

## FORMS

Number	Name	Revision Date
DHHS 126	<a href="#">Confidential Complaint</a>	06/2007
DHHS 205	<a href="#">Medicaid Refunds</a>	01/2008
DHHS 931	<a href="#">Health Insurance Information Referral Form</a>	01/2008
	<a href="#">Reasonable Effort Documentation</a>	06/2007
	<a href="#">Authorization Agreement for Electronic Funds Transfer</a>	03/2011
	<a href="#">Duplicate Remittance Advice Request Form</a>	10/2012
CMS-1500	<a href="#">Sample Claim Showing TPL Denial with NPI</a>	08/2005
	<a href="#">Sample Edit Correction Form</a>	10/2008
	<a href="#">Sample Remittance Advice</a>	06/2007
DHHS 259	<a href="#">Interim Medicaid Targeted Case Management Transition Form w/Instructions (four pages)</a>	01/2013
	<a href="#">Freedom of Choice</a>	12/2012



**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 Form for Medicaid Refunds

**Purpose:** This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

**Items 1, 2 or 3, 4, 5, 6, & 7 must be completed.**

**Attach appropriate document(s) as listed in item 8.**

**1. Provider Name:** \_\_\_\_\_

**2. Medicaid Legacy Provider #**        
(Six Characters)

OR

**3. NPI#**

**& Taxonomy**

**4. Person to Contact:** \_\_\_\_\_

**5. Telephone Number:** \_\_\_\_\_

**6. Reason for Refund:** [check appropriate box]

- Other Insurance Paid (please complete a – f below and attach insurance EOMB)
  - a Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
  - b Insurance Company Name \_\_\_\_\_
  - c Policy #: \_\_\_\_\_
  - d Policyholder: \_\_\_\_\_
  - e Group Name/Group: \_\_\_\_\_
  - f Amount Insurance Paid: \_\_\_\_\_

- Medicare
  - ( ) Full payment made by Medicare
  - ( ) Deductible not due
  - ( ) Adjustment made by Medicare

Requested by DHHS (please attach a copy of the request)

Other, describe in detail reason for refund:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**7. Patient/Service Identification:**

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

**8. Attachment(s):** [Check appropriate box]

- Medicaid Remittance Advice (required)
- Explanation of Benefits (EOMB) from Insurance Company (if applicable)
- Explanation of Benefits (EOMB) from Medicare (if applicable)
- Refund check

Make all checks payable to: South Carolina Department of Health and Human Services  
Mail to: SC Department of Health and Human Services  
Cash Receipts  
Post Office Box 8355  
Columbia, SC 29202-8355



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM**

Provider or Department Name: \_\_\_\_\_ Provider ID or NPI: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ Date: \_\_\_\_\_

**I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS**

Beneficiary Name: \_\_\_\_\_ Date Referral Completed: \_\_\_\_\_

Medicaid ID#: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured SSN: \_\_\_\_\_

Employer's Name/Address: \_\_\_\_\_

**II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS**

- \_\_\_\_\_ a. beneficiary has never been covered by the policy – close insurance.
- \_\_\_\_\_ b. beneficiary coverage ended - terminate coverage (date) \_\_\_\_\_
- \_\_\_\_\_ c. subscriber coverage lapsed - terminate coverage (date) \_\_\_\_\_
- \_\_\_\_\_ d. subscriber changed plans under employer - new carrier is \_\_\_\_\_  
- new policy number is \_\_\_\_\_
- \_\_\_\_\_ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.  
(name) \_\_\_\_\_

**ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.**

Submit this information to Medicaid Insurance Verification Services (MIVS).

<b>Fax:</b>	<b>or</b>	<b>Mail:</b>
803-252-0870		Post Office Box 101110
		Columbia, SC 29211-9804

**III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN  
(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)**

Medicaid Beneficiary ID: \_\_\_\_\_ SSN: \_\_\_\_\_

Carrier Name/Code: \_\_\_\_\_ New Unique Policy Number: \_\_\_\_\_

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

<b>Fax:</b>	<b>or</b>	<b>Mail:</b>
803-255-8225		Post Office Box 8206, Attention TPL
		Columbia, SC 29202-8206



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
REASONABLE EFFORT DOCUMENTATION**

