FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 140	Medicaid Provider Inquiry	06/2007
DHHS 142	Request for Medicaid Forms and Publications	06/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	06/2007
	Reasonable Effort Documentation	05/2007
	Authorization Agreement for Electronic Funds Transfer	12/2005
CMS-1500	Sample Claim Form Showing NPI and Medicaid Provider ID	08/2005
CMS-1500	Sample Claim Form Showing NPI Only	08/2005
	Sample Edit Correction Form	06/2007
	Sample Remittance Advice	06/2007
DHHS 945	Verification of Retroactive Medicaid	05/2004
DHHS 216	Authorization Form for Medicaid	11/2007
DHEC 1050	DHEC Ambulance Run Report (two pages)	01/2004

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:_____

DHHS Form 130 Revision date: 03-13-2007

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

MEDICAID PROVIDER INQUIRY

MAIL TO: ATTENTION _____ UNIT S.C. DEPT. OF HEALTH AND HUMAN SERVICES POST OFFICE BOX 8206 COLUMBIA, SOUTH CAROLINA 29202-8206	TODAY'S DATE: NPI or MEDICAID PROVIDER ID: TELEPHONE:
PROVIDER NAME AND ADDRESS:	TYPE OF PROVIDER (i.e., Dentist, Group, etc.) DATE CLAIM FILED:

----------FOLD HERE----------

PATIENT'S NAME (First, Initial, Last)	MEDICAID NUMBER (10 Digits)	DATE OF SERVICE
HAS THE CLAIM APPEARED ON THE PROVIDER'S REMITTANCE ADVICE? (CHECK ONE) ☐ YES ☐ NO	IS MEDICARE COVERAGE INVOLVED? ☐ YES ☐ NO	
CLAIMS STATUS ON REMITTANCE ADVICE	PAYMENT DATE	17-DIGIT CLAIM REFERENCE NUMBER
STATEMENT OF PROBLEM OR QUESTION		
	SIGNATURE OF PROVIDER	
RESPONSE		
	AGENCY REPRESENTATIVE	DATE

SCDHHS Form 140 (revised 06/07)

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

REQUEST FOR MEDICAID FORMS AND PUBLICATIONS

WHEN COMPLETED PLEASE FORWARD TO:

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUPPLY
POST OFFICE BOX 8206
COLUMBIA, SOUTH CAROLINA 29202-8206

***-OR-* FAX TO: (803) 898-4528**

NPI or MEDICAID PROVIDER ID:

TYPE OF PROVIDER:

TELEPHONE: - -

CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY ***(PLEASE PRINT OR TYPE)***

ITEMS REQUESTED

FORM/PUBLICATION NO.	TITLE OF FORM OR PUBLICATION	QUANTITY

SCDHHS FORM 142 (revised 06/07)

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

DHHS Form 205 (01/08

Medicaid Insurance Verification Services
For
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH INSURANCE INFORMATION REFERRAL FORM

This form is designed to give the Medicaid program information that can be used to verify or reverify private health insurance coverage for Medicaid beneficiaries.

Beneficiary Name: _____ Date Referral Completed _____

Medicaid ID#: _____ SSN: _____

Insurance Company Name:_____

Policy Number: _____ Group Number: _____

Insured's Name: _____

Employer's Name: _____

Employer's Address: _____

REASON FOR REFERRAL: (PLEASE SUPPLY AS MUCH INFORMATION AS POSSIBLE)

_____ 1. The beneficiary's Medicaid Eligibility File does not list the policy above.

_____ 2. Insurance documentation gives information that should be used to update Medicaid's files, such as the following:

_____ a. beneficiary has never been covered by the policy

_____ b. beneficiary's coverage ended (date) _____

_____ c. policy lapsed (date) _____

_____ d. carrier has changed; new carrier is _____

_____ e. other _____

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

Fax this information to Medicaid Insurance Verification Services at 803 252 0870 **OR**
Please send this form to the following address: Medicaid Insurance Verification Services
Post Office Box 101110
Columbia, SC 29211-9804

