

SECTION 5

ADMINISTRATIVE SERVICES

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SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

ADMINISTRATION

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

CORRESPONDENCE AND INQUIRIES

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

Department of Health and Human Services
Attn: Division of Care Management
Post Office Box 8206
Columbia, SC 29202-8206
(803) 898-4614

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

SECTION 5 ADMINISTRATIVE SERVICES

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 DHHS.

**REPRODUCIBLE
NEGATIVES**

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

SOFTWARE

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

HARD COPY CLAIM FORMS

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

PRIVATE VENDORS

Wallace Computer Service
2008 Marion 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 DHHS 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 DHHS Web site at **www.dhhs.state.sc.us**.

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

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

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

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

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

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

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

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

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

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

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

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

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

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

County	Telephone No.	Address
Union County	(864) 429-1660	Medicaid Eligibility Union County DHHS 200 S. Mountain St. Post Office Box 1068 Union, SC 29379
Williamsburg County	(843) 355-5411	Medicaid Eligibility Williamsburg County DSS 831 Eastland Ave. Kingstree, SC 29556
York County	(803) 327-9061	Medicaid Eligibility York County DHHS 1890 Neely's Creek Road Rock Hill, SC 29730 Post Office Box 710 Rock Hill, SC 29731

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

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SECTION 5 ADMINISTRATIVE SERVICES**EXHIBITS**

Form Number	Exhibit	Revision Date
CMS 1500	Health Insurance Claim Form	12/1990
DHHS 130	Claim Adjustment	11/2004
DHHS 205	Medicaid Refunds (two pages)	03/2000
DHHS 126	Confidential Complaint	12/2004
	Health Insurance Information Referral Form	03/2004
DHHS 140	Medicaid Provider Inquiry	11/1987
DHHS 142	Request for Medicaid Forms and Publications	05/1997
	Authorization Agreement for Electronic Funds Transfer	11/2004
	Sample Edit Correction Form	
	Sample Remittance Advice	
	Referral Form for Broken Appointments	
	Reasonable Effort Documentation	
	MAPPS Documentation Points	
	MAPPS Basic Needs Assessment	
	MAPPS Individual or Group Session Form	
	Standing Order (Sample)	

[illegible]

PICA			
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(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMP

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

For Agency Use Only

Analyst ID:

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

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

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 #: _____

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			
		SIGNATURE OF PROVIDER	
RESPONSE			
AGENCY REPRESENTATIVE			DATE



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
Columbia, South Carolina 29202-8206

- OR -

FAX TO: (803) 253-4027

MEDICAID NO:

TYPE OF PROVIDER:

TELEPHONE:

CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY (PLEASE PRINT OR TYPE)

ITEMS REQUESTED

FORM/PUBLICATION NO.	TITLE OF FORM OR PUBLICATION	QUANTITY

DHHS FORM 142 (5/97)

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



STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR STATEMENT OF PHARMACY SERVICES

DHHS FORM 3211 (11/96)

WHEN COMPLETED PLEASE FORWARD OR FAX:

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

MEDICAID NO:

TELEPHONE:

CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY (PLEASE PRINT OR TYPE)

QUANTITY REQUESTED

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

DHHS FORM 142 (5/97)

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

Provider Name: _____

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

Provider EIN Number: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

I (we) hereby authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to my account indicated below and the financial institution named below, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.

I (we) understand that credit entries to the account of the above named payee are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws.

I (we) certify that the information shown is correct and that this account is used solely for business purposes. I (we) further agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

Please contact your bank to obtain the correct electronic deposit information:

Financial Institution: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Transit/ABA Number: ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ /

Account No.: ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ /

Type of Account: ____ **Checking** ____ **Savings**

Signed: _____ (Signature)

_____ (Print)

Title: _____ **Date:** _____

Contact Name: _____ **Phone:** _____

ATTACH VOIDED CHECK OR DEPOSIT SLIP

RETURN TO:

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

RUN DATE 01/31/2004 0000
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM

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

1

ANALYST ID
SIGNON ID

HIC - 60 PRAC SPEC - 12
CLAIM RESTART DATE / / DOC IND N

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

INSURANCE EDITS

CLAIM EDITS

XXXXXX XXXXXXXXX 170.1 .