**PROVIDER** \_\_\_\_\_ **DOS** \_\_\_\_\_

**NPI or MEDICAID PROVIDER ID** \_\_\_\_\_

**MEDICAID BENEFICIARY NAME** \_\_\_\_\_

**MEDICAID BENEFICIARY ID#** \_\_\_\_\_

**INSURANCE COMPANY NAME** \_\_\_\_\_

**POLICYHOLDER** \_\_\_\_\_

**POLICY NUMBER** \_\_\_\_\_

**ORIGINAL DATE FILED TO INSURANCE COMPANY** \_\_\_\_\_

**DATE OF FOLLOW UP ACTIVITY** \_\_\_\_\_

**RESULT:**

**FURTHER ACTION TAKEN:**

**DATE OF SECOND FOLLOW UP** \_\_\_\_\_

**RESULT:**

**I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT  
RESPONSE FROM THE PRIMARY INSURER.**

\_\_\_\_\_  
**(SIGNATURE AND DATE)**

**ATTACH A COPY OF FORM TO THE APPROPRIATE CLAIM OR ECF AND FORWARD TO  
YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.**

**South Carolina**  
**Department of Health and Human Services**  
**Electronic Funds Transfer (EFT) Authorization Agreement**

**PROVIDER INFORMATION**

Provider Name \_\_\_\_\_  
Medicaid Provider Number \_\_\_\_\_  
Provider NPI Number \_\_\_\_\_  
Provider Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**BANKING INFORMATION** *(Please include a copy of the electronic deposit information on bank letterhead. This is required and the information will be used to verify your bank account information).*

Financial Institution Name \_\_\_\_\_  
Financial Institution Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Routing Number (nine digit) \_\_\_\_\_  
Account Number \_\_\_\_\_  
Type of Account (check one)     Checking     Savings

I (we) hereby authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to my account indicated below and the financial institution named below, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.

I (we) understand that credit entries to the account of the above named payee are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws.

I (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signed \_\_\_\_\_ (Signature)  
\_\_\_\_\_ (Print)

Title \_\_\_\_\_ Date \_\_\_\_\_

**All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.**

**RETURN COMPLETED FORM & BANK VERIFICATION DOCUMENT TO:**

**Department of Health and Human Services**  
**Medicaid Provider Enrollment**  
**P.O. BOX 8809, COLUMBIA, S.C. 29202-8809**  
**FAX (803) 870-9022**

**South Carolina Department of Health and Human Services  
Duplicate Remittance Advice Request Form**

**Purpose:** This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

Please contact the SCDHHS Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us> for instructions on submission of your request.

1. **Provider Name:** \_\_\_\_\_

2. **Medicaid Legacy Provider #** \_\_\_\_\_ **(Six Characters)**

**NPI#** \_\_\_\_\_ **& Taxonomy** \_\_\_\_\_

3. **Person to Contact:** \_\_\_\_\_ 4. **Telephone Number:** \_\_\_\_\_

5. **Requesting:**

- Complete Remittance Package**       **Remittance Pages Only**       **Edit Correction Pages Only**

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. **Street Address for delivery of request:**

**Street:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

8. **Charges for a duplicate remittance advice are as follows:**

**Request Processing Fee - \$20.00**

**Page(s) copied - .20 per page**

**I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.**

\_\_\_\_\_  
**Authorizing Signature**

\_\_\_\_\_  
**Date**

1500

HEALTH INSURANCE CLAIM FORM

Psychological Services
Sample Claim Showing TPL Denial
With NPI

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/CHAMPUS/CHAMPUS (Sponsor's SSN)/CHAMPVA (Member ID)/GROUP HEALTH PLAN (SSN or ID)/FECA BLK/LUNG (SSN)/OTHER (#D); 2. PATIENT'S NAME (Last Name, First Name, Middle Initial); 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS; 22. MEDICAID RESUBMISSION CODE; 23. PRIOR AUTHORIZATION NUMBER; 24. TABLE OF SERVICE DATES, CHARGES, UNITS, QUALITY, PROVIDER ID; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

RUN DATE 05/01/2007 000001204  
REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID  
TAXONOMY:  
1 2  
PROV/XWALK RECIPIENT  
ID ID  
ABC123 1111111111  
NPI: 1234567890

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
HIC - 76 SPEC -  
DOC IND N

CLAIM CONTROL #9999999999999999A  
PAGE 1136 ECF 1136 PAGE 1 OF 1  
EMC Y  
ORIGINAL CCN:  
ADJ CCN:

SFL ZIP: PRV ZIP:  
3 4 5 6 7 8 9  
P AUTH TPL INJURY EMERG PC COORD  
NUMBER CODE PRIMARY SECONDARY  
871.3 .

