SECTION 5
ADMINISTRATIVE SERVICES

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SECTION 5 ADMINISTRATIVE SERVICES

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 and addresses for county DHHS offices.

CORRESPONDENCE AND INQUIRIES

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

Department of Health and Human Services
Local Education Agency
Post Office Box 8206
Columbia, SC 29202-8206
(803) 898-2590

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 beneficiary's Medicaid number and the date of service when requesting the status of outstanding claims. **Allow 45 days from the submission date before requesting the status of the claim.**

Questions concerning beneficiary eligibility or identification numbers should be directed to the 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.

SECTION 5 ADMINISTRATIVE SERVICES

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SECTION 5 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

The Department of Health and Human Services will not supply the CMS-1500 claim form (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 Ave.
Berwyn, IL 60402-0724
(800) 323-9268 (toll free)

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

SECTION 5 ADMINISTRATIVE SERVICES

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

The most current version of this manual is available on the DHHS Web site at **www.dhhs.state.sc.us**.

To order a paper or CD version of this manual, please contact South Carolina Medicaid Provider Outreach at (803) 264-9609. Charges for printed manuals are based on actual costs of printing and mailing.

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
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

SECTION 5 ADMINISTRATIVE SERVICES

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

SECTION 5 ADMINISTRATIVE SERVICES

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

SECTION 5 ADMINISTRATIVE SERVICES

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

SECTION 5 ADMINISTRATIVE SERVICES

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

SECTION 5 ADMINISTRATIVE SERVICES

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	(864) 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

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
Union County	(864) 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

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

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SECTION 5 ADMINISTRATIVE SERVICES

EXHIBITS

Form Number	Exhibit	Revision Date
	Medical Necessity Statement for Children's Behavioral Health Services	
254	Referral Form/Authorization for Services for Children's Behavioral Health Services (two pages)	02/2005
	Medical Necessity Statement for Therapeutic Behavioral Services	
560	Assessment for Therapeutic Behavioral Services (two pages)	02/2005
561	Weekly Progress Summary Notes for Therapeutic Behavioral Services	02/2005
562	Individual Treatment Plan for Therapeutic Behavioral Services	02/2005
	Consumer Satisfaction Survey	
CMS-1500	Health Insurance Claim Form	12/1990
130	Claim Adjustment Form	11/2004
205	Medicaid Refunds (two pages)	03/2000
126	Confidential Complaint	12/2004
	Health Insurance Information Referral Form	03/2004
	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)	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL NECESSITY STATEMENT
FOR
CHILDREN'S BEHAVIORAL HEALTH SERVICES

Child's Name:_____ Social Security Number:_____

Date of Birth:_____ Medicaid Number:_____

Based on professional staffing recommendations, review of treatment history and/or personal observation or evaluation, I recommend that the above-named Medicaid recipient receive _____

_____
(Specific Rehabilitative Service)

for maximum reduction of physical or mental disability and restoration of the recipient to his/her highest level of functioning. This recipient meets the medical necessity criteria for this level of care.

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

_____ _____
(Please print name signed above) (Phone Number)

Date of Signature: _____ (Services must be initiated within 90 days)

Diagnosis and Diagnosis Code: _____

In the absence of a full clinical assessment and evaluation, use of a V-Code may be appropriate. A more thorough diagnosis and the corresponding diagnosis code should replace the V-Code when available.

V61.20	Parent-child relational problem	V62.81	Interpersonal problems, not elsewhere classified
V61.21	Neglect/Abuse of Child	V62.82	Bereavement
V61.9	Relational Problem Related to a Mental Disorder	V71.02	Child or Adolescent Antisocial Behavior

Child's identified problems areas or needs. These may be based on professional staffing recommendations, review of treatment history and/or personal observation or evaluation.

_____

_____

_____

_____

_____

_____

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
REFERRAL FORM/AUTHORIZATION FOR SERVICES (Form 254)
CHILDREN'S BEHAVIORAL HEALTH SERVICES

FORM 254

PROVIDER'S MEDICAID I. D. #

CHILD'S MEDICAID I. D. #

REFERRED TO: _____

_____

_____

AUTHORIZATION DATE: / /

EXPIRATION DATE: / /

Name	County	Address

Date of Birth / /	Sex	Agency Reference No.	City	State	Zip

Prior Authorization Number	Parent/Guardian

Services are authorized for the period from the Authorization Date through the Expiration Date as noted above. The authorization period is subject to change pending notification by the Authorizing Agency or by the Department of Health and Human Services.