Provider or Department Name: _____ NPI or Medicaid Provider ID: _____

Contact Person: _____ Phone #: _____

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

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

Provider Name: _____

Provider DBA Name *(if applicable)*: _____

Medicaid Provider Number: _____

Provider NPI Number: _____

Provider EIN Number: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

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 and that this account is used solely for business purposes. I (we) further agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

Please contact your bank to obtain the correct electronic deposit information:

Financial Institution: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Transit/ABA Number: _____

Account No.: _____

Type of Account: ___ **Checking** ___ **Savings**

Signed: _____ *(Signature)*

_____ *(Print)*

Title: _____

Date: _____

Contact Name: _____ **Phone:** _____

RETURN TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P. O. BOX 8806
COLUMBIA, S.C. 29202-8809
FAX (803) 699-8637

Revised 12/05

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Ambulance Services
Sample Claim Form Showing
NPI and Medicaid Provider ID

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: 01 31 1947 SEX: M [x] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 Windy Lane

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: SC

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 29999 TELEPHONE (Include Area Code): (803) 898-2590

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] 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 [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 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. 250.91

2.

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	31	07	01	31	07	41		A0428	NH		117.71	1		1D	ABC123
															NPI	1234567890
2	01	31	07	01	31	07	41		A0999	HN		79.65	1		1D	ABC123
															NPI	1234567890
3	01	31	07	01	31	07	41		A0425	NH		25.00	5		1D	ABC123
															NPI	1234567890
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 222.36

29. AMOUNT PAID $ 0.00

30. BALANCE DUE $ 222.36

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 Ambulance Company
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. 1DABC123

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Ambulance Services
Sample Claim Form Showing
NPI Only

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [x] | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John A.

3. PATIENT'S BIRTH DATE MM DD YY: 01 31 1947 SEX M [x] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Windy Lane

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: SC

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY STATE

ZIP CODE: 29999 TELEPHONE (Include Area Code): (803) 898-2590

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | 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 | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 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. 250.91
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	31	07	01	31	07	41		A0428	NH		117.71	1		ZZ	1212121212
															NPI	1234567890
2	01	31	07	01	31	07	41		A0999	HN		79.65	1		ZZ	1212121212
															NPI	1234567890
3	01	31	07	01	31	07	41		A0425	NH		25.00	5		ZZ	1212121212
															NPI	1234567890
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $ 222.36

29. AMOUNT PAID $ 0.00

30. BALANCE DUE $ 222.36

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 Ambulance Company
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 - 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
PROVIDER ID	RECIPIENT ID	P AUTH NUMBER	TPL	INJURY CODE	EMERG	PC COORD	---- DIAGNOSIS ---- PRIMARY	SECONDARY
ABC123	1111111111						170.0	.

NPI: 1234567890

EDITS
INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 510
02)
03)

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 NO	DATE OF SERVICE	PLACE	PROC CODE	MOD	INDIVIDUAL PROVIDER	CHARGE IND	PAY	UNITS
						23 NDC				
	.00	1	05/07/04	11	A0429	000	XXXXXX	117.71		1.000

NPI: 1234567890 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:

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

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

24	25	26
INS CARR NUMBER	POLICY NUMBER	INS CARR PAID
01		
02		
03		

27 TOTAL CHARGE 117.71
28 AMT REC'D INS
29 BALANCE DUE 117.71
30 OWN REF # 012345

RESOLUTION DECISION ___

ADDITIONAL DIAG CODES: . . . . . .

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

INSURANCE POLICY INFORMATION

PROVIDER:
ACME TRANSPORT
PO BOX 00000
ANYWHERE, XO 00000-0000

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

Sample Remittance Advice (page 1)

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

AB0008 ACME TRANSPORT PO BOX 000000 FLORENCE SC000000000

.121212121234. Y

PROVIDER ID. PROFESSIONAL SERVICES PAYMENT DATE PAGE

AB00080000 | DEPT OF HEALTH AND HUMAN SERVICES | 03/26/2007 | 1

SOUTH CAROLINA MEDICAID PROGRAM REMITTANCE ADVICE

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	A0428	800.00	117.71	P			0HH			0.00
	02		021507	A0425	392.00	126.00	P			0HH			0.00
	VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0406001089000400U				1412.00-	273.71-		1112233333	M CLARK				
	01		012107	A0427	1112.00-	143.71-				0HH			
	02		012107	A0425	300.00-	130.00-				0HH			
	REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0407701389002500A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		012107	A0427	142.50	42.75	P			0HH			0.00
	02		012107	A0425	859.00	0.00	R			0HH			0.00
	TOTALS		2		2193.50	286.46						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	0.00