EDITS  
INSURANCE EDITS  
CLAIM EDITS  
LINE EDITS  
01) 234

10 RECIPIENT NAME - DOE, JANE 11 DATE OF BIRTH 01/25/1992 12 SEX F

13 14 15 16 17 18 19 20 21 22  
RES ALLOWED LN DATE OF PLACE PROC MOD INDIVIDUAL CHARGE PAY UNITS  
NO SERVICE CODE PROVIDER IND

\*\*\*\*\*  
\*\* AGENCY USE ONLY \*\*  
\*\* APPROVED EDITS \*\*  
\*\* REJECTED LINE EDITS \*\*  
\*\*\*\*\*

.00 1 02/01/04 96100 000 000 30.00 001  
NPI: 1234567890 TAXONOMY:  
2 / /  
NPI: TAXONOMY:  
3 / /  
NPI: TAXONOMY:  
4 / /  
NPI: TAXONOMY:  
5 / /  
NPI: TAXONOMY:  
6 / /  
NPI: TAXONOMY:  
7 / /  
NPI: TAXONOMY:  
8 / /  
NPI: TAXONOMY:

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!  
! CLAIMS/LINE PAYMENT INFO !  
! EDIT PAYMENT DATE !  
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 25 26  
INS CARR POLICY INS CARR  
NUMBER NUMBER PAID  
01 27 TOTAL CHARGE 90.00  
02 28 AMT REC'D INS  
03 29 BALANCE DUE 90.00  
30 OWN REF # 012345

RESOLUTION DECISION \_\_\_\_

ADDITIONAL DIAG CODES:

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

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

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

# Sample Remittance Advice (page 1)

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

# AB0008 ABC GROUP HOME .121212121234. PROVIDER ID.	Y	PO BOX 000000 FLORENCE SC000000000				
		PROFESSIONAL SERVICES	PAYMENT DATE	PAGE		
DEPT OF HEALTH AND HUMAN SERVICES		REMITTANCE ADVICE	03/26/2007	1		
AB00080000					SOUTH CAROLINA MEDICAID PROGRAM	

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	0406001089000400A				1192.00	243.71	P	1112233333	M CLARK			0.00	
	01		021507	96100	800.00	117.71	P			000			0.00
	02		021507	90804	392.00	126.00	P			000			0.00
VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04													
ABB222222	0406001089000400U				1412.00-	273.71-		1112233333	M CLARK				
	01		012107	90804	1112.00-	143.71-				000			
	02		012107	96100	300.00-	130.00-				000			
REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04													
ABB222222	0407701389002500A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		012107	90804	142.50	42.75	P			000			0.00
	02		012107	96100	859.00	0.00	R			000			0.00
TOTALS				2	2193.50	286.46						0.00	0.00

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".  IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.	CERT. PG TOT \$0.00  CERTIFIED AMT \$0.00	MEDICAID PG TOT \$286.46  MEDICAID TOTAL 0.00	STATUS CODES: P = PAYMENT MADE R = REJECTED S = IN PROCESS E = ENCOUNTER	PROVIDER NAME AND ADDRESS ABC GROUP HOME PO BOX 000000 FLORENCE SC 00000-0000
FEDERAL RELIEF MAXIMUS AMT CHECK TOTAL CHECK NUMBER				

# Sample Remittance Advice (page 2)

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

PROVIDER ID.	DEPT OF HEALTH AND HUMAN SERVICES	CLAIM ADJUSTMENTS	PAYMENT DATE	PAGE
AB11110000	SOUTH CAROLINA MEDICAID PROGRAM		03/26/2007	2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	M F I	M O D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	0406001089000400U		012107	90804	513.00-	197.71-	1112233333	CLARK	M		022807	0404711253670430A
	01		012107	90804	453.00	160.71- P					000	
	02		012107	96100	60.00	33.00- P					000	
	TOTALS		1		513.00-	193.71-						

SAMPLE ONLY

DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
	\$243.71	0.00	0.00	0.00
0.00	ADJUSTMENTS	MAXIMUS AMT	PROVIDER NAME AND ADDRESS	
	\$193.71-		ABC GROUP HOME	
YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PO BOX 000000	
0.00	\$50.00	4197304	FLORENCE SC 00000-0000	

# Sample Remittance Advice (page 3)

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

PROVIDER ID.	DEPT OF HEALTH AND HUMAN SERVICES	ADJUSTMENTS	PAYMENT DATE	PAGE
AB11110000	SOUTH CAROLINA MEDICAID PROGRAM		03/26/2007	3

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

SAMPLE ONLY

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

Interim Medicaid Targeted Case Management Transition Form

**Beneficiary Identification:**

\_\_\_\_\_

Last Name

First Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

Medicaid #

Agency Client #

**Current Targeted Case Management Agency:**

\_\_\_\_\_

Agency Name

Phone Number

\_\_\_\_\_

Mailing Address:

\_\_\_\_\_

Agency Contact Name and Fax Number

**Initial Client Validation/Revalidation of Existing Client: Circle Status then** Describe the beneficiary's behavior and circumstances which indicate the need for Targeted Case Management Services listed below. The recommendation must be based on clinical information, staffing recommendations that are based on the beneficiary's current situation. (Attach supporting Psychiatric Medical Assessment, Medical Assessment by primary Care Physician, Psychological, Social Summary or discharge summary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Target Groups**

(Target group definitions can be found in the Targeted Case Management manual on the SCDHHS Web site: <http://provider.scdhhs.gov>.)

