SECTION 5
ADMINISTRATIVE SERVICES

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GENERAL INFORMATION

ADMINISTRATION

The Department of Health and Human Services (DHHS) administers the South Carolina Medicaid Program including Partners for Health. This section outlines the available resources for Medicaid providers, with telephone numbers, addresses, and the individuals available for provider assistance.

CORRESPONDENCE AND INQUIRIES

All correspondence to the Medicaid administrative staff should be directed to:

Department of Health and Human Services (DHHS)
ATTN: Division of Hospice Services
Post Office Box 8206
Columbia, SC 29202-8206
(803) 898-2882

Correspondence concerning specific policy and procedural problems must be directed to the appropriate program manager. Inquiries concerning specific claims should also be directed to the appropriate program manager, but only after corrections have been made on rejected claims and all claims filing requirements have been met. Medicaid Provider Inquiry (DHHS Form 140) may be used to check the status on outstanding claims. Always include the provider's Medicaid number, the recipient's Medicaid number and the date of service when requesting the status of outstanding claims. **Allow 45 days from the submission date before requesting the status of the claim.** See the sample form at the end of this section.

Questions concerning beneficiary eligibility or identification numbers should be directed to the DHHS county office in the beneficiary's county of residence. Beneficiaries who have questions regarding specific coverage issues should be referred to the appropriate staff of their county DHHS office for assistance. To verify eligibility status, please call the Medicaid Interactive Voice Response System (IVRS) at (888) 809-3040 or use the South Carolina Medicaid Web-based Claims Submission Tool.

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PROCUREMENT OF FORMS

The Department of Health and Human Services will not supply the CMS-1500 claim form (12/90 version) to providers. Providers should purchase the form in its approved format from the private vendor of their choice. Examples of vendors who supply the form are listed below. This list should not be viewed as an endorsement of these vendors by DHHS.

REPRODUCIBLE NEGATIVES

Government Printing Office
Room C-836
Building Three
Washington, DC 20401
(202) 275-1189

SOFTWARE

Attn: Orders Department
American Medical Association
Post Office Box 10946
Chicago, IL 60610

HARD COPY CLAIM FORMS

Government Printing Office
Superintendent of Documents
Post Office Box 371954
Pittsburgh, PA 15250-7954
(202) 512-1800
FAX: (202) 512-2250

PRIVATE VENDORS

Wallace Computer Service
2008 Marion Street, Suite A
Columbia, SC 29201
(803) 252-0614

Physicians' Record Company
3000 S. Ridgeland Avenue
Berwyn, IL 60402-0724
(800) 323-9268 (toll free)

Standard Register Company
140 Stoneridge Drive, Suite 300
Columbia, SC 29210
(803) 256-0004

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PROCUREMENT OF FORMS

PRIVATE VENDORS (CONT'D.)

Duplex Products
Post Office Box 546
Columbia, SC 29202-0546
(803) 256-7692

FAX REQUESTS

A provider may request the following forms via fax number (803) 898-4528:

1. Confidential Medicaid Complaint (Form 126)
2. Medicaid Provider Inquiry (Form 140)
3. Request for Medicaid Forms (142)
4. Medicaid Refund Check Remittance (Form 205)

WEB ADDRESS

This manual is available on the DHHS Web site at **www.dhhs.state.sc.us**. Requests for copies on paper or disk should be sent to:

Department of Health and Human Services
ATTN: Division of Hospice Services
Post Office Box 8206
Columbia, SC 29202

