient**<br>**15 minute session** | 99213 | AF<br>AM<br>SA | Physician/psychiatrist<br>Physician team member svc (PA)<br>Nurse practitioner (APRN) | Encounter = 1 unit | Per date of service | This code is outside of the bundle package |
| Family Psychotherapy<br>**w/o patient present** | 90846 | AF<br>AM<br>AH<br>SA<br>HO | Physician/psychiatrist<br>Physician team member (PA)<br>Clinical psychologist<br>Nurse practitioner (APRN)<br>Master's level | Encounter = 1 unit | 12 units per rolling 12 months | Hour session |
| Family Psychotherapy<br>**w/ Patient present**<br>**60 minute session** | 90847 | AF<br>AM<br>AH<br>SA<br>HO | Physician/psychiatrist<br>Physician team member (PA)<br>Clinical psychologist<br>Nurse practitioner (APRN)<br>Master's level | Encounter = 1 unit | 12 units per rolling 12 months | Hour session |
| Group Psychotherapy<br>**60 minute session** | 90853 | AF<br>AM<br>AH<br>SA<br>HO | Physician/psychiatrist<br>Physician team member (PA)<br>Clinical psychologist<br>Nurse practitioner (APRN)<br>Master's level | Encounter = 1 unit | 12 units per rolling 12 months | Hour session or more |
| | | | | | | |

When billing for beneficiaries in an MCO, the provider must follow the MCO contract guidelines.

# SECTION 4 PROCEDURE CODES

## PROCEDURE CODES

**Assessment, Therapy, and Support Services** **Effective February 1, 2013**

| SERVICE NAME | PROC CODE | MODIFIER / DESCRIPTION | | UNIT FREQ | FREQ. LIMITS DAILY | BRIEF DESCRIPTION |
|---|---|---|---|---|---|---|
| Alcohol and Drug Counseling<br>**Individual** | H0004 | | | 15 minutes = 1 unit | 32 units per week | Summary must be signed off by a BA staff with CAC II or higher credential staff |
| Alcohol and Drug Counseling<br>**Group 60 minute session** | H0005 | | | Encounter = 1 unit | 3 units per week | Summary must be signed off by a BA staff with CAC II or higher credential staff |
| Medication Management | H0034 | UB<br>AH<br>HO<br>HN<br>TD<br>TE | Pharmacist<br>Clinical psychologist<br>Master's level<br>Bachelors' level<br>Registered nurse (RN)<br>Licensed practical nurse (LPN) | 15 minutes = 1 unit | 18 – units per rolling 12 months | Cannot be billed on same date of services as 90833 and 90836 |
| Crisis Management | H2011 | 00<br>HF | Face-to face - no modifier<br>Telephonic | 15 minutes = 1 unit | 16 units per day | Summary must be signed off by a BA staff with CAC II or higher credential staff |
| Family Support | S9482 | 00 | No modifier | 15 minutes = 1 unit | 32 units per week | Summary must be signed off by a BA staff with CAC II or higher credential staff |
| Peer Support Service | H0038 | 00<br>HQ | Individual – no modifier<br>Group | 15 minutes = 1 unit | 32 units per week | Summary must be signed off by a BA staff with CAC II or higher credential staff |
| Psychosocial Rehabilitation Service | H2017 | 00<br>HQ | Individual – no modifier<br>Group | 15 minutes = 1 unit | 32 units per week | Summary must be signed off by a BA staff with CAC II or higher credential staff |
| Skills Training and Development Service<br>**0 to 6 years of age** | H2014 | | | 15 minutes = 1 unit | 32 units per day | Summary must be signed off by a BA staff with CAC II or higher credential staff |

When billing for beneficiaries in an MCO, the provider must follow the MCO contract guidelines.

# SECTION 4 PROCEDURE CODES

## PROCEDURE CODES

**Assessment, Therapy, and Support Services** **Effective February 1, 2013**

| SERVICE NAME | PROC CODE | MODIFIER / DESCRIPTION | | UNIT FREQ | FREQ. LIMITS | BRIEF DESCRIPTION |
|---|---|---|---|---|---|---|
| Medication Administration | 96372 | | Must be provided by Medical staff within their scope of practice | 1 unit | 1 per date of service | Billed in conjunction with J2315 |
| Vivitrol Injection | J2315 | | Must be provided by Medical staff within their scope of practice | 1 unit | 1 per month | 380 units |

**Services Descriptions, Modifiers, and Frequency Limits**

| SERVICE NAME | PROC CODE | MODIFIER | UNIT/ FREQ | FREQUENCY LIMITS | BRIEF DESCRIPTION |
|---|---|---|---|---|---|
| | | | | DAILY | |
| Alcohol and /or Drug Services –Intensive Outpatient Treatment | H0015 | 00 | Encounter | All inclusive hourly rate | Level II.1 Intensive Outpatient Treatment Program |
| Alcohol and /or Drug Treatment – Outpatient | H2035 | 00 | Encounter | All inclusive hourly rate | Level II.5 Day Treatment/Partial Hospitalization |
| Alcohol and /or Drug Services – Sub–acute Detox Residential | H0010 | 00 | Encounter | Daily Per–diem | Level III.2–D Clinically Managed Residential Detox |
| Alcohol and /or Drug Services – Acute Detox Residential | H0011 | 00 | Encounter | Daily Per–diem | Level III.7–D Medically Monitored Residential Detox |
| Behavioral Health – Long–Term Residential Treatment Program | H0019 | 00 | Encounter | Daily Per–diem | Level III.5–R Clinically Managed High-Intensity Residential Treatment |

When billing for beneficiaries in an MCO, the provider must follow the MCO contract guidelines.

