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	02/2018
	Reasonable Effort Documentation	04/2014
	Electronic Funds Transfer (EFT) Authorization Agreement	08/2019
	Duplicate Remittance Advice Request Form	09/2017
	Claim Reconsideration Form	11/2018
CMS-1500 (02/12)	Sample Claim Form Showing TPL Denial with NPI	02/2012
	Sample Remittance Advice (four pages)	04/2014
	Fax Cover Sheet for RBHS Exception	03/2018
	Request for Rehabilitative Behavioral Health Services Limit Exception (two pages)	03/2018
	Rehabilitative Behavioral Health Services (RBHS) Referral Form (four pages)	03/2018
	Accreditation Crosswalk for Rehabilitative Behavioral Health Services	03/2021
	Accreditation for Rehabilitative Behavioral Health Services	04/2017
	Program Changes for Rehabilitative Behavioral Health Services	04/2021
	Voluntary Termination Notification for Rehabilitative Behavioral Health Services	04/2017
	Rehabilitative Behavioral Health Services (RBHS) Parent/Caregiver/Guardian Agreement to Participate in Community Support Service (two pages)	04/2017
	Rehabilitative Behavioral Health Services (RBHS) Parent/Caregiver/Guardian Agreement to Participate in Community Support Service - Spanish (two pages)	04/2017
	Community Integration Services Provider Credentialing Request (three pages)	03/2018
	Therapeutic Childcare Center Credentialing Request (three pages)	03/2018

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

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

PROGRAM INTEGRITY

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

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:		
NPI or MEDICAID PROVIDER ID: (if applicable)	MEDICAID RECIPIENT ID NUMBER: (if applicable)	
ADDRESS OF SUSPECT:	LOCATION OF INCIDENT:	
	DATE OF INCIDENT:	
COMPLAINT:		
NAME OF PERSON REPORTING: (Please print)	SIGNATURE OF PERSON REPORTING:	DATE OF REPORT
ADDRESS OF PERSON REPORTING:	TELEPHONE NUMBER OF PERSON REPORTING:	
	SIGNATURE: (SCDHHS Representative Receiving Report)	

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Provider ID:

NPI:

Recipient ID:

Adjustment Type:

◯ Void ◯ Void/Replace

Originator:

◯ DHHS ◯ MCCS ◯ Provider ◯ MIVS

Reason For Adjustment: (Fill One Only)

- ◯ Insurance payment different than original claim
- ◯ Keying errors
- ◯ Incorrect recipient billed
- ◯ Voluntary provider refund due to health insurance
- ◯ Voluntary provider refund due to casualty
- ◯ Voluntary provider refund due to Medicare
- ◯ Medicaid paid twice - void only
- ◯ Incorrect provider paid
- ◯ Incorrect dates of service paid
- ◯ Provider filing error
- ◯ Medicare adjusted the claim
- ◯ Other

For Agency Use Only

Analyst ID:

- ◯ Hospital/Office Visit included in Surgical Package
- ◯ Independent lab should be paid for service
- ◯ Assistant surgeon paid as primary surgeon
- ◯ Multiple surgery claims submitted for the same DOS
- ◯ MMIS claims processing error
- ◯ Rate change
- ◯ Web Tool error
- ◯ Reference File error
- ◯ MCCS processing error
- ◯ Claim review by Appeals

Comments:

Signature:_____ Date:_____

Phone:_____

DHHS Form 130 Revision date: 03-13-2007

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: 803-252-0870 **or** **Mail:** Post Office Box 101110, Columbia, SC 29211-9804

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 THE FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Electronic Funds Transfer (EFT) Authorization Agreement

REASON FOR SUBMISSION			
☐ **Change to Current EFT** ***(i.e. account or bank changes)***	◯ ***Individual***	◯ ***Organization***	

INDIVIDUAL PROVIDER/ORGANIZATION NFORMATION					
Individual Provider/Organization Legal Business Name					
Doing Business as Name (DBA)					
Street					
City		State		Zip Code/Postal Code	-
Medicaid Provider Number		National Provider Identifier (NPI)			
Designate Tax Identification Number (TIN)	◯ SSN (individual)	◯ EIN (organization)			
SSN	- -	EIN	-		

ORGANIZATION/INDIVIDUAL PROVIDER EFT CONTACT INFORMATION			
Provider Contact Name			
Telephone Number		Extension	
Email Address			

FINANCIAL INSTITUTION INFORMATION					
Financial Institution Name					
Financial Institution Address					
City		State		Zip Code/Postal Code	-

PROVIDER'S ACCOUNT NUMBER WITH FINANCIAL INSTITUTION		
Financial Institution Routing Number (Nine digits)		
Provider's Account Number with Financial Institution (Up to 17 digits)		
Type of Account at Financial Institution (TRANSIT CODE)	◯ 22 – Checking Account **or**	◯ 32 – Savings Account

By signing this form, I authorize the SCDHHS to initiate credit entries, if necessary, debit entries for any credits in error to the checking or savings account at the financial institution identified above. Credit entries will pertain only to the SCDHHS payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the SCDHHS to make an adjusting debit entry to the account up to the amount of the excess payment. Credit entries to the above account 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 certify that the information shown is correct and agree to provide 30 days written notice to the address shown below prior to revoking or revising this authorization.

☐ **I acknowledge that I have read and understand that payments will be issued only to the bank account of the provider designated to receive payments beginning July 2019 with the transition of Medicaid claims payments to the South Carolina Enterprise Information System (SCEIS). For more information, please visit https://vip.scdhhs.gov/sceis or contact 888-289-0709.**

ALL EFT REQUESTS ARE SUBJECT TO A 10-DAY PRENOTE PERIOD IN WHICH ALL ACCOUNTS ARE VERIFIED BY THE QUALIFYING FINANCIAL INSTITUTION BEFORE ANY MEDICAID DIRECT DEPOSITS ARE MADE.