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
Abbeville County	(864) 366-5638	Medicaid Eligibility Abbeville County DSS Human Services Building 903 W. Greenwood St. Abbeville, SC 29620
Aiken County	(803) 643-1938	Medicaid Eligibility Aiken County DSS County Commissioner's Building 1410 Park Ave. S.E. Aiken, SC 29801
Allendale County	(803) 584-8137	Medicaid Eligibility Allendale County DHHS 611 Mulberry St. Allendale, SC 29810
Anderson County	(864) 260-4541	Medicaid Eligibility Anderson County DHHS 224 McGee Road Anderson, SC 29625
Bamberg County	(803) 245-4361	Medicaid Eligibility Bamberg County DHHS 374 Log Branch Road Bamberg, SC 29003
Barnwell County	(803) 541-1200	Medicaid Eligibility Barnwell County DSS T. Ed Richardson Building 10913 Ellenton St. Barnwell, SC 29812

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
Beaufort County	(843) 470-4625	Medicaid Eligibility Beaufort County DHHS 1905 Duke St. Beaufort, SC 29902
Berkeley County	(843) 719-1131	Medicaid Eligibility Berkeley County DSS 2 Belt Drive Moncks Corner, SC 29461
Calhoun County	(803) 874-3384	Medicaid Eligibility Calhoun County DHHS 2831 Old Belleville Road St. Matthews, SC 29135
Charleston County	(843) 792-0444	Medicaid Eligibility Charleston County DSS 326 Calhoun St. Charleston, SC 29403
Cherokee County	(864) 487-2521	Medicaid Eligibility Cherokee County DHHS 1434 N. Limestone St. Gaffney, SC 29340 Post Office Box 89 Gaffney, SC 29343
Chester County	(803) 377-8131	Medicaid Eligibility Chester County DHHS 115 Reedy St. Post Office Box 447 Chester, SC 29706
Chesterfield County	(843) 623-5226	Medicaid Eligibility Chesterfield County DHHS 202 N. Page St. Chesterfield, SC 29709
Clarendon County	(803) 435-4305	Medicaid Eligibility Clarendon County DSS 3 S. Church St. Manning, SC 29102

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
Colleton County	(843) 549-1894	Medicaid Eligibility Colleton County DSS Bernard Warshaw Building 215 S. Lemacks St. Walterboro, SC 29488
Darlington County	(843) 398-4420	Medicaid Eligibility Darlington County DHHS 300 Russell St., Room 145 Darlington, SC 29540-2077
	(843) 332-2289	404 S. Fourth St., Suite 300 Hartsville, SC 29550
Dillon County	(843) 774-2713	Medicaid Eligibility Dillon County DHHS 1213 Highway 34 W. Dillon, SC 29536
Dorchester County	(843) 563-9524	Medicaid Eligibility Dorchester County DSS 201 Johnson St., Bldg 17 Post Office Box 56 St. George, SC 29477
Edgefield County	(803) 637-4040	Medicaid Eligibility Edgefield County DSS 500 W. A. Reel Drive Edgefield, SC 29824
Fairfield County	(803) 635-5502 Ext. 425	Medicaid Eligibility Fairfield County DHHS 1136 Kincaid Bridge Road Post Office Box 1139 Winnsboro, SC 29180
Florence County	(843) 669-3354	Medicaid Eligibility Florence County DHHS 2685 S. Irby St., Box 1 Florence, SC 29505

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
Georgetown County	(843) 546-5134	Medicaid Eligibility Georgetown County DSS 330 Dozier St. Georgetown, SC 29440
Greenville County	(864) 467-7926	Medicaid Eligibility Greenville County DSS County Square 301 University Ridge, Suite 6700 Greenville, SC 29603
Greenwood County	(864) 229-5258	Medicaid Eligibility Greenwood County DSS 1118 Phoenix St. Greenwood, SC 29648
Hampton County	(803) 914-0053	Medicaid Eligibility Hampton County DHHS 102 Ginn Altman Ave. Hampton, SC 29924
Horry County	(843) 381-8260	Medicaid Eligibility Horry County DHHS 1601 11th Ave., 2nd Floor Conway, SC 29526
Jasper County	(843) 726-7747	Medicaid Eligibility Jasper County DSS 204 N. Jacob Smart Blvd. Ridgeland, SC 29936
Kershaw County	(803) 432-7676 Ext. 106	Medicaid Eligibility Kershaw County DHHS 110 E. DeKalb St. Camden, SC 29020
Lancaster County	(803) 286-8208	Medicaid Eligibility Lancaster County DHHS 200 E. Dunlap St. Post Office Box 2169 Lancaster, SC 29720