# SECTION 4 PROCEDURE CODES

## PROCEDURE CODES

### Services Descriptions, Modifiers, and Frequency Limits

| SERVICE NAME | PROC CODE | MODIFIER | UNIT/ FREQ | FREQUENCY LIMITS | BRIEF DESCRIPTION |
|---|---|---|---|---|---|
| Behavioral Health–Short–Term Residential Treatment Program – Acute **age 21 and over** | H0018 | 00 | Encounter | Daily<br>Per–diem | Level III.7–R<br>Medically Monitored Residential Acute Treatment |
| Behavioral Health–Short–Term Residential Treatment Program – Adolescent Residential **under age 21** | H0018 | HA | Encounter | Daily<br>Per–diem | Level III.7–RA<br>Medically Monitored High–Intensity Adolescent Residential Treatment |

When billing for beneficiaries in an MCO, the provider must follow the MCO contract guidelines.

# SECTION 5

# ADMINISTRATIVE SERVICES

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# SECTION 5 ADMINISTRATIVE SERVICES

## GENERAL INFORMATION

### ADMINISTRATION

The Department of Health and Human Services (SCDHHS) administers the South Carolina Medicaid Program. This section outlines the available resources for Medicaid providers, with telephone numbers and addresses for county SCDHHS 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.

# SECTION 5 ADMINISTRATIVE SERVICES

## GENERAL INFORMATION

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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<br>Abbeville County DHHS<br>Human Services Building<br>903 W. Greenwood St.<br>Abbeville, SC 29620-5678<br><br>Post Office Box 130<br>Abbeville, SC 29620-0130 |
| **2.** | Aiken County | (803) 643-1938<br><br>Toll Free:<br>1-888-866-8852 | Medicaid Eligibility<br>Aiken County DHHS<br>1410 Park Ave. S.E.<br>Aiken, SC 29801-4776<br><br>Post Office Box 2748<br>Aiken, SC 29802-2748 |
| **3.** | Allendale County | (803) 584-8137 | Medicaid Eligibility<br>Allendale County DHHS<br>521 Barnwell Highway<br>Allendale, SC 29810<br><br>Post Office Box 326<br>Allendale, SC 29810 |
| **4.** | Anderson County | (864) 260-4541 | Medicaid Eligibility<br>Anderson County DHHS<br>224 McGee Rd.<br>Anderson, SC 29625<br><br>Post Office Box 160<br>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<br>Bamberg County DHHS<br>374 Log Branch Rd.<br>Bamberg, SC 29003<br><br>Post Office Box 544<br>Bamberg, SC 29003 |
| **6.** Barnwell County | (803) 541-3825 | Medicaid Eligibility<br>Barnwell County DHHS<br>10913 Ellenton Street<br>Barnwell, SC 29812<br><br>Post Office Box 648<br>Barnwell, SC 29812 |
| **7.** Beaufort County | (843) 255-6095 | Medicaid Eligibility<br>Beaufort County DHHS<br>1905 Duke St.<br>Beaufort, SC 29902-4403<br><br>Post Office Box 1255<br>Beaufort, SC 29901-1255 |
| **8.** Berkeley County | (843) 719-1170 | Medicaid Eligibility<br>Berkeley County DSS<br>2 Belt Dr.<br>Moncks Corner, SC 29461-2801 |
| | Toll Free:<br>1-800-249-8751 | Post Office Box 13748<br>Charleston, SC 29422-3748 |
| **9.** Calhoun County | (803) 874-3384 | Medicaid Eligibility<br>Calhoun County DHHS<br>2831 Old Belleville Rd.<br>St. Matthews, SC 29135<br><br>Post Office Box 378<br>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<br>Charleston County DHHS<br>326 Calhoun St.<br>Charleston, SC 29401-1124 |
| | Toll Free:<br>1-800-249-8751 | Post Office Box 13748<br>Charleston, SC 29422-3748 |
| **11.** Cherokee County | (864) 487-2521 | Medicaid Eligibility<br>Cherokee County DHHS<br>1434 N. Limestone St.<br>Gaffney, SC 29340-4734<br><br>Post Office Box 89<br>Gaffney, SC 29342 |
| **12.** Chester County | (803) 377-8135 | Medicaid Eligibility<br>Chester County DHHS<br>115 Reedy St.<br>Chester, SC 29706-1881 |
| **13.** Chesterfield County | (843) 623-5226 | Medicaid Eligibility<br>Chesterfield County DHHS<br>201 N. Page St.<br>Chesterfield, SC 29709-1201<br><br>Post Office Box 855<br>Chesterfield, SC 29709-0855 |
| **14.** Clarendon County | (803) 435-4305 | Medicaid Eligibility<br>Clarendon County DSS<br>3 S. Church St.<br>Manning, SC 29102<br><br>Post Office Box 788<br>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<br>Colleton County DHHS<br>Bernard Warshaw Building<br>215 S. Lemacks St.<br>Walterboro, SC 29488<br><br>Post Office Box 110<br>Walterboro, SC 29488 |
| **16.** Darlington County | (843) 398-4427 | Medicaid Eligibility<br>Darlington County DHHS<br>300 Russell St., Room 145<br>Darlington, SC 29532-3340<br><br>Post Office Box 2077<br>Darlington, SC 29540-2077 |
| | (843) 332-2289 | 404 S. Fourth St., Suite 300<br>Hartsville, SC 29550-5718 |
| **17.** Dillon County | (843) 774-2713 | Medicaid Eligibility<br>Dillon County DHHS<br>1213 Highway 34 W.<br>Dillon, SC 29536-8141<br><br>Post Office Box 351<br>Dillon, SC 29536-0351 |
| **18.** Dorchester County | (843) 821-0444<br>Toll Free:<br>1-800-249-8751 | Medicaid Eligibility<br>Dorchester County DSS<br>216 Orangeburg Rd<br>Summerville, SC 29483-8945<br><br>Post Office Box 13748<br>Charleston, SC 29422-3748 |
| **19.** Edgefield County | (803) 637-4040 | Medicaid Eligibility<br>Edgefield County DHHS<br>120 W. A. Reel Dr.<br>Edgefield, SC 29824-1607<br><br>Post Office Box 386<br>Edgefield, SC 29824-0386 |