FEDERAL RELIEF	MAXIMUS AMT	CHECK TOTAL	CHECK NUMBER

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

PROVIDER NAME AND ADDRESS

ACME TRANSPORT
PO BOX 000000
FLORENCE SC 00000-0000

Sample Only

Sample Remittance Advice (page 2)

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

PROVIDER ID. AB00080000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE 03/26/2007

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	O D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	0406001089000400U				513.00-	197.71-		1112233333	CLARK		M		022807	0404711253670430A
	01		012107	A0428	453.00	160.71-	P					0HH		
	02		012107	A0425	60.00	33.00-	P					0HH		
	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
0.00	$243.71	0.00	0.00	0.00

ADJUSTMENTS	MAXIMUS AMT
$193.71-	

YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER
0.00	$50.00	4197304

PROVIDER NAME AND ADDRESS

ACME TRANSPORT
PO BOX 000000
FLORENCE SC 00000-0000

Sample Remittance Advice (page 3)

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

PROVIDER ID.: AB00080000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE: 03/26/2007

PAGE: 3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME F M I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	04086000037000000U	-						DEBIT	-2389.05	
TPL 4	04086000047000000U	-						DEBIT	-1949.90	
TPL 5	04086000057000000U	-						DEBIT	-477.25	
TPL 6	04086000067000000U	-						DEBIT	-477.25	
						PAGE TOTAL:			5293.45	0.00

Sample Only

DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
0.00	0.00	0.00	0.00	0.00

ADJUSTMENTS	MAXIMUS AMT
0.00	0.00

YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER
5293.45	0.00	

PROVIDER NAME AND ADDRESS

ACME TRANSPORT
PO BOX 000000
FLORENCE SC 00000-0000

South Carolina Department of Health and Human Services

Verification of Retroactive Medicaid

Date: _____

To: _____

_____

_____

Re: _____

Medicaid Number: _____

Retroactive Medicaid coverage was entered into the Department of Health and Human Services computer system for the above-named individual on the following date:

_____.

The retroactive period began on the following date: _____.

The retroactive period ended on the following date: _____.

Please be reminded that all bills must be submitted within six (6) months of the individual's eligibility determination or one (1) year from the date of service delivery, whichever is later.

_____ _____

Medicaid Eligibility Worker Telephone Number

DHHS Form 945 (May 2004)

AMBULANCE AUTHORIZATION FORM FOR MEDICAID

Beneficiary's Name: _____ **Date of Transport:** ____/____/____

Medicaid I.D. Number: _____

_____ Ambulance Service, Basic Life Support, Non-Emergency Transport (BLS) – (Procedure Code A0428)
(A DHEC licensed ambulance vehicle with staff and equipment on board that provides treatment in basic life support situations.)

I understand that Medicaid will only cover transport to Medicaid-sponsored services in accordance with the following age limitations. This recipient is being transported to and from the following Medicaid service:

From

___ R-Residence
___ H-Hospital
___ N-Nursing Home
___ P-Physician Office
___ G-Hospital-Based Dialysis
___ J-Non-Hospital-Based Dialysis
___ Adult Residential Facility
___ Unlisted/Other -- **Provide complete address and telephone number below**:

_____
_____
_____

To

___ P-Physician Office
___ H-Hospital
___ N-Nursing Home
___ G-Hospital-Based Dialysis
___ J-Non-Hospital-Based Dialysis
___ 076 (Duplicate procedure, same day of service)
___ Emergency Vision Care (to age 21)
___ Preventive and Restorative Dental Care (to age 21)
___ Emergency Dental Care (over age 21)
___ Adult Day Health Care

Check all that apply:

- ☐ Need to suction airway
- ☐ Contractures
- ☐ Non-healed fractures
- ☐ Special Handling en route – Isolation
- ☐ Moderate to severe pain on movement
- ☐ Danger to self or others – monitoring
- ☐ Confused, combative, lethargic, comatose
- ☐ DVT requires elevation of a lower extremity
- ☐ I.V. medications/fluids required during transport
- ☐ Danger to self or others – seclusion (flight risk)
- ☐ Cardiac/Hemodynamic monitoring required during transport
- ☐ Morbid Obesity requires additional personnel/equipment to handle
- ☐ Restraints (physical or chemical) anticipated or used during transport
- ☐ Third party assistance/attendant required to apply, administer, or regulate
- ☐ Risk of falling off wheelchair or stretcher while in motion (not related to obesity)
- ☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling in transit
- ☐ Severe muscular weakness and de-conditioned state precludes any significant physical activity
- ☐ Other: Please specify current medical condition requiring transport: _____

_____

I certify that it is medically necessary for this patient to be transported by ambulance. Transportation by any other means could be detrimental and medically inadvisable. This certification is provided within my professional scope of practice and applicable state law.

_____ (**Signature of Requestor, Title**) **Date**: _____/_____/_____
(Attending physician, physician assistant, nurse practitioner, clinical nurse specialist or registered nurse)

_____ (**Print Name of Requestor, Title**)

_____ (Facility Name) County: _____

Vehicle odometer reading (To): _____ Vehicle odometer reading (From): _____

(**A DHEC Run Report must be attached to DHHS Form 216 when submitting a claim for reimbursement.**)

DHEC Ambulance Run Report (page 1)

DHEC PATIENT CARE FORM

Q.A. NO.

TRIP NO.

PATIENT IDENTIFICATION (Please Print)

LAST NAME (10–29) FIRST NAME (30–45) MI (46)

STREET (47–71) APT. #

CITY (72–87) STATE (88–89) ZIP CODE (90–94)

SSN (95-103)

SEX (104)

1 ☐ Male
2 ☐ Female
3 ☐ Undetermined

RACE (105)

1 ☐ White
2 ☐ Black
3 ☐ Am. Indian
4 ☐ Hispanic
5 ☐ Asian
6 ☐ Other

AGE (106–109)

CHECK ONE
1 ☐ YRS.
2 ☐ MOS.
3 ☐ DAYS

DISPOSITION (110–111)

01 ☐ TREAT/NO TRANS.
02 ☐ DOA AT SCENE
03 ☐ HOSPITAL ER
04 ☐ HOSP. DIR. ADMIT.
06 ☐ PATIENT'S HOME
07 ☐ NURSING HOME
08 ☐ DR.'S OFFICE
09 ☐ OUTPATIENT
10 ☐ PT. REFUSED TREAT.
13 ☐ EMS TRANSFER

TYPE OF INCIDENT

TRAUMA (112)	MEDICAL (113)
1 ☐ MVA	1 ☐ ENVIRON
2 ☐ MC	2 ☐ BEHAV
3 ☐ BIKES	3 ☐ OB/GYN
4 ☐ PED	4 ☐ RESP
5 ☐ ASSAULT	5 ☐ CARDIAC
6 ☐ FALL	6 ☐ INTERFAC
7 ☐ FIRE	7 ☐ OTHER
8 ☐ INTERFAC	
9 ☐ OTHER	

CALL TYPE

TO SCENE (114)
1 ☐ EMERGENT
2 ☐ NONEMERGENT
CODE

PATIENT STATUS

ON SCENE (115)
1 ☐ URGENT
2 ☐ NON URGENT
CODE

FROM SCENE (116)
1 ☐ URGENT
2 ☐ NON URGENT

INCIDENT LOCATION

ST. OR HWY. NAME OR NO.

CITY

County (117-118) Zip Code (119-123)

SAFETY EQP (124)

1 ☐ Seatbelts 4 ☐ Child Seat
2 ☐ Helmets 5 ☐ None
3 ☐ Airbags 6 ☐ Unkn.