LINE EDITS

01) 510

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 UNITS
	.00	1	05/07/02	11	S9445	0FP	XXXXXX	250.00	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 250.00

01

27 AMT REC'D INS

02

28 BALANCE DUE 250.00

RESOLUTION DECISION _R_

29 OWN REF # 012345

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

INSURANCE POLICY INFORMATION

PROVIDER:
ABC TEEN SERVICES
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 TEEN SERVICES .1212121234. PROVIDER ID.	Y	PO BOX 000000 FLORENCE SC000000000
DEPT OF HEALTH AND HUMAN SERVICES	PROFESSIONAL SERVICES	PAYMENT DATE
AB0008	REMITTANCE ADVICE	03/26/2004
SOUTH CAROLINA MEDICAID PROGRAM		PAGE 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	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	S9445	800.00	117.71 P			0FP			0.00
	02		021504	H1010	392.00	126.00 P			0FP			0.00
ABB222222	VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04											
	01		012104	S9445	1412.00	273.71 P	1112233333	M CLARK				
	02		012104	H1010	1112.00	143.71 P			0FP			
					300.00	130.00 P			0FP			
ABB222222	REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04											
	01		012104	S9445	1001.50	42.75 P	1112233333	M CLARK			0.00	
	02		012104	H1010	142.50	42.75 P			0FP			0.00
					859.00	0.00 R			0FP			0.00
	TOTALS		2		2193.50	286.46					0.00	0.00

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

Sample Remittance Advice (page 2)

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

PROVIDER ID.				CLAIM ADJUSTMENTS		PAYMENT DATE		PAGE	
+-----+ AB1111 +-----+		DEPT OF HEALTH AND HUMAN SERVICES				+-----+ 03/26/2004 +-----+		+-----+ 2 +-----+	
		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	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME I I	M F M O I I D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	0406001089000400U				513.00-	197.71-	1112233333	CLARK	M	022804	0404711253670430A
	01		012104	S9445	453.00	160.71- P			0FP		
	02		012104	H1010	60.00	33.00- P			0FP		
	TOTALS		1		513.00-	193.71-					

DEBIT BALANCE PRIOR TO THIS REMITTANCE		+-----+ \$243.71 +-----+	MEDICAID TOTAL	+-----+ 0.00 +-----+	CERTIFIED AMT	+-----+ 0.00 +-----+	FEDERAL RELIEF	+-----+ 0.00 +-----+	TO BE REFUNDED IN THE FUTURE
0.00			ADJUSTMENTS	MAXIMUS AMT		PROVIDER NAME AND ADDRESS			
YOUR CURRENT DEBIT BALANCE		+-----+ \$193.71- +-----+	CHECK TOTAL	CHECK NUMBER		ABC TEEN SERVICES 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.				PAYMENT DATE		PAGE	
DEPT OF HEALTH AND HUMAN SERVICES		ADJUSTMENTS		03/26/2004		3	
AB1111							
SOUTH CAROLINA MEDICAID PROGRAM							

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME F M LAST NAME I I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	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 TEEN SERVICES		
YOUR CURRENT DEBIT BALANCE		CHECK TOTAL	CHECK NUMBER	PO BOX 000000	
5293.45		0.00		FLORENCE SC 00000	

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

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

Dentist _____

Phone Number _____

Dental Office Contact Person _____

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

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

REASONABLE EFFORT DOCUMENTATION

HOSPITAL _____ **DOS** _____

MEDICAID BENEFICIARY NAME _____

MEDICAID ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP CALL _____

RESULT OF CALL:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP CALL _____

RESULT OF CALL:

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

(SIGNATURE AND DATE)

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

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES DOCUMENTATION POINTS

S9445-FP — Patient Education, not otherwise classified, non-physician provider, Individual, per session. Address a minimum of three (3) documentation points from the list below plus the client's response.

