FORMS

Number	Name	Revision Date
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	Authorization Agreement for Electronic Funds Transfer	12/2005
DHEC 0762	Children's Rehabilitative Services Orthodontic Referral Form	06/2002
DHHS 219-DG	Medicaid Enrollment Data Group Dentist and Attachments (two pages)	07/2006
DHHS 219-DI	Medicaid Enrollment Data Individual Dentist and Attachments (three pages)	07/2006
DHHS 214	Prior Authorization Form	04/1997
IRS W-9	Request for Taxpayer Identification Number and Certification (W-9 Form) (three pages)	12/1996
	S.C. Medicaid Dental Program Referral Form for Broken Appointments	
ADA J400	Example Dental Claim Form	2006
ADA J400	Example Dental Claim Form Reporting Third-Party or Medicare Information	2006
CMS-1500	Example Dental Claim Form Oral and Maxillofacial Surgeons Only	08/2005
CMS-1500	Example Dental Claim Form Reporting Third-Party and/or Medicare Payments or Denials Oral and Maxillofacial Surgeons Only	08/2005
	Sample Remittance Advices	
	Sample ECF for American Dental Association 2006 Claim Form	
	Sample ECF for the CMS-1500 Claim Form	

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

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

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Provider ID:

NPI:

Recipient ID:

Adjustment Type:

◯ Void ◯ Void/Replace

Originator:

◯ DHHS ◯ MCCS ◯ Provider ◯ MIVS

Reason For Adjustment: (Fill One Only)

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

For Agency Use Only

Analyst ID:

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

Comments:

Signature:_____ Date:_____

Phone:_____

DHHS Form 130 Revision date: 03-13-2007

South Carolina Department of Health and Human Services
Form for Medicaid Refunds

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

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. **Attach appropriate document(s) as listed in item 8.**

1. Provider Name: _____

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

OR

3. NPI# ☐☐☐☐☐☐☐☐☐☐ **& Taxonomy** ☐☐☐☐☐☐☐☐☐☐

4. Person to Contact: _____ **5. Telephone Number:** _____

6. Reason for Refund: [check appropriate box]

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

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

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

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

7. Patient/Service Identification:

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

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

☐ Medicaid Remittance Advice (required)

☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)

☐ Explanation of Benefits (EOMB) from Medicare (if applicable)

☐ Refund check

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

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

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

Contact Person: _____ Phone #: _____ Date: _____

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

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

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

_____ a. beneficiary has never been covered by the policy – close insurance.

_____ b. beneficiary coverage ended - terminate coverage (date) _____

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

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

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

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

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

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

Fax:	**or**	**Mail:**
803-255-8225		Post Office Box 8206, Attention TPL Columbia, SC 29202-8206

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

D H E C

PROMOTE PROTECT PROSPER

Children's Rehabilitative Services
Orthodontic Referral Form

Patient's Name _____ Date of Birth _____

Address _____ City _____ State/Zip Code _____

Have the child position their teeth in the centric position. Record all measurements in the order given and round off to the nearest millimeter (mm).

Score all conditions listed.

1. Overjet in millimeters.....*(class II's only / positive numbers only)*..... ____
2. Overbite in millimeters...*(positive numbers only)* ..... ____
3. Mandibular protrusion in millimeters ..... Number ____ mm x 5 = ____
4. Anterior open bite in millimeters ..... Number ____ mm x 4 = ____
5. Number of impacted anterior teeth ..... Number of teeth ____ x 5 = ____

6a. Moderate crowding (<6 millimeters) 2 points per arch ..... Number of Arches ____ x 2 = ____

6b. Severe crowding (>6 millimeters) 4 points per arch ..... Number of Arches ____ x 4 = ____

7a. Number of teeth in anterior crossbite ..... Number of teeth ____ x 2 = ____

7b. Number of teeth in posterior crossbite ..... Number of teeth ____ x 2 = ____

8. Habits affecting arch development ..... 2 points ____

***TOTAL** ____

Other Comments

***Any child with a total score of thirty (30) or more points should take the completed referral form along with any supporting documentation that the referring provider deems appropriate to the nearest health department to complete an application for the CRS Program where eligibility will be determined. When clients do not score 30 points yet have unique circumstances requiring special consideration, an orthodontia justification and photographs to document those circumstances must be submitted with the referral form.**

_____
Signature of Referring Dentist or Orthodontist Date

_____ (____)_____
Please print name Phone Number

_____
Address

_____

South Carolina
Department of Health and Human Services

Forward completed form to: Medicaid Provider Enrollment
Post Office Box 8809
Columbia, South Carolina 29202-8809

MEDICAID ENROLLMENT DATA
GROUP DENTIST

SHADED ITEMS ARE FOR AGENCY USE ONLY AND NO INFORMATION SHOULD BE ENTERED BY THE MEDICAID PROVIDER.
ITEMS IN **BOLD CAPITALS** MUST BE COMPLETED OR THIS FORM WILL BE RETURNED TO YOU.
ITEMS MARKED WITH AN ASTERISK (*) SHOULD BE COMPLETED BASED ON THE CODES LISTED ON THE BACK OF THIS FORM.

