

## SECTION 4

### ADMINISTRATIVE SERVICES

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## **SECTION 4**

# **ADMINISTRATIVE SERVICES**

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## SECTION 4 ADMINISTRATIVE SERVICES

### GENERAL INFORMATION

#### ADMINISTRATION

The Department of Health and Human Services (DHHS) administers the South Carolina Medicaid Program, as well as the Optional State Supplementation Program. This section outlines the available services for providers, with telephone numbers and addresses for county and regional DHHS offices.

#### CORRESPONDENCE AND INQUIRIES

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.

Correspondence concerning specific policies and procedures should be directed to the appropriate program or entity from the following list:

#### Facility Licensure

S.C. Department of Health and Environmental Control  
Division of Health Licensing  
2600 Bull Street  
Columbia, SC 29201  
(803) 545-7201

#### Facility Enrollment

S.C. Department of Health and Human Services  
OSS Enrollments  
Post Office Box 8809  
Columbia, SC 29202-8809  
(803) 788-7622 Ext. 41650

#### Cost Reports

S.C. Department of Health and Human Services  
Long Term Care Reimbursements  
Post Office Box 8206  
Columbia, SC 29202-8206  
(803) 898-1014

**SECTION 4 ADMINISTRATIVE SERVICES****GENERAL INFORMATION****Policies and Procedures**

S.C. Department of Health and Human Services  
Community and Facility Services  
Post Office Box 8206  
Columbia, SC 29202-8206  
(803) 898-2590  
Fax (803) 898-4509

**Waiting List**

S.C. Department of Health and Human Services  
Regional Office  
(see full list in this section)

**Eligibility**

S.C. Department of Health and Human Services  
County Eligibility Office  
(see full list in this section)

**Send Completed TADs to:**

Claims Receipt – CRCF Claims Section  
Post Office Box 67  
Columbia, SC 29202-0067  
(803) 788-7622 Ext. 41613  
Fax (803) 699-8637

## SECTION 4 ADMINISTRATIVE SERVICES

### PROCUREMENT OF FORMS

#### 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 (Form 142)
4. Medicaid Refund Check Remittance (Form 205)

#### WEB ADDRESS

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

Department of Health and Human Services  
(DHHS)  
Optional State Supplementation Program  
Post Office Box 8206  
Columbia, SC 29202

## **SECTION 4 ADMINISTRATIVE SERVICES**

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**SECTION 4 ADMINISTRATIVE SERVICES****DEPARTMENT OF  
HEALTH AND  
HUMAN SERVICES  
REGIONAL  
OFFICES**

**Aiken** 2330 Woodside Executive Ct.  
Aiken, SC 29803  
Counties: Aiken, Barnwell Telephone: (803) 641-7680  
Fax: (803) 641-7682  
1-888-364-3310

**Anderson** Post Office Box 5947  
Anderson, SC 29623-5947  
Counties: Anderson, Oconee 3215 Mall Road, Suite H  
Anderson, SC 29621  
Telephone: (864) 224-9452  
Fax: (864) 225-0871  
1-800-713-8003

**Charleston** 5900 Core Road, Suite 505  
N. Charleston, SC 29406  
Counties: Berkeley, Telephone: (843) 529-0142  
Charleston, Dorchester Fax: (843) 566-0171  
1-888-805-4397

**Columbia** 7499 Parklane Road, Suite 164  
Columbia, SC 29223  
Counties: Fairfield, Telephone: (803) 741-0826  
Lexington, Newberry, Fax: (803) 741-0830  
Richland 1-888-847-0908

**Conway** PO Box 2150  
914 Norman Street  
Conway, SC 29526  
Counties: Georgetown, Telephone: (843) 248-7249  
Horry, Marion, Williamsburg Fax: (843) 248-3809  
1-888-539-8796