# SECTION 5 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

| County | Telephone No. | Address |
|---|---|---|
| **20.** Fairfield County | (803) 589-8035 | Medicaid Eligibility<br>Fairfield County DHHS<br>1136 Kincaid Bridge Rd.<br>Winnsboro, SC 29180-7116<br><br>Post Office Box 1139<br>Winnsboro, SC 29180-5139 |
| **21.** Florence County | (843) 673-1761 | Medicaid Eligibility<br>Florence County DHHS<br>2685 S. Irby St., Box I<br>Florence, SC 29505-3440 |
| | (843) 394-8575 | 345 S. Ron McNair Blvd<br>Lake City, SC 29560-3434 |
| **22.** Georgetown County | (843) 546-5134 | Medicaid Eligibility<br>Georgetown County DSS<br>330 Dozier St.<br>Georgetown, SC 29440-3219<br><br>Post Office Box 371<br>Georgetown, SC 29442 |
| **23.** Greenville County | (864) 467-7800 | Medicaid Eligibility<br>Greenville County DSS<br>301 University Ridge, Suite 6700<br>Greenville, SC 29601<br><br>Post Office Box 100101<br>Columbia, SC 29202-3101 |
| **24.** Greenwood County | (864) 229-5258 | Medicaid Eligibility<br>Greenwood County DHHS<br>1118 Phoenix St.<br>Greenwood, SC 29646-3918<br><br>Post Office Box 1016<br>Greenwood, SC 29648-1016 |

# SECTION 5 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

| County | Telephone No. | Address |
|---|---|---|
| **25.** Hampton County | (803) 914-0053 | Medicaid Eligibility<br>Hampton County DHHS<br>102 Ginn Altman Ave., Suite B<br>Hampton, SC 29924<br><br>Post Office Box 693<br>Hampton, SC 29924 |
| **26.** Horry County | (843) 381-8260 | Medicaid Eligibility<br>Horry County DHHS<br>1601 11th Ave., 1st Floor<br>Conway, SC 29526<br><br>Post Office Box 290<br>Conway, SC 29528 |
| **27.** Jasper County | (843) 726-7747 | Medicaid Eligibility<br>Jasper County DHHS<br>10908 N. Jacob Smart Blvd.<br>Ridgeland, SC 29936 |
| **28.** Kershaw County | (803) 432-3164 | Medicaid Eligibility<br>Kershaw County DHHS<br>110 E. DeKalb St.<br>Camden, SC 29020-4432<br><br>Post Office Box 220<br>Camden, SC 29021-0220 |
| **29.** Lancaster County | (803) 286-8208 | Medicaid Eligibility<br>Lancaster County DHHS<br>1599 Pageland Highway<br>Lancaster, SC 29720-2409 |
| **30.** Laurens County | (864) 833-6109 | Medicaid Eligibility<br>Laurens County DHHS<br>93 Human Services Rd.<br>Clinton, SC 29325-7546<br><br>Post Office Box 388<br>Laurens, SC 29360-0388 |

# SECTION 5 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

| County | Telephone No. | Address |
|---|---|---|
| **31.** Lee County | (803) 484-5376 | Medicaid Eligibility<br>Lee County DHHS<br>820 Brown St.<br>Bishopville, SC 29010-4207<br><br>Post Office Box 406<br>Bishopville, SC 29010-0406 |
| **32.** Lexington County | (803) 785-2991<br>(803) 785-5050 | Medicaid Eligibility<br>Lexington County DHHS<br>605 West Main St.<br>Lexington, SC 29072-2550 |
| **33.** McCormick County | (864) 465-5221 | Medicaid Eligibility<br>McCormick County DHHS<br>215 N. Mine St.<br>McCormick, SC 29835-8363 |
| **34.** Marion County | (843) 423-5417 | Medicaid Eligibility<br>Marion County DHHS<br>137 Airport Ct., Suite J<br>Mullins, SC 29574 |
| **35.** Marlboro County | (843) 479-4389 | Medicaid Eligibility<br>Marlboro County DHHS<br>County Complex<br>1 Ag St.<br>Bennettsville, SC 29512-4424<br><br>Post Office Box 1074<br>Bennettsville, SC 29512-1074 |
| **36.** Newberry County | (803) 321-2159 | Medicaid Eligibility<br>Newberry County DHHS<br>County Human Services Center<br>2107 Wilson Rd.<br>Newberry, SC 29108-1603<br><br>PO Box 1225<br>Newberry, SC 29108-1225 |

# SECTION 5 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

| County | Telephone No. | Address |
|---|---|---|
| **37.** Oconee County | (864) 638-4420 | Medicaid Eligibility<br>Oconee DHHS<br>223 B Kenneth St.<br>Walhalla, SC 29691 |
| **38.** Orangeburg County | (803) 515-1793 | Medicaid Eligibility<br>Orangeburg County DHHS<br>2570 Old St. Matthews Rd., N.E.<br>Orangeburg, SC 29118<br><br>Post Office Box 1407<br>Orangeburg, SC 29116-1407 |
| **39.** Pickens County | (864) 898-5815 | Medicaid Eligibility<br>Pickens County DHHS<br>212 McDaniel Ave.<br>Pickens, SC 29671<br><br>Post Office Box 160<br>Pickens, SC 29671-0160 |
| **40.** Richland County | (803) 714-7562<br>(803) 714-7549 | Medicaid Eligibility<br>Richland County DHHS<br>3220 Two Notch Rd.<br>Columbia, SC 29204-2826 |
| **41.** Saluda County | (864) 445-2139<br>Toll Free:<br>1-800-551-1909 | Medicaid Eligibility<br>Saluda County DHHS<br>613 Newberry Highway<br>Saluda, SC 29138-8903<br><br>Post Office Box 245<br>Saluda, SC 29138-0245 |
| **42.** Spartanburg County | (864) 596-2714 | Medicaid Eligibility<br>Spartanburg County DHHS<br>Pinewood Shopping Center<br>1000 N. Pine St., Suite 23<br>Spartanburg, SC 29303 |

