

SECTION 5

ADMINISTRATIVE SERVICES

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SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

ADMINISTRATION

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

CORRESPONDENCE AND INQUIRIES

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

Department of Health and Human Services
Attn: Diabetes Education Program
Post Office Box 8206
Columbia, SC 29202-8206
(803) 898-2882

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

Questions concerning beneficiary eligibility or identification numbers should be directed to the SCDHHS 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 SCDHHS office for assistance. To verify eligibility status, please call the Medicaid Interactive Voice Response System (IVRS) at (888) 809-3040 or use the South Carolina Medicaid Web-based Claims Submission Tool.

SECTION 5 ADMINISTRATIVE SERVICES**GENERAL INFORMATION**

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SECTION 5 ADMINISTRATIVE SERVICES**PROCUREMENT
OF FORMS**

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

**REPRODUCIBLE
NEGATIVES**

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

SOFTWARE

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

HARD COPY CLAIM FORMS

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

PRIVATE VENDORS

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

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

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

SECTION 5 ADMINISTRATIVE SERVICES**PROCUREMENT OF FORMS****PRIVATE VENDORS
(CONT'D.)**

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

FAX REQUESTS

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

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

WEB ADDRESS

The most current version of this manual is available on the SCDHHS Web site at **www.scdhhs.gov**.

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

SECTION 5 ADMINISTRATIVE SERVICES**DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
COUNTY OFFICES**

County	Telephone No.	Address
1. Abbeville County	(864) 366-5638	Medicaid Eligibility Abbeville County DSS Human Services Building 903 W. Greenwood St. Abbeville, SC 29620 Post Office Box 130 Abbeville, SC 29620
2. Aiken County	(803) 643-1938	Medicaid Eligibility Aiken County DHHS County Commissioner's Building 1410 Park Ave. S.E. Aiken, SC 29801 Post Office Box 2748 Aiken, SC 29802
3. Allendale County	(803) 584-8137	Medicaid Eligibility Allendale County DHHS 611 Mulberry St. Allendale, SC 29810 Post Office Box 326 Allendale, SC 29224-0326
4. Anderson County	(864) 260-4541	Medicaid Eligibility Anderson County DHHS 224 McGee Rd. Anderson, SC 29625 Post Office Box 160 Anderson, SC 29622-0160

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
5. Bamberg County	(803) 245-4361	<p>Medicaid Eligibility Bamberg County DHHS 374 Log Branch Rd. Bamberg, SC 29003</p> <p>Post Office Box 544 Bamberg, SC 29003</p>
6. Barnwell County	(803) 541-1200	<p>Medicaid Eligibility Barnwell County DHHS T. Ed Richardson Building 10913 Ellenton St. Barnwell, SC 29812</p> <p>Post Office Box 648 Barnwell, SC 29812</p>
7. Beaufort County	(843) 470-4625	<p>Medicaid Eligibility Beaufort County DHHS 1905 Duke St. Beaufort, SC 29902-4403</p> <p>Post Office Box 1255 Beaufort, SC 29901-1255</p>
8. Berkeley County	(843) 719-1131	<p>Medicaid Eligibility Berkeley County DSS 2 Belt Dr. Moncks Corner, SC 29461</p> <p>Post Office Box 13748 Charleston, SC 29422-3748</p>
9. Calhoun County	(803) 874-3384	<p>Medicaid Eligibility Calhoun County DHHS 2831 Old Belleville Rd. St. Matthews, SC 29135</p> <p>Post Office Box 378 St. Matthews, SC 29135</p>

SECTION 5 ADMINISTRATIVE SERVICES**DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES**

County	Telephone No.	Address
10. Charleston County	(843) 740-5900	Medicaid Eligibility Charleston County DHHS 326 Calhoun St. Charleston, SC 29401-1124 Post Office Box 13748 Charleston, SC 29422-3748
11. Cherokee County	(864) 487-2521	Medicaid Eligibility Cherokee County DHHS 1434 N. Limestone St. Gaffney, SC 29340-4734 Post Office Box 89 Gaffney, SC 29342
12. Chester County	(803) 377-8135	Medicaid Eligibility Chester County DHHS 115 Reedy St. Chester, SC 29706 Post Office Box 447 Chester, SC 29706
13. Chesterfield County	(843) 623-5226	Medicaid Eligibility Chesterfield County DHHS 201 N. Page St. Chesterfield, SC 29709 Post Office Box 855 Chesterfield, SC 29709
14. Clarendon County	(803) 435-4305	Medicaid Eligibility Clarendon County DSS 3 S. Church St. Manning, SC 29102 Post Office Box 788 Manning, SC 29102