**SECTION 4 ADMINISTRATIVE SERVICES****DHHS REGIONAL OFFICES**

<b>Florence</b>	201 Dozier Boulevard Florence, SC 29501 Telephone: (843) 667-8718 Fax: (843) 667-9354 1-888-798-8995
Counties: Darlington, Dillon, Florence, Chesterfield, Marlboro	
<b>Greenville</b>	620 North Main Street Greenville, SC 29601 Telephone: (864) 242-2211 Fax: (864) 242-2107 1-888-535-8523
Counties: Greenville, Pickens	
<b>Greenwood</b>	617 South Main Street PO Box 3088 Greenwood, SC 29648 Telephone: (864) 223-8622 Fax: (864) 741-0830 1-888-628-3838
Counties: Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	
<b>Orangeburg</b>	1857 Joe S. Jeffords Highway Orangeburg, SC 29115 Telephone: (803) 536-0122 Fax: (803) 534-2358 1-888-218-4915
Counties: Allendale, Bamberg, Calhoun, Orangeburg	
<b>Point South</b>	Highway 17-South Post Office Box 2065 Ridgeland, SC 29936 Telephone: (843) 726-5353 Fax: (843) 726-5113 Beaufort Line: (843) 521-9191 1-800-262-3329
Counties: Beaufort, Colleton, Hampton, Jasper	
<b>Rock Hill</b>	1890 Neely's Creek Road Rock Hill, SC 29732 Telephone: (803) 327-9061 Fax: (803) 327-9065 1-888-286-2078
Counties: Chester, Lancaster, York	



**SECTION 4 ADMINISTRATIVE SERVICES****DHHS REGIONAL OFFICES****Spartanburg**

Counties: Cherokee,  
Spartanburg, Union

1411 W. O Ezell Blvd., Suite 6  
Spartanburg, SC 29301  
Telephone: (864) 587-4707  
Fax: (864) 587-4716  
1-888-551-3864

**Sumter**

Counties: Clarendon,  
Kershaw, Lee, Sumter

30 Wesmark Court  
Sumter, SC 29150  
Telephone: (803) 905-1980  
Fax (803) 905-1987  
1-888-761-5991

## **SECTION 4 ADMINISTRATIVE SERVICES**

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**SECTION 4 ADMINISTRATIVE SERVICES****DEPARTMENT OF  
HEALTH AND  
HUMAN SERVICES  
COUNTY OFFICES**

<b>County</b>	<b>Telephone No.</b>	<b>Address</b>
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 4 ADMINISTRATIVE SERVICES

### DHHS COUNTY OFFICES

<b>County</b>	<b>Telephone No.</b>	<b>Address</b>
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 4 ADMINISTRATIVE SERVICES

### DHHS 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 4 ADMINISTRATIVE SERVICES

### DHHS COUNTY OFFICES

<b>County</b>	<b>Telephone No.</b>	<b>Address</b>
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 11 <sup>th</sup> Ave., 2 <sup>nd</sup> 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 4 ADMINISTRATIVE SERVICES****DHHS COUNTY OFFICES**

<b>County</b>	<b>Telephone No.</b>	<b>Address</b>
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 4 ADMINISTRATIVE SERVICES

### DHHS COUNTY OFFICES

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



**SECTION 4 ADMINISTRATIVE SERVICES****DHHS COUNTY OFFICES**

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

## **SECTION 4 ADMINISTRATIVE SERVICES**

### **DHHS COUNTY OFFICES**

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## SECTION 4 ADMINISTRATIVE SERVICES

### EXHIBITS

FORM NUMBER	EXHIBIT	REVISION DATE
219-RCF	Enrollment Data Form	01/2003
	Levels of Sanctioning for CRCFs	
CRCF-01	Notice of Admission, Authorization & Change of Status for Community Residential Care Facility	01/2003
CRCF-02	Communication Form	
3264-ME	OSS Slot Reservation Form	07/2002
	SSI Recipient Request for Optional State Supplementation	
ELD018	Medicaid Approval Letter	09/2003
	OSS Preadmission Flowchart	
	OSS Discharge/Transfer Flowchart	
	Sample Turn Around Document (TAD)	
	Sample Remittance Advice	
	Authorization Agreement for Electronic Funds Transfer	07/1995
126	Confidential Complaint	12/2004
140	Medicaid Provider Inquiry	11/1987
205	Medicaid Refunds (two pages)	03/2000
	Health Insurance Information Referral Form	03/2004
142	Request for Medicaid Forms	05/1997

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**Shaded Items** are for Agency use only and no information should be entered by the CRCF provider.

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Authorized Signature \_\_\_\_\_ 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 C.F.R. 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 proceeding 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 in 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.

