

FORMS

Number	Name	Revision Date
DHHS 126	<u>Confidential Complaint</u>	06/2007
DHHS 130	<u>Claim Adjustment Form 130</u>	03/2007
DHHS 140	<u>Medicaid Provider Inquiry</u>	06/2007
DHHS 142	<u>Request for Medicaid Forms and Publications</u>	06/2007
DHHS 205	<u>Medicaid Refunds</u>	01/2008
DHHS 931	<u>Health Insurance Information Referral Form</u>	01/2008
	<u>Reasonable Effort Documentation</u>	05/2007
	<u>Authorization Agreement for Electronic Funds Transfer</u>	03/2011
	<u>Duplicate Remittance Request Form</u>	11/2010
	<u>Sample Edit Correction Form</u>	10/2008
	<u>Sample Remittance Advice (three pages)</u>	06/2007
	<u>Allied Professional Registration Form</u>	03/2012
	<u>LISW Allied Professional Registration Form</u>	03/2012
	<u>Mental Health Form</u>	04/2012



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:

NPI or MEDICAID PROVIDER ID: (if applicable)

MEDICAID RECIPIENT ID 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)

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:

Grid for Original CCN (15 boxes)

Provider ID:

Grid for Provider ID (6 boxes)

NPI:

Grid for NPI (10 boxes)

Recipient ID:

Grid for Recipient ID (8 boxes)

Adjustment Type:

- Void, Void/Replace

Originator:

- DHHS, MCCS, Provider, MIVS

Reason For Adjustment: (Fill One Only)

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

For Agency Use Only

Analyst ID:

Grid for Analyst ID (6 boxes)

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

Comments:

Signature: _____ Date: _____

Phone: _____



**STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES**

MEDICAID PROVIDER INQUIRY

MAIL TO: ATTENTION _____ UNIT S.C. DEPT. OF HEALTH AND HUMAN SERVICES POST OFFICE BOX 8206 COLUMBIA, SOUTH CAROLINA 29202-8206	TODAY'S DATE:
	NPI or MEDICAID PROVIDER ID:
	TELEPHONE:
PROVIDER NAME AND ADDRESS:	TYPE OF PROVIDER (i.e., Dentist, Group, 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)		IS MEDICARE COVERAGE INVOLVED?	
<input type="checkbox"/> YES <input type="checkbox"/> NO		<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



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

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

Contact Person: _____ Phone #: _____ Date: _____

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

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

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

- _____ a. beneficiary has never been covered by the policy – close insurance.
- _____ b. beneficiary coverage ended - terminate coverage (date) _____
- _____ c. subscriber coverage lapsed - terminate coverage (date) _____
- _____ d. subscriber changed plans under employer - new carrier is _____
- new policy number is _____
- _____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.
(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

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

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

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

Medicaid Beneficiary ID: _____ SSN: _____

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

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

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



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION**

PROVIDER _____ **DOS** _____

NPI or MEDICAID PROVIDER ID _____

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.**

South Carolina
Department of Health and Human Services
Electronic Funds Transfer (EFT) Authorization Agreement

PROVIDER INFORMATION

Provider Name _____
Medicaid Provider Number _____
Provider NPI Number _____
Provider Address _____
City _____ State _____ Zip _____

BANKING INFORMATION *(Please include a copy of the electronic deposit information on bank letterhead. This is required and the information will be used to verify your bank account information).*

Financial Institution Name _____
Financial Institution Address _____
City _____ State _____ Zip _____
Routing Number (nine digit) _____
Account Number _____

Type of Account (check one) Checking Savings

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. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

Contact Name: _____ Phone Number: _____

Signed _____ (Signature)
_____ (Print)

Title _____ Date _____

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.

RETURN COMPLETED FORM & BANK VERIFICATION DOCUMENT TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 870-9022

South Carolina Department of Health and Human Services Duplicate Remittance Request Form

Purpose: This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

Please contact your South Carolina Medicaid program manager for instructions on submission of your request via program facsimile number or mailing address.

1. Provider Name: _____

2. Medicaid Legacy Provider # _____ (Six Characters)

NPI# _____ **& Taxonomy** _____

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

5. Requesting:

**Complete
Remittance
Package**

**Remittance Pages
Only**

**Edit Correction
Pages Only**

6. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy.

7. Street Address for delivery of request:

Street: _____

City: _____

State: _____

Zip Code: _____

I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.