Signature of Person Submitting Form (print to sign)	
Printed Name of Person Submitting Form	
Submission Date	

SPECIAL INSTRUCTIONS: For questions regarding the status of your EFT update, please contact the Provider Service Center at 888-289-0709. Please refer to the EFT section of the provider enrollment manual found at https://www.scdhhs.gov/provider for instructions on how to complete updates to your EFT information.

Effective Jan 01, 2014, providers can link their EFT with their electronic remittance advice (ERA) by a matching EFT Reassociation Trace Number. This trace number will automatically be included in your electronic remittance advice. In order for this trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding the EFT Reassociation Trace Number and ERA can be directed to the Provider Service Center at 888-289-0709.

To process **EFT updates**, please return this completed form along with verification of your electronic deposit information on your financial institution's letterhead to:

SCDHHS, Medicaid Provider Enrollment • PO BOX 8809 • Columbia, South Carolina 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 Medicaid 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: _____ Telephone Number: _____

4. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:
   _____
   _____
   _____
   _____
   _____

   Note: Remittance advices are available electronically through the Web Tool. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

5. Street Address for delivery of request:

   Street: _____

   City: _____

   State: _____

   Zip Code: _____

6. Charges for duplicate remittance advice(s) 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**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Submit your Claim Reconsideration request to:

Fax: 1-855-563-7086

or

Mail: South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

CLAIM RECONSIDERATION FORM

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. A separate SCDHHS CR form is required for each claim control number (CCN). Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709. **Note:** Timely filing guidelines apply.

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____ Medicaid Beneficiary ID: _____

Section 2: Provider Information

Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other (DME, Lab, Home Health Agency, etc.): _____

NPI: _____ Medicaid Provider ID: _____ Facility/Group/Provider Name: _____

Return Mailing Address: _____
Street or Post Office Box *State* *ZIP*

Contact: _____ Email: _____ Telephone #: _____ Fax #: _____

Section 3: Claim Information *(Only one CCN allowed per request.)*

Communication ID: _____ CCN: _____ Date(s) of Service: _____

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below)

- ☐ Ambulance Services
- ☐ Autism Spectrum Disorder (ASD) Services
- ☐ Clinic Services
- ☐ Community Long Term Care (CLTC)
- ☐ Community Mental Health Services
- ☐ Department of Disabilities and Special Needs (DDSN) Waivers
- ☐ Durable Medical Equipment (DME)
- ☐ Early Intervention Services
- ☐ Enhanced Services
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Home Health Services
- ☐ Hospice Services
- ☐ Hospital Services
- ☐ Licensed Independent Practitioner's Rehabilitative Services (LIPS)
- ☐ Local Education Agencies (LEA)
- ☐ Medically Complex Children's (MCC) Waivers
- ☐ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- ☐ Optional State Supplementation (OSS)
- ☐ Pharmacy Services
- ☐ Physicians Laboratories, and Other Medical Professionals Specify: _____
- ☐ Private Rehabilitative Therapy and Audiological Services
- ☐ Psychiatric Hospital Services
- ☐ Rehabilitative Behavioral Health Services (RBHS)
- ☐ Rural Health Clinic (RHC)
- ☐ Targeted Case Management (TCM)
- ☐ Other: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature:_____ Date: _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) X | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN X (ID#) | FECA BLK LUNG (ID#) | 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 DD YY: 01 01 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. RESERVED FOR NUCC USE

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 | NO X

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M F

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES | NO X PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC): 0 00

c. RESERVED FOR NUCC USE: 22

c. OTHER ACCIDENT? YES | NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: 401

d. INSURANCE PLAN NAME OR PROGRAM NAME: 401

10d. CLAIM CODES (Designated by NUCC): 1

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO — If yes, complete items 9, 9a, and 9d.

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 295 32 B. C. D.

E. F. G. H.

I. J. K. L.

22. 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 07 14	01 07 14	11		H0001			102 00	1		ZZ	1212121212
										NPI	1234567890
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 555555555 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. Rsvd for NUCC Use 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

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample Remittance Advice (page 1)

This page of the sample Remittance Advice shows a paid claim, suspended claim and rejected claim.

PROVIDER ID. AB00080000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE 02/14/2014

PAGE 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB1AA	1403004803012700A				27.00	6.72	P	1112233333	M CLARK				
	01		101713	71010	27.00	6.72	P			026		0.00	0.00
ABB2AA	1403004804012700A				259.00	0.00	S	1112233333	M CLARK				
	01		101713	74176	259.00	0.00	S			026		0.00	0.00
ABB3AA	1403004805012700A				24.00	0.00	R	1112233333	M CLARK			0.00	
	01		071913	A5120	12.00	0.00	R			000			0.00
	02		071913	A4927	12.00	0.00	R			000			0.00
									Edits: L00 946 L02 852 08/30/13				
	TOTALS		3		310.00							0.00	0.00

$6.72

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

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

CERT. PG TOT	MEDICAID PG TOT
$0.00	$286.46

CERTIFIED AMT	MEDICAID TOTAL
	0.00

CHECK TOTAL

CHECK NUMBER

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 2)

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.

PROVIDER ID. | DEPT OF HEALTH AND HUMAN SERVICES | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE

AB00080000 | SOUTH CAROLINA MEDICAID PROGRAM | REMITTANCE ADVICE | 02/28/2014 | 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER		SERVICE RENDERED DATE(S) PY IND	MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	1405200415812200A					1192.00	243.71	P	1112233333	M CLARK			0.00	
	01		021814	S0315		800.00	117.71	P			000			0.00
	02		021814	S9445		392.00	126.00	P			000			0.00
	VOID OF ORIGINAL CCN 13283002244813300A PAID 20131018													
ABB222222	1405200077700000U					1412.00-	273.71-	P	1112233333	M CLARK				
	01		100213	S0315		1112.00-	143.71-	P			000			
	02		100213	S9445		300.00-	130.00-	P			000			
	REPLACEMENT OF ORIGINAL CCN 1304711253670430A PAID 20131018													
ABB222222	1405200414812200A					1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		100213	S0315		142.50	42.75	P			000			0.00
	02		100313	S9445		859.00	0.00	R			000			0.00
													0.00	0.00

$286.46

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

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

CERT. PG TOT	MEDICAID PG TOT
$0.00	$286.46

CERTIFIED AMT	MEDICAID TOTAL
	0.00

CHECK TOTAL

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

CHECK NUMBER

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 3)

This page of the sample Remittance Advice shows a claim-level Void without a corresponding Replacement claim.