S9446-FP — Patient Education, not otherwise classified, non-physician provider, Group, per session. Address a minimum of five (5) documentation points from the list below plus the client's response.

- 1) Discussion of adolescent development as it relates to human growth, development, sexuality, and pregnancy prevention
- 2) Information on the importance of family planning, responsible sexual behavior, and its effect on overall reproductive health
- 3) Discussion of the benefits of abstinence as it relates to normal growth and development for teens and pregnancy prevention
- 4) Discussion of the benefits of delaying sexual activity as it relates to healthier birth outcomes and pregnancy prevention
- 5) Discussion of the benefits of delaying pregnancy
- 6) Discussion of the long- and short-term health risks related to early sexual activity
- 7) Discussion of birth control methods, including abstinence, and the options available
- 8) Instruction on the proper and appropriate use of birth control methods
- 9) Importance of compliance with prescribed family planning methods and follow-up medical visits
- 10) Information on the benefits and risks of long-term birth control methods
- 11) Identification of family planning problems
- 12) Discussion of the availability of other health care resources related to family planning
- 13) Information on STDs and prevention of STDs as it relates to reproductive health and family planning

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES **BASIC NEEDS ASSESSMENT FORM**

1. Name of Participant: (First, Middle Initial, Last) _____

2. Case Number Identification:

Medicaid Number	
Social Security Number	
Patient Account Number	

3. Eligibility: (Check One) ☐ Medicaid ☐ Foster Care ☐ Child Protective Services

4. Date of Assessment: (Month, Date, Year) _____

5. Age of Participant: _____ Date of Birth: (Month, Date, Year) _____

6. Gender of Participant: ☐ Male (M) ☐ Female (F)

7. Racial or Ethnic Background of Participant: (Check one)

☐ White or Anglo, Not of Hispanic Origin

☐ Asian or Pacific Islander

☐ Black, Not of Hispanic Origin

☐ Hispanic

☐ American Indian

☐ Other: _____

8. Parent/Guardian: _____ SSN: _____

ENVIRONMENTAL

9. Address of Participant:

Street Address:		
Mailing Address: (If Different from Street Address)		
City/Town:	State:	Zip Code:
Telephone: (Home)	(Other)	<input type="checkbox"/> No Telephone

10. Household Members:

Name	Relationship to Participant	Age	Grade	School or Place of Employment of Household Members

11. Financial Support: (Check All That Apply)

- ☐ Employment ☐ Unemployment Benefits ☐ Family Independence ☐ Food Stamps
☐ Social Security ☐ Disability ☐ Other: (Specify) _____

12. Dwelling and Living Conditions:

- ☐ Apartment ☐ House ☐ Manufactured Home ☐ Public Housing
☐ Own ☐ Rent ☐ Housing Assistance ☐ Other: _____
☐ Condition of the Home: _____

13. Access to Transportation: (Check One)

- ☐ Have Transportation ☐ No Transportation ☐ Have Access to Transportation ☐ No Access to Transportation

14. Name of the Head of Household: _____ SSN: _____

15. Household Income: (Check One)

- ☐ Less than \$9,900 ☐ \$10,000 - \$12,000 ☐ \$12,001 - \$14,999 ☐ Over \$15,000

16. Employment Status of the Mother/Guardian: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Other: _____

17. Employment Status of the Father/Guardian: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Other: _____

18. Martial Status of Parent (s): ☐ Married ☐ Single ☐ Separated ☐ Widowed ☐ Other: _____

19. Does Parent (s), guardian or other household member have a history of drug/alcohol abuse?

- ☐ Yes ☐ No ☐ Unknown

If yes, specify name of individual and relationship to participant: _____

Type of drug/alcohol: _____

Referral/ Health Risk Factors

20. What was the referral source for MAPPS? (Check One)

- ☐ DSS ☐ Teacher ☐ Counselor ☐ Relative ☐ Friend ☐ Other: (Specify) _____

21. Referral Risk Factor (s): (Check All That Apply)

- ☐ Parent (s) were Teen Parents ☐ Sibling is Pregnant and/or Teen Parent ☐ Participant is a Teen Parent
☐ Peer Pressure to engage in sexual activity is identified as a problem by the adolescent
☐ Participant is Sexually Active and/or has a history of Sexual Abuse