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
Laurens County	(864) 833-0100	Medicaid Eligibility Laurens County DSS Human Services Complex Industrial Park Road Laurens, SC 29361
Lee County	(803) 484-5376	Medicaid Eligibility Lee County DSS County Welfare Building 820 Brown St. Bishopville, SC 29010
Lexington County	(803) 957-2975 (803) 957-2991	Medicaid Eligibility Lexington County DHHS Social Services Center 541 Gibson Road Lexington, SC 29072
McCormick County	(864) 465-2627	Medicaid Eligibility McCormick County DSS 215 N. Mine St. Highway 28 N. McCormick, SC 29835
Marion County	(843) 423-5417	Medicaid Eligibility Marion County DHHS 200 Airport Court Mullins, SC 29574
Marlboro County	(843) 479-4389	Medicaid Eligibility Marlboro County DSS County Complex Ag St. Bennettsville, SC 29512
Newberry County	(803) 321-1255	Medicaid Eligibility Newberry County DSS County Human Services Center 2107 Wilson Road Newberry, SC 29108

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
Oconee County	(864) 638-4400	Medicaid Eligibility Oconee County DHHS 100 Brown Square Drive Post Office Box 979 Walhalla, SC 29691
Orangeburg County	(803) 531-3101	Medicaid Eligibility Orangeburg County DSS 2570 Old St. Matthews Road, N.E. Orangeburg, SC 29116
Pickens County	(864) 898-5815	Medicaid Eligibility Pickens County DHHS Social Services Building 212 McDaniel Ave. Post Office Box 160 Pickens, SC 29671
Richland County	(803) 714-7562 (803) 714-7549	Medicaid Eligibility Richland County DHHS 3220 Two Notch Road Columbia, SC 29204
Saluda County	(843) 445-2139	Medicaid Eligibility Saluda County DSS Highway 121 N. Saluda, SC 29138
Spartanburg County	(864) 596-2714	Medicaid Eligibility Spartanburg County DHHS Pinewood Shopping Center 1000 N. Pine St., Suite 23 Spartanburg, SC 29303 Post Office Box 4847 Spartanburg, SC 29305
Sumter County	(803) 773-5531	Medicaid Eligibility Sumter County DSS 105 N. Magnolia St., 4th Floor Sumter, SC 29151

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
Union County	(843) 429-1660	Medicaid Eligibility Union County DHHS 200 S. Mountain St. Post Office Box 1068 Union, SC 29379
Williamsburg County	(843) 355-5411	Medicaid Eligibility Williamsburg County DSS 831 Eastland Ave. Kingstree, SC 29556
York County	(803) 327-9061	Medicaid Eligibility York County DHHS 1890 Neely's Creek Road Rock Hill, SC 29730 Post Office Box 710 Rock Hill, SC 29731

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

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EXHIBITS

Form Number	Exhibit	Revision Date
151	Medicaid Hospice Physician Certification/ Recertification	10/1995
152	Medicaid Hospice Provider Change Request Form	10/1995
149	Medicaid Hospice Election Form	10/1995
153	Medicaid Hospice Revocation Form	10/1995
154	Medicaid Hospice Discharge Form	10/1995
154 (reverse side)	Procedures For Appeals	10/1995
CMS-1500	Health Insurance Claim Form	12/1990
DHHS 130	Claim Adjustment Form	11/2004
205	Medicaid Refunds (two pages)	03/2000
126	Confidential Complaint	12/2004
	Health Insurance Information Referral Form	02/2003
	Reasonable Effort Documentation	
140	Medicaid Provider Inquiry	11/1987
142	Request for Medicaid Forms and Publications	05/1997
	Authorization Agreement for Electronic Funds Transfer	11/2004
	Sample Edit Correction Form	
	Sample Remittance Advice (three pages)	