## **DHHS LEVELS OF SANCTIONING FOR CRCF'S**

\*The offense will determine the sanctioning level. Appeals with the Department of Health and Environmental Control (DHEC) are not exempt from DHHS sanctioning.

### **1. Denial of Payment for New Admissions and Readmissions/ Approval – Division Level**

- A. Multiple substantiated complaints from various agencies such as the Long Term Care Ombudsman, Protection & Advocacy, DHEC, etc. related to the physical conditions and/or quality of care in the facility. This sanction will be imposed until the facility develops and adheres to a corrective action plan to adequately address these concerns.

### **2. Holding of OSS Reimbursement/Approval Level – Bureau Level**

- A. Failure to submit a notarized cost report within the scheduled time frames to DHHS.
- B. Failure to submit Turn Around Document (TAD) for payment by the due date.
- C. Failure to promptly notify the DHHS eligibility worker and area DHHS Regional Office.
- D. Substantiated finding of failure to follow policy for the administration of the recipient's personal needs accounts.

### **3. Recoupment of Payment/Approval Level – Bureau level**

- A. Failure to follow the Agency Policies and Procedures.
- B. Billing for more residents than the facility has licensed beds.

### **4. Termination of OSS Participation Agreement/Approval Level – Executive Level**

- A. DHEC Health Licensing Division sends notice to suspend or revoke the license.
- B. DHEC or law enforcement substantiates life threatening physical conditions.
- C. Continuous substantiated complaints and/or violations of the licensing regulations.

---

Authorized Signature

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Date

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OPTIONAL STATE SUPPLEMENTATION & INTEGRATED PERSONAL CARE PROGRAMS  
NOTICE OF ADMISSION, AUTHORIZATION & CHANGE OF STATUS FOR COMMUNITY RESIDENTIAL CARE FACILITY**

**SECTION I – IDENTIFICATION OF PROVIDER AND RESIDENT**

1. RESIDENTS NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE  _____ _____ _____ (MO.) (DAY) (YR.)	2. RESIDENTS MEDICAID I.D. NUMBER  _____
4. RESIDENTS ADDRESS	5. COUNTY NAME	6. SOCIAL SECURITY NO.  _____ _____ _____
7. CRCFS NAME & ADDRESS (ST. NAME, CITY, STATE)	8. CRCFS I.D. #	9. DATE OF REQUEST  _____ _____ _____ (MO.) (DAY) (YR.)

**SECTION II – ADMISSION, INCOME, TRANSFER, TERMINATION OR CHANGE IN STATUS**

\* (A) ADMITTED TO THIS CRCF ON \_\_\_\_\_  
(MO.) (DAY) (YR.)

(B) AUTHORIZATION TO BEGIN PAYMENT \_\_\_\_\_  
(MO.) (DAY) (YR.)

(C) RESIDENTS COUNTABLE INCOME EFFECTIVE: \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_  
(MO.) (YR.) AMOUNT PERSONAL NEEDS AMOUNT

(D) TRANSFERRED TO ANOTHER CRCF \_\_\_\_\_  
(MO.) (DAY) (YR.) NAME OF FACILITY COUNTY

\* (E) TERMINATION/DISCHARGE \_\_\_\_\_ IF DECEASED, SPECIFY DATE OF DEATH \_\_\_\_\_  
(MO.) (DAY) (YR.) (MO.) (DAY) (YR.)

SPECIFY REASON FOR TERMINATION OR OTHER CHANGE IN STATUS IF NOT COVERED BY ABOVE ITEMS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*REMINDER: DATE OF ADMISSION IS BILLED, DATE OF DISCHARGE IS NOT**

**SECTION III – ABSENCES**

(A) ADMITTED TO A NURSING FACILITY	_____ (MO.) (DAY) (YR.)	NAME OF FACILITY _____
(B) ADMITTED TO A MEDICAL INSTITUTION OR MENTAL HEALTH FACILITY	_____ (MO.) (DAY) (YR.)	NAME OF FACILITY _____
(C) READMITTED FROM A MEDICAL INSTITUTION, MENTAL HEALTH FACILITY OR NURSING FACILITY	_____ (MO.) (DAY) (YR.)	NAME OF FACILITY _____
(D) TEMPORARY MEDICAL ABSENCE – BEGINNING	_____ (MO.) (DAY) (YR.)	ENDING _____ (MO.) (DAY) (YR.)
(E) TEMPORARY NON-MEDICAL ABSENCES – BEGINNING	_____ (MO.) (DAY) (YR.)	ENDING _____ (MO.) (DAY) (YR.)