1 Medicaid No.

2 Provider Type 3 1

4 Sort Key

3 **NAME OF GROUP**

5 Tax Payer Identification Name (If different from group name)

Physical Location Address
7 **NUMBER AND STREET**

9 CITY

10 **STATE**

11 ZIP + 4

Payment Address (If different from mailing address)
6 In care of, Attention, Building Name, etc.

8 Number and Street, PO Box or Route No.

12 City

13 STATE

14 ZIP + 4

15 COUNTY*

16 TELEPHONE (INCLUDE AREA CODE) ( ) –

17 **IRS EMPLOYER ID NO.**

18 Medicare No.

19 Type Ownership

20 EC Indicator N

21 PRACTICE SPECIALTY*

22 Enroll Status

23 Enroll Date

24 **LIST NAMES AND SC MEDICAID INDIVIDUAL PROVIDER NUMBER** of all practitioners who participate in your group.
Medicaid provider numbers are not required for practitioners for whom an Individual Provider Enrollment Form is attached.

Practitioner Name	Medicaid Number	Practitioner Name	Medicaid Number

25 CLIA Number

Cert Type*

Attach Copy of CMS CLIA Certificate

Effective Date

Expiration Date

26 **NPI NO.**

27 **NPI ISSUE DATE**

28 **TAXONOMY CODE**

Taxonomy Code

Taxonomy Code

ATTENTION: A statistically valid random sampling technique with extrapolation may be used for determining overpayments/underpayments to medical providers.

I certify that I have read the conditions of participation and payment on the reverse side of this form, that I understand and agree to the conditions of participation on the reverse side of this form, that the enrollment information I have furnished is true, accurate, and complete and that I will report any change affecting my enrollment. I further certify that I will obtain authorization from each Medicaid patient to release to SCDHHS medical information necessary for processing Medicaid claims.

Signature and Title of Authorized Agent: _____ Date _____
A facsimile stamp is not acceptable.

AS A CONDITION OF PARTICIPATION AND PAYMENT, I UNDERSTAND AND AGREE;

- That this agreement shall not be assigned or transferred.
- That upon acceptance of this agreement, the South Carolina Department of Health and Human Services (SCDHHS) will issue a Medicaid provider number, which must be used in filing all claims.
- That services shall be provided to Medicaid recipients in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, as amended, and the Age Discrimination Act of 1975 and any regulations promulgated pursuant to any of these Acts.
- In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 et seq.) and regulations pursuant thereto, (45 CFR Part 80, 1996. as amended). In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 et. seq.) and its implementing regulation at 45 CFR Part 80, the provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement.
- That adequate and correct fiscal and medical records shall be kept to disclose the extent of services rendered and to assure that claims for funds are in accordance with all applicable laws, regulations, and policies.
- That all fiscal and medical records shall be retained for a period of three (3) years after last payment was made for services rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the three (3) years, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the three (3) year period, whichever is later.
- That, for the purposes of reviewing, copying, and reproducing documents, access shall be allowed to all records concerning services and payment under this agreement to the SCDHHS, the State Auditor's Office, the South Carolina Attorney General's Office, the Department of Health and Human Services and/or their designee during normal business hours.
- That upon request, information must be furnished regarding any claim for payment to the SCDHHS.
- That requests for reimbursement for services shall reflect any third party payment received and that any payment received subsequent to claims filing shall be reported.
- That Medicaid will reimburse the co-insurance and/or deductible portions (cost sharing) of Medicare claims for recipients with both coverages only if the provider accepts Medicare assignment. Cost sharing is limited by the Medicaid allowed amount for the service.
- That Medicaid reimbursement is always made to the provider of services and that the recipient shall not be billed pending receipt of such payment.
- That Medicaid reimbursement is payment in full and that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient or any other person, family member, relative, organization or entity for care or services to a recipient/patient except as may otherwise be allowed under Federal regulations or in accordance with SCDHHS policy.
- That this statement applies only to those recipients for whom Medicaid claims are filed and that it in no way requires that the provider render services to any Medicaid recipient.
- Either party may terminate this agreement upon providing the other party with thirty (30) days written notice termination. Such termination shall be sent by Certified Mail, Return Receipt Requested, and be effective thirty (30) days after the date of receipt.
- That the provider shall disclose full and complete information as to ownership, business transactions, and criminal activity in accordance with 42 CFR 455.104 through 455.106 (1999). Furthermore, the provider shall disclose any felony convictions under Federal or State law in accordance with 42 CFR 1001.101 Subpart B through 1001.1701 Subpart C (1999).
- That, for any dispute arising under this agreement, the provider shall have as his sole and exclusive remedy the right to request a hearing from SCDHHS within thirty (30) calendar days of the Commission action which he believes himself aggrieved. Such proceedings shall be in accordance with SCDHHS appeals procedures and S.C. Code Ann. 1-23-310 et. seq. (1976, as amended). Judicial review of any final agency administrative decision shall be in accordance with S.C. Code Ann. 1-23-380 (1976, as amended).
- That the provider shall safeguard the use and disclosure of information concerning applicants for or recipients of Title XIX (Medicaid) services in accordance with 42 CFR Part 431 Subpart F (1991), SHHSFC's regulation R.126-170, et seq., Code of Laws of South Carolina (1976) Volume 27 as amended, and all applicable State laws and regulations.
- That none of the funds provided under this agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for political office, or otherwise in violation of the "Hatch Act".
- That all services rendered and claims submitted shall be in compliance with all applicable federal and state laws and regulations and in accordance with SCDHHS policies, procedures, and Medicaid Provider Manuals.
- That all information provided on the Medicaid enrollment form is incorporated as a part of this agreement.
- That the provider shall be held personally liable for all claims submitted by him or on his behalf as evidenced by his endorsement of his Medicaid reimbursement check.
- That Medicaid reimbursement (payment of claims) is from state and federal funds and that any falsification (false claims, statement or documents) or concealment of material fact may be prosecuted under applicable state and federal laws.
- That the provider must comply with all requirements of the Americans with Disabilities Act of 1990 (ADA), as applicable.
- That the provider shall comply with all terms and conditions of the Drug Free Workplace Act, S.C. Code Ann. Section 44-107-10 et seq. (1976, as amended) if this agreement is for a stated or estimated value of Fifty Thousand Dollars or more.
- That in accordance with 31 U.S.C. 1352, funds received through this agreement may not be expended to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered Federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. This restriction is applicable to all contractors and subcontractors.
- The Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification: Standard Unique Health Identifier for Health Care Providers regulations (42 CFR 165 Subparts A & D), states that all covered entities: health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a standard transaction must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES) no later than May 23, 2007.
- Pursuant to the Standard Unique Health Identifier regulations (42 CFR 165 Subparts A & D), and if the provider is a covered health care provider as defined in 42 CFR §162.402, the provider agrees to disclose its NPI to SCDHHS once obtained from the NPPES. Provider also agrees to use the NPI it obtained from the NPPES to identify itself on all standard transactions that it conducts with SCDHHS.