# SECTION 5 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

| County | Telephone No. | Address |
|---|---|---|
| **43.** Sumter County | (803) 774-3447 | Medicaid Eligibility<br>Sumter County DHHS<br>105 N. Magnolia St., 3rd Floor<br>Sumter, SC 29150-4941<br><br>Post Office Box 2547<br>Sumter, SC 29151-2547 |
| **44.** Union County | (864) 424-0227 | Medicaid Eligibility<br>Union County DHHS<br>200 S. Mountain St.<br>Union, SC 29379<br><br>Post Office Box 1068<br>Union, SC 29379 |
| **45.** Williamsburg County | (843) 355-5411 | Medicaid Eligibility<br>Williamsburg County DSS<br>831 Eastland Ave.<br>Kingstree, SC 29556<br><br>Post Office Box 767<br>Kingstree, SC 29556 |
| **46.** York County | (803) 366-1900 | Medicaid Eligibility<br>York County DHHS<br>1890 Neelys Creek Road<br>Rock Hill, SC 29730<br><br>Post Office Box 710<br>Rock Hill, SC 29731-6710 |

# SECTION 5 ADMINISTRATIVE SERVICES

## DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

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# FORMS

| Number | Name | Revision Date |
|---|---|---|
| DHHS 126 | Confidential Complaint | 06/2007 |
| DHHS 130 | Claim Adjustment Form 130 | 03/2007 |
| DHHS 205 | Medicaid Refunds | 01/2008 |
| DHHS 931 | Health Insurance Information Referral Form | 01/2008 |
| | Reasonable Effort Documentation | 06/2007 |
| | Authorization Agreement for Electronic Funds Transfer | 03/2011 |
| | Duplicate Remittance Advice Request Form | 10/2012 |
| CMS-1500 | Sample Claim Form Showing TPL Denial with NPI | 08/2005 |
| | Sample Edit Correction Form | 10/2008 |
| | Sample Remittance Advice (three pages) | 06/2007 |
| DHHS 254 | Referral/Authorization for Rehabilitative Services | 02/2013 |
| | Medical Necessary Statement for Rehabilitative Services | 05/2010 |
| | Sample Attestation Statement (two pages) | 05/2010 |
| | Rehabilitative Behavioral Health Services (RBHS) – Program Update Form | 05/2013 |

**STATE OF SOUTH CAROLINA**
**DEPARTMENT OF HEALTH**
**AND HUMAN SERVICES**

# CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

## PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

| | |
|---|---|
| SUSPECTED INDIVIDUAL OR INDIVIDUALS: | |
| NPI or MEDICAID PROVIDER ID: (if applicable) | MEDICAID RECIPIENT ID NUMBER: (if applicable) |
| ADDRESS OF SUSPECT: | LOCATION OF INCIDENT: |
| | DATE OF INCIDENT: |
| COMPLAINT: | |

| | | |
|---|---|---|
| NAME OF PERSON REPORTING: (Please print) | SIGNATURE OF PERSON REPORTING: | DATE OF REPORT |

| | |
|---|---|
| ADDRESS OF PERSON REPORTING: | TELEPHONE NUMBER OF PERSON REPORTING: |
| | SIGNATURE: (SCDHHS Representative Receiving Report) |

SCDHHS Form 126 (revised 06/07)

# 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<br>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<br>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**

1500

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Alcohol & Drug Rehabilitation Services
Sample Claim Form Showing TPL Denial
with NPI

PICA

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [x] (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): 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 [x] Married [ ] Other [ ]; Employed [x] 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: A1111111

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: 401

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. 295.32

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 | 31 | 07 | 01 | 31 | 07 | 53 | | H0001 | | | | | | 102 00 | 1 | | 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 $ 102 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 102 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 Provider
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

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 PRAC SPEC - EMC Y
SIGNON ID DOC IND N ORIGINAL CCN:
TAXONOMY: SFL ZIP: PRV ZIP: ADJ CCN:

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|
| PROV/XWALK ID | RECIPIENT ID | P AUTH NUMBER | TPL | INJURY CODE | EMERG | PC COORD | ---- DIAGNOSIS ---- PRIMARY | SECONDARY |
| ABC123 | 1111111111 | | | | | | v71.02 | . |

NPI: 1234567890

EDITS
INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 712 951

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 | 05/07/07 | 99 | H2020 | HA | 900MXH | 836.00 | | 017 |

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 836.00
.00
28 AMT REC'D INS
29 BALANCE DUE 836.00
30 OWN REF # 012345

RESOLUTION DECISION _R_
ADDITIONAL DIAG CODES: . . . . . .

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
ABC PROVIDER
PO BOX 00000
ANYWHERE XO 00000-0000