MEDICAID HOSPICE PHYSICIAN CERTIFICATION / RECERTIFICATION

RECIPIENT INFORMATION:

NAME LAST FIRST			MEDICAID ID NUMBER
CURRENT MAILING ADDRESS STREET			SOCIAL SECURITY NUMBER
CITY	STATE	ZIP CODE	MEDICARE NUMBER
HOME PHONE NUMBER (INCLUDE AREA CODE)			BIRTH DATE
NAME OF PARENT, LEGAL GUARDIAN OR REPRESENTATIVE			ICD-9 NUMBER INDICATING THE PRIMARY HOSPICE DIAGNOSIS

CERTIFICATIONS AND SIGNATURES: TO BE COMPLETED BY ATTENDING PHYSICIAN / MEDICAL DIRECTOR

PHYSICIANS, PLEASE SIGN AND DATE TO INDICATE CERTIFICATION.

FIRST BENEFIT PERIOD (90 DAYS):

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal course.

SIGNATURE OF ATTENDING PHYSICIAN	CERTIFICATION DATE
SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE

SECOND BENEFIT PERIOD (90 DAYS):

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal course.

SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE

BENEFIT PERIOD (60 DAYS):

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal course.

SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE

BENEFIT PERIOD (60 DAYS):

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal course.

SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE

BENEFIT PERIOD (60 DAYS):

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal course.

SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE

DHHS FORM 151 (10/96) (REVISED 07/98) Forward a copy of this form and a copy of the plan of care within ten (10) working days of the beginning of each benefit period to the SCDHHS Medicaid Hospice Program. Failure to submit this form within the given time frame may result in delay or loss of payment for hospice services.

MEDICAID HOSPICE PROVIDER CHANGE REQUEST FORM

EFFECTIVE DATE OF REVOCATION: _ _ _ _ _ _ _ _ _ _

APPLICABLE BENEFIT PERIOD:

_____FIRST 90 DAYS _____ SECOND 90 DAYS _____ ( ) PERIOD OF 60 DAYS

RECIPIENT INFORMATION:

NAME LAST	FIRST	SOCIAL SECURITY NUMBER
MEDICAID ID NUMBER		MEDICARE NUMBER

SENDING PROVIDER INFORMATION: The above named recipient requests that the designation of their selected hospice be changed from:

NAME OF HOSPICE	MEDICAID PROVIDER NUMBER HSP
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE	HOSPICE PHONE NUMBER

The sending hospice must complete the above section. A copy of this form must be sent to the SCDHHS Medicaid Hospice Program within five (5) days of the effective date and be forwarded to the receiving hospice with two (2) days of the effective date.

RECEIVING PROVIDER INFORMATION: The above named recipient requests that the designation of their selected hospice be changed to:

NAME OF HOSPICE	MEDICAID PROVIDER NUMBER HSP
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE	HOSPICE PHONE NUMBER

The receiving hospice must forward a completed copy to the SCDHHS Medicaid Hospice Program within five (5) working days of the effective date.

SIGNATURES:

As a recipient of hospice services, I understand that I may change hospice providers only ONCE during each hospice benefit period. I also understand that this request for a change of hospice provider is not a revocation of the remainder of my current election benefit period.

SIGNATURE OF RECIPIENT OR RECIPIENT REPRESENTATIVE	DATE OF SIGNATURE
SIGNATURE OF WITNESS	DATE OF SIGNATURE

DHHS FORM 152 (10/95) (REVISED 07/98) Each hospice must maintain a copy of this Provider Change Request Form. It is the responsibility of the receiving hospice to forward a completed copy to the SCDHHS Medicaid Hospice Program within five (5) days of the effective date of the change.