COUNTY CODES (ITEM 15)

01	Abbeville	24	Greenwood
02	Aiken	25	Hampton
03	Allendale	26	Horry
04	Anderson	27	Jasper
05	Bamberg	28	Kershaw
06	Barnwell	29	Lancaster
07	Beaufort	30	Laurens
08	Berkeley	31	Lee
09	Calhoun	32	Lexington
10	Charleston	33	McCormick
11	Cherokee	34	Marion
12	Chester	35	Marlboro
13	Chesterfield	36	Newberry
14	Clarendon	37	Oconee
15	Colleton	37	Orangeburg
16	Darlington	39	Pickens
17	Dillon	40	Richland
18	Dorchester	41	Saluda
19	Edgefield	42	Spartanburg
20	Fairfield	43	Sumter
21	Florence	44	Union
22	Georgetown	45	Williamsburg
23	Greenville	46	York

60 Georgia within SC Svc. Area
61 Georgia outside SC Svc. Area
62 North Carolina within SC Service Area
63 North Carolina outside SC Service Area
64 Other

PRACTICE SPECIALTY (ITEM 21)

08 Dentistry
35 Orthodontics
43 Pedodontics
66 Oral Surgery
EN Endodontist
PE Periodontist

CLIA (ITEM 25)

A Accreditation
C Compliance
P PPMP
R Registration
T Partial Accredited
W Waiver

South Carolina
Department of Health and Human Services

Forward completed form to: Medicaid Provider Enrollment
Post Office Box 8809
Columbia, South Carolina 29202-8809

MEDICAID ENROLLMENT DATA
INDIVIDUAL DENTIST

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ITEMS IN **BOLD CAPITALS** MUST BE COMPLETED OR THIS FORM WILL BE RETURNED TO YOU.
ITEMS MARKED WITH AN ASTERISK (*) SHOULD BE COMPLETED BASED ON THE CODES LISTED ON THE BACK OF THIS FORM.

1 Medicaid No.

2 Provider Type 3 0

4 Sort Key

3 **PROVIDER'S NAME**

5 Tax Payer Identification Name

Physical Location Address
7 **NUMBER AND STREET**

9 **CITY**

10 **STATE**

11 ZIP + 4

Payment Address (If different from mailing address)
6 In care of, Attention, Building Name, etc.

8 Number and Street, PO Box or Route No.

12 City

13 STATE

14 ZIP + 4

15 **COUNTY***

16 **TELEPHONE (INCLUDE AREA CODE)** ( )

18 **IRS EMPLOYER ID NO.**

OR

SOCIAL SECURITY NO.