PROVIDER ID. AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE 02/28/2014

PAGE 2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	ORG CHECK D	CHECK DATE	ORIGINAL CCN
ABB222222	14052000777000000U				513.00-	197.71-	P	1112233333	CLARK	M		131018		1328300224813300A
	01		100213	S0315	453.00	160.71-	P				000			
	02		100213	S9445	60.00	33.00-	P				000			
	TOTALS	1			513.00-	193.71-								

PROVDER INCENTIVE CREDIT AMOUNT: 0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 0.00

MEDICAID TOTAL: $243.71

ADJUSTMENTS: $193.71-

CHECK TOTAL: $50.00

CERTIFIED AMT: 0.00

CHECK NUMBER: 4197304

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 4)

This page of the sample Remittance Advice shows four gross-level adjustments.
Gross-level adjustments always appear on the final page of the Remittance Advice.

PROVIDER ID. AB11110000

DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE 02/28/2014

PAGE 3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME F M I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	14049000040001000U	-						DEBIT	-2389.05	
TPL 4	14055000760004000U	-						DEBIT	-1949.90	
TPL 5	14049000040001000U	-						DEBIT	-477.25	
TPL 6	14055000760004000U	-						CREDIT	477.25	
							PAGE TOTAL:		4338.95	0.00

PROVDER INCENTIVE CREDIT AMOUNT	DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT		TO BE REFUNDED IN THE FUTURE
0.00	0.00	0.00	0.00	0.00	0.00

ADJUSTMENTS	YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER
-4338.95	0.00	0.00	

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster
Governor

Joshua D. Baker
Director

FAX COVER SHEET

CONFIDENTIAL INFORMATION ENCLOSED

DATE: _____

TO: SCDHHS – Division of Behavioral Health
Attn: RBHS Exceptions
Fax #: 803-255-8204

FROM: _____
Telephone #: _____
Contact Person: _____

Total Number of Pages Transmitted: _____ (Including Cover Sheet)

COMMENTS:

Long Term Care and Behavioral Health Services
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2565 Fax (803) 255-8204

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Joshua D. Baker DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Request for Rehabilitative Behavioral Health Services Limit Exception

Beneficiary Information	
Name:	
Address:	
Medicaid ID #:	
Date of Birth:	

Provider Information	
Provider Name:	
Provider NPI:	
Address:	
City / State / Zip Code	
Phone Number	
Fax Number	

Diagnosis - Code / Description:	/
Diagnosis - Code / Description:	/
Diagnosis - Code / Description:	/

Clinical Rationale for Request

Community Support Services (PRS, B-Mod, FS, TCC and CIS only)			
Procedure Code	**Service Name**	**# of Daily Units Currently Authorized**	**# of Daily Units Requested**

All Other Rehabilitative Behavioral Health Services			
Procedure Code	**Service Name**	**# of Units Requested**	**# of Encounters Requested**

LPHA Name: _____

Credentials: _____

Signature: _____

Date: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Joshua D. Baker DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Rehabilitative Behavioral Health Services (RBHS) Referral Form

This form shall be completed only by state agencies and submitted to private RBHS providers in accordance with HIPAA regulations as it contains Protected Health Information (PHI) of Medicaid beneficiaries.

Referring State Agency	☐ Department of Social Services Region: ☐ Department of Mental Health CMHC: ☐ Continuum of Care Region: ☐ Department of Alcohol and Other Drug Abuse Services Commission:	☐ Department of Disabilities and Special Needs Region: ☐ Department of Juvenile Justice Region: ☐ Department of Education District:

Provider (Referred to)				**NPI**	
Address					
City		**State**		**Zip**	
Phone Number		**Fax Number**			

Beneficiary Name					
Legally Responsible Person(s)					
Address					
City		**State**		**Zip**	
Date of Birth		**Gender**	☐ Female	☐ Male	
Social Security Number (last 4 digits)		**Medicaid Number**			

Medical Necessity	
Diagnosis – Code / Description	/
Diagnosis – Code / Description	/
Diagnosis – Code / Description	/
Clinical Rationale for Rehabilitative Behavioral Health Services Recommendations	

I recommend that the above-named Medicaid beneficiary receive Rehabilitative Behavioral Health Services. This beneficiary meets the Medical Necessity criteria for services as evidenced by a mental health and/or substance use disorder from the current edition of the DSM or the ICD.

Name of LPHA: _____ Credentials: _____

Signature of LPHA: _____ Date: _____

Recommendations for Rehabilitative Behavioral Health Services							
	Service Description	Procedure Code	Unit	Total Units Authorized	Start Date	End Date	Specific Frequency (# of units per day, # of days per week)
SCREENING AND ASSESSMENT SERVICES							
☐	Behavioral Health Screening	H0002	15 minutes				
☐	Psychiatric Diagnostic Assessment without Medical Services - Initial	90791	Encounter				
☐	Psychiatric Diagnostic Assessment with Medical Services – Initial	90792	Encounter				
☐	Mental Health Comprehensive Diagnostic Assessment – Follow–up	H0031	Encounter				
☐	Psychological Testing / Evaluation	96101	60 minutes				
☐	Comprehensive Evaluation – Initial	H2000	Encounter (average of 3 hours)				
☐	Comprehensive Evaluation – Follow up	H0031	Encounter				
SERVICE PLAN DEVELOPMENT							
☐	Mental Health Service Plan Development (Non-physician)	H0032	15 minutes				
☐	Service Plan Development (Team Conference w/ Client/Family)	99366	Encounter (minimum 30 minutes)				
☐	Service Plan Development (Team Conference w/o Client/Family)	99367	Encounter (minimum 30 minutes)				
CORE TREATMENT – PSYCHOTHERAPY AND COUNSELING SERVICES							
☐	Individual Psychotherapy	90832	30 minutes				
☐	Individual Psychotherapy	90834	45 minutes				