22. Is the participant currently sexually active? ☐ Yes ☐ No

If no, has the participant ever used a birth control method? ☐ Yes ☐ No

23. Has the participant ever used a birth control method? ☐ Yes ☐ No

Method Used: (Check All That Apply)

- ☐ Birth Control Pills ☐ Condom ☐ IUD ☐ Diaphragm ☐ Norplant ☐ Depo-Provera Shot
☐ Rhythm ☐ Other: _____

24. Does the participant understand or know the health risks associated with becoming sexually active? ☐ Yes ☐ No

25. Has the participant ever had a STD? ☐ Yes ☐ No If yes, specify: _____

26. Has the participant ever experimented with alcohol, tobacco, and/or other drugs? ☐ Yes ☐ No

If yes, what kind? _____

Educational/Career

27. Name of school the participant attends: _____
28. Present grade of participant: _____
29. Special needs of the participant: (Check All That Apply)
- ☐ None ☐ Attention Deficit Disorder (ADD) ☐ Learning Disability ☐ Emotionally Handicapped
- ☐ Other: (Specify) _____
30. What are the parent/guardian's educational/career goals for the participant? (Check One)
- ☐ Partial High School ☐ High School Diploma ☐ College (B.S., etc.) ☐ Professional Degree (Ph.D., etc.)
- ☐ Technical School ☐ Work ☐ Don't Know ☐ Other: _____
- What are the participant's education/career goals? (Check One)
- ☐ Partial High School ☐ High School Diploma ☐ College (B.S., etc.) ☐ Professional Degree (Ph.D., etc.)
- ☐ Technical School ☐ Work ☐ Don't Know ☐ Other: _____
31. Does the participant engage in extracurricular activities? ☐ Yes ☐ No
- If yes, list activities: _____
32. How does the participant spend his/her free time?
- After School: _____
- Weekends: _____
33. Does the participant have any household rules to follow? ☐ Yes ☐ No
- If yes, what are some household rules that the participant has to follow? (Keep Room Clean, Do Housework, Wash Dishes or Cook, Curfew, No Dating, Do School Work, etc.)
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____
- Does the participant abide by the rules? ☐ Always ☐ Most of the Time ☐ Sometimes ☐ Rarely ☐ Not at all
34. Do the household rules cause any conflict for the parent/guardian and the participant? ☐ Yes ☐ No
- If yes, explain: _____
- _____
- What are the parent/guardian's and the participant's feelings about the household rules? _____
- _____
35. Does the participant have a curfew? ☐ Yes ☐ No
- If yes, specify time and day (s) of the week: _____
- Does the participant adhere to the curfew? ☐ Always ☐ Most of the Time ☐ Sometimes ☐ Rarely ☐ Not At All
36. Does participant have friends? ☐ Yes ☐ No
- If yes, gender and age? _____
- When they spend time together, what do they do? _____
- How does the participant get along with friends? _____
37. How does the participant get along with adults? (Including teachers) _____
- _____

SCREENING/CASE PLAN

Participant's Name: _____

Date of Service: _____ **Medicaid Number:** _____

Service Provider

SIGNATURE (and credentials): _____ Date: _____

Supervisor

CO-SIGNATURE (and credentials)
Date:

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES

Individual or Group Session Form

Participant's Name: _____

Date of Service: _____ **DOB:** _____ **Age:** _____

Medicaid Number: _____ ☐ **Individual** ☐ **Group**

PLACE: ☐ Participant's Home ☐ Office ☐ School ☐ Other **UNITS OF SERVICE:** _____

Risk Factors: (Check All That Apply)