SITE OF INCIDENT (125)

1 ☐ ROADWAY 4 ☐ RECREATIONAL
2 ☐ RESIDENCE 5 ☐ AGRICULTURAL
3 ☐ INDUSTRIAL 6 ☐ OTHER

PRELIMINARY IMPRESSIONS (MARK NO MORE THAN 4) (126–137)

003 ☐ Seizure	024 ☐ Multitrauma/Shock	074 ☐ Respiratory Distress
004 ☐ Diabetic	030 ☐ Head Injury	080 ☐ Coronary Problems
011 ☐ Abrasion/Contusions	032 ☐ Spinal Injury	083 ☐ Cardiac Arrest
013 ☐ Laceration	084 ☐ Stroke	
023 ☐ Fracture	051 ☐ G.I. Problems	Other / Other

PRIMARY IMPRESSION (138–140)

TREATMENT PROCEDURES (141–174)

01 ☐ Dressing Applied	07 ☐ Oxygen Given	13 ☐ Cardiac Massage
02 ☐ Limb Splinted	08 ☐ Suction Used	14 ☐ Bleeding Controlled
03 ☐ Spine Immobilized	09 ☐ Antishock Trousers	15 ☐ Cold Application
04 ☐ Neck Immobilized	10 ☐ Airway Maintained	16 ☐ Patient Restrained
05 ☐ OB Assistance	11 ☐ Antishock Treatment	17 ☐ Other (Use Comments)
06 ☐ Oral Airway Used	12 ☐ Artificial Resp.	18 ☐ Ventilator

HCFA CODES (175–180)

SITE OF TRAUMA (181–189)

1 ☐ Head
2 ☐ Face
3 ☐ Neck
4 ☐ Chest
5 ☐ Abdomen
6 ☐ Hip/Pelvis
7 ☐ Upper Extr.
8 ☐ Lower Extr.
9 ☐ Back

ADVANCED PROCEDURES (190–223)

1. ☐ EKG Monitored Rhythm ____ Time ____
2. ☐ First Defib Attempted Watt Sec. ____ Time ____
   Post Defib Rhythm ____
3. ☐ Second Defib Attempted Watt Sec. ____ Time ____
   Post Defib Rhythm ____
4. ☐ Third Defib Attempted Watt Sec. ____ Time ____
   Post Defib Rhythm ____

INTUBATED 5. ☐ ET Size ____ Total # Attempts ☐ (224)
15 ☐ RSI 16 ☐ LMA 17 ☐ Crico

6. ☐ EXTERNAL PACING
7. ☐ BLOOD DRAWN DEXTROSE BGL ____
8. ☐ IV STARTED/GAUGE SOLUTION ____
   RATE ____ IV TIME IV VOLUME
9. ☐ IV STARTED/GAUGE SOLUTION ____
   RATE ____ IV TIME IV VOLUME
14 ☐ IV ATTEMPTED Total # ☐ (225)
10. ☐ PLEURAL DECOMPRESSION Time ____
11. ☐ INTRAOSSEOUS INF. ____
12. ☐ AUTOMATIC DEFIB
13. ☐ PATIENT ASSISTED MEDS. ____

Ordering Physician ____ (Name) (Signature)

DRUGS USED (226–241)

DRUG	DOSE	TIME	DRUG	DOSE	TIME

REVISED TRAUMA SCORE

GCS: (242) EYES ____ (247–249) SBP ____ RTS (254–255)
(243) VERBAL ____ (250–252) RR ____
(244) MOTOR ____
(245–246) GLASGOW ____ (253) ANATOMICAL INJ. 1 ☐ YES 2 ☐ NO

VITAL SIGNS

BP	PULSE	RESPIRATONS	PUPIL	LEVEL OF CONSC.	TIME
/	RATE ☐ REG. ☐ IRREG.	RATE ☐ REG. ☐ IRREG.	E U N C D	A V P U	
/	☐ REG. ☐ IRREG.	☐ REG. ☐ IRREG.			
/	☐ REG. ☐ IRREG.	☐ REG. ☐ IRREG.			
/	☐ REG. ☐ IRREG.	☐ REG. ☐ IRREG.			
/	☐ REG. ☐ IRREG.	☐ REG. ☐ IRREG.			