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
15. Colleton County	(843) 549-1894	Medicaid Eligibility Colleton County DHHS Bernard Warshaw Building 215 S. Lemacks St. Walterboro, SC 29488
		Post Office Box 110 Walterboro, SC 29488
16. Darlington County	(843) 398-4420	Medicaid Eligibility Darlington County DHHS 300 Russell St., Room 145 Darlington, SC 29532
		Post Office Box 2077 Darlington, SC 29532
	(843) 332-2289	404 S. Fourth St., Suite 300 Hartsville, SC 29550
17. Dillon County	(843) 774-2713	Medicaid Eligibility Dillon County DHHS 1213 Highway 34 W. Dillon, SC 29536
		Post Office Box 351 Dillon, SC 29536
18. Dorchester County	(843) 821-0444	Medicaid Eligibility Dorchester County DSS 201 Johnson St., Bldg. 17 St. George, SC 29477
		Post Office Box 13748 Charleston, SC 29422-3748
19. Edgefield County	(803) 637-4040	Medicaid Eligibility Edgefield County DHHS 500 W. A. Reel Dr. Edgefield, SC 29824
		Post Office Box 386 Edgefield, SC 29824

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
20. Fairfield County	(803) 635-5502 Ext. 425	Medicaid Eligibility Fairfield County DHHS 1136 Kincaid Bridge Rd. Winnsboro, SC 29180-7116 Post Office Box 1139 Winnsboro, SC 29180-5139
21. Florence County	(843) 669-3354	Medicaid Eligibility Florence County DHHS 2685 S. Irby St., Box I Florence, SC 29505
	(843) 394-8575	245 S. Ron McNair Blvd Lake City, SC 29560
22. Georgetown County	(843) 546-5134	Medicaid Eligibility Georgetown County DSS 330 Dozier St. Georgetown, SC 29440-3219 Post Office Box 371 Georgetown, SC 29442
23. Greenville County	(864) 467-7926	Medicaid Eligibility Greenville County DSS 301 University Ridge, Suite 6700 Greenville, SC 29601 Post Office Box 9399 Greenville, SC 29604-9399
24. Greenwood County	(864) 229-5258	Medicaid Eligibility Greenwood County DHHS 1118 Phoenix St. Greenwood, SC 29646-3918 Post Office Box 1016 Greenwood, SC 29648

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
25. Hampton County	(803) 914-0053	Medicaid Eligibility Hampton County DHHS 102 Ginn Altman Ave., Suite B Hampton, SC 29924 Post Office Box 693 Hampton, SC 29924
26. Horry County	(843) 381-8260	Medicaid Eligibility Horry County DHHS 1601 11 th Ave., 2 nd Floor Conway, SC 29526 Post Office Box 290 Conway, SC 29528
27. Jasper County	(843) 726-7747	Medicaid Eligibility Jasper County DSS 204 N. Jacob Smart Blvd. Ridgeland, SC 29936 Post Office Box 1150 Ridgeland, SC 29936
28. Kershaw County	(803) 432-7676 Ext. 106	Medicaid Eligibility Kershaw County DHHS 110 E. DeKalb St. Camden, SC 29020-4432 Post Office Box 220 Camden, SC 29020-0220
29. Lancaster County	(803) 286-8208	Medicaid Eligibility Lancaster County DHHS 200 E. Dunlap St. Lancaster, SC 29720 Post Office Box 2169 Lancaster, SC 29721-2169

SECTION 5 ADMINISTRATIVE SERVICES**DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES**