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

# Sample Remittance Advice (page 1)

This page of the sample Remittance Advice shows a paid claim, as well as a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle.

```
# AB0008 ABC PROVIDER                                          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|
+---------+-----------------+------+---------+------+--------+--------+-+----------+-------------------+---+-------+-------+-------+
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|2212345  |0406001089000400A|      |         |      | 1192.00|  243.71|P|1112233333|M   CLARK          |   |       |       |       |
|         |              01 |      |021507   |H2020 |  800.00|  117.71|P|          |                   |0TF|       |   0.00|   0.00|
|         |              02 |      |021507   |H2019 |  392.00|  126.00|P|          |                   |000|       |   0.00|   0.00|
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|         |VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04       | |          |                   |   |       |       |       |
|ABB222222|0406001089000400U|                |      |1412.00-| 273.71-| |1112233333|M   CLARK          |   |       |       |       |
|         |              01 |      |012107   |H2020 |1112.00-| 143.71-| |          |                   |0TF|       |       |       |
|         |              02 |      |012107   |H2019 | 300.00-| 130.00-| |          |                   |000|       |       |       |
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|         |REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04| |          |                   |   |       |       |       |
|ABB222222|0407701389002500A|      |         |      | 1001.50|   42.75|P|1112233333|M   CLARK          |   |       |   0.00|       |
|         |              01 |      |012107   |H2020 |  142.50|   42.75|P|          |                   |0TF|       |       |   0.00|
|         |              02 |      |012107   |H2019 |  859.00|    0.00|R|          |                   |000|       |       |   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  |  ABC PROVIDER                  |
FORM REFER TO:  "MEDICAID                 |       $0.00 |  |      $286.46|    R = REJECTED      |                                |
PROVIDER MANUAL".                         +-------------+  +-------------+    S = IN PROCESS    |  PO BOX 000000                 |
                                            CERTIFIED AMT   MEDICAID TOTAL    E = ENCOUNTER     |  ANYWHERE XO  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.                                                  +----------------+              PAYMENT DATE                  PAGE
+--------------+  DEPT OF HEALTH AND HUMAN SERVICES           |     CLAIM      |             +------------+                 +----+
|  AB00080000  |                                              |  ADJUSTMENTS   |             | 03/26/2007 |                 |  2 |
+--------------+   SOUTH CAROLINA MEDICAID PROGRAM            |                |             |            |                 +----+
                                                              +----------------+             +------------+
+---------+-----------------+---+---------+------+--------+--------+-+-+-+----------+----------+---+------+------------------------+
|PROVIDERS|     CLAIM       |   |SERVICE RENDERED| AMOUNT |TITLE 19|S|RECIPIENT |RECIPIENT NAME|M  | ORG  |                        |
| OWN REF.|   REFERENCE     |PY | DATE(S) |      | BILLED |PAYMENT |T|    ID.   |          F  M|O  |CHECK |    ORIGINAL CCN        |
|  NUMBER |     NUMBER      |IND| MMDDYY  | PROC.|        |MEDICAID|S|  NUMBER  |LAST NAME I  I|  D|DATE  |                        |
+---------+-----------------+---+---------+------+--------+--------+-+----------+--------------+---+------+------------------------+
|         |                 |   |         |      |        |        | |          |              |   |      |                        |
|         |                 |   |         |      |        |        | |          |              |   |      |                        |
|ABB222222|0406001089000400U|   |         |      | 513.00-| 197.71-| |1112233333|CLARK     M   |   |022807| 0404711253670430A      |
|         |              01 |   |012107   |H2020 | 453.00 | 160.71-|P|          |              |0TF|      |                        |
|         |              02 |   |012107   |H2019 |  60.00 |  33.00-|P|          |              |000|      |                        |
|         |                 |   |         |      |        |        | |          |              |   |      |                        |
|         |          TOTALS |           1 |      | 513.00-| 193.71-| |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
|         |                 |             |      |        |        | |          |              |   |      |                        |
+---------+-----------------+-------------+------+--------+--------+-+----------+--------------+---+------+------------------------+
                                                   MEDICAID TOTAL     CERTIFIED AMT      FEDERAL RELIEF      TO BE REFUNDED
                                DEBIT BALANCE     +-------------+     +-------------+   +-------------+      IN THE FUTURE
                                PRIOR TO THIS     |      $243.71|     |     0.00|   |   |         0.00|        +----------+
                                REMITTANCE        +-------------+     +-------------+   +-------------+        |      0.00|
                               +-------------+                                                                 +----------+
                               |         0.00|      ADJUSTMENTS       MAXIMUS AMT
                               +-------------+     +-------------+     +-------------+       PROVIDER NAME AND ADDRESS
                                                   |     $193.71-|     |             |   +-----------------------------------+
                                YOUR CURRENT       +-------------+     +-------------+   |  ABC PROVIDER                     |
                                DEBIT BALANCE        CHECK TOTAL       CHECK NUMBER      |                                   |
                               +-------------+     +-------------+     +---------+       |  PO BOX 000000                    |
                               |        0.00 |     |       $50.00|     |  4197304|       |  ANYWHERE XO  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.                                                  +----------------+             PAYMENT DATE                PAGE
+--------------+  DEPT OF HEALTH AND HUMAN SERVICES              |                |             +------------+               +----+
|   AB00080000 |                                                 |  ADJUSTMENTS   |             | 03/26/2007 |               |  3 |
+--------------+   SOUTH CAROLINA MEDICAID PROGRAM               |                |             |            |               +----+
                                                                 +----------------+             +------------+
```

| PROVIDERS OWN REF. NUMBER | CLAIM REFERENCE NUMBER | SERVICE DATE(S) MMDDYY | PROC / DRUG CODE | RECIPIENT ID. NUMBER | RECIPIENT NAME LAST NAME F M I I | ORIG. CHECK DATE | ORIGINAL PAYMENT | ACTION | DEBIT / CREDIT AMOUNT | EXCESS REFUND |
|---|---|---|---|---|---|---|---|---|---|---|
| TPL 2 | 0408600003700000U | - | | | | | | DEBIT | -2389.05 | |
| TPL 4 | 0408600004700000U | - | | | | | | DEBIT | -1949.90 | |
| TPL 5 | 0408600005700000U | - | | | | | | DEBIT | -477.25 | |
| TPL 6 | 0408600006700000U | - | | | | | | DEBIT | -477.25 | |
| | | | | | | | PAGE TOTAL: | | 5293.45 | 0.00 |

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

South Carolina Department of Health & Human Services

REFERRAL FORM / AUTHORIZATION FOR REHABILITATIVE SERVICES

FORM **254**

NATIONAL PROVIDER IDENTIFIER #

BENEFICIARY'S MEDICAID #

REFERRED TO: _____

AUTHORIZATION DATE: _____

EXPIRATION DATE: _____
Last Date of Service

SAMPLE

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

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

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

**Authorizing Agency: (One must be marked )**

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

Authorized Agency Representative _____

Title _____

Phone _____

Signature _____

Date _____

State Agency Use Only:

South Carolina Department of Health & Human Services

# MEDICAL NECESSITY STATEMENT FOR REHABILITATIVE SERVICES

Beneficiary's Name: _____ Social Security Number: _____

Date of Birth: _____ Medicaid Number: _____

Diagnosis code(s): _____

[Diagnosis codes must be based on the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* or the International *Classification of Diseases (ICD).*]

I recommend that the above-named Medicaid beneficiary receive Rehabilitative Services(s) for the maximum reduction of emotional, behavioral, and functional developmental delays and restoration of the beneficiary to his or her best possible functioning level. This beneficiary meets the Medical Necessity criteria for Rehabilitative Services as evidenced by a Psychiatric diagnosis from the current edition of the DSM or the ICD.