Recommendations for Rehabilitative Behavioral Health Services							
	Service Description	Procedure Code	Unit	Total Units Authorized	Start Date	End Date	Specific Frequency (# of units per day, # of days per week)
☐	Individual Psychotherapy	90837	60+ minutes				
☐	Group Psychotherapy	90853	60+ minutes				
☐	Family Psychotherapy w/o Client	90846	60+ minutes				
☐	Family Psychotherapy w/ Client	90847	60+ minutes				
☐	Multiple Family Group Psychotherapy	90849	60+ minutes				
☐	Crisis Management	H2011	15 minutes				
☐	Medication Management	H0034	15 minutes				
COMMUNITY SUPPORT SERVICES							
☐	Psychosocial Rehabilitation Service (PRS)	H2017	15 minutes				
☐	Behavior Modification (B-Mod)	H2014	15 minutes				
☐	Family Support (FS)	S9482	15 minutes				
☐	Therapeutic Child Care	H2037	15 minutes				
☐	Community Integration Services	H2030	15 minutes				

Note: Prior authorized periods of time for Community Support Services are as follows:

- Beneficiaries ages 0 to 21: Up to 90 days
- Beneficiaries age 22 and older: Up to 180 days

State Agency Representative Authorization (optional, per internal state agency processes)

Name: _____

Phone: _____

Title: _____

Signature: _____ Date: _____

SOUTH CAROLINA Healthy Connections MEDICAID

Accreditation Crosswalk for Rehabilitative Behavioral Health Services

Commission on Accreditation of Rehabilitation Facilities (CARF)

General Program Standards: For an organization to achieve quality services, the persons served are active participants in the planning, prioritization, implementation, and ongoing evaluation of the services offered. The service planning process is individualized, establishing goals and objectives that incorporate the unique strengths, needs, abilities, and preferences of the persons served. General program standards typically require the following (but should be verified and reviewed within Section 2 of the CARF Child and Youth Services [CYS] & Behavioral Health [BH]Standards Manuals):

- Comprehensive Program Structure
- Screening and Access to Services
- Person-centered Plans
- Transition/Discharge Planning
- Medication Use
- Non-Violent Practices
- Records of Persons Served
- Quality Records Management

Behavioral Health Field Categories: For each behavioral healthcare program selected for accreditation from Section 3, an organization must identify which behavioral health field category the core program operates. Field categories are used to characterize the purpose, intent, and overall focus of a core program. A field category is not required for any program under the CYS Manual.

Providers must choose one of the following field categories:

- Substance Use Disorders (SUD)
- Mental Health
- Psychosocial Rehabilitation
- Family Services
- Integrated SUD/Mental Health
- Integrated DD/Mental Health

Specific Population Designation: Child and adolescent providers must demonstrate evidence of designation

- Children and Adolescents (CA) (up to age 18)

Accepted Levels of Accreditation Decisions:

- Three-Year Accreditation
- Provisional Accreditation
- One-Year Accreditation

CARF Manuals

- Behavioral Health (BH) Standards Manual
- Child and Youth Services (CYS) Standards Manual
- Employment and Community Services (ECS) Standards Manual

CARF's standards can be accessed at: **http://www.carf.org/home/**

CARF Standards	Covered Rehabilitative Services
Assessment and Referral **(BH Manual or CYS Manual)**	Behavioral Health Screening (BHS), Diagnostic Assessment (DA), Psychological Testing and Evaluation (PTE), Service Plan Development (SPD)
Behavioral Consultation **(CYS Manual)**	BHS, Behavior Modification (B-Mod), DA, PTE
Case Management/Services Coordination **(BH Manual or CYS Manual)**	BHS, DA, PTE, SPD
Community Employment Services **(ECS Manual)**	SPD, MM (Medication Management), Individual Psychotherapy (IP), Group Psychotherapy (GP)
Community Integration **(BH Manual)**	BHS, Community Integration Services (CIS), DA, PRS, PTE, SPD
Counseling/Outpatient **(CYS Manual)**	BHS, DA, Family Psychotherapy (FP), Family Support (FS), GP, IP, Multiple Family Group Psychotherapy (MFGP), Psychosocial Rehabilitation Services (PRS), PTE, SPD, Therapeutic Childcare Center (TCC)
Crisis Intervention **(BH Manual or CYS Manual)**	BHS, Crisis Management (CM), DA, PTE, SPD
Day Treatment **(BH Manual or CYS Manual)**	BHS, DA, FP, GP, MFGP, IP, PTE, SPD
Early Childhood Development **(CYS Manual)**	BHS, B-Mod, DA, PRS, PTE, SPD, TCC
Foster Family and Kinship Care **(CYS Manual)**	BHS, B-Mod, DA, FP, FS, GP, IP, MFGP, PRS, PTE, SPD
Intensive Family Based Services **(BH Manual or CYS Manual)**	BHS, B-Mod, CM, DA, FP, FS, GP, IP, MFGP, MM, PRS, PTE, SPD, TCC
Intensive Outpatient Treatment **(BH Manual or CYS Manual)**	BHS, DA, FP, FS, GP, MFGP, IP, PTE, SPD, TCC
Outpatient Treatment **(BH Manual)**	BHS, DA, FP, FS, GP, IP, MFGP, PRS, PTE, SPD, TCC
Residential Treatment **(BH Manual or CYS Manual)**	BHS, B-Mod, CM, DA, FP, FS, GP, IP, MFGP, PRS, PTE, SPD
Specialized or Treatment Foster Care **(BH Manual or CYS Manual)**	BHS, B-Mod, DA, FP, FS, GP, IP, MFGP, MM, PTE, SPD
Supported Living **(BH Manual)**	BHS, DA, FS, MM, PRS, PTE, SPD