County	Telephone No.	Address
30. Laurens County	(864) 833-6109	Medicaid Eligibility Laurens County DHHS 93 Human Services Rd. Clinton, SC 29325-7546 Post Office Box 388 Laurens, SC 29360-0388
31. Lee County	(803) 484-5376	Medicaid Eligibility Lee County DHHS County Welfare Building 820 Brown St. Bishopville, SC 29010 Post Office Box 406 Bishopville, SC 29010
32. Lexington County	(803) 785-2991 (803) 785-2975	Medicaid Eligibility Lexington County DHHS 605 West Main St. Lexington, SC 29072-2550
33. McCormick County	(864) 465-2627	Medicaid Eligibility McCormick County DSS 215 N. Mine St. Highway 28 N. McCormick, SC 29835
34. Marion County	(843) 423-5417	Medicaid Eligibility Marion County DHHS 1311 N. Main St. Marion, SC 29571-6012 Post Office Box 1837 Marion, SC 29571

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
35. Marlboro County	(843) 479-4389	Medicaid Eligibility Marlboro County DHHS County Complex 1 Ag St. Bennettsville, SC 29512 Post Office Box 1074 Bennettsville, SC 29512-1074
36. Newberry County	(803) 321-2155	Medicaid Eligibility Newberry County DSS County Human Services Center 2107 Wilson Rd. Newberry, SC 29108 PO Box 1225 Newberry, SC 29108
37. Oconee County	(864) 638-4400	Medicaid Eligibility Oconee County DHHS 100 Browns Square Dr. Walhalla, SC 29691 Post Office Box 979 Walhalla, SC 29691-0979
38. Orangeburg County	(803) 531-3101	Medicaid Eligibility Orangeburg County DSS 2570 Old St. Matthews Rd., N.E. Orangeburg, SC 29115 Post Office Box 1407 Orangeburg, SC 29116
39. Pickens County	(864) 898-5815	Medicaid Eligibility Pickens County DHHS 212 McDaniel Ave. Pickens, SC 29671 Post Office Box 160 Pickens, SC 29671-0160

SECTION 5 ADMINISTRATIVE SERVICES**DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES**

County	Telephone No.	Address
40. Richland County	(803) 714-7562 (803) 714-7549	Medicaid Eligibility Richland County DHHS 3220 Two Notch Rd. Columbia, SC 29204-2826
41. Saluda County	(864) 445-2139	Medicaid Eligibility Saluda County DSS 613 Newberry Highway Saluda, SC 29138 Post Office Box 245 Saluda, SC 29138
42. Spartanburg County	(864) 596-2714	Medicaid Eligibility Spartanburg County DHHS Pinewood Shopping Center 1000 N. Pine St., Suite 23 Spartanburg, SC 29305 Post Office Box 4847 Spartanburg, SC 29305
43. Sumter County	(803) 773-5531	Medicaid Eligibility Sumter County DHHS 105 N. Magnolia St., 3rd Floor Sumter, SC 29150-4941 Post Office Box 2547 Sumter, SC 29151
44. Union County	(864) 429-1660	Medicaid Eligibility Union County DHHS 200 S. Mountain St. Union, SC 29379 Post Office Box 1068 Union, SC 29379

SECTION 5 ADMINISTRATIVE SERVICES**DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES**

County	Telephone No.	Address
45. Williamsburg County	(843) 355-5411	Medicaid Eligibility Williamsburg County DSS 831 Eastland Ave. Kingstree, SC 29556 Post Office Box 767 Kingstree, SC 29556
46. York County	(803) 327-9061	Medicaid Eligibility York County DHHS 1890 Neelys Creek Road Rock Hill, SC 29730 Post Office Box 710 Rock Hill, SC 29731-6710

SECTION 5 ADMINISTRATIVE SERVICES**EXHIBITS**

Form Number	Exhibit	Revision Date
CMS-1500	Health Insurance Claim Form (two pages)	12/1990
DHHS 130	Claim Adjustment Form	11/2004
205	Medicaid Refunds (two pages)	03/2000
126	Confidential Complaint	12/2004
	Health Insurance Information Referral Form	03/2004
	Reasonable Effort Documentation	
140	Medicaid Provider Inquiry	11/1987
142	Request for Medicaid Forms and Publications	05/1997
	Authorization Agreement for Electronic Funds Transfer	12/2005
DME 001	Medicaid Certificate of Medical Necessity Form for Equipment and Supplies (two pages)	10/2006
	Sample Edit Correction Form	
	Sample Remittance Advice (three pages)	