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

Rehabilitative Service(s): _____, _____, _____

Rehabilitative Service(s): _____, _____, _____

Rehabilitative Service(s): _____, _____, _____

Rehabilitative Service(s): _____, _____, _____

Identify the Beneficiary's problem areas for Rehabilitative Services listed above. The recommendation must be based on recent clinical information, staffing recommendations, review(s) of treatment history and/ or evaluation(s) made within federal and state standards

_____

_____

_____

_____

_____

_____

_____

_____

SAMPLE ONLY

_____ _____

(Signature of Physician or other Licensed Practitioner of the Healing Arts) (Professional Title)

_____ _____

(Please print name signed above) (Phone Number)

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

**Must be handwritten**

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

Revised: 05/2010

**Sample Attestation Statement**

*An individual who has the legal authority to obligate the entity must sign the attestation. Letter must be on organization's letterhead.*

<Name of the Entity/Organization enrolled with Medicaid>
<Address >
<City, State, Zip Code>
<Telephone Number>
<Fax Number>
<NPI registered with Medicaid>

Dear:

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

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

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

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

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

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

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

In addition, I will notify the SC Medicaid Program if I vacate this position so that an attestation can be submitted by my successor. I will also notify the participating state agencies and other

SAMPLE ONLY

agencies as appropriate if it is my belief that <Name of Entity/Organization> is out of compliance with the Medicaid requirements.

Signature,

<Printed Name>
<Title>
<Date>

SAMPLE ONLY

South Carolina Department of
Health & Human Services

## Rehabilitative Behavioral Health Services (RBHS) – PROGRAM UPDATE FORM

| PROVIDER INFORMATION | | | |
|---|---|---|---|
| Organization Name | | Business Director /CEO-Name | |
| NPI Number | Taxonomy Number | | Medicaid ID Number |
| **ADD ONLY NEW INFORMATION** | | | |
| Provider Name Change | | | |
| Business Director /CEO-Name | | Clinical Director-Name | |
| Business Physical Address | | Suite/Unit # | |
| City | State | County | ZIP+4 |
| County | | E-mail Address | |
| Business Phone | Fax Number | Number (Other) | |
| **Business Mailing Address (if different from physical address)** | | | |
| City | State | County | ZIP+4 |
| **LICENSURE AND ACCREDITATION – Attach a copy of the most recent documentation** | | | |
| Business License Number | Place of Municipality | Expiration Date | |
| Accreditation Body | | Expiration Date | |
| Facility License | | Expiration Date | |
| **CLINICAL SPECIALTY (CHECK ALL THAT APPLY)** | | | |
| Children | Adolescents | Adults | Families |

**PROVIDER STAFF (BACKGROUND VERIFICATION INFORMATION MUST BE SUBMITTED FOR ALL STAFF)**

Please list all staff and job titles. Include professional license type and number, if applicable. Attach additional sheets if necessary. Background Information must be maintained on site for all Staff. Review the current manual for details.

| Name of Professional | Job Title | License Type | License Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

I acknowledge and agree to maintain on file original enrollment information along with required updated information and to make documents available to SCDHHS or its designee. Should the provider cease to operate, files must be retained for five years after final payment for Medicaid claims.

I hereby certify that all statements made in this application are true and correct to the best of my knowledge and that Rehabilitative Behavioral Health Services shall be provided in accordance with Medicaid policies and procedures.

| **Business Director Name Printed** | **Signature Date** |
|---|---|
| **Business Director Signature** | |

# 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.<br>**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.<br>**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

**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 |
|---|---|---|---|---|
| 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.<br>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.<br>**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.<br>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.<br>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.<br>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) |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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 |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>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.<br>**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.<br>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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>**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.<br>**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.<br>**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.<br>**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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>**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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>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.<br>**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.<br>**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