Council on Accreditation (COA)

Administration and Management Standards and Service Delivery Administration Standards

All organizations are required to implement COA's Administration and Management Standards and Service Delivery Administration Standards which include:

- Ethical Practice (ETH) ***
- Financial Management (FIN)
- For-Profit Administration and Financial Management (AFM)*
- Governance (GOV)
- Human Resources Management (HR)

- Network Administration (NET)**
- Performance and Quality Improvement (PQI)
- Risk Prevention and Management (RPM)
- Administrative and Service Environment (ASE)
- Behavior Support and Management (BSM)
- Client Rights (CR)
- Program Administration (PRG)****
- Training and Supervision (TS)

**This standard is only applicable to for-profit entities*
***This standard is only applicable to network management entities*
**** This standard will not apply to organizations accredited after 2020*
***** This standard only applies to organizations accredited after 2020*

Service Standards
As a result of COA's comprehensive structure of its Service Standards, Core Rehabilitative Services, Core Treatment, and Community Support Services can be contained within many different COA Service Standards as they are components of a larger program. The chart below details the varying applicable COA Service Standard sections.

Organizations currently accredited for Supported Community Living (SCL) will maintain this designated accreditation until they transition to Housing Stabilization and Community Living Services (HSCL).

Accepted Levels of Accreditation Decisions:
Accreditation or Reaccreditation Approval (effective for a period of four years)

COA's standards can be accessed at: www.coanet.org

COA Standards	Covered Rehabilitative Services
Adult Day Services (AD)	Service Plan Development (SPD), Behavioral Health Screening (BHS), Diagnostic Assessment (DA), Community Integration Services (CIS)
Child and Family Development and Support Services (CFD)	SPD, BHS, DA, Psychosocial Rehabilitation Services (PRS), Behavior Modification (B-Mod), Family Support (FS), Therapeutic Childcare Center (TCC)
Counseling/Coaching Support, and Education Services (CSE)	BHS, PRS, B-Mod, FS, CIS
Crisis Response and Information Services (CRI)	BHS, DA, Crisis Management (CM)
Day Treatment Services (DTX)	BHS, DA, SPD, PRS, B-Mod, FS, Individual Psychotherapy (IT), Group Psychotherapy (GT), Multiple Family Group Psychotherapy (MFT), Family Psychotherapy (FT), CM, CIS, TCC
Family Foster Care and Kinship Care (FKC)	Psychological Testing and Evaluation (PTE), DA, BHS, SPD, IT, FT, CM, PRS, B-Mod, FS
Family Preservation and Stabilization Services (FPS)	BHS, DA, SPD, IT, FT, CM, PRS, B-Mod, FS, TCC
Group Living Services (GLS)	PTE, BHS, DA, SPD, IT, GT, MFT, FT, PRS, B-Mod, FS

Housing Stabilization and Community Living Services (HSCL)	SPD, BHS, DA, PRS, CIS
Medication Control and Administration	Medication Management (MM)
Psychiatric Rehabilitation Services (PRS)	BHS, DA, SPD, PRS, CIS
Residential Treatment Services (RTX)	PTE, DA, BHS, SPD, IT, GT, MFT, FT, PRS, B-Mod, FS, CM
Services for Mental Health and/or Substance Use Disorders (MHSU)	PTE, BHS, DA, SPD, IT, GT, MFT, FT, CM, PRS, B-Mod, FS, CIS, TCC
Shelter Services (SH)	BHS, DA, SPD, PRS, B-Mod, FS
Supervised Visitation and Exchange (SVE)	SPD, BHS, DA, IT, FT
Supported Community Living Services (SCL)	SPD, BHS, DA, PRS, CIS
Vocational Rehabilitation Services (VOC)	SPD, BHS, DA, CIS
Youth Independent Living Services (YIL)	BHS, DA, SPD, PRS

The Joint Commission (TJC)

Comprehensive Accreditation Manual for Behavioral Health Care: Providers are required to demonstrate compliance with all applicable standards contained in the Behavioral Health Care Manual.

The standards-based performance areas for all behavioral health care organizations are:

- Care, Treatment and Services (CTS)
- Environment of Care (EC)
- Emergency Management (EM)
- Human Resources Management (HRM)
- Infection Prevention and Control (IC)
- Information Management (IM)
- Leadership (LD)
- Life Safety (LS) (in 24-hour settings)
- Medication Management (MM)
- National Patient Safety Goals (NPSG)
- Performance Improvement (PI)
- Record of Care, Treatment and Services (RC)
- Rights and Responsibilities of the Individual (RI)
- Waived Testing (WT) (when applicable)

Accepted Levels of Accreditation Decisions:

- Accreditation

TJC's standards can be accessed at: http://www.jointcommission.org/

Core Rehabilitative Service Standards	TJC Standards
Service Plan Development (SPD)	Care, Treatment, and Services
Behavioral Health Screening (BHS)	Care, Treatment, and Services
Diagnostic Assessment (DA)	Care, Treatment, and Services
Psychological Testing and Evaluation (PTE)	Care, Treatment, and Services
Core Treatment	**TJC Service**

Individual Psychotherapy (IT)	Outpatient Mental Health/Substance Use Services
Group Psychotherapy (GT)	Outpatient Mental Health/Substance Use Services
Multiple Family Group Psychotherapy (MFT)	Outpatient Mental Health/Substance Use Services
Family Psychotherapy (FT)	Outpatient Mental Health/Substance Use Services
Crisis Management (CM)	Outpatient Mental Health/Substance Use Services
Medication Management (MM)	Outpatient Mental Health/Substance Use Services
Community Support Services	**TJC Service/Setting**
Psychosocial Rehabilitation Services (PRS)	Service: Mental Health/Substance Use Services Setting: Outpatient, Day Treatment, Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP)
Behavior Modification (B-Mod)	Service: Mental Health/Substance Use Services Setting: Outpatient
Family Support (FS)	Service: Mental Health/Substance Use Services, Family Support Services, Community Integration Setting: Outpatient
Therapeutic Childcare Services (TCC)	Service: Mental Health, Child/Youth Category Setting: Day Treatment
Community Integration Services (CIS)	Service: Mental Health, Adult and Community Integration Setting: Day Treatment, Outpatient

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Accreditation for Rehabilitative Behavioral Health Services

This form shall be completed and submitted to the Division of Behavioral Health for each office location via the following options:
Email: behavioralhealth002@scdhhs.gov or Fax: (803) 255-8204.