EXPOSURE TO PT's BODY FLUIDS? (256) 1. ☐ YES 2. ☐ NO

1st Responder (257) 1. ☐ YES Name ____ 2. ☐ NO

COMMENTS (INCLUDE CHIEF COMPLAINTS, OBSERVATIONS AT SCENE, RESPONSE TO STIMULI)

Patient Care Form Left In (258): 1. ☐ ED 2. ☐ ICU 3. ☐ OTHER ____ See Page 2

TIME RECORD

RUN DATE (259–266) MONTH DAY YEAR

Call Received: (267–270)	
Call Dispatched: (271–274)	
Departed Base: (275–278)	
Arrive Scene: (279–282)	
Departed Scene: (283–286)	
Arrive Destination: (287–290)	

CAUSE OF DELAY ____

DHEC PERMIT NO. (291–295)

RECEIVING AGENCY (296–299)

SENDING AGENCY (300–303)

PROVIDER TIME (OPTIONAL)

ATTENDANT'S SIGNATURE & CERTIFICATION NO.

PRIMARY PATIENT ATTENDANT (304–308)

2ND ATTENDANT/DRIVER (309–313)

3RD ATTENDANT/DRIVER (314–318)

(RECEIVING NURSE OR PHYSICIAN)

PATIENT COMPLAINT SIGNALS

Type of Incident

TRAUMA
011 ABRASION/CONTUSION
012 AVULSION
013 LACERATION
014 PUNCTURE/STAB
015 GUNSHOT WOUND
016 BURN
017 HEMORRHAGE
018 ELECTROCUTION
019 CHEST INJURY
020 CRUSHING
021 AMPUTATION
022 DISLOCATION
023 FRACTURE
024 MULTITRAUMA/SHOCK
025 PATIENT TRAPPED
026 EYE INJURY
029 SPRAIN/STRAIN
030 HEAD INJURY
031 PARALYSIS
032 SPINAL INJURY
037 ANIMAL BITE
038 SNAKE BITE

CARDIAC/STROKE
080 CORONARY PROBLEM
081 CONGESTIVE HEART FAILURE
082 HYPERTENSION
083 CARDIAC ARREST
084 CVA/TIA/STROKE
085 HYPOTENSION
086 CHEST PAIN

RESPIRATORY
070 APNEA
071 AIRWAY OBSTRUCTION/ CHOKING
072 HYPERVENTILATION
073 PULMONARY EDEMA
074 RESPIRATORY DISTRESS
075 ANAPHYLACTIC/TOXIN SHOCK
076 NEAR DROWNING

ENVIRONMENTAL
001 HEAT EXHAUSTION
002 HEAT STROKE
101 COLD EXPOSURE/ HYPOTHERMIA

BEHAVIORAL
040 HYSTERIA
041 FAINTING
043 PSYCHIATRIC/ BEHAVIORAL
044 OVERDOSE
045 IMPAIRMENT SIMILAR TO ALCOHOL
046 ALTERED MENTAL STATUS

OB/GYN
060 OB PRENATAL
061 OB POSTNATAL
062 OB EMERGENCY
063 OB ABORTION
064 GYN PROBLEM
065 OB DELIVERY

OTHER
003 SEIZURE
004 DIABETIC REACTION
005 INSULIN SHOCK
006 POISONING
007 COMMUNICABLE DISEASE
008 UNCONSCIOUS
009 DEAD ON ARRIVAL-NO TRANS.
010 DEAD ON ARRIVAL- TRANS.
050 VOMITING
051 G.I. PROBLEMS
052 G.U. PROBLEMS
090 UNKNOWN COMPLAINT
091 TRANSPORT FOR EXAM
092 NONEMERGENCY TRANSPORT
093 NO TRANSPORT
094 CANCELLED CALL
095 FALSE CALL
102 SEXUAL ASSAULT
103 COLD/FLU
104 HEADACHE
105 WEAKNESS/DIZZNESS
106 PAIN
107 CANCER
108 DIALYSIS
109 MEDICAL DEVICE FAILURE
110 POST OPERATIVE COMPLICATIONS
111 BED CONFINED
112 ALS MONITORING REQUIRED
113 BLS MONITORING REQUIRED
114 SPECIALTY CARE MONITORING