\_\_\_\_\_  
AUTHORIZED ELIGIBILITY WORKER SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
AUTHORIZED COMMUNITY RESIDENTIAL CARE FACILITY SIGNATURE

\_\_\_\_\_  
DATE



State of South Carolina  
Department of Health and Human Services

Iim Hodges  
Governor

12/11/02

William A. Prino  
Director

Dear

RE: 0412723

An Optional State Supplement (OSS) slot is now available for you.

As of the above date, you may select a licensed community residential care facility (CRCF) that participates in the OSS program. Please take this notification to the CRCF you select. This letter is valid for 30 calendar days from the date of the letter. If you are not admitted by 1/10/03, you must reapply for OSS at your DSS County Office. The CRCF must complete the bottom portion of this form on the day you are admitted and return it to the Community Long Term Care office listed below.

Signature and Date of CLTC Staff: \_\_\_\_\_

**SECTION II**

**TO BE COMPLETED BY A LICENSED COMMUNITY RESIDENTIAL CARE FACILITY ENROLLED IN THE OSS PROGRAM:**

**INSTRUCTIONS FOR CRCF:** Complete and return this form to the following CLTC area office:

Community Long Term Care  
1890 Neely's Creek Road

Rock Hill, SC 29730

Please note that a delay in return of this form, incorrect information or blanks in Section II shall result in a delay of the OSS Payment to your facility.

CRCF name: \_\_\_\_\_

CRCF provider number: \_\_\_\_\_

Date resident entered facility: \_\_\_\_\_

Date completed: \_\_\_\_\_

Signature and title of CRCF official: \_\_\_\_\_



South Carolina Department of Health and Human Services  
**OSS SLOT RESERVATION FORM**

**Section I—OSS Slot Request**  
To be completed by the Medicaid Worker and forwarded to the Area CLTC

Applicant's Name: \_\_\_\_\_ County Number: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Medicare No.: \_\_\_\_\_ Medicaid No.: \_\_\_\_\_

Authorized Rep.'s Name: \_\_\_\_\_ If applicant receives services from another state agency, indicate below:

Address: \_\_\_\_\_ Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Address: \_\_\_\_\_

Race: \_\_\_\_\_ Sex: ☐ M ☐ F Telephone: \_\_\_\_\_

Date of OSS Application: \_\_\_\_\_

Adult Protective Service Priority: ☐ Yes ☐ No

Date of Entry: (If CRCF resident at time of application) \_\_\_\_\_ CRCF Name: \_\_\_\_\_ CRCF No.: \_\_\_\_\_

Applicant's CRCF Preference: (If not CRCF resident at time of application)

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

☐ Current SSI Recipient

☐ Determined to be financially eligible for OSS but case cannot be approved until OSS slot is authorized and applicant residing in CRCF.

Countable Income: \$ \_\_\_\_\_

Medicaid Worker's Signature: \_\_\_\_\_ County: \_\_\_\_\_ Date: \_\_\_\_\_

**Section II—Receipt of OSS Slot Request**  
To be completed by the Area CLTC and returned to Medicaid Worker

☐ OSS Slot Request Acknowledged

CLTC Worker's Signature: \_\_\_\_\_ CLTC Area: \_\_\_\_\_ Date: \_\_\_\_\_

Distribution: Return one copy to Medicaid Worker

**Section III—Verification of Slot Authorization and CRCF Admission**  
To be completed by the Area CLTC and returned to Medicaid Worker

Date Applicant Entered CRCF: \_\_\_\_\_ CRCF Name: \_\_\_\_\_

Effective Date of OSS Slot: \_\_\_\_\_ Address: \_\_\_\_\_

Notified of available slot, applicant did not enter CRCF within \_\_\_\_\_ days.

CLTC Worker's Signature: \_\_\_\_\_ CLTC Area: \_\_\_\_\_ Date: \_\_\_\_\_

Distribution: Return one copy to Medicaid Worker

CLTC retains one copy

## SSI Recipient Request for Optional State Supplementation (OSS)

1. I, \_\_\_\_\_, am currently eligible for supplemental Security Income (SSI).
2. I live or plan to live in a Community Residential Care Facility (CRCF).
3. I need help with paying the cost of living in a CRCF.
4. I request this help through the Optional State Supplementation (OSS) program.