The applicable accreditation letter, certificate, and most recent survey report must be submitted as evidence with this form.

PROVIDER INFORMATION			
Legal Name of Organization:			
Address:			Suite:
City:	State:		Zip Code:
Phone:	Fax:		
NPI#:	Medicaid ID#:		
Primary Contact Name:	Primary Contact Title:		
Primary Contact Phone:	Primary Contact Fax:		
Primary Contact Email Address:			

Column A: List each service the provider requests to render to Medicaid beneficiaries (limit of one service per row)	**Column B: List the accreditation organization / List the corresponding accreditation standard per the accreditation crosswalk for each service listed in Column A**
Example: Psychosocial Rehabilitation Services	*Example: CARF / Community Integration*
	/
	/
	/
	/
	/
	/
	/
	/
	/
	/
	/

Signature of Provider Representative:	Date:

SCDHHS Use Only	
Date received:	Received by:
Actions taken:	

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Program Changes for Rehabilitative Behavioral Health Services

This form shall be completed and submitted to the Division of Behavioral Health for each office location via the following options:

Email: behavioralhealth002@scdhhs.gov or Fax: (803) 255-8324

PROVIDER INFORMATION		
Legal Name of Organization:		
Address:		Suite:
City:	State:	Zip Code:
Phone:	Fax:	
NP #I:	Medicaid ID #:	
Primary Contact Name:	Primary Contact Title:	
Primary Contact Phone:	Primary Contact Fax:	
Primary Contact Email Address:		

PROGRAM CHANGES	
• Provide pertinent details for each applicable change, including but not limited to: name(s) of new staff, effective date of each change, conditions of status changes, expiration dates, etc. • Evidence for each applicable change must be submitted with this form • Refer to the Reporting Program Changes section of the RBHS manual for further information	
Change in Administrator (CEO/Director):	
Change in Clinical Director:	
Change in the number of RBHS staff resulting in less than two professional or paraprofessional staff available to provide services at any time :	
Adverse event(s) concerning staff licensure:	

Any change in accreditation status:	
Any change in facility license:	
Other:	
Other:	

Signature of Provider Representative:	Date:

SCDHHS Use Only	
Date received:	Received by:
Actions taken:	

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Voluntary Termination Notification for Rehabilitative Behavioral Health Services

This form shall be completed and submitted to the Division of Behavioral Health via the following options:
Encrypted Email: behavioralhealth002@scdhhs.gov or Fax: (803) 255-8204.

PROVIDER INFORMATION		
Legal Name of Organization:		
Address:		Suite:
City:	State:	Zip Code:
Phone:	Fax:	
NPI#:	Medicaid ID#:	
Primary Contact Name:	Primary Contact Title:	
Primary Contact Phone:	Primary Contact Fax:	
Primary Contact Email Address:		

Level of Change (select only one):

☐ **Voluntary Termination**

Intent to completely terminate enrollment as an RBHS provider. This change requires adequate notice to beneficiaries. Evidence of such notification shall be retained by the provider.

☐ **Voluntary Reduction in Array of Services**

Intent is to reduce the array of services offered/rendered to beneficiaries as an RBHS provider; is not a full termination of enrollment as a provider. This change requires adequate notice to beneficiaries. Evidence of such notification shall be retained by the provider.

Please answer each item below for either level:

1. Effective date of termination/reduction:
2. Rationale for voluntary termination/reduction:
3. Service(s) to be voluntarily terminated/reduced (identify each service to be terminated and population(s) of each service to be terminated):
4. Number of beneficiaries affected:
5. Plans for either (1) discharge or (2) assistance with referral and linkage to follow-up services for continuity of care for affected beneficiaries (attach supporting documentation as evidence):
6. Impact on Staff:
7. Records management and security plan:
8. Other entities notified of voluntary termination/reduction:

This letters serves to notify the Division of Behavioral Health that

has elected to voluntarily terminate participation in the South Carolina Medicaid Program. I understand that the organization must reapply for enrollment and be approved before rendering services again to beneficiaries in the future.

Signature of Provider Representative:	Date:

SCDHHS Use Only	
Date received:	Received by:
Actions taken:	

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Rehabilitative Behavioral Health Services (RBHS)
Parent/Caregiver/Guardian Agreement to Participate in Community Support Services

Name of Beneficiary: Date of Birth:
Medicaid Number:

What are Rehabilitative Behavioral Health Services (RBHS) Community Support Services? RBHS Community Support Services help the child and you develop skills to live successfully in the home and community. Services include Psychosocial Rehabilitation Services (PRS), Behavior Modification (B-Mod), Family Support (FS), and Therapeutic Child Care (TCC). These services are for youth with mental health and/or substance use disorders. Services are not for summer camps, after-school programs, recreation or mentoring services.

The child has been diagnosed with the following mental health and/or substance use disorder(s). Please list both code and description (*your provider is <u>required</u> to explain the diagnoses to you*):

Diagnosis - Code / Description	/
Diagnosis - Code / Description	/
Diagnosis - Code / Description	/
Diagnosis - Code / Description	/
Diagnosis - Code / Description	/

The provider has recommended the following services (check all that apply):

☐ <u>Psychosocial Rehabilitation Services (PRS)</u>: PRS helps the child build skills to successfully live in the home and community, succeed in school and/or work and build healthy relationships with family, friends and others.