SECTION 5 ADMINISTRATIVE SERVICES

EXHIBITS

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PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

HEALTH INSURANCE CLAIM FORM										PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
<input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (ID)										1234567890	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE			4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
John Doe					MM DD YY M F						
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)			
123 Main Street					Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						
CITY			STATE		8. PATIENT STATUS			CITY			
Columbia			SC		Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>						
ZIP CODE			TELEPHONE (Include Area Code)		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE			
29200			()					()			
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)			A-12315			
b. OTHER INSURED'S DATE OF BIRTH					b. AUTO ACCIDENT?			a. INSURED'S DATE OF BIRTH			
MM DD YY M F					YES <input type="checkbox"/> NO <input type="checkbox"/>			MM DD YY M F			
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT?			b. EMPLOYER'S NAME OR SCHOOL NAME			
					YES <input type="checkbox"/> NO <input type="checkbox"/>						
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE			c. INSURANCE PLAN NAME OR PROGRAM NAME			
								401			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
Signature on File					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.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 a-d.			
SIGNED					DATE			SIGNED			
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION			
MM DD YY					MM DD YY			FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES			
								FROM MM DD YY TO MM DD YY			
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? & CHARGES			22. MEDICAID RESUBMISSION CODE			
					YES <input type="checkbox"/> NO <input type="checkbox"/>			ORIGINAL REF. NO.			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)					23. PRIOR AUTHORIZATION NUMBER						
1. _____					3. _____						
2. _____					4. _____						
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J OOB K RESERVED FOR LOCAL USE											
1											
2											
3											
4											
5											
6											
25. FEDERAL TAX I.D. NUMBER					26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back)			
								YES <input type="checkbox"/> NO <input type="checkbox"/>			
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.)					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)			33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #			
SIGNED					DATE			PIN#			
								GRP#			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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

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

Provider Address:

Provider City, State, Zip:

Total paid amount on the original claim:

Original CCN:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Provider ID:

--	--	--	--	--	--	--

Recipient ID:

--	--	--	--	--	--	--	--	--	--	--	--	--	--

Adjustment Type:

- ☐ Void
 ☐ Void/Replace

Originator:

- ☐ DHHS
 ☐ MCCS
 ☐ Provider
 ☐ MIVS

Reason For Adjustment: (Fill One Only)

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="radio"/> Insurance payment different than original claim
<input type="radio"/> Keying errors
<input type="radio"/> Incorrect recipient billed
<input type="radio"/> Voluntary provider refund due to health insurance
<input type="radio"/> Voluntary provider refund due to casualty
<input type="radio"/> Voluntary provider refund due to Medicare | <input type="radio"/> Medicaid paid twice - void only
<input type="radio"/> Incorrect provider paid
<input type="radio"/> Incorrect dates of service paid
<input type="radio"/> Provider filing error
<input type="radio"/> Medicare adjusted the claim
<input type="radio"/> Other |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

For Agency Use Only

Analyst ID:

--	--	--	--	--	--	--

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

Comments:

Signature: _____ Date: _____

Phone: _____

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

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

Items 1 - 6 must be completed.

Attach appropriate document(s) as listed in item 7.

1. Provider Name: _____ **2. Medicaid Provider #**

--	--	--	--	--	--

(Six Digits)

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

5. Reason for Refund: [check appropriate box]

☐ Other Insurance Paid (please complete **a - f** below and attach insurance EOMB)

a Type of Insurance: () Accident/Auto Liability () Health/ Hospitalization

b Insurance Company Name: _____

c Policy # : _____

d Policyholder: _____

e Group Name/Group: _____

f Amount Insurance Paid: _____

☐ Medicare

() Full payment made by Medicare

() Deductible not due

() Adjustment made by Medicare

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

☐ Other, describe in detail reason for refund:

6. Patient/Service Identification:

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

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

☐ Medicaid Remittance Advice (required)

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

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

Instructions
Form for Medicaid Refunds

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

Mail all checks to:

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

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

Item 1 – Provider Name. Self explanatory.

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

Item 3 – Person to contact. Self – explanatory.

Item 4 – Telephone Number. Self – explanatory.