The following statements explain your rights and responsibilities. If there are statements you do not understand, you should discuss those statements with the worker during the interview. You are responsible for giving complete and accurate information.

I understand that I must report any and all changes in my income, living arrangements, or other information that will affect my eligibility for OSS within 10 days of the date of the change(s).

I understand that my case record is confidential and no information will be released from it unless properly authorized by me or as provided for under State/Federal laws.

I understand that any information I have given is subject to being reviewed by staff members of the Department of Social Services and the Department of Health and Human Services. Also, I understand that I must cooperate fully with State and Federal workers if my case is selected for a complete review.

I understand that this request will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

I understand that I may request a hearing if I am not satisfied with the actions taken on my case or if I feel that I have been discriminated against.

I certify that I have read or had read to me all the statements on this form and the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any information regarding my situation, I am liable for prosecution for fraud and/or perjury. I hereby give the Department(s) permission to verify, without additional consent from me, information discovered by the Department(s) or given by me that is needed to determine my eligibility for OSS.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Applicant/Responsible Party

Applicant's SSN \_\_\_\_\_ Telephone Number \_\_\_\_\_

Applicant's Address  
(Name of facility  
if already residing  
in CRCF)

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

Worker's Signature \_\_\_\_\_ Date \_\_\_\_\_

## MEDICAID APPROVAL LETTER

Date:  
Worker:  
Telephone:  
BG #:

Your application has been approved. The person listed below is eligible:

Recipient Name	Recipient ID	Medicaid Card Effective Date
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The Medicaid card will be mailed to your current address. If you move, you must tell your County Department of Health and Human Services (DHHS) because the Post Office cannot forward your Medicaid cards. You must present this card to the doctor, hospital, drug store each time you go.

You have been approved for a payment to a residential care facility on your behalf effective . All of your monthly income except for your personal needs must be paid to the facility.

You may have a choice about the way that you receive your Medicaid services. For more information, call toll free 1-888-549-0820.

X As a condition of eligibility when you apply for medical assistance, you are assigning to the state your rights to any medical support or other payments for medical care and you are agreeing to cooperate with the state in obtaining third party payments.

X You may ask for a fair hearing before the Department of Health and Human Services if you believe an error was made in processing your application.

### To Request A Fair Hearing From the Department of Health and Human Services

- o Ask your Medicaid worker in writing within 30 days of the date on this letter. Attach a copy of this letter to your request.