MEDICAID HOSPICE ELECTION FORM

EFFECTIVE DATE: ** INCOMPLETE FORMS CANNOT BE PROCESSED BY SCDHHS **

RECIPIENT INFORMATION:

NAME LAST FIRST			MEDICAID ID NUMBER
CURRENT MAILING ADDRESS STREET			SOCIAL SECURITY NUMBER
CITY	STATE	ZIP CODE	MEDICARE NUMBER

HOME PHONE NUMBER	BIRTH DATE	ICD-9 NUMBER INDICATING THE PRIMARY HOSPICE DIAGNOSIS:

NAME OF FACILITY OF RESIDENCE, IF APPLICABLE:

NAME OF PARENT, LEGAL GUARDIAN OR REPRESENTATIVE	SEX: M / F

HOSPICE PROVIDER INFORMATION:

NAME	MEDICAID PROVIDER NUMBER: HSP _ _ _
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE	HOSPICE PHONE NUMBER
ATTENDING PHYSICIAN'S NAME	PHYSICIAN'S MEDICAID PROVIDER NUMBER

HOSPICE BENEFIT INFORMATION:

APPLICABLE BENEFIT PERIOD:

FIRST 90 DAYS SECOND 90 DAYS ( ) PERIOD OF 60 DAYS

ELECTION STATEMENT

* The South Carolina Medicaid Hospice Benefit program has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitations of this program and the terms of the election statement.

* I understand that by signing the election statement I am waiving all rights to regular Medicaid services except for payment to my attending physician, treatment for medical conditions unrelated to my terminal illness, medical transportation, dental services and Medicaid pharmacy services for prescriptions not covered under hospice.

* I understand that I will be entitled to Medicaid sponsored hospice services as long as I am Medicaid eligible. These services are provided in benefit periods of an initial 90 day period, a subsequent 90 day period and unlimited subsequent 60 day periods.

* I understand that I may revoke the hospice benefit at any time by completing the appropriate form, specifying the date when the revocation is to be effective and submitting the statement to the hospice prior to that date, however, that if I choose to revoke hospice services during a benefit period, I am not entitled to coverage for the remaining days of that benefit period. At the same time I revoke hospice services, I understand my rights to other Medicaid services will resume, provided I continue to be Medicaid eligible.

* I understand that I may change the designated hospice provider, one time during a benefit period, without affecting the provision of my hospice benefits. To change the designation of hospice programs, I must disenroll with the hospice from which care has been received and elect a new hospice provider.

* I understand that if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefits.

* I understand that if I elected the Medicare Hospice Benefit and am eligible for Medicaid, I must also elect the Medicaid Hospice Benefit.

SIGNATURES:

RECIPIENT OR RECIPIENT REPRESENTATIVE SIGNATURE / DATE	WITNESS SIGNATURE / DATE

DHHS FORM 149 (10/95) (REVISED 09/96, 07/98) This form must be forwarded to the SCDHHS Medicaid Hospice Programs within ten (10) days of election of benefits. Failure to submit his form within that time frame will result in a change of the election date to the date this form is received by SCDHHS.

MEDICAID HOSPICE REVOCATION FORM

EFFECTIVE DATE OF REVOCATION: _ _ _ _ _ _ _ _ _ _

APPLICABLE BENEFIT PERIOD:

FIRST 90 DAYS SECOND 90 DAYS ( ) PERIOD OF 60 DAYS

RECIPIENT INFORMATION:

NAME LAST	FIRST	SOCIAL SECURITY NUMBER

MEDICAID ID NUMBER		MEDICARE NUMBER

PROVIDER INFORMATION:

NAME OF HOSPICE	MEDICAID PROVIDER NUMBER HSP

SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE	HOSPICE PHONE NUMBER

REVOCATION STATEMENT:

* The South Carolina Medicaid Hospice Services Program has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitations of the program and the terms of the revocation of these services.

* I understand that by signing the revocation statement that, if eligible, I will resume Medicaid coverage of benefits waived when hospice care was elected.