CORE DRUGS

28 Activated Charcoal USP
29 Adenosine
31 Albuterol
43 Amiodarone
37 Ativan
04 Atropine Sulfate
83 Atrovent
34 Calcium Gluconate
15 Dextrose 50%
10 Diazepam
08 Diphenhydramine
24 Dopamine HCL
03 Epinephrine IV
02 Epinephrine SQ
06 Furosemide
30 Glucagon USP
05 Lidocaine HCL
45 Magnesium Sulfate
22 Morphine Sulfate
11 Naloxone
13 Nitroglycerin Spray
14 Nitroglycerin Sublingual
25 Procainamide HCL
42 Racemic Epinephrine
01 Sodium Bicarbonate
27 Syrup of Ipecac
26 Terbutaline Sulfate SQ
35 Thiamine
46 Vasopressin
84 Xopenex

SPECIAL PURPOSE / LOCAL OPTION DRUGS

44 Acetaminophen
36 Aspirin
38 Diltiazem
69 Dobutamine
39 Flumazenil
09 Heparin Lock Flush
40 Ibuprofen
41 Labetalol
19 Nalbuphine HCL
16 Nitrous Oxide
23 Oxytocin
68 Promethazine
33 Proparacaine HCL

Toxicology
71 Amyl Nitrite
77 Calcium Gluconate (tox)
72 Methylene Blue
73 Pralidoxime Chloride (2-PAM)
74 Propranolol (Inderal)
82 Pyridoxine HCL
75 Sodium Nitrite
76 Sodium Thiosulfate

Rapid Seq Intubation
81 Etomidate
78 Midazolam HC (Versed)
79 Succinylcholine (Anectine)
80 Vecuronium Bromide (Norcuron)

GLASGOW

EYE OPENING:		VERBAL:		MOTOR:	
SPONTANEOUS	4	ORIENTED	5	OBEYS COMMANDS	6
TO VOICE	3	CONFUSED	4	LOCALIZES PAIN	5
TO PAIN	2	INAPPROPRIATE WORDS	3	WITHDRAW (Pain)	4
NONE	1	INCOMPREHENSIBLE	2	FLEXION (Pain)	3
		NONE	1	EXTENSION (Pain)	2
				NONE	1

REVISED TRAUMA SCORE

GLASGOW COMA SCORE	SYSTOLIC BP	RESPIRATORY RATE	CODE VALUE
13–15	>89	10–29	4
9–12	76–89	>29	3
6–8	50–75	6–9	2
4–5	1–49	1–5	1
3	0	0	0

SELECTED ANATOMICAL INJURIES

1. ALL PENETRATING INJURIES TO HEAD, NECK, TORSO AND EXTREMITIES PROXIMAL TO ELBOW AND KNEE.
2. FLAIL CHEST.
3. COMBINATION TRAUMA WITH BURNS.
4. TWO OR MORE PROXIMAL LONG BONE FRACTURES.
5. PELVIC FRACTURES.
6. LIMB PARALYSIS.
7. AMPUTATION PROXIMAL TO WRIST AND ANKLE.

VITAL SIGNS

PUPILS	LEVEL OF CONSC.
E = EQUAL	A = ALERT
U = UNEQUAL	V = VERBAL ST.
N = NO RESP.	P = PAINFUL ST.
C = CONSTR.	U = UNRESP.
D = DILATED	

LIST OF CODE NUMBERS OF S.C. COUNTIES

01 Abbeville
02 Aiken
03 Allendale
04 Anderson
05 Bamberg
06 Barnwell
07 Beaufort
08 Berkeley
09 Calhoun
10 Charleston
11 Cherokee
12 Chester
13 Chesterfield
14 Clarendon
15 Colleton
16 Darlington
17 Dillon
18 Dorchester
19 Edgefield
20 Fairfield
21 Florence
24 Greenwood
25 Hampton
26 Horry
27 Jasper
28 Kershaw
29 Lancaster
30 Laurens
31 Lee
32 Lexington
33 McCormick
34 Marion
35 Marlboro
36 Newberry
37 Oconee
38 Orangeburg
39 Pickens
40 Richland
41 Saluda
42 Spartanburg
43 Sumter
44 Union