- ☐ Parent (s) were Teen Parents ☐ Sibling is Pregnant and/or Teen Parent
- ☐ Participant is a Teen Parent ☐ Peer Pressure to engage in sexual activity is identified as a problem by the adolescent
- ☐ Participant is sexually and/or has a history of sexual abuse

A narrative description of services must be provided. Documentation of session must support time billed and points discussed. Check the Documentation Points discussed:

- ☐ 1. Discussion of adolescent development as it relates to human growth, development, sexuality, and pregnancy prevention
- ☐ 2. Information on the importance of family planning, responsible sexual behavior, and its affect on overall reproductive health
- ☐ 3. Discussion of the benefits of abstinence as it relates to normal growth and development for teens and pregnancy prevention
- ☐ 4. Discussion of the benefits of delaying sexual activity as it relates to healthier birth outcomes and pregnancy prevention
- ☐ 5. Discussion of the benefits of delaying pregnancy
- ☐ 6. Discussion of the long and short-term health risks related to early sexual activity
- ☐ 7. Discussion of birth control methods, including abstinence, and the options available
- ☐ 8. Instruction on the proper and appropriate use of birth control methods
- ☐ 9. Importance of compliance with prescribed family planning methods and follow up medical visits
- ☐ 10. Information on the benefits and risks of long term birth control methods
- ☐ 11. Identification of family planning problems
- ☐ 12. Discussion of the availability of other health care resources related to family planning
- ☐ 13. Information on STDs and prevention of STDs as it relates to reproductive health and family planning

PATIENT EDUCATION
□ Individual □ Group

Participant's Name: _____

Date of Service: _____ **Medicaid Number:** _____

Service Provider
SIGNATURE (and credentials): _____ Date: _____

Supervisor
CO-SIGNATURE (and credentials) _____ Date: _____

STANDING ORDER (SAMPLE)

In order for individuals to maintain an optimal state of health, it is imperative that they be linked with a Primary Care Physician (PCP) who provides medical preventive and acute care, that they use care appropriately, and that they practice healthy behaviors. *(Insert Name of Facility)* staff may perform the following PSPCE and RSPCE:

- Assessment provided by Licensed Practitioner of the Healing Arts (LPHA) to determine client strengths, resources, perceptions of need relative to appropriate use of primary medical care, and practice of healthy behaviors;
- Evaluation of information and developing a plan of care in conjunction with the patient and PCP (must be verbal or written) which addresses health-related, medical, and developmental risks/needs appropriate for P/RSPCE;
- Determination of the patient's risks and his or her readiness for intervention;
- Determination of interventions indicated, and whether interventions should be PSPCE or RSPCE;
- Implementation, coordination, and monitoring of the plan of care to determine patient progress toward goal achievement;
- Ongoing reassessment to determine necessary changes in the plan of care and/or interventions;
- Communication (must be verbal or written) will be maintained and documented in the clinical record during all phases of the patient's care; and
- Identification of PCP (medical home):
 1. It is the responsibility of the PSPCE or RSCPE provider to assist the patient in locating a PCP within six months; to obtain permission to share PSPCE or RSPCE information with the PCP; and to communicate (must be verbal or written) the activities to the PCP during all phases of the patient's care.
 2. This Standing Order may be used to authorize provision of PSPCE or RSPCE as long as efforts are being made to locate a PCP for the patient, but no longer than six months.

PSPCE may be provided by a LPHA as determined in the assessment in order to:

- prevent disease, disability, and other health conditions or their progression;
- prolong life; and
- promote physical and mental health efficiency.

PSPCE promotes full and appropriate use of medical care, promote positive health outcomes, prevents deterioration of chronic conditions, and enhances the practice of healthy behaviors.

RSPCE may be recommended by LPHA as determined in the assessment in order to reduce physical or mental disability and restore an individual to his or her best possible functioning level. This service also promotes changes in behavior, improves health status, and develops healthier practices to restore and maintain the patient at the highest possible functioning level.

P/RSPCE Dental Services

Signed by

Date

Documentation Note: If this Standing Order is being used to authorize PSPCE or RSPCE, a copy must be placed in the patient's chart.