Authorizing Signature

Date

1500

HEALTH INSURANCE CLAIM FORM

Sample Claim Showing TPL Denial With NPI

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

<input type="checkbox"/> PICA PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> FECA BLKLUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John A.					3. PATIENT'S BIRTH DATE 01 01 1999 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
5. PATIENT'S ADDRESS (No., Street) 123 Windy Lane					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)		
CITY Anytown			STATE SC		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE
ZIP CODE 29999		TELEPHONE (Include Area Code) ()			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (Include Area Code) ()
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:				
a. OTHER INSURED'S POLICY OR GROUP NUMBER A123450A					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)				
c. EMPLOYER'S NAME OR SCHOOL NAME 0.00					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
d. INSURANCE PLAN NAME OR PROGRAM NAME 401					10d. RESERVED FOR LOCAL USE 1				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED				
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
19. RESERVED FOR LOCAL USE					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 295 32					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) EPT/HCPCS MODIFIER E. DIAGNOSIS POINTER					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
1 01 20 07 01 20 07 11 90804					23. PRIOR AUTHORIZATION NUMBER				
25. FEDERAL TAX I.D. NUMBER SSN EIN <input checked="" type="checkbox"/> 55555555					F. \$ CHARGES G. DAYS OR UNITS H. EPSOT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #				
26. PATIENT'S ACCOUNT NO. DOE1234					27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
28. TOTAL CHARGE \$ 60 00					29. AMOUNT PAID \$ 0 00				
30. BALANCE DUE \$ 60 00					31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				
32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.					33. BILLING PROVIDER INFO & PH # (555) 5555555 Jane Smith, MD 111 Main Street Anytown, SC 22222-2222				
SIGNED DATE					a. 1234567890 b. ZZ1212121212				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Only

RUN DATE 05/01/2007 000001204
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 76 SPEC -

CLAIM CONTROL #9999999999999999A
PAGE 1136 ECF 1136 PAGE 1 OF 1

ANALYST ID
SIGNON ID

TAXONOMY:

1 2
PROV/XWALK RECIPIENT
ID ID
ABC123 1111111111
NPI: 1234567890

SFL ZIP:

3 4
P AUTH TPL
NUMBER

PRV ZIP:

5 6 7
INJURY EMERG PC COORD
CODE

DOC IND N

8 9
---- DIAGNOSIS ----
PRIMARY SECONDARY
871.3 .

ORIGINAL CCN:

ADJ CCN:

EDITS
INSURANCE EDITS

CLAIM EDITS

LINE EDITS

01) 234

10 RECIPIENT NAME - DOE, JANE

11 DATE OF BIRTH 01/25/1992 12 SEX F

13 14 15 16 17 18 19 20 21 22
RES ALLOWED LN DATE OF PLACE PROC MOD INDIVIDUAL CHARGE PAY UNITS
NO SERVICE CODE PROVIDER IND

23
NDC

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

.00 1 02/01/04 96100 000 000 30.00 001
NPI: 1234567890 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

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

24 25 26
INS CARR POLICY INS CARR
NUMBER NUMBER PAID

27 TOTAL CHARGE 90.00

01 28 AMT REC'D INS

02 29 BALANCE DUE 90.00

03 30 OWN REF # 012345

RESOLUTION DECISION ____

ADDITIONAL DIAG CODES:

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

INSURANCE POLICY INFORMATION

PROVIDER:
ABC GROUP HOME
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 GROUP HOME .121212121234. PROVIDER ID.	Y	PO BOX 000000 FLORENCE SC000000000	PROFESSIONAL SERVICES REMITTANCE ADVICE	PAYMENT DATE 03/26/2007	PAGE 1
DEPT OF HEALTH AND HUMAN SERVICES		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		021507	96100	800.00	117.71	P				000		0.00
	02		021507	90804	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		012107	90804	1112.00	143.71					000		
	02		012107	96100	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		012107	90804	142.50	42.75	P				000		0.00
	02		012107	96100	859.00	0.00	R				000		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". IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.	<table border="0"> <tr><td>CERT. PG TOT</td><td>\$0.00</td></tr> <tr><td>CERTIFIED AMT</td><td>\$0.00</td></tr> <tr><td>FEDERAL RELIEF</td><td></td></tr> <tr><td>MAXIMUS AMT</td><td></td></tr> <tr><td>CHECK TOTAL</td><td></td></tr> </table>	CERT. PG TOT	\$0.00	CERTIFIED AMT	\$0.00	FEDERAL RELIEF		MAXIMUS AMT		CHECK TOTAL		<table border="0"> <tr><td>MEDICAID PG TOT</td><td>\$286.46</td></tr> <tr><td>MEDICAID TOTAL</td><td>\$286.46</td></tr> <tr><td>CHECK TOTAL</td><td></td></tr> </table>	MEDICAID PG TOT	\$286.46	MEDICAID TOTAL	\$286.46	CHECK TOTAL		STATUS CODES: P = PAYMENT MADE R = REJECTED S = IN PROCESS E = ENCOUNTER	PROVIDER NAME AND ADDRESS ABC GROUP HOME PO BOX 000000 FLORENCE SC 00000-0000
CERT. PG TOT	\$0.00																			
CERTIFIED AMT	\$0.00																			
FEDERAL RELIEF																				
MAXIMUS AMT																				
CHECK TOTAL																				
MEDICAID PG TOT	\$286.46																			
MEDICAID TOTAL	\$286.46																			
CHECK TOTAL																				