- Individuals with Intellectual and Related Disabilities
- At Risk Children
- Adults with Serious and Persistent Mental Illness
- At Risk Women and Children
- Individuals with Psychoactive Substance Disorder
- Individuals at Risk for Genetic Disorders
- Individuals with Head and Spinal Cord Injuries and Similar Disabilities
- Individuals with Sensory Impairments
- Adults with Functional Impairments

This form must be maintained in the beneficiary's MTCM record. The form must be completed on or prior to billing for dates of service beginning January 1, 2013.



## **INTERIM MEDICAID TARGETED CASE MANAGEMENT (MTCM) TRANSITION FORM 259 INSTRUCTIONS**

### **Purpose**

The purpose of this form is to provide a process for transitioning existing clients to the new MTCM system on or after January 1, 2013 and to also accommodate any new referrals until April 1, 2013 when the prior authorization (PA) process will be in place. The form must indicate the target group and provide the appropriate documentation to support medical necessity during the transition period from January 1, 2013 through March 31, 2013. In addition to documenting the specific target group(s) and providing the required medical necessity component, the form also moves the program toward Phase II implementation which will include (PA) based on documented medical necessity reviewed by SCDHHS or a quality improvement entity. The implementation for Phase II is projected to be April 1, 2013 and will include PA and the other reforms to the MTCM program.

### **Completion of transition Form 259**

The form must be completed by the case manager during the three month transition period, but no later than March 31, 2013, and placed in the beneficiary's case file. The Office of Program Integrity at SCDHHS will not audit MTCM records during this transitional period for compliance on completion of Form 259 on dates of service after January 1, 2013.

### **Beneficiary Identification** – self explanatory

### **Current Targeted Case Management Agency**

This contact information will be used for the (PA) Process once Phase II is implemented in order to notify the agency of the PA status.

### **Interim Validation/Revalidation of Existing Beneficiary**

This section should indicate if the beneficiary is a new referral or an existing beneficiary until Phase II is operational. The form should indicate the target group and provide the appropriate documentation to support medical necessity. Examples of supporting documents are provided on the form.

### **Target Groups**

Circle the arrow in the left margin to indicate the appropriate target group(s).

### **Medical Necessity Criteria**

This section is used to assist the person completing the validation portion of the form on what type of information helps define the Medical Necessity Criteria and does not require annotation.

### **Current or Past Service Providers**

If additional information is required to meet medical necessity, this section provides information to the PA reviewer on previous and current services being rendered. Past services would include those provided within the last 6 months to a year.

**INTERIM MEDICAID TARGETED CASE MANAGEMENT (MTCM) TRANSITION FORM 259  
INSTRUCTIONS (Continued)**

**Freedom of Choice**

As of January 1, 2013 the following providers of MTCM include:

Department of Social Services	Department of Mental Health
Department of Disabilities and Special Needs	Department of Juvenile Justice
Department of Alcohol and Other Substance Abuse	Continuum of Care
School for the Deaf and Blind	First Steps
James R. Clark Sickle Cell Foundation	

Once other providers enroll, a list of qualified Medicaid providers geographically will be maintained on the agency web site. A Freedom of Choice form is attached.

## FREEDOM OF CHOICE

*This form should be completed after MTCM eligibility determinations have been made.*

I have been informed of the Medicaid Targeted Case Management (MTCM) services available to me or my child. I understand I have a right to choose the provider of Medicaid Targeted Case Management services, and I have been given the opportunity to choose between enrolled Medicaid providers in my community setting.

As long as I remain eligible for MTCM services, I will continue to have the opportunity to choose between qualified MTCM providers.

I understand that I have the right to refuse MTCM services. Refusal of MTCM services does not prevent me from receiving other Medicaid services for which I may qualify.

I agree to receive Medicaid Targeted Case Management services for

\_\_\_\_\_  
Beneficiary Name

\_\_\_\_\_  
Medicaid Number

I select \_\_\_\_\_ as my provider for MTCM Services.  
Name of Provider

I decline Medicaid Targeted Case Management Services

\_\_\_\_\_  
Beneficiary Name

\_\_\_\_\_  
Medicaid Number

\_\_\_\_\_  
Signature of recipient

\_\_\_\_\_  
Date signed (month, day, year)

\_\_\_\_\_  
Signature of: (check one) \_\_\_ Family  
\_\_\_ Guardian \_\_\_ Witness

\_\_\_\_\_  
Date signed (month, day, year)

\_\_\_\_\_  
Signature of Case Manager

\_\_\_\_\_  
Date signed (month, day, year)

DISTRIBUTION: Original – Provider Case File

Beneficiary Copy