### To Get Help With Your Fair Hearing

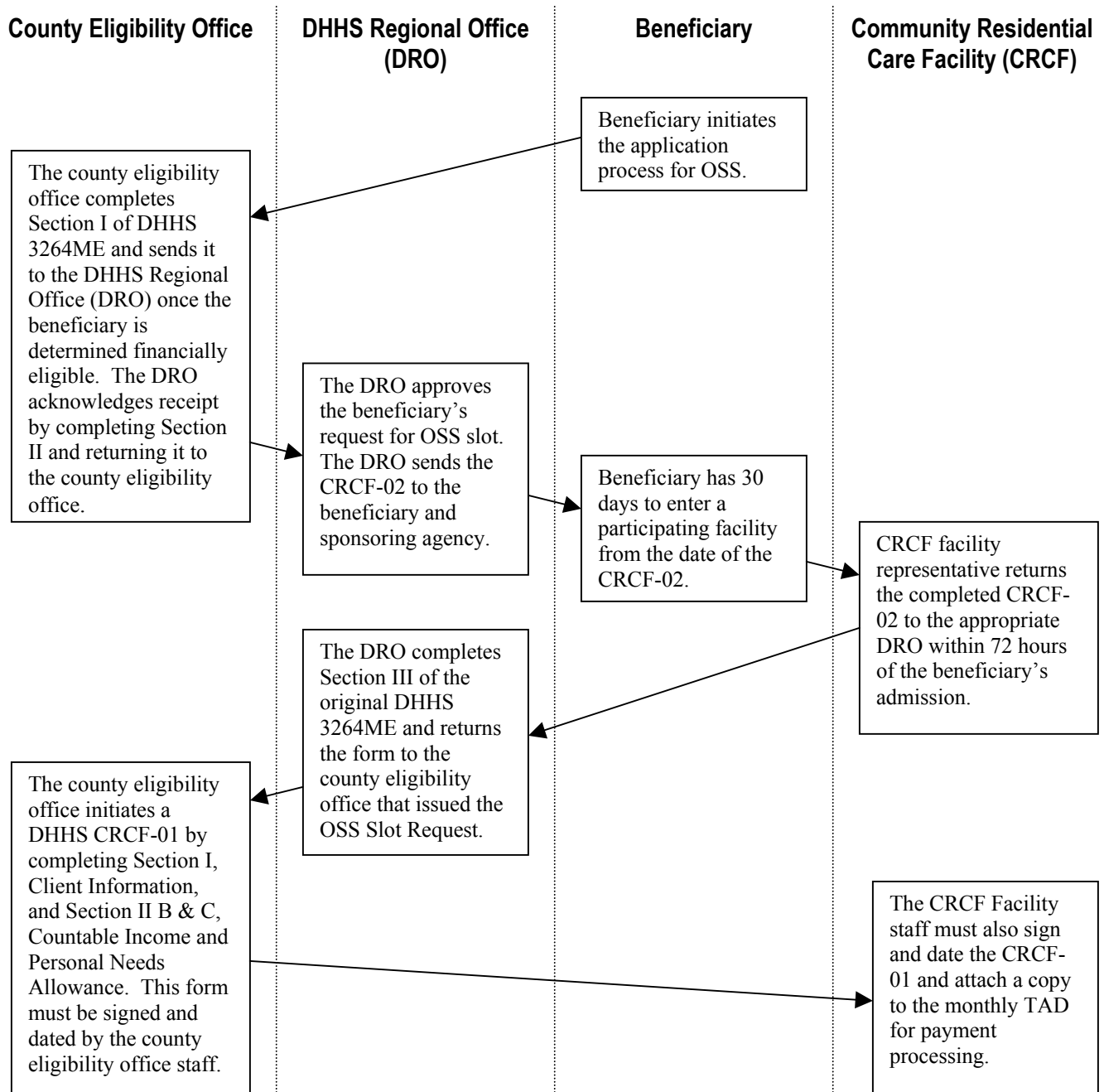
- o You can hire an attorney to help you
- o You can have someone you know come to the hearing and speak for you
- o Contact your Medicaid worker in person or by phone to get help in asking for a hearing.

You must tell your Medicaid worker in ten days if you have a change in:

- o Where you live
- o Income
- o Resources
- o Family size (someone moves in or out)
- o Any news that would change your case

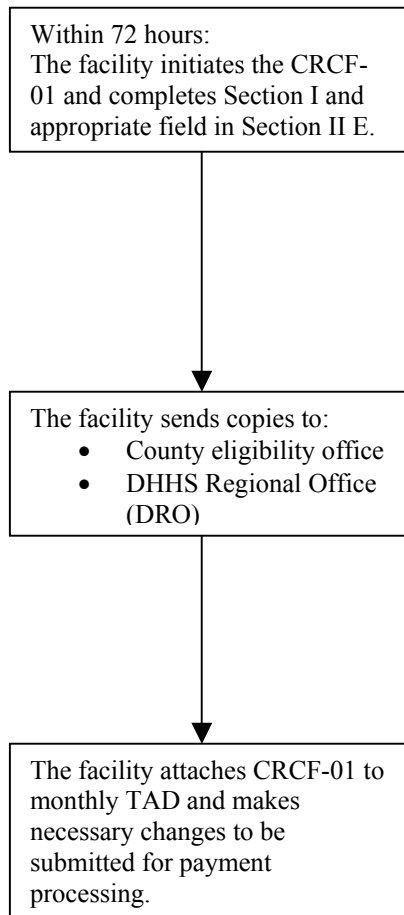
YOU WILL RECEIVE A REVIEW FORM IN THE MAIL EVERY 12 MONTHS (SOMETIMES SOONER). WHEN YOU RECEIVE THE REVIEW FORM, YOU MUST COMPLETE AND RETURN IT OR YOUR MEDICAID WILL STOP.