☐ <u>Behavior Modification (B-Mod)</u>: B-Mod helps the child to reduce undesirable behaviors. You and the child will receive training in managing these behaviors. This training will help the child replace undesired behaviors with suitable ones, during and after treatment.

☐ <u>Family Support (FS)</u>: FS helps you to serve as an active member of the child's treatment team and improve your ability to care for the child's behavioral health needs. FS can connect you to groups that support youth with mental health needs. FS may also encourage you to participate in other types of groups which may be helpful to you.

☐ <u>Therapeutic Child Care (TCC)</u>: TCC helps children with severe emotional and/or behavioral problems. You and your child will work on your relationship in order to reduce the impact of traumatic experiences. TCC helps children to gain social and emotional skills needed to interact well with parents, adults, and playmates.

What will be asked of you?
You will be asked to:

- Participate in treatment planning meetings
- Participate in training sessions where you will be taught skills to help the child like modeling, redirecting, coaching, and reinforcing
- Monitor the child's behaviors and report to the treatment team
- Based on the child's needs, you may be asked to participate in other activities the treatment team recommends

What can you expect of _____ staff?
(Provider Name)

- Explain all treatments in language you will understand
- Explain all known benefits and risks of the treatment in a way you will understand

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Name of Beneficiary: Date of Birth:
Medicaid Number:

- Treat you and all your family members with respect
- Treat you as an essential member of the treatment team
- Work with you to schedule visits, and notify you in advance if the provider must cancel or reschedule
- Discuss the child's progress with you during every visit
- Answer any questions you have regarding the child's treatment
- Respond to your concerns in a timely and respectful manner
- Provide information about community resources

Because your participation is a key to success, you will be asked to confirm your willingness to participate in these services every ninety (90) days.

By signing this form:

- I, _____, agree to participate in the following recommended RBHS
  (Name of Parent/Caregiver/Guardian)
  Community Support Services:

  ☐ Psychosocial Rehabilitation Services (PRS)
  ☐ Behavior Modification (B-Mod)
  ☐ Family Support (FS)
  ☐ Therapeutic Child Care (TCC)

- I give permission for _____, to participate in the following
  (Name of Beneficiary)
  recommended RBHS Community Support Services:

  ☐ Psychosocial Rehabilitation Services (PRS)
  ☐ Behavior Modification (B-Mod)
  ☐ Family Support (FS)
  ☐ Therapeutic Child Care (TCC)

- I agree the provider has explained the mental health and/or substance use disorder diagnoses to me.

I understand that at any time I can let staff know, either verbally in or writing, that I (a) no longer wish to participate in these services and/or (b) no longer wish for the child to receive these services. I also understand that I can end these services at any time, unless participation is court-ordered.

_____ _____
Printed Name of Parent/Caregiver/Guardian Relationship to Beneficiary

_____ _____
Signature of Parent/Caregiver/Guardian Date

_____
Printed Name of Staff

_____
Name of Provider

_____ _____
Signature and Credentials of Staff Date

SOUTH CAROLINA Healthy Connections MEDICAID

Servicios de Rehabilitación de la Salud Conductual (RBHS por sus siglas en inglés)
Acuerdo del padre, cuidador o tutor para participar en los servicios de apoyo comunitario

Nombre del beneficiario: Fecha de nacimiento:
Número de Medicaid:

¿Qué son los Servicios de Rehabilitación de Salud Conductual (RBHS) Servicios de Apoyo Comunitario?
Los Servicios de Apoyo Comunitario de les RBHS ayudan al niño y a usted a desarrollar habilidades para vivir exitosamente en el hogar y la comunidad. Los servicios incluyen Servicios de Rehabilitación Psicosocial (PRS por sus siglas en inglés), Modificación de la Conducta (B-Mod por sus siglas en inglés), Apoyo Familiar (FS por sus siglas en inglés) y Cuidado Infantil Terapéutico (TCC por sus siglas en inglés). Estos servicios son para los jóvenes que padecen de trastornos de salud mental y / o consumo de sustancias. Los servicios no son para campamentos de verano, programas extracurriculares, recreación o servicios de tutoría.

El niño ha sido diagnosticado con los siguientes trastornos de salud mental y / o uso de sustancias.
Por favor, indique el código y la descripción (*su proveedor debe explicar los diagnósticos*):

Diagnóstico - Código / Descripción	/
Diagnóstico - Código / Descripción	/
Diagnóstico - Código / Descripción	/
Diagnóstico - Código / Descripción	/
Diagnóstico - Código / Descripción	/

El proveedor ha recomendado los siguientes servicios (compruebe todos los que aplican):

☐ Servicios de Rehabilitación Psicosocial (PRS): PRS ayuda al niño a desarrollar habilidades para vivir exitosamente en el hogar y la comunidad, tener éxito en la escuela y / o en el trabajo y construir relaciones saludables con la familia, los amigos y demás personas.

☐ Modificación del Comportamiento (B-Mod): B-Mod ayuda al niño a reducir los comportamientos indeseables. Usted y el niño recibirán capacitación en el manejo de estos comportamientos. Este entrenamiento ayudará al niño a reemplazar los comportamientos no deseados por otros adecuados, durante y después del tratamiento.

☐ Apoyo Familiar (FS por sus siglas en inglés): FS le ayuda a funcionar como miembro activo del equipo de tratamiento del niño y mejorar su capacidad para atender las necesidades de salud conductual del niño. FS puede conectarlo con grupos que apoyan a los jóvenes que tienen necesidades de salud mental. FS también puede animarlo a participar en otros tipos de grupos que pueden ser útiles para usted.