List in Field 5 the Tax Payer Name that match Id# in Field 18

19 **MEDICARE ID NO.**

20 EC Ind. N

21 **LICENSE NO.**

22 **LICENSE ISSUE DATE**

23 **STATE LIC. BOARD***

24 Type Owner

25 **PRIMARY SPECIALTY***

26 Secondary Specialty*

27 Group Numbers
If a member of a PA, enter ID number assigned by Medicaid.

28 Enroll Status

29 Enroll Date

30 CLIA Number

Cert Type*

Attach Copy of CMS CLIA Certificate

Effective Date

Expiration Date

31 **NPI NO.**

32 **NPI ISSUE DATE**

33 **TAXONOMY CODE**

Taxonomy Code

Taxonomy Code

ATTENTION: A statistically valid random sampling technique with extrapolation may be used for determining overpayments/underpayments to medical providers.

I certify that I have read the conditions of participation and payment on the reverse side of this form, that I understand and agree to the conditions of participation on the reverse side of this form, that the enrollment information I have furnished is true, accurate, and complete and that I will report any change affecting my enrollment. I further certify that I will obtain authorization from each Medicaid patient to release to SCDHHS medical information necessary for processing Medicaid claims.

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- That Medicaid reimbursement is always made to the provider of services and that the recipient shall not be billed pending receipt of such payment.
- That Medicaid reimbursement is payment in full and that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient or any other person, family member, relative, organization or entity for care or services to a recipient/patient except as may otherwise be allowed under Federal regulations or in accordance with SCDHHS policy.
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- That in accordance with 31 U.S.C. 1352, funds received through this agreement may not be expended to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered Federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. This restriction is applicable to all contractors and subcontractors.
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05	Bamberg	28	Kershaw
06	Barnwell	29	Lancaster
07	Beaufort	30	Laurens
08	Berkeley	31	Lee
09	Calhoun	32	Lexington
10	Charleston	33	McCormick
11	Cherokee	34	Marion
12	Chester	35	Marlboro
13	Chesterfield	36	Newberry
14	Clarendon	37	Oconee
15	Colleton	38	Orangeburg
16	Darlington	39	Pickens
17	Dillon	40	Richland
18	Dorchester	41	Saluda
19	Edgefield	42	Spartanburg
20	Fairfield	43	Sumter
21	Florence	44	Union
22	Georgetown	45	Williamsburg
23	Greenville	46	York

60	Georgia within SC service area
61	Georgia outside SC service area
62	North Carolina within SC service area
63	North Carolina outside SC service area
64	Other

STATE LICENSE BOARD (Item 23)

01	Alabama	27	Nebraska
02	Alaska	28	Nevada
03	Arizona	29	New Hampshire
04	Arkansas	30	New Jersey
05	California	31	New Mexico
06	Colorado	32	New York
07	Connecticut	33	North Carolina
08	Delaware	34	North Dakota
09	Florida	35	Ohio
10	Georgia	36	Oklahoma
11	Hawaii	37	Oregon
12	Idaho	38	Pennsylvania
13	Illinois	39	Rhode Island
14	Indiana	40	South Carolina
15	Iowa	41	South Dakota
16	Kansas	42	Tennessee
17	Kentucky	43	Texas
18	Louisiana	44	Utah
19	Maine	45	Vermont
20	Maryland	46	Virginia
21	Massachusetts	47	Washington
22	Michigan	48	West Virginia
23	Minnesota	49	Wisconsin
24	Mississippi	50	Wyoming
25	Missouri	51	Canada
26	Montana		

PRIMARY & SECONDARY SPECIALTY (Item 25 & 26)

08	Dentistry
35	Orthodontics
43	Pedodontics
66	Oral Surgery
EN	Endodontist
PE	Periodontist

CLIA (Item 30)

A	Accreditation
C	Compliance
P	PPMP
R	Registration
T	Partial Accredited
W	Waiver

MAIL TO: DEPT. OF HEALTH AND HUMAN SERVICES, P. O. BOX 8206, COLUMBIA, S. C. 29202-8206

PRIOR AUTHORIZATION

1 CLAIM CONTROL NUMBER (DO NOT WRITE IN THIS SPACE)

TYPEWRITER ALIGNMENT
USE CAPITAL LETTERS ONLY

PROVIDER INFORMATION

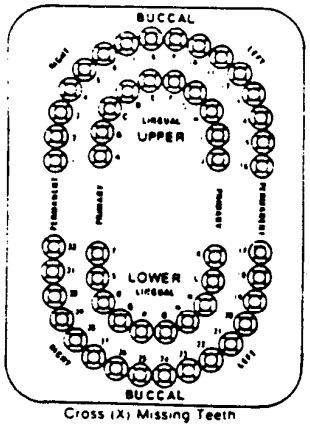
2 PROVIDERS NAME
3 PROVIDER ID NUMBER
4 OWN REFERANCE #
5 DATE SUBMITTED
6 STREET ADRESS
7 CITY/ STATE/ZIP
8 NAME AND CITY OF MEDICAL PROVIDER
9 PRIOR AUTHORIZATION #