- ☐ PSYCHIATRIC HOSPITAL
- ☐ RESIDENTIAL TREATMENT FACILITY
- ☐ THERAPEUTIC BEHAVIORAL SERVICES (Formerly High Management Rehabilitative Services) (H2020)
- ☐ THERAPEUTIC BEHAVIORAL SERVICES (Formerly Moderate Management Rehabilitative Services) (H2020)
- ☐ THERAPEUTIC FOSTER CARE
  - ☐ LEVEL I (S5145) ☐ LEVEL II (S5145) ☐ LEVEL III (S5145)
- ☐ COMPREHENSIVE COMMUNITY SUPPORT (Formerly Intensive Family Services) (H0046)
- ☐ PSYCHOSOCIAL REHABILITATIVE SERVICES (Formerly Clinical Day Programming) (H2018)
- ☐ THERAPEUTIC BEHAVIORAL SERVICES (Formerly Therapeutic Child Treatment) (H2019 & H2020)
- ☐ THERAPEUTIC BEHAVIORAL SERVICES (Formerly Supervised Independent Living) (H2020)
- ☐ SEXUAL OFFENDERS TREATMENT SERVICES (Formerly Specialized Treatment Services For Sexual Offenders) (H2029)

Agency Representative:_____ Title: _____

Signature: _____ Phone: _____

Authorizing Agency: (one must be checked)

- ☐ Department of Social Services
- ☐ Continuum of Care for Emotionally Disturbed Children
- ☐ United Way
- ☐ Department of Mental Health
- ☐ Department of Disabilities and Special Needs
- ☐ Department of Juvenile Justice
- ☐ School District/ Department of Education

AGENCY USE ONLY

DHHS Form 254 (Revised 02/2005) White – Provider Green – State Office Canary – Local Office

INSTRUCTIONS FOR COMPLETING REFERRAL FORM 254

(Items of information not listed are self-explanatory)

Please Print Clearly)

PROVIDER'S MEDICAID I.D.#: Enter the Provider's 6-digit Medicaid identification number.

CHILD'S MEDICAID I.D.#: Enter the recipient's complete 10-digit Medicaid identification number.

REFERRED TO: Enter the name and address of the facility/program to which the recipient is being referred.

AUTHORIZATION DATE: Enter the date the authorized period begins.

EXPIRATION DATE: Enter the date the authorized period ends. (The date range must not crossover into the following state fiscal year. If the Medicaid recipient is to continue in the facility/program past June 30th, a new referral form must be completed).

NAME, ADDRESS, ETC.: Enter recipient's current information.

AGENCY REFERENCE NO.: Enter up to nine (9) numeric and/or alpha characters, which will assist your agency with identification of the recipient. (optional)

PRIOR AUTHORIZATION NO.: Enter the agency assigned number (alpha and numeric) specific to this recipient and this referral form. The first two (2) characters must reflect the agency origin (DSS - SS; DOE - ED; COC - CC; DJJ - YS; DDSN - MR; DMH - MH; United Way - UW). The remaining five (5) characters are left up to the Authorizing Agency, unless otherwise instructed.

AUTHORIZED SERVICES: Indicate the type(s) of service(s) that the designated provider is authorized to render by checking the applicable box(es). **NOTE:** When applicable, be sure to specify the appropriate level of care. Also, if entering the authorized service on the blank line, be specific in the type of service and include the five (5) digit procedure code in the space provided.

AGENCY REPRESENTATIVE: Enter the name of the Authorized Agency Representative, generally the on completing the form.

TITLE: Enter the Authorized Agency Representative's title.

SIGNATURE: In order to be valid, this form must be signed by the Authorized Agency Representative.

PHONE: Enter the Authorized Agency Representative's telephone number.

AUTHORIZING AGENCY: The appropriate box must be checked.

AGENCY USE ONLY: This box is for use, if needed, by the Referring Agency only.