## OSS PREADMISSION FLOW CHART

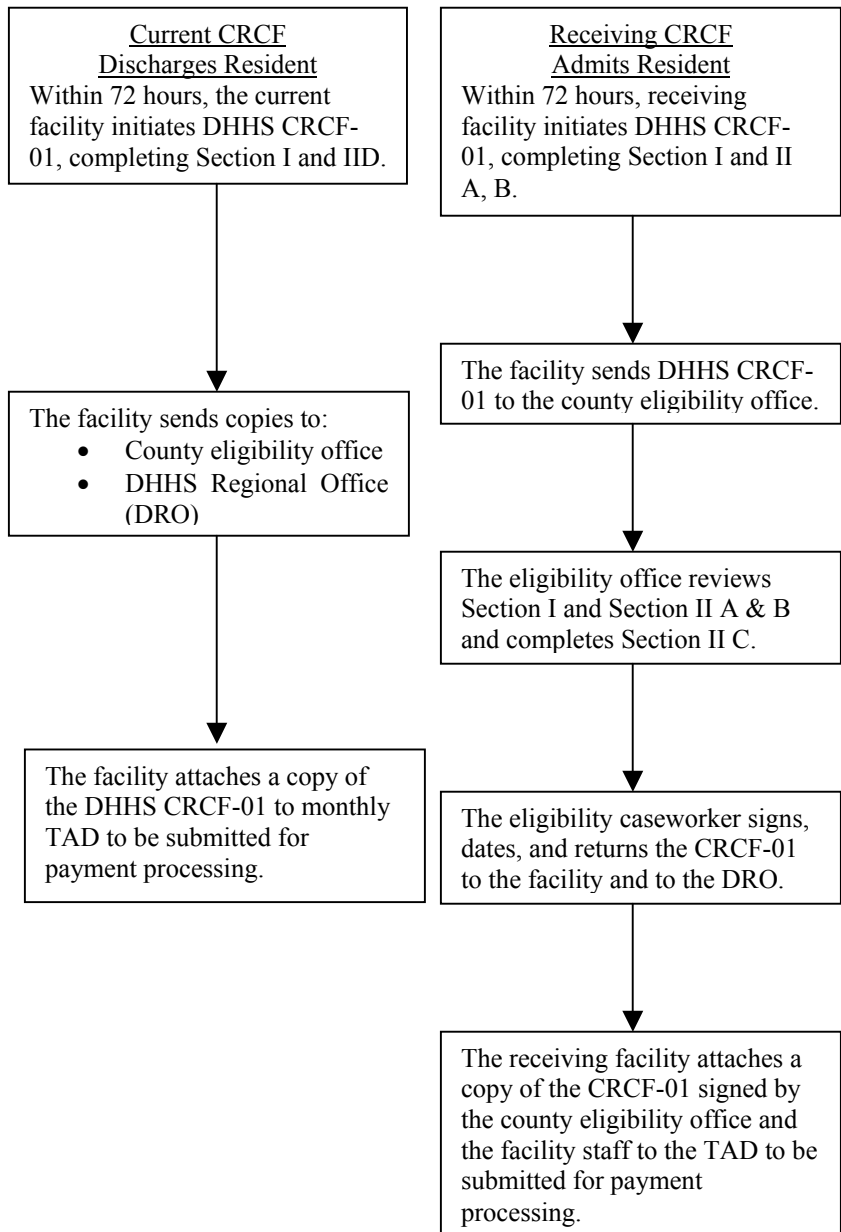


## OSS DISCHARGE/TRANSFER FLOW CHART

### Beneficiary Discharge



### Beneficiary Transfer



REPORT NH4545R1

DATE 12/16/2002

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

PAGE 1

COMMUNITY RESIDENTIAL CARE  
FOR MONTH OF FEBRUARY

(1) CRCF NO. RC0999 HAPPY HOME (2)  
111 VALLEY ST  
LEXINGTON

SC 29687

(3) LINE	(4) COUNTY	(5) RECIPIENT NAME	(6) RECIPIENT ID NO	(7) MONTHLY INCOME	(8) DATE OF SERVICE MO/YR	(9) CRCF DAYS	(10) IPC DAYS	(11) CHANGED CRCF DAYS	(12) CHANGED IPC DAYS	(13) DELETE FROM NEXT MONTH'S TA
01	32	MARY SMITH	1234567801		02/03	28				
02	32	SAM PERKINS	9876543201		02/03	28				
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										
13										
14										
15										
16										
17										