RECIPIENT INFORMATION

10 RECIPIENT NAME (FIRST, MIDDLE INITIAL, LAST)
11 RECIPIENT ID NUMBER
12 SEX
13 BIRTH DATE

	SERVICE INDICATOR	SERVICE CODE	MODIFIER	TYPE OF SALE	REQUESTED # BILLINGS	EPSDT REFERRAL	PROPOSED CHARGE	AUTHORIZED	ALLOWED # BILLINGS	DELETE
1	14	15	16	17	18	19	20	21	22	23
2	29	30	31	32	33	34	35	36	37	38
3	44	45	46	47	48	49	50	51	52	53
4	59	60	61	62	63	64	65	66	67	68
5	74	75	76	77	78	79	80	81	82	83

	SERVICE NAME	TOOTH #	TOOTH SURFACES	AUTHORIZED CHARGE	EXPIRATION DATE
1	24	25	26	27	28
2	39	40	41	42	43
3	54	55	56	57	58
4	69	70	71	72	73
5	84	85	86	87	88



Cross (X) Missing Teeth

89 DOCUMENTATION ATTACHED
90 TOTAL LINES ENTERED
91 TOTAL PROPOSED CHARGES
92 TOTAL AUTHORIZED CHARGES

EXPLAIN MEDICAL NECESSITY FOR EACH PROCEDURE BELOW

X _____

93 REVIEWED BY (FOR DEPARTMENT USE ONLY)

X _____

94 PROVIDERS SIGNATURE

DHHS FORM 214 (4/97) Replaces DSS Form 3204 (1-79) which may be used until exhausted.

Form **W-9**
(Rev. January 2003)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► _____ ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 3.

Note: *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number
___ ___ ___ – ___ ___ – ___ ___ ___ ___

or

Employer identification number
___ ___ – ___ ___ ___ ___ ___ ___ ___

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person ►** **Date ►**

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a **nonresident alien or a foreign entity** not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments (29% **after** December 31, 2003; 28% **after** December 31, 2005). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will **not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under **4** above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note: *You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).*

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note: *If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.*

Exempt payees. Backup withholding is **not required** on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2);

2. The United States or any of its agencies or instrumentalities;

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities;

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities; or

5. An international organization or any of its agencies or instrumentalities.

Other payees that **may be exempt** from backup withholding include:

6. A corporation;

7. A foreign central bank of issue;

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States;

9. A futures commission merchant registered with the Commodity Futures Trading Commission;

10. A real estate investment trust;

11. An entity registered at all times during the tax year under the Investment Company Act of 1940;

12. A common trust fund operated by a bank under section 584(a);

13. A financial institution;

14. A middleman known in the investment community as a nominee or custodian; or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, **1** through **15.**

If the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for **9**
Broker transactions	Exempt recipients **1** through **13.** Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients **1** through **5**
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients **1** through **7** [2]

[1] See **Form 1099-MISC**, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are **not exempt** from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner **LLC** that is disregarded as an entity separate from its owner (see **Limited liability company (LLC)** on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note: *See the chart on page 4 for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5,** Application for a Social Security Card, from your local Social Security Administration office or get this form on-line at **www.ssa.gov/online/ss5.html**. You may also get this form by calling 1-800-772-1213. Use **Form W-7,** Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or **Form SS-4,** Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at **www.irs.gov**.

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: *Writing "Applied For" means that you have already applied for a TIN* ***or*** *that you intend to apply for one soon.*

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

S.C. Medicaid Dental Program
Referral Form for Broken Appointments

This form is used to refer Medicaid beneficiaries who are non-compliant. The referral will be followed up by appropriate Department of Health and Environmental Control (DHEC) staff and efforts will be made to encourage beneficiary compliance. Please provide as much information as you can to assist in contacting the beneficiary or the beneficiary's parent/guardian.

Dentist _____

Phone Number _____

Dental Office Contact Person _____

Beneficiary's Name	Medicaid ID Number	Date of Birth
Beneficiary's Phone Number	Beneficiary's Address	
Parent/Caregiver's Name		
CHECK ONE BLOCK BELOW		
Missed Sedation/Complex/Emergency Appointment (URGENT)		
Missed Restorative Appointment (Moderate)		
Missed Preventive Appointment (Minor)		
Reason Given for Missed Appointment:		
Other Concerns/Comments:		

Beneficiary's Name	Medicaid ID Number	Date of Birth
Beneficiary's Phone Number	Beneficiary's Address	
Parent/Caregiver's Name		
CHECK ONE BLOCK BELOW		
Missed Sedation/Complex/Emergency Appointment (URGENT)		
Missed Restorative Appointment (Moderate)		
Missed Preventive Appointment (Minor)		
Reason Given for Missed Appointment:		
Other Concerns/Comments:		

ADA Dental Claim Form

EXAMPLE DENTAL CLAIM FORM

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination / Preauthorization
☐ EPSDT / Title XIX

2. Predetermination / Preauthorization Number
1234567 OR Emergency IF APPLICABLE

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Medicaid Claims Receipt
PO Box 2136 OPTIONAL
Columbia SC 29202-2136

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
John Doe
1801 Main St OPTIONAL
Columbia SC 29202

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)
0000000000

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	00/00/0000					D0120		35 00
2	00/00/0000					D1110		42 00
3	00/00/0000					D1204		26 00
4	00/00/0000					D0272		30 00
5	00/00/0000			16		D0220		18 00
6	00/00/0000			16		D7140		75 00
7	00/00/0000			66		D7140		65 00
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33 Total Fee	291 00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 00/00/0000
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below-named dentist or dental entity.