☐ Cuidado Terapéutico del Niño (TCC por sus siglas en inglés): TCC ayuda a los niños que tienen problemas emocionales y / o del comportamiento graves. Usted y su hijo trabajarán en su relación con el fin de reducir el impacto de las experiencias traumáticas. TCC ayuda a los niños a adquirir las habilidades sociales y emocionales necesarias para interactuar bien con sus padres, los adultos y sus compañeros de juego.

¿Qué se le pedirá?
Se le pedirá que:

- Participe en las reuniones de planificación del tratamiento
- Participará en sesiones de entrenamiento donde se le enseñarán habilidades para ayudar al niño como modelar, redirigir, entrenar y reforzar
- Monitoreará los comportamientos del niño e informar al equipo del tratamiento
- Según las necesidades del niño, es posible que se le pida que participe en otras actividades que les recomiende el equipo de tratamiento

¿Qué puede esperar del _____ **personal?**
(Nombre del proveedor)

- Explique todos los tratamientos en un lenguaje que pueda entender
- Explique todos los beneficios conocidos y los riesgos del tratamiento de una manera que usted comprenderá

Nombre del beneficiario: Fecha de nacimiento:

Número de Medicaid:

- Los trata a usted y a todos los miembros de su familia con respeto
- Le trata como un miembro esencial del equipo de tratamiento
- Trabaja con usted para programar las visitas y notificarle con antelación si el proveedor debe cancelar o reprogramar
- Habla con usted sobre el progreso del niño durante cada visita
- Responde a cualquier pregunta que tenga sobre el tratamiento del niño
- Responde a sus preocupaciones de manera oportuna y respetuosa
- Proporciona información sobre los recursos comunitarios

Debido a que su participación es clave para el éxito, se le pedirá que confirme su voluntad de participar de estos servicios cada noventa (90) días.

Al firmar este formulario:

- Yo, _____ acuerdo participar en la siguiente recomendación de la RBHS
  (Nombre del padre, madre, cuidador o tutor)

  Servicios de apoyo a la comunidad:

  ☐ Servicios de Rehabilitación Psicosocial (PRS)
  ☐ Modificación del Comportamiento (B-Mod)
  ☐ Apoyo Familiar (FS)
  ☐ Cuidado Infantil Terapéutico (TCC)

- Doy el permiso para _____ para participar en lo siguiente
  (Nombre del beneficiario)

  recomendó los Servicios de Apoyo Comunitario de RBHS:

  ☐ Servicios de Rehabilitación Psicosocial (PRS)
  ☐ Modificación del Comportamiento (B-Mod)
  ☐ Apoyo Familiar (FS)
  ☐ Cuidado Infantil Terapéutico (TCC)

- Estoy de acuerdo con que el proveedor que me ha explicado los diagnósticos de salud mental y / o trastorno por uso de sustancias.

Entiendo que en cualquier momento puedo hacerle saber al personal, ya sea verbalmente o por escrito, que (a) ya no deseo participar de estos servicios y / o (b) ya no deseo que el niño reciba estos servicios. También entiendo que puedo terminar estos servicios en cualquier momento, a menos que la participación sea ordenada por un tribunal.

_____ _____
Nombre, en letra de molde, del padre/la madre/ el cuidador/el tutor legal — Relación con el beneficiario

_____ _____
Firma del padre/la madre/el cuidador/el tutor legal — Fecha

_____
Nombre del miembro del personal en letra de molde

_____
Nombre del proveedor

_____ _____
Firma y credenciales del miembro del personal — Fecha

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Joshua D. Baker DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Community Integration Services Provider Credentialing Request

Provider Information	
Provider Name	
Provider NPI	
Provider Medicaid ID #	
Address	
City / State / Zip Code	
Phone Number	
Fax Number	
Email Address	

Accreditation Information			
Accreditation Body	Accreditation Program/Standard	Date Accredited	Expiration Date

Program Information	
Days of Operation	Hours of Operation (list open and closing times OR "closed")
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Evidenced Based/Best Practice Treatment Model (s)	Staff credentialed

Description of Population Served (Ages, diagnoses, length of time in treatment)		
Age Range	Primary Diagnoses	Average length of time in treatment

Description of Program	
Description of Program Structure	
Types of Educational and Pre-vocational activities	
Cognitive and Adult role competencies	
Personal Adjustment Competencies	
Social and Interpersonal Competencies	
Community Living Competencies	

Staff Information		
Staff Name	Staff Credentials	Supervisory Responsibilities (Y/N)

Staff Information		
Staff Name	Staff Credentials	Supervisory Responsibilities (Y/N)

I attest that the aforementioned information is accurate.

Owner name (printed) _____

Signature_____

Date _____

Please attach the following supporting documentation:

1. Copies of all accreditation documentation (i.e. certificate, letter and survey)
2. Copies of credentialing documentation for all staff who will be providing the service of CIS

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Joshua D. Baker DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Therapeutic Childcare Center Credentialing Request

Provider Information	
Provider Name:	
Provider NPI:	
Provider Medicaid ID #	
Address:	
City / State / Zip Code	
Phone Number	
Fax Number	
Email Address	

Licensing and Accreditation Information			
Accreditation Body	Accreditation Program/Standard	Date Accredited	Expiration Date
SCDSS License or Approval Number		Date Licensed	Expiration Date

Program Information	
Days of Operation	Hours of Operation (list open and closing times OR "closed")
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Evidenced Based/Best Practice Treatment Model (s)	Staff credentialed

Description of Population Served (Ages, diagnoses, length of time in treatment)		
Age Range	Primary Diagnoses	Average length of time in treatment

Description of Program

Staff Information		
Staff Name	Staff Credentials	Supervisory Responsibilities (Y/N)

I attest that the aforementioned information is accurate.

Owner name_____

Signature_____

Date: _____

Please attach the following supporting documentation:

1. Copies of all accreditation documentation (i.e. certificate, letter and survey)
2. Copies of current DSS daycare license or approval and most recent site visit survey
3. Copies of credentialing documentation for all staff who will be providing the service of TCC