* I will forfeit all hospice coverage days remaining in this benefit period.

* I may at any time elect to receive hospice coverage for any other hospice benefit period for which I am eligible.

SIGNATURE OF RECIPIENT OR RECIPIENT REPRESENTATIVE	DATE OF SIGNATURE

DHHS FORM 153 (10/95) (REVISED 07/98) This form must be forwarded to the SCDHHS Medicaid Hospice Program within five (5) working days of the effective date of the revocation.

MEDICAID HOSPICE DISCHARGE FORM

RECIPIENT INFORMATION:

NAME LAST	FIRST	SOCIAL SECURITY NUMBER

MEDICAID ID NUMBER		MEDICARE NUMBER

PROVIDER INFORMATION:

NAME OF HOSPICE	MEDICAID PROVIDER NUMBER HSP
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE	HOSPICE PHONE NUMBER

DISCHARGE STATEMENT:

Hospice benefits for the above named recipient, enrolled with this agency since _____ terminated _____ for the following reason: (check all that apply)

_____ Recipient is deceased. Date of death is __ / __ / ____.

_____ Prognosis is now more than six (6) months.

_____ Recipient moved out of state / service area.

_____ Safety of recipient or hospice staff is compromised. (Explanation must appear below)

_____ Recipient is non-compliant. (Explanation must appear below and documentation of efforts to counsel the recipient must be attached)

EXPLANATION:

When a Medicaid recipient is discharged from a hospice program for one of the reasons listed above, the recipient has the right to a fair hearing regarding the decision. Procedures regarding that appeal are found on the reverse side of this page. The signature below indicates that the recipient was given this statement for his/her records/use.

SIGNATURE OF AUTHORIZED HOSPICE REPRESENTATIVE	DATE OF SIGNATURE

DHHS FORM 154 (10/95) (REVISED 07/98) This form must be forwarded to the SCDHHS Medicaid Hospice Program within five (5) working days of the effective date of the discharge.

PROCEDURES FOR APPEALS

When a Medicaid recipient is discharged from a hospice program for one of the reasons listed on the reverse side of this page, the recipient has the right to a fair hearing regarding the decision.

The recipient or his representative has the right to appeal the hospice discharge within thirty (30) days of the receipt of the MEDICAID HOSPICE DISCHARGE STATEMENT, DHHS FORM 154 by submitting a written request to the following address:

Director, Division of Appeals and Fair Hearings
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

A copy of the MEDICAID HOSPICE DISCHARGE STATEMENT, DHHS FORM 154 must accompany the request and the request must state with specificity which issues are being appealed.

A request for a fair hearing is considered filed if postmarked by the thirtieth (30^{th}) calendar day following receipt of the MEDICAID HOSPICE DISCHARGE STATEMENT, DHHS FORM 154. Both the Medicaid recipient and the provider will be notified of the date, time and place the fair hearing will take place.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 0100123401

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Maney, William G.

3. PATIENT'S BIRTH DATE MM DD YY: 01 31 47 SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 1000 Main Street

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

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

CITY: Columbia | STATE: SC

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

CITY | STATE

ZIP CODE: 29205 | 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: 123456789A

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. [illegible]'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME: 0.00

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: 618

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 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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 31 03	10 31 03	12		S9126			$ 100.00					
2 10 31 03	10 31 03	12		A9900			$ 25.00					
3 11 13 03	11 13 03	12		S9126			$ 100.00					
4 11 13 03	11 13 03	12		T1021			$ 50.00					
5 11 13 03	11 13 03	12		A9900			$ 25.00					
6												

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 $ $ 300.00

29. AMOUNT PAID $ $ 0 00

30. BALANCE DUE $ $ 300.00

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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

ABC Hospice, Inc.
100 Memorial Drive
Columbia, SC 29201

PIN# 0001HH GRP#

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:

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: 11-15-2004

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 - 6 must be completed. ***Attach appropriate document(s) as listed in item 7.***