When the form is complete, mail appropriate copies to the designated locations listed on the bottom of the form. If any required information is left off or incorrect, the Authorized Agency Representative will be notified and asked to correct or complete a new form.

S. C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL NECESSITY STATEMENT
FOR
THERAPEUTIC BEHAVIORAL SERVICES

Beneficiary's Name: _____

Beneficiary's Date of Birth: ____ / ____ / _____

Beneficiary's Social Security Number: ____ / ____ / _____

Beneficiary's Medicaid Number: _____

Diagnosis Code: _____

I recommend that the above named Medicaid beneficiary receive Therapeutic Behavioral Services for maximum reduction of physical or mental disability and restoration of the beneficiary to his/her best possible functional level. The beneficiary meets the medical necessity criteria for this service as evidenced by:

1. The attached developmental and emotional screening tool used. (Must be comparable to the Denver Developmental Screening Test II as used in Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings), and

2. Meeting one of the following criteria: (circle the appropriate criteria(s))

   2.1 Not able to attend regular child care due to substantiated developmental or behavioral problems,

   2.2 Children with substantiated cases of abuse/neglect with behavior problems, or

   2.3 Children who are in imminent danger of being removed from the home and display substantiated developmental or behavioral problems.

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

Date of Signature: ___/___/_____ (Service must be initiated within 90 days)

Therapeutic Behavioral Services
(formerly Therapeutic Child Treatment)
Assessment

Attachment H

Client: Birth Date: / /

DATES
Admission: / / Plan: / /

Participants	Initial Goals / Desired Outcomes	Strengths	Barriers
Primary Caregiver			
Secondary Caregiver			
Other Family			
TBS Child			
School / Day Care			
Neighborhood/Community			

_____ _____ _____ _____
Primary Caregiver Signature Date Lead Clinical Staff (LCS) Signature Date

_____ _____ _____ _____
Other Caregiver Signature Date Supervising LCS Signature Date

Genogram	Presenting Problem and the Impacting Issues

Therapeutic Behavioral Services Assessment

Client:

DHHS Form 560 (02/2005 Version)

Primary Caregiver Signature	Date	Lead Clinical Staff (LCS) Signature	Date
Other Caregiver Signature	Date	Supervising LCS Signature	Date

Therapeutic Behavioral Services

(formerly Therapeutic Child Treatment)

WEEKLY PROGRESS SUMMARY NOTES

Client:
Birth Date: / /

	Mon	Tue	Wed	Thu	Fri
Date					
Number of Units					

Page 1 Attachment DHHS Form 561

Short Term Goals addressed this week (These should complement the Overarching and Short Term Goals listed in the child's ITP)	**Intervention(s) used to address Short Term Goals**	**Barriers to Short Term Goals**	**Advancement in Treatment**	**Changes in Assessment**	**Short Term Goals for Next Week**

Non-LCS Signature (When Required) _____ Date _____

Lead Clinical Staff (LCS) Signature_____ Date _____

Supervising LCS Signature:_____Date _____

Therapeutic Behavioral Services

(formerly Therapeutic Child Treatment)

INDIVIDUAL TREATMENT PLAN

Attachment G

Client:

Birth Date: / /

DATES

Admission: / /

Plan: / /

1st Review: / /

2nd Review: / /

3rd Review: / /

Re-Development: / /

Reasons for Referral / Presenting Problems:

Overarching Goals	Criteria for Achievement	Target Date	Completion Date
1		/ /	/ /
2.		/ /	/ /
3.		/ /	/ /
4.		/ /	/ /

Therapeutic Behavioral Services
(formerly Therapeutic Child Treatment)
Individual Treatment Plan

Client:

DHHS Form 562 (02/2005 Version)

_____ _____ _____ _____

Primary Caregiver Signature | Date | Lead Clinical Staff (LCS) Signature | Date

_____ _____ _____ _____

Other Caregiver Signature | Date | Supervising LCS Signature | Date

Consumer Satisfaction Survey

Please help us improve this program by answering some questions about the services you have gotten over the past several months. We are interested in your honest opinions, good or bad. Please answer all the questions. Thank you very much. We appreciate your help.