**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 |
|---|---|---|---|---|
| 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.<br>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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>**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.<br>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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>**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.<br>**NURSING HOME PROVIDERS:** Resubmit ECF and appropriate documentation to :<br>MCCS Nursing Facility Claims<br>Post Office Box 100112<br>Columbia, SC 29202.<br>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.<br>1) DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker, or<br>2) The computer generated Medicaid eligibility approval letter notifying the recipient that Medicaid benefits have been approved.<br>This can be furnished by the recipient or the eligibility worker. (This is different from the Certificate of Creditable Coverage.)<br>**For NURSING HOME PROVIDERS:** Resubmit ECF and appropriate documentation to:<br>MCCS Nursing Facility Claims<br>Post Office Box 100112<br>Columbia, SC 29202.<br>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.<br>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.<br>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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>**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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>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.<br>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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>**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.<br>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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br><br>**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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br><br>**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.<br><br>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.<br>**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.<br>**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.<br>**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.<br>**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.<br>**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.<br>**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.<br>**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.<br>**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.<br>**UB CLAIM:** Please enter prior authorization number in field 63 and resubmit the ECF.<br>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.<br>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.<br>**UB CLAIM:** Verify the recipient's Medicaid number in field 60 and the procedure code in field 44 and resubmit the ECF. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>**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.<br>**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.<br>For review and consideration for payment, attach appropriate clinical documentation to the ECF verifying where the procedure/service was provided and resubmit. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>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.<br>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.<br>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.<br>If the code/modifier is not valid and non-covered by Medicaid, the claim will not be considered for payment.<br>**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.<br>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.<br>**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.<br>**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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>**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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>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.<br>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.<br>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.<br>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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>**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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>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.<br>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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>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.<br>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.<br>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.<br>**UB CLAIM:** Contact QIO for authorization number. Enter authorization number in field 63 on the ECF and resubmit.<br>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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>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.<br><br>**CMS-1500 CLAIM:** Enter authorization number in field 3 on the ECF and resubmit.<br><br>**UB CLAIM:** Enter authorization number in field 63 on the ECF and resubmit.<br><br>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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br><br>**CMS-1500 CLAIM:** Enter the valid authorization number in field 3 on the ECF and resubmit.<br><br>**UB CLAIM:** Enter the valid authorization number in field 63 on the ECF and resubmit.<br><br>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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br><br>CMS-1500 CLAIM: Enter authorization number in field 3 on the ECF and resubmit.<br><br>UB CLAIM: Enter authorization number in field 63 on the ECF and resubmit.<br><br>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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br><br>**CMS-1500 CLAIM:** Enter the valid authorization number in field 3 on the ECF and resubmit.<br><br>**UB CLAIM:** Enter the valid authorization number in field 63 on the ECF and resubmit.<br><br>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.<br><br>**UB CLAIM:** Contact QIO for authorization number. Enter authorization number in field 63 on the ECF and resubmit.<br><br>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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>**UB CLAIM**: Enter the prior authorization number in field 63 and resubmit.<br>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.<br>**UB CLAIM**: Enter the correct prior authorization number in field 63 and resubmit.<br>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.<br>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.<br>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.<br><br>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.<br>Effective for dates of service on and after October 1, 2012, prior authorization is required from the QIO.<br>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.<br>2. Check the patient's financial record to see whether payment was received. If so, discard the ECF.<br>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.<br>4. If a void and replacement claim cannot be done, attach supporting documentation to the ECF and resubmit for review and consideration for payment.<br>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.<br>Please refer to your manual for further instructions on Void and Replacement claims.<br>**FOR PHYSICIANS:**<br>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.<br>2. Check the patient's financial record to see if payment was received. If so, discard the ECF.<br>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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>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.<br>For provider's eligibility status, contact Provider Enrollment at 1-888-289-0709.<br>**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.<br>For provider's eligibility status, contact Provider Enrollment at 1-888-289-0709.<br>**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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>Medicaid Provider Enrollment<br>Mailing address: PO Box 8809, Columbia, SC 29202-8809<br>Phone: 1-888-289-0709<br>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.<br>Medicaid Provider Enrollment<br>Mailing address: PO Box 8809, Columbia, SC 29202-8809<br>Phone: 1-888-289-0709<br>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.<br>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.<br>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.<br>**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.<br>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.<br>Attach appropriate documentation to the ECF for review and consideration for payment and resubmit, if applicable. |

# 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 |
|---|---|---|---|---|
| 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.<br>**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.<br>**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. |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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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.<br>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.<br>**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.<br>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.<br>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.<br>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.<br>**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:<br>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.<br>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.<br>3. All timely filing requirements must be met.<br>A provider has two options:<br>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**<br>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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>If the services are not directly related to institutional services, the services are non-covered and will not be considered for payment.<br>**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 |

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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 |

# APPENDIX 2 CARRIER CODES

## CARRIER CODES: ARRANGED ALPHABETICALLY

| CARR | TPL NAME | ADDRESS LINE | CITY | ST | ZIP | PHONE NUM | CARRIER COMMENT |
|---|---|---|---|---|---|---|---|
| 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 | |

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| 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. |

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## 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

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| 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

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| 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 | |

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| 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 | |

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## 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 | |

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## 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 |

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| 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 |

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| 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

## CARRIER CODES: ARRANGED NUMERICALLY

| 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 |

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| 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

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| 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)<br>(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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PROVIDER MANUAL SUPPLEMENT

# MANAGED CARE

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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.

# MANAGED CARE SUPPLEMENT

## MANAGED CARE OVERVIEW

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

# MANAGED CARE SUPPLEMENT

## MANAGED CARE OVERVIEW

- 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

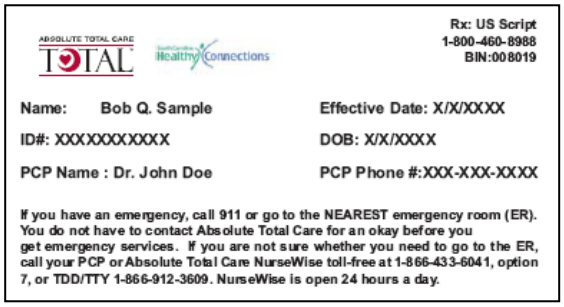
South Carolina Healthy Connections (Medicaid) Managed Care Organizations are required to issue a plan identification card to enrolled beneficiaries. Beneficiaries should present both the MCO-issued identification card and the Healthy Connections Medicaid card. MCO cards contain important information 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.

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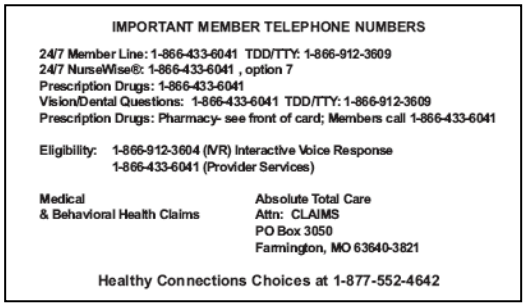
IMPORTANT MEMBER TELEPHONE NUMBERS

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

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# MANAGED CARE SUPPLEMENT

## BlueChoice

BlueChoice HealthPlan of South Carolina Medicaid
(866) 781-5094
www.bluechoicesc.com

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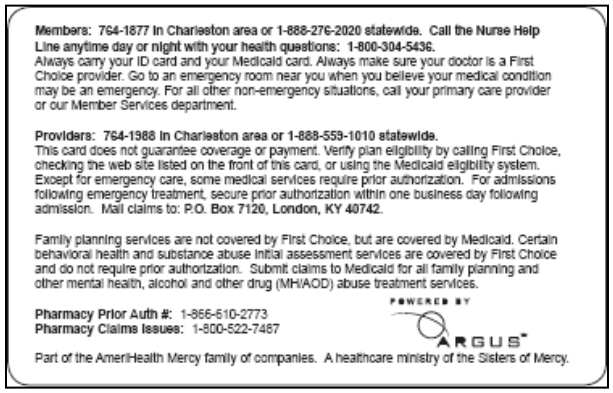
## First Choice by Select Health