- 1) IF THE ABOVE INFORMATION IS CORRECT AND THERE HAVE BEEN NO ADMISSIONS OR DISCHARGES, SIGN AND DATE AS INDICATED BELOW.
- 2) IF THERE HAS BEEN A NEW OSS APPROVED ADMISSION TO YOUR FACILITY DURING THE MONTH OF DECEMBER, ENTER A NEW LINE FOR THAT RESIDENT WITH THE NAME, ID NUMBER, DATE OF ADMISSION, AND NUMBER OF DAYS IN YOUR FACILITY.
- 3) IF THE FACILITY HAS RECEIVED AUTHORIZATION FROM SCDHHS TO PROVIDE INTEGRATED PERSONAL CARE (IPC) SERVICES TO ANY OSS RESIDENT, REDUCE THE NUMBER OF CRCF DAYS BY THE NUMBER OF DAYS THE RESIDENT WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES AND INSERT THE NUMBER OF DAYS THE RESIDENT RECEIVED AUTHORIZED IPC SERVICES IN THE IPC DAYS COLUMN.
- 4) IF THERE HAS BEEN A DISCHARGE/DEATH FROM YOUR FACILITY DURING THE MONTH OF DECEMBER, INDICATE THE NUMBER OF DAYS, NOT COUNTING THE DATE OF DISCHARGE/DEATH THAT THE RESIDENT WAS IN YOUR FACILITY IN THE COLUMN TITLED "CHANGED CRCF DAYS". IF THE RESIDENT WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES, ENTER THE NUMBER OF DAYS, NOT COUNTING THE DATE OF DISCHARGE/DEATH THAT THE RESIDENT WAS IN YOUR FACILITY AND WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES IN THE "CHANGED IPC DAYS" COLUMN.
- 5) IF ANY OF THE RESIDENTS LISTED WILL NOT BE IN YOUR FACILITY NEXT MONTH, ENTER AN 'X' IN THE COLUMN TITLED 'DELETE FROM NEXT MONTH'S TA'.

I CERTIFY THAT THE INFORMATION SHOWN ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION WILL BE USED TO GENERATE PAYMENTS OF STATE FUNDS, AND I UNDERSTAND THAT SUBMITTING FALSE OR MISLEADING INFORMATION IS AGAINST THE LAW AND COULD RESULT IN CRIMINAL PROSECUTION.

SIGNATURE

TITLE

DATE









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)

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)  <input type="checkbox"/> YES <input type="checkbox"/> NO		IS MEDICARE COVERAGE INVOLVED?  <input type="checkbox"/> YES <input type="checkbox"/> NO	
CLAIMS STATUS ON REMITTANCE ADVICE	PAYMENT DATE	17 DIGIT CLAIM REFERENCE NUMBER	
STATEMENT OF PROBLEM OR QUESTION			
RESPONSE			

**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 #**

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(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)

**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.**

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 #: \_\_\_\_\_



STATE OF SOUTH CAROLINA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

## REQUEST FOR MEDICAID FORMS AND PUBLICATIONS

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

#### WHEN COMPLETED PLEASE FORWARD TO:

SC Department of Health and Human Services  
Supply

Post Office Box 8206

- or -

Columbia, South Carolina 29202-8206

FAX TO: (803) 253-4027

MEDICAID NO:

TYPE OF PROVIDER:

TELEPHONE:

CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY (PLEASE PRINT OR TYPE)

#### ITEMS REQUESTED

FORM/PUBLICATION NO.	TITLE OF FORM OR PUBLICATION	QUANTITY

DHHS FORM 142 (5/97)

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



STATE OF SOUTH CAROLINA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

## REQUEST FOR STATEMENT OF PHARMACY SERVICES

DHHS FORM 3211 (11/96)

#### WHEN COMPLETED PLEASE FORWARD OR FAX:

- REQUEST FOR PREPRINTED FORMS TO YOUR PROVIDER REPRESENTATIVE; OR

- REQUEST FOR BLANK FORMS 3211 TO SUPPLY

MEDICAID NO:

TELEPHONE:

CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY (PLEASE PRINT OR TYPE)

QUANTITY REQUESTED

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

DHHS FORM 142 (5/97)