(Circle your answer)

1. How would you rate the quality of service you and your child received?

   Excellent Good Fair Poor

2. Did your child get the kind of service you wanted?

   No, definitely not Not really Yes, generally Yes, definitely

3. Have these services met your child's needs?

   Almost all of his/her needs have been met. Most of his/her needs have been met. Only a few of his/her needs have been met. None of his/her needs have been met.

4. How satisfied are you with the amount of help you and your child received?

   Quite dissatisfied Indifferent or mildly dissatisfied Mostly satisfied Very satisfied

5. Have the services your child has received helped you to deal with your child's problems?

   Yes, they helped a great deal. Yes, they helped somewhat. No, they didn't really help. No, they seemed to make things worse.

6. If you were to look for help again, would you use these same services?

   No, definitely not No, not really Yes, generally Yes, definitely

Sample CMS-1500 Claim Form

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (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): X 1112345678

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

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

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

5. PATIENT'S ADDRESS (No., Street): 777 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: 29000 | TELEPHONE (Include Area Code): ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: A12345

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: 0.00

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES

c. INSURANCE PLAN NAME OR PROGRAM NAME: 401 BCBS of South Carolina

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL US

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

READ BACK OF FORM BEFORE COMPLETING & SI FO

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the rele ar ical d nation necessary to process this claim. I also request payment of government benefit o m the party w accepts assignment below.

SIGNED _____ 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 SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY | ILLNESS (Fir) OR INJURY (Acci) OR PREGNANCY (LMP)

IF PATIENT HAS HAD SAME OR SIM 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 REFERRIN HYSICIAN OR R SOURCE

17a. I.D. NUMBER OF REFERRING CIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCA

20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. 295.32 3. 2. 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C 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	11 01 03	11 01 03	53		H2020			$ 102.00	1						
2															
3															
4															
5															
6															

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: EXAM01

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

28. TOTAL CHARGE $ $ 102.00

29. AMOUNT PAID $

30. BALANCE DUE $ $102.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. 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 #

RICHLAND DISTRICT 2
111 MEDICAID AVE ANYTOWN SC
29000 123456

PIN# 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: _____

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

7. 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

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

Sample Edit Correction Form

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 - 76 SPEC - 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	9 SECONDARY
ABC000	2022222301	YSG1399					V71.02	

10 RECIPIENT NAME - JANE R DOE 11 DATE OF BIRTH 03/17/1974 12 SEX F

13 RES	14 ALLOWED	LN	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	19 INDIVIDUAL PROVIDER	20 CHARGE	21 PAY IND	22 UNITS
	.00	1	02/01/00	99	H2020	HA	900MXH	836.00		017
	.00	2							**	
		3	/ /							
		4	/ /							
		5	/ /							
		6	/ /							
		7	/ /							
		8	/ /							

EDITS

INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 712 951

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

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

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

26 TOTAL CHARGE 836.55
27 AMT REC'D INS .00
28 BALANCE DUE 836.55
29 OWN REF # 012345

RESOLUTION DECISION _R_

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

INSURANCE POLICY INFORMATION

PROVIDER:
ABC SCHOOL DISTRICT
PO BOX 00000
ANYWHERE, XO 00000-0000

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"

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 SCHOOL DISTRICT PO BOX 000000 FLORENCE SC000000000
.121212121234. Y

PROVIDER ID. PROFESSIONAL SERVICES PAYMENT DATE PAGE

AB0008 | DEPT OF HEALTH AND HUMAN SERVICES | 03/26/2004 | 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	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	H2020	800.00	117.71	P			HA		0.00
	02		021504	H2021	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	H2020	1112.00-	143.71-				HA		
	02		012104	H2021	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	H2020	142.50	42.75	P			HA		0.00
	02		012104	H2021	859.00	0.00	R					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

ABC SCHOOL DISTRICT
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 2)

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

PROVIDER ID. AB1111

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			H2020	513.00-	197.71-	P	1112233333	CLARK	M			022804	0404711253670430A
	01		012104	H2020	453.00	160.71-	P							
	02		012104	H2021	60.00	33.00-	P					HA		
	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 SCHOOL DISTRICT
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.: AB1111

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	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 SCHOOL DISTRICT
PO BOX 000000
FLORENCE SC 00000