Select Health of South Carolina, Inc.
(888) 276-2020
www.selecthealthofsc.com

(front)

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# MANAGED CARE SUPPLEMENT

## UnitedHealthcare Community Plan

UnitedHealthcare Community Plan
(800) 414-9025
www.uhccommunityplan.com

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# PROVIDER MANUAL SUPPLEMENT

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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**<br>Enter the policy number. | **11 Insured's Policy Group or FECA Number**<br>Enter the policy number. |
| **9c Employer's Name or School Name**<br>If the insurance has paid, indicate the amount paid in this field.<br>If the insurance has denied payment, enter "0.00" in this field. | **11b Employer's Name or School Name**<br>If the insurance has paid, indicate the amount paid in this field.<br>If the insurance has denied payment, enter "0.00" in this field. |
| **9d Insurance Plan Name or Program Name**<br>Enter the three-digit carrier code. | **11c Insurance Plan Name or Program Name**<br>Enter the three-digit carrier code. |

| |
|---|
| **10d Reserved for Local Use**<br>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**<br>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<br>(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<br>Health Insurance Information Referral Form: Coverage ended<br><br>Reasonable Effort Documentation Form: Failure to respond – beneficiary<br>Reasonable Effort Documentation Form: Failure to respond – insurer<br><br>Reasonable Effort Flowchart<br><br>Adjustment Form 130: Primary insurer paid after the appeal process<br>Adjustment Form 130: Primary insurer payment received after Medicaid payment<br><br>UB-04: Medicare paid; private insurer denied<br><br>CMS-1500: Two private insurers; one paid, one denied<br>CMS-1500: Medicare and private insurer paid<br><br>ECF: Correction to add carrier payment<br>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<br>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<br>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.**

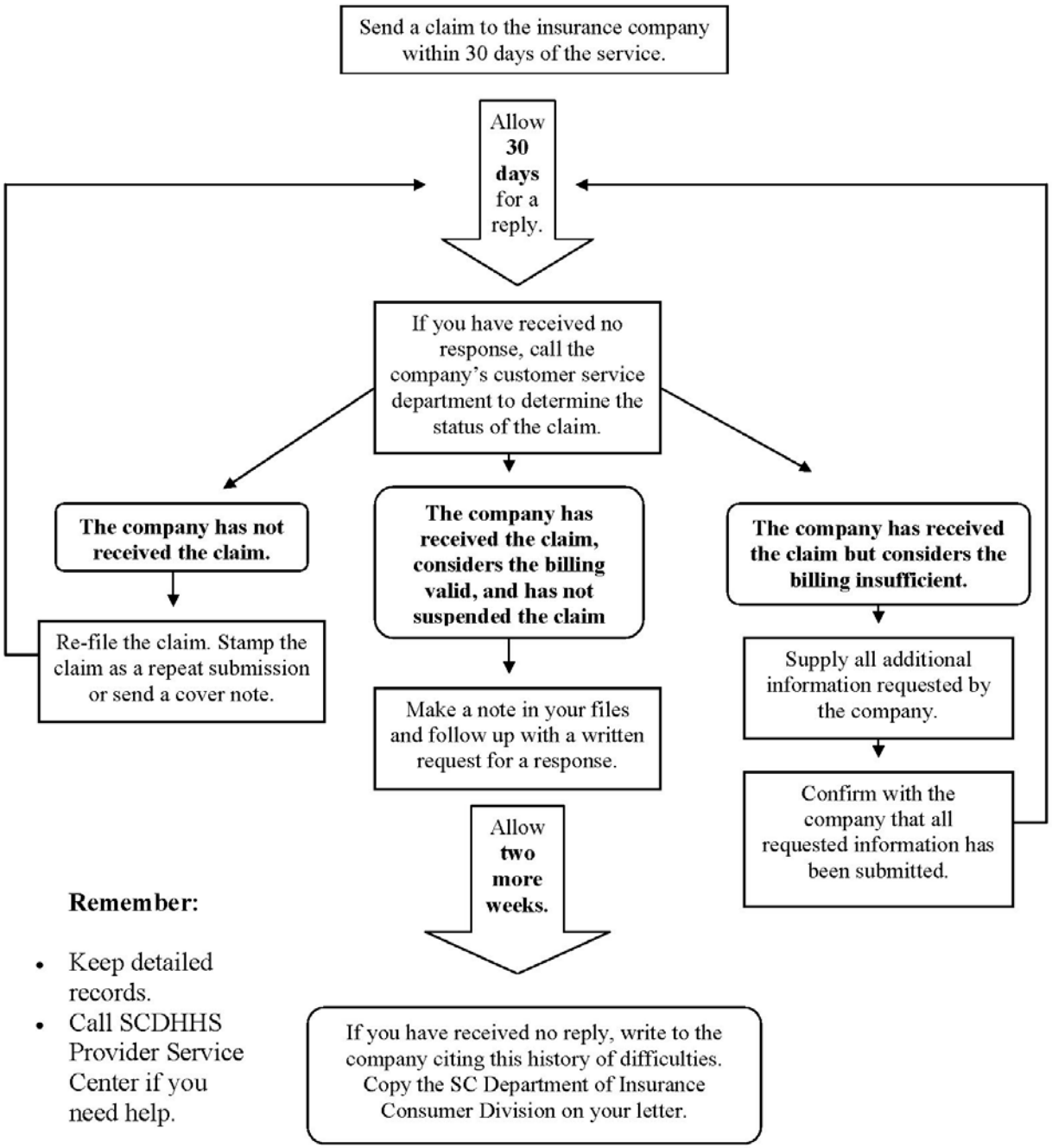
Betty Smith 06/03/10
**(SIGNATURE AND DATE)**

**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<br>NPI | 1212121212<br>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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