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

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

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

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



STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

MEDICAID PROVIDER ENROLLMENT NUMBER: (if applicable)

MEDICAID RECIPIENT I.D. NUMBER: (if applicable)

ADDRESS OF SUSPECT:

LOCATION OF INCIDENT:

DATE OF INCIDENT:

COMPLAINT:

NAME OF PERSON REPORTING: (Please print)

SIGNATURE OF PERSON REPORTING:

DATE OF REPORT:

ADDRESS OF PERSON REPORTING:

TELEPHONE NUMBER OF PERSON REPORTING:

SIGNATURE: (SCDHHS Representative Receiving Report)

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 #: _____

REASONABLE EFFORT DOCUMENTATION

PROVIDER _____ **DOS** _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

**I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT
RESPONSE FROM THE PRIMARY INSURER.**

(SIGNATURE AND DATE)

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

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			



STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR MEDICAID FORMS AND PUBLICATIONS

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

WHEN COMPLETED PLEASE FORWARD TO:

SC Department of Health and Human Services
Supply

Post Office Box 8206

- OR -

Columbia, South Carolina 29202-8206

FAX TO: (803) 253-4027

MEDICAID NO:

TYPE OF PROVIDER:

TELEPHONE:

CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY (PLEASE PRINT OR TYPE)

ITEMS REQUESTED

FORM/PUBLICATION NO.	TITLE OF FORM OR PUBLICATION	QUANTITY

DHHS FORM 142 (5/97)

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



STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR STATEMENT OF PHARMACY SERVICES

DHHS FORM 3211 (11/96)

WHEN COMPLETED PLEASE FORWARD OR FAX:

- REQUEST FOR PREPRINTED FORMS TO YOUR PROVIDER REPRESENTATIVE; OR
- REQUEST FOR BLANK FORMS 3211 TO SUPPLY

MEDICAID NO:

TELEPHONE:

CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY (PLEASE PRINT OR TYPE)

QUANTITY REQUESTED

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

DHHS FORM 142 (5/97)

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

Provider Name: _____

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

**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR EQUIPMENT/ SUPPLIES**

CERTIFICATION TYPE / DATE: **INITIAL** ____/____/____ **REVISED** ____/____/____ **RECERTIFICATION** ____/____/____

SECTION A: TO BE COMPLETED BY PROVIDER:

- (1) Recipient's name: _____ Height: _____ Weight: _____
- (2) Recipient's Medicaid # (10 digits): _____ Sex: _____ DOB: _____
- (3) Date of (telephone/written/fax) order: _____ Date of service: _____
- (4) Provider's name: _____ Provider's DME # / NPI # _____
- (5) Provider's signature: _____ Date: _____
- (6) Street address: _____ City: _____
- (7) State: _____ Zip: _____ Local telephone # _____
- (8) Diagnosis codes (ICD-9) _____ (Descriptions): _____

- (9) Print treating/ordering physician's name: _____ License # _____

Is additional information attached on separate sheet? ____ Yes ____ No (If "yes", enter recipient's name & I.D. Medicaid number on attachment)

(10) SPECIFICALLY LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT ON THE BACK OF THIS FORM.

NOTE: ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISH PRICE MUST INCLUDE MANUFACTURER PRICE LIST. RECERTIFICATION IS REQUIRED PRIOR TO EXPIRATION OF THE CURRENT CMN/AF FOR RENTAL ITEM(S).

SECTION B: TO BE COMPLETED BY TREATING/ORDERING PHYSICIAN ONLY

(11) Indicate patient's ambulatory status while performing activities of daily living: ____ Non-ambulatory ____ Ambulatory, without assistance
____ Ambulatory with the aid of a walker or cane, ____ Ambulatory, with other assistance as described

Does the patient have decubitus ulcers? ____ Yes ____ No. If yes, circle stage(s): I, II, III, or IV. Indicate the wound size(s): _____

Please describe how this equipment / supply is medically necessary, the benefits to the recipient and how long will it take for the benefit to be evident:

(12) For supplies, please indicate the dressing change required per day, week, month, etc. _____

Is additional information attached on separate sheet? ____ Yes ____ No (If "yes", enter recipient's name & I.D. Medicaid number on attachment)

(13) Please indicate the date that the patient was seen for the equipment/supplies ordered: _____

(14) Duration of need (maximum of 12 months): _____

(If physician expects that the patient will require the equipment/supplies for the duration of his/her life, than enter 12 months)

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies is appropriate for the patient.