1. Provider Name: _____ **2. Medicaid Provider #** ☐☐☐☐☐☐
(Six Digits)

3. Person to Contact: _____ **4. Telephone Number:** _____

5. 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:

_____
_____
_____
_____
_____

6. Patient/Service Identification:

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

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)

DHHS Form 205 (3/00) (92 edition obsolete)

Instructions
Form for Medicaid Refunds

Make all checks payable to: **South Carolina Department of Health and Human Services**

Mail all checks to:

Reporting and Receivables Division
South Carolina Department of Health and Human Services
Post Office Box 8355
Columbia, South Carolina 29202-8355

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.

Item 1 – Provider Name. Self explanatory.

Item 2 – Medicaid Provider Number. Enter the six – digit provider number under which payment was made. This number appears in the upper left – hand corner of the Medicaid remittance advice.

Item 3 – Person to contact. Self – explanatory.

Item 4 – Telephone Number. Self – explanatory.

Item 5 – Reason for refund. Check one of the four boxes shown. If box one "Other Insurance Paid" is checked, items a – f must be completed.

Item 6 – Patient/Service Identification. Self – explanatory.

Item 7 – Attachments. Submit attachment(s) with this form.

Please complete Items 1 – 6. Attach appropriate document(s) as listed in Item 7.

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:	
MEDICAID PROVIDER ENROLLMENT NUMBER: (if applicable)	MEDICAID RECIPIENT I.D. 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 12/04)

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: _____ Provider ID# _____

Contact Person: _____ Phone #: _____

March 2004

REASONABLE EFFORT DOCUMENTATION

HOSPITAL _____ **DOS** _____

MEDICAID BENEFICIARY NAME _____

MEDICAID ID# _____

INSURANCE COMPANY NAME _____

POLICY HOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP CALL _____

RESULT OF CALL:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP CALL _____

RESULT OF CALL:

THE ABOVE EFFORTS WERE TAKEN AND NO REPLY WAS RECEIVED FROM THE INSURANCE COMPANY.

_____

(SIGNATURE AND DATE)

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

STATE OF SOUTH CAROLINA HEALTH AND HUMAN SERVICES	MEDICAID PROVIDER INQUIRY
MAIL TO: ATTENTION _____ UNIT SC DEPT OF HEALTH AND HUMAN SERVICES POST OFFICE BOX 8206 COLUMBIA, SOUTH CAROLINA 29202-8206	TODAY'S DATE PROVIDER NUMBER, SIX DIGITS – INCLUDE GROUP NBR, IF ANY TELEPHONE
PROVIDER NAME AND ADDRESS	TYPE OF PROVIDER I.E. DENTIST – GP, 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 (NOV. 87) Replaces Form 1735 (Feb. 81) which obselete.

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR MEDICAID FORMS AND PUBLICATIONS

PART I *(FOR ALL ITEMS EXCEPT PHARMACY SERVICES CLAIM FORM)*

WHEN COMPLETED PLEASE FORWARD TO:
SC Department of Health and Human Services
Supply
Post Office Box 8206
- or- Columbia, South Carolina 29202-8206
FAX TO: (803) 253-4027

MEDICAID NO:

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

DHHS FORM 142 (5/97)

PART II *(TO BE COMPLETED WHEN ORDERING PHARMACY SERVICES CLAIM FORMS)*

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR STATEMENT OF PHARMACY SERVICES

DHHS FORM 3211 (11/96)

WHEN COMPLETED PLEASE FORWARD OR FAX:
- **REQUEST FOR PREPRINTED FORMS TO YOUR PROVIDER REPRESENTATIVE; OR**
- **REQUEST FOR BLANK FORMS 3211 TO SUPPLY**

MEDICAID NO:

TELEPHONE: - -

CONTACT NAME:

NAME OF PROVIDER

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

QUANTITY REQUESTED

PREPRINTED WITH NAME, ADDRESS AND PROVIDER NUMBER [ ] YES [ ] NO

DHHS FORM 142 (5/97)