X
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI 0000000000 | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52A. Additional Provider ID ZA0000

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X
Signed (Treating Dentist) Date

54. NPI 0000000000 | 55. License Number

56. Address, City, State, Zip Code
DR JOHN SMITH
2000 MAIN ST
COLUMBIA SC 29000-0000

56A. Provider Specialty Code 122300000X

57. Phone Number ( ) - | 58. Additional Provider ID ZX0000

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

ADA Dental Claim Form

EXAMPLE DENTAL CLAIM FORM

REPORTING THIRD-PARTY OR MEDICARE INFORMATION

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination / Preauthorization
☐ EPSDT / Title XIX

2. Predetermination / Preauthorization Number
1234567 OR Emergency IF APPLICABLE

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Medicaid Claims Receipt
PO Box 2136 OPTIONAL
Columbia SC 29202-2136

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#) 000000000

9. Plan/Group Number 401 | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
$86.00
OR 1, if denied
$0.00

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
$25.00
OR 1, if denied
$0.00

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#) 000000000

16. Plan/Group Number 134 | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
John Doe
1801 Main St OPTIONAL
Columbia SC 29202

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID / Account # (Assigned by Dentist) 0000000000

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	00/00/0000					D0120		35 00
2	00/00/0000					D1110		42 00
3	00/00/0000					D1204		26 00
4	00/00/0000					D0272		30 00
5	00/00/0000			16		D0220		18 00
6	00/00/0000			16		D7140		75 00
7	00/00/0000			66		D7140		65 00
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	291 00

35. Remarks
$111.00 (Total from Boxes 11 and/or 12)

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 00/00/0000
Patient / Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI 0000000000 | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52A. Additional Provider ID ZA0000

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) | Oral Image(s) | Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X
Signed (Treating Dentist) Date

54. NPI 0000000000 | 55. License Number

56. Address, City, State, Zip Code
DR JOHN SMITH
2000 MAIN ST
COLUMBIA SC 29000-0000

56A. Provider Specialty Code 122300000X

57. Phone Number ( ) - | 58. Additional Provider ID ZX0000

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

1500

EXAMPLE DENTAL CLAIM FORM
ORAL AND MAXILLOFACIAL SURGEONS ONLY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | 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)

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)

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

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

CITY | STATE

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

CITY | STATE

ZIP CODE | 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

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

PHYSICIAN OR SUPPLIER INFORMATION

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. V72.2 (OPTIONAL)
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	00	00	00	00	00	00	11	Y	99202			60 00			1D	ZX0000
															NPI	1111111111
2	00	00	00	00	00	00	11	Y	20670			206 00			1D	ZX0000
															NPI	1111111111
3	^ ("Y" IF EMERGENCY)														NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. SMITHMARY

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

28. TOTAL CHARGE $ 320 00

29. AMOUNT PAID $

30. BALANCE DUE $ 320 00

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
COMPLETE IF SERVICES WERE RENDERED IN A FACILITY OTHER THAN THE PATIENT'S HOME OR PROVIDER'S OFFICE

a. 9999999999 b. 1DXXXXXX

33. BILLING PROVIDER INFO & PH # (555) 555-5555
ABC Clinic
123 Oak St
Anywhere, SC 22222-2222
PAY-TO PROVIDER IN THIS FIELD

a. 1111111111 b. 1DZA0000

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

EXAMPLE DENTAL CLAIM FORM
REPORTING THIRD-PARTY AND/OR MEDICARE PAYMENTS OR DENIALS
ORAL AND MAXILLOFACIAL SURGEONS ONLY

CARRIER

PICA

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) 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)

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)

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY STATE

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

CITY STATE

ZIP CODE 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: XXXXXXXXX

a. OTHER INSURED'S POLICY OR GROUP NUMBER: YYYYYYYYYYY

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: $15.00

c. EMPLOYER'S NAME OR SCHOOL NAME: $25.00

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: 132

d. INSURANCE PLAN NAME OR PROGRAM NAME: 401

10d. RESERVED FOR LOCAL USE: 1 if denied, 6 if crime victim

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

PATIENT AND INSURED INFORMATION

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 MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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. V72.2 (OPTIONAL) 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. 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	00	00	00	00	00	00	11	Y	99202			60 00			1D	ZX0000
															NPI	1111111111
2	00	00	00	00	00	00	11	Y	20670			206 00			1D	ZX0000
															NPI	1111111111
3									^ ("Y" IF EMERGENCY)						NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: SMITHMARY