(15) PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATES STAMPS ARE NOT ACCCCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY ON PAGE 200-1 IN THE DME MEDICAID PROVIDER MANUAL.
(DME 001 - Dated 10/01/06)

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY

SECTION A:

LINES 1 THRU 9 TO BE COMPLETED BY ENROLLED DME PROVIDER:

Line 1 - Enter recipient's full name, height and weight.

Line 2 - Enter recipient's Medicaid 10-digit number, sex and date of birth.

Line 3 - Enter the date of telephone/written/fax order and date of service.

Line 4 - Print provider's name and provider's DME and/or NPI number.

Line 5 - Provider's signature and date.

Line 6 - Enter provider's street address and city.

Line 7 - Enter provider's state, zip code and local telephone number.

Line 8 - Enter diagnosis code(s) and description.

Line 9 - Print treating/ordering physician's name and enter License number.

SECTION B:

LINE 10 THRU 14 TO BE COMPLETED BY TREATING/ORDERING PHYSICIAN

Line 10 - List all procedure codes for Equipment/Supplies.

Line 11-This medical information is used to determine the patient's ambulatory status, information regarding decubitus ulcers, if applicable, medical necessity, benefits and expected outcomes.

Line 12 – This is used to explain the amount of supplies requested.

Line 13-Date the treating/ordering physician saw the patient and ordered the equipment/supplies.

Line 14 - Enter duration of need.

Line 15 – Physician/Nurse Practitioner or Physician Assistant must sign and date the MCMN.

Please list all procedure codes that will be utilized on the following lines:

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper has a slight shadow on the right side, suggesting it's resting on a surface. There is no handwriting or other markings on the paper.

RUN DATE 11/31/2004 0000
REPORT NUMBER CLM3500
ANALYST ID
SIGNON ID

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 60 PRAC SPEC - 12
CLAIM RESTART DATE / / DOC IND N

CLAIM CONTROL #0401000123810220A
PAGE 37267 ECF 37249 PAGE 1 OF 1
EMC N

EDITS

1 PROVIDER ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 ---- DIAGNOSIS ---- PRIMARY SECONDARY	9
---------------------	----------------------	-----------------------	----------	---------------------	------------	---------------	-----------------------------------------------	---

XXXXXX XXXXXXXXX

170.1 .

INSURANCE EDITS

CLAIM EDITS

LINE EDITS

01) 102

02)

03)

10 RECIPIENT NAME - DOE, JOHN

11 DATE OF BIRTH 01/31/1947 12 SEX M

13 RES	14 ALLOWED	15 LN NO	16 DATE OF SERVICE	17 PLACE	18 PROC CODE	19 MOD MD2 MD3 MD4	20 INDIVIDUAL PROVIDER	21 CHARGE IND	22 PAY	23 UNITS
	.00	1	05/07/04	11	S0315	000	XXXXXX	50.00		1.000
	.00	2	/ /							
	.00	3	/ /							
		4	/ /							
		5	/ /							
		6	/ /							
		7	/ /							
		8	/ /							

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

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

23
INS CARR
NUMBER

24
POLICY
NUMBER

25
INS CARR
PAID

26 TOTAL CHARGE 50.00

01

27 AMT REC'D INS

02

28 BALANCE DUE 50.00

03

29 OWN REF # 012345

RESOLUTION DECISION _R_

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

INSURANCE POLICY INFORMATION

PROVIDER:
ABC HEALTH PROVIDER
PO BOX 00000
ANYWHERE

XO 00000-0000

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

Sample Remittance Advice (page 1)

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

# AB0008 ABC HEALTH PROVIDER .121212121234. PROVIDER ID.	Y	PO BOX 000000	FLORENCE	SC000000000
DEPT OF HEALTH AND HUMAN SERVICES		PROFESSIONAL SERVICES	PAYMENT DATE	PAGE
AB0008		REMITTANCE ADVICE	03/26/2004	1
SOUTH CAROLINA MEDICAID PROGRAM				