South Carolina
Department of Health and Human Services
Authorization Agreement For Electronic Funds Transfer

Provider Name: _____

Medicaid Provider Type: _____ **Medicaid Provider 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:** _____

ATTACH VOIDED CHECK OR DEPOSIT SLIP

RETURN TO:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID PROVIDER ENROLLMENT
P.O. BOX 8809
COLUMBIA, S.C. 29202-8809
FAX: (803) 699-8637

Revised 11/04

RUN DATE 01/31/2004 0000 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #0401000123810220A
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 37267 ECF 37249 PAGE 1 OF 1
ANALYST ID HIC - 60 PRAC SPEC - 12 EMC Y
SIGNON ID CLAIM RESTART DATE / / DOC IND N

1 PROVIDER ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 ---- DIAGNOSIS ---- PRIMARY	SECONDARY
HSP111	0123456789						569.81	.

10 RECIPIENT NAME - G J MANEY 11 DATE OF BIRTH 01/31/1947 12 SEX M

13 RES	14 ALLOWED	LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD MD2 MD3 MD4	19 INDIVIDUAL PROVIDER	20 CHARGE IND	21 PAY	22 UNITS
	.00	1	01/02/04	12	S9126	000	HHA000	100.00		1.000
	.00	2	/ /							
	.00	3	/ /							
		4	/ /							
		5	/ /							
		6	/ /							
		7	/ /							
		8	/ /							

EDITS

INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 892
02)
03)

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

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
!  CLAIMS/LINE PAYMENT INFO  !
!                            !
!  EDIT        PAYMENT DATE  !
! 01-892         01/16/04    !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
```

23 INS CARR NUMBER	24 POLICY NUMBER	25 INS CARR PAID
01		
02		

26 TOTAL CHARGE 100.00
27 AMT REC'D INS
28 BALANCE DUE 100.00
29 OWN REF # 012345

RESOLUTION DECISION ___

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

INSURANCE POLICY INFORMATION

PROVIDER:
ABC HOSPICE CARE
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.

```
# HSP111 ABC HOSPICE CARE                                   PO BOX 000000          FLORENCE          SC000000000
 .121212121234.                  Y
  PROVIDER ID.                                          PROFESSIONAL SERVICES          PAYMENT DATE                 PAGE
+--------------+  DEPT OF HEALTH AND HUMAN SERVICES                                    +------------+                +----+
| AB0008       |                                            REMITTANCE ADVICE         | 03/26/2004 |                |  1 |
+--------------+   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		021504	S9126	800.00	117.71	P						0.00
	02		021504	S9126	392.00	126.00	P						0.00
	VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0406001089000400U				1412.00-	273.71-		1112233333	M CLARK				
	01		012104	S9126	1112.00-	143.71-							
	02		012104	S9126	300.00-	130.00-							
	REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0407701389002500A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		012104	S9126	142.50	42.75	P						0.00
	02		012104	S9126	859.00	0.00	R						0.00
	TOTALS		2		2193.50	286.46						0.00	0.00

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

Sample Remittance Advice (page 2)

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

PROVIDER ID. HSP111

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE 03/26/2004

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	M O D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	0406001089000400U				513.00-	197.71-	1	1112233333	CLARK		M		022804	0404711253670430A
	01		012104	S9126	453.00	160.71-	P							
	02		012104	S9126	60.00	33.00-	P							
	TOTALS	1			513.00-	193.71-								

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

ABC HOSPICE CARE
PO BOX 000000
FLORENCE SC 00000

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. HSP111

DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE 03/26/2004

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

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

	ADJUSTMENTS	MAXIMUS AMT
	0.00	0.00

YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER
5293.45	0.00	

PROVIDER NAME AND ADDRESS

ABC HOSPICE CARE
PO BOX 000000
FLORENCE SC 00000