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

28. TOTAL CHARGE: $ 320 00

29. AMOUNT PAID: $ 40 00

30. BALANCE DUE: $ 320 00

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
COMPLETE IF SERVICES WERE RENDERED IN A FACILITY OTHER THAN THE PATIENT'S HOME OR PROVIDER'S OFFICE

a. 9999999999 b. 1DXXXXXX

33. BILLING PROVIDER INFO & PH # (555) 555-5555
ABC Dental
123 Oak St
Anywhere, SC 22222-2222
PAY-TO PROVIDER IN THIS FIELD

a. 1111111111 b. 1DZA0000

Sample Remittance Advice

PROVIDER ID. | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE

1111111111

DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

REMITTANCE ADVICE

03/26/2008

1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE DATE(S) MMDDYY	RENDERED PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
T22222222	4444444444444444B							1234567890	JOHN DOE				
	01		021508	D1120	35.00	31.00	P			000		0.00	0.00
	02		021508	D1203	17.00	17.00	P			000		0.00	0.00
	TOTALS		2		52.00	48.00						0.00	0.00

$48.00

CERT. PG TOT	MEDICAID PG TOT
$0.00	$48.00

CERTIFIED AMT	MEDICAID TOTAL
$0.00	0.00

FEDERAL RELIEF	MAXIMUS AMT	CHECK TOTAL	CHECK NUMBER
	0.00	0.00	

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

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

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

SMILE DENTAL PRACTICE
111 DENTAL ST
ANYWHERE , SC 29532-1111

Sample Remittance Advice —Void/Replacement

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.

Z11111 JANE DOE DDS
.999999999999. Y
PROVIDER ID. PROFESSIONAL SERVICES PAYMENT DATE PAGE

DEPT OF HEALTH AND HUMAN SERVICES
1111111111 REMITTANCE ADVICE 03/26/2008 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	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
T22222222	4444444444444444B				1192.00	243.71	P	1234567890	M JONES			0.00		
	01		021508	D0428	800.00	117.71	P						0.00	
	02		021508	D0425	392.00	126.00	P						0.00	
	VOID OF ORIGINAL CCN 9999999999999999B PAID 02/28/04													
T33333333	5555555555555555U				1412.00-	273.71-		8888888888	M JONES					
	01		012108	D0425	1112.00-	143.71-								
	02		012108	D0434	300.00-	130.00-								
	REPLACEMENT OF ORIGINAL CCN 9999999999999999B PAID 02/28/04													
T33333333	6666666666666666B				1001.50	42.75	P	8888888888	M JONES			0.00		
	01		012108	D0425	142.50	42.75	P						0.00	
	02		012108	D0434	859.00	0.00	R						0.00	
	TOTALS		2		2193.50	286.46						0.00	0.00	

$286.46

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
	0.00	0.00	

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

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

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

PROVIDER NAME AND ADDRESS
JANE DOE DDS
111 DENTAL ST
ANYWHERE , SC 29532-1111

Sample Remittance Advice —Void Only

This page of the sample Remittance Advice shows claim-level Voids without corresponding Replacement claims.

PROVIDER ID. 1111111111

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE 03/26/2008

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
T22222222	7777777777777777U				513.00-	197.71-		1122334455	JONES		M		022804	5555555222222222D
	01		012108	D0425	453.00	160.71-	P							
	02		012108	D0434	60.00	33.00-	P							
T22222222	8888888888888888U				513.00-	197.71-		6677889900	JONES		M		022804	6666666666222222D
	01		012108	D0425	453.00	160.71-	P							
	02		012108	D0434	60.00	33.00-	P							
T22222222	0000000000000000U				513.00-	197.71-		9876543210	JONES		M		022804	7777777772222222D
	01		012108	D0425	453.00	160.71-	P							
	02		012108	D0434	60.00	33.00-	P							
	TOTALS	3			1539.00-	593.13-								

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 593.13

MEDICAID TOTAL: 0.00

ADJUSTMENTS: 0.00

CHECK TOTAL: 0.00

CERTIFIED AMT: 0.00

MAXIMUS AMT:

CHECK NUMBER:

FEDERAL RELIEF: 0.00

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

JANE DOE DDS
111 DENTAL ST
ANYWHERE , SC 22222-1111

Sample Remittance Advice —Gross Level Adjustments

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. Z11111

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE 03/26/2008

PAGE 3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME F M LAST NAME I I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	00000000000001111U	-						DEBIT	-2389.05	
TPL 4	00000000000002222U	-						DEBIT	-1949.90	
TPL 5	00000000000003333U	-						DEBIT	-477.25	
TPL 6	00000000000004444U	-						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

YOUR CURRENT DEBIT BALANCE	ADJUSTMENTS	MAXIMUS AMT
5293.45	0.00	0.00

CHECK TOTAL	CHECK NUMBER
0.00	

PROVIDER NAME AND ADDRESS

JANE DOE DDS
111 DENTAL ST
ANYWHERE , SC 29202-1111

Sample ECF for American Dental Association 2006 Claim Form

RUN DATE 05/01/2007 000099822 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #0000000000000000B
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 44802 ECF 44802 PAGE 1 OF 1
ANALYST ID PROV DENTAL - 31 EMC
SIGNON ID CLAIM RESTART DATE / / DOC IND N ORIGINAL CCN:
ADJ CCN:

TAXONOMY: PRV ZIP: 29526 EDITS

1 2 3 4 5 6 7 8 9

PROVIDER P AUTH# OWN REF# RECIPIENT ID TPL INJURY EPSDT DIAGNOSIS RECIPIENT NAME INSURANCE EDITS
ZA1111 1111111111 N V72.2 NEED A NAME 01-400 01-733
NPI: 2222222222

10 DATE OF BIRTH 02/06/2002 CLAIM EDITS

LINES 1 THRU 15 SERVICE PROVIDER NPI: 0000000000 TAXONOMY:

11 RES	12 ALLOWED	LN NO	13 INDIVIDUAL PROVIDER	14 DATE OF SERVICE	15 TOOTH NUMBER	16 TOOTH SURFACES	17 PLACE	18 PROC CODE	19 MOD	20 UNITS	21 CHARGE
	.00	1	ZA0000	03/13/07			3	D0120	000	001	47.00
	.00	2	ZA0000	03/13/07			3	D1120	000	001	45.00
	.00	3	ZA0000	03/13/07			3	D0272	000	001	32.00
	.00	4	ZA0000	03/13/07			3	D1203	000	001	25.00
		5	/ /								
		6	/ /								
		7	/ /								
		8	/ /								
		9	/ /								
		10	/ /								

LINE EDITS

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

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

22 INS CARR NUMBER | 23 POLICY NUMBER | 24 INS CARR PAID

01 4267887103

02

25 TOTAL CHARGE 149.00

26 AMT REC'D INS .00

27 BALANCE DUE

RESOLUTION DECISION ___

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 2136
COLUMBIA, S.C. 29202-2136

INSURANCE POLICY INFORMATION

PROVIDER:
ACME PEDIATRIC DENTAL
111 OAK STREET
CONWAY SC 00000-0000

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

Sample ECF for the CMS-1500 Claim Form

```
RUN DATE 12/01/2007 000008032          SC DEPARTMENT OF HEALTH AND HUMAN SERVICES              CLAIM CONTROL #0000000000000000A
REPORT NUMBER CLM3500                          EDIT CORRECTION FORM                        PAGE  7641 ECF  7641 PAGE  1 OF  1
    ANALYST ID                                HIC - 21  PRAC SPEC - 54                      EMC Y
    SIGNON ID                                                DOC IND  N                   ORIGINAL CCN:
 TAXONOMY:               SFL ZIP: 30901          PRV ZIP:                                     ADJ CCN:
    1          2          3      4      5      6       7          8           9                      EDITS
 PROVIDER   RECIPIENT    P AUTH  TPL  INJURY  EMERG  PC COORD     ---- DIAGNOSIS ----          INSURANCE EDITS
    ID         ID        NUMBER        CODE                      PRIMARY   SECONDARY
  ZX0000    1111111111                                           170.1         .             CLAIM EDITS
  NPI: 1234567890
                                                                                            LINE EDITS
                                                                                            01) 852
 10 RECIPIENT NAME - NEED     A NAME             11 DATE OF BIRTH  03/23/1949   12 SEX   M
                                                                                            ******************************
   13        14               15       16     17     18              19         20     21  22  **    AGENCY USE ONLY       **
   RES    ALLOWED    LN    DATE OF   PLACE   PROC    MOD             INDIVIDUAL CHARGE  PAY  UNITS **     APPROVED EDITS       **
                     NO    SERVICE           CODE                    PROVIDER     IND           **                           **
                                                      23                                        **   REJECTED LINE EDITS     **
                                                      NDC                                       **                           **
                                                                                                ******************************
              .00     1    09/05/07    11   99204                    ZA0000       50.00     1.000
          NPI: 1111111111     TAXONOMY: 200000000X                                              !!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
                     2      /  /                                                               !  CLAIMS/LINE PAYMENT INFO  !
          NPI:                TAXONOMY:                                                         !                            !
                     3      /  /                                                               !  EDIT        PAYMENT DATE  !
          NPI:                TAXONOMY:                                                         ! 01-852         09/29/06    !
                     4      /  /                                                               !!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
          NPI:                TAXONOMY:
                     5      /  /
          NPI:                TAXONOMY:
                     6      /  /
          NPI:                TAXONOMY:
      24                25                  26
 INS CARR            POLICY              INS CARR
  NUMBER             NUMBER                PAID                    27  TOTAL CHARGE       50.00

01 620     250063050A                          8.82                 28  AMT REC'D INS       8.82

02                                                                  29  BALANCE DUE        50.00

03                                                                  30     OWN REF #   JOHNDOE

RESOLUTION DECISION ___

  ADDITIONAL DIAG CODES:       .        .        .        .        .        .

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

                        PROVIDER:
                        ACME DENTAL
                        P O BOX 1111
                        AUGUSTA             GA 00000-0000

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