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	0406001089000400A				1192.00	243.71	P	1112233333	M CLARK			0.00	
	01		021504	S0315	800.00	117.71	P			000			0.00
	02		021504	S9445	392.00	126.00	P			000			0.00
VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04													
ABB222222	0406001089000400U				1412.00-	273.71-		1112233333	M CLARK				
	01		012104	S0315	1112.00-	143.71-				000			
	02		012104	S9445	300.00-	130.00-				000			
REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04													
ABB222222	0407701389002500A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		012104	S0315	142.50	42.75	P			000			0.00
	02		012104	S9445	859.00	0.00	R			000			0.00
TOTALS				2	2193.50	286.46						0.00	0.00

				\$286.46
FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".	CERT. PG TOT	MEDICAID PG TOT	STATUS CODES:	
	\$0.00	\$286.46	P = PAYMENT MADE	
			R = REJECTED	
			S = IN PROCESS	
			E = ENCOUNTER	
IF YOU STILL HAVE QUESTIONS+ PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.	FEDERAL RELIEF	MAXIMUS AMT	CHECK TOTAL	CHECK NUMBER
	\$0.00	\$0.00	0.00	

PROVIDER NAME AND ADDRESS	
ABC HEALTH PROVIDER	
PO BOX 000000	
FLORENCE	SC 00000

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

PROVIDER ID.		DEPT OF HEALTH AND HUMAN SERVICES				CLAIM ADJUSTMENTS			PAYMENT DATE				PAGE		
AB1111		SOUTH CAROLINA MEDICAID PROGRAM							03/26/2004				2		
PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	O D	ORG CHECK DATE	ORIGINAL CCN	
ABB222222	0406001089000400U				513.00-	197.71-		1112233333	CLARK	M			022804	0404711253670430A	
	01		012104	S0315	453.00	160.71-	P						000		
	02		012104	S9445	60.00	33.00-	P						000		
	TOTALS		1		513.00-	193.71-									
					MEDICAID TOTAL		CERTIFIED AMT		FEDERAL RELIEF		TO BE REFUNDED IN THE FUTURE				
					DEBIT BALANCE PRIOR TO THIS REMITTANCE		\$243.71		0.00		0.00		0.00		
					ADJUSTMENTS		MAXIMUS AMT		PROVIDER NAME AND ADDRESS						
					\$193.71-				ABC HEALTH PROVIDER						
					YOUR CURRENT DEBIT BALANCE		CHECK TOTAL		CHECK NUMBER		PO BOX 000000 FLORENCE SC 00000				
					0.00		\$50.00		4197304						

Sample Remittance Advice (page 3)

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

PROVIDER ID.		DEPT OF HEALTH AND HUMAN SERVICES				ADJUSTMENTS		PAYMENT DATE		PAGE	
AB1111		SOUTH CAROLINA MEDICAID PROGRAM						03/26/2004		3	
PROVIDERS	CLAIM	SERVICE	PROC / DRUG	RECIPIENT	RECIPIENT NAME	ORIG.	ORIGINAL		DEBIT /	EXCESS	
OWN REF.	REFERENCE	DATE (S)		ID.	F M	CHECK	PAYMENT	ACTION	CREDIT		
NUMBER	NUMBER	MMDDYY	CODE	NUMBER	LAST NAME I I	DATE			AMOUNT	REFUND	
TPL 2	0408600003700000U	-						DEBIT	-2389.05		
TPL 4	0408600004700000U	-						DEBIT	-1949.90		
TPL 5	0408600005700000U	-						DEBIT	-477.25		
TPL 6	0408600006700000U	-						DEBIT	-477.25		
PAGE TOTAL:									5293.45	0.00	
DEBIT BALANCE PRIOR TO THIS REMITTANCE				MEDICAID TOTAL		CERTIFIED AMT		FEDERAL RELIEF		TO BE REFUNDED IN THE FUTURE	
0.00				0.00		0.00		0.00		0.00	
ADJUSTMENTS				MAXIMUS AMT		PROVIDER NAME AND ADDRESS					
0.00				0.00		ABC HEALTH PROVIDER					
YOUR CURRENT DEBIT BALANCE				CHECK TOTAL		CHECK NUMBER		PO BOX 000000			
5293.45				0.00				FLORENCE SC 00000			