Sample Remittance Advice (page 2)

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
AB11110000	SOUTH CAROLINA MEDICAID PROGRAM		03/26/2007	2

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		0404711253670430A
	01		012107	90804	453.00	160.71-	P			000	
	02		012107	96100	60.00	33.00-	P			000	
	TOTALS		1		513.00-	193.71-					

SAMPLE ONLY

	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
0.00	ADJUSTMENTS	MAXIMUS AMT	PROVIDER NAME AND ADDRESS	
	\$193.71-		ABC GROUP HOME	
YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PO BOX 000000 FLORENCE SC 00000-0000	
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
AB11110000	SOUTH CAROLINA MEDICAID PROGRAM		03/26/2007	3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME F M LAST NAME I I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	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

SAMPLE ONLY

	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
DEBIT BALANCE PRIOR TO THIS REMITTANCE	0.00	0.00	0.00	0.00
0.00	ADJUSTMENTS	MAXIMUS AMT	PROVIDER NAME AND ADDRESS	
	0.00	0.00	ABC GROUP HOME PO BOX 000000 FLORENCE SC 00000-0000	
YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER		
5293.45	0.00			



Please return signed original Attestation to:

Mailing Address:

SC Dept. of Health and Human Services c/o
 Division of Family Services
 Post Office Box 8206
 Columbia, South Carolina 29202-8206

Tel: (803) 898-2565

Fax: (803) 255-8204

Section I: Demographic Information

Please Print:

Physician or APRN Name	
Address:	
Telephone:	
National Provider Identifier Number (NPI)	
Fax:	
Email:	

Section II: Allied Professional Update Form

The Allied Professional(s) listed below are under my supervision and services rendered and billed to South Carolina Medicaid will be in compliance with the guidelines as provided in the South Carolina Medicaid FQHC or RHC Standard. All allied professionals must be listed and a maximum of three allied professionals are permitted.

Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage and Family Therapist

Name (as it appears on their license):	
License Number & Expiration Date:	
Name (as it appears on their license):	
License Number & Expiration Date:	
Name (as it appears on their license):	
License Number & Expiration Date:	

If there are any changes to this list, i.e. the allied professional's qualifications, physician or APRN information, I will notify South Carolina Medicaid utilizing this form within thirty days (30). Failure to comply shall result in the recoupment for services rendered. My signature and signature date certifies, that the information provided in the **Attestation** is correct.

 Physician or APRN Signature

 Date



Please return signed original Attestation to:

Mailing Address:

SC Dept. of Health and Human Services c/o
 Division of Family Services
 Post Office Box 8206
 Columbia, South Carolina 29202-8206

Tel: (803) 898-2565

Fax: (803) 255-8204

Section I: Demographic Information

Please Print:

LISW-CP Name	
Address:	
Telephone:	
National Provider Identifier Number (NPI)	
Fax:	
Email:	

Section II: Allied Professional LMSW Update Form

The Allied Professional(s) LMSW listed below are under my LISW-CP (licensed Independent social worker-clinical practice) supervision and services rendered and billed to South Carolina Medicaid will be in compliance with the guidelines as provided in the South Carolina Medicaid FQHC or RHC Standard. All allied professional(s) LMSW must be listed and a maximum of three LMSW(s) are permitted to be supervised by the LISW-CP.

Licensed Master Social Worker (LMSW)

Name (as it appears on their license):	
License Number & Expiration Date:	
Name (as it appears on their license):	
License Number & Expiration Date:	
Name (as it appears on their license):	
License Number & Expiration Date:	

If there are any changes to this list, i.e. the allied professional's qualifications, LISW-CP information, I will notify South Carolina Medicaid utilizing this form within thirty days (30). Failure to comply shall result in the recoupment for services rendered. My signature and signature date certifies, that the information provided in the **Attestation** is correct.

 LISW-CP Signature

 Date

**South Carolina
Department of Health and Human Services
Mental Health Form**

FILL OUT COMPLETELY TO AVOID DELAYS

Beneficiary's Name:		Organization NPI:	
Medicaid ID #:		Center's Name:	
Date of Birth:		Service Location Address:	
Individual NPI:		City & State:	

DSM-IV TR Diagnosis

Axis I _____ / _____ / _____ Axis II _____ / _____ Axis III _____ / _____

Date first seen: _____ **Date of last service:** _____ **# of additional visits requested:** _____

Current Clinical Information: (Circle each. Scale 0=None, 1=Mild, 2=Moderate, 3=Severe, 4=Extreme)

Aggression	0 1 2 3 4	Depressions	0 1 2 3 4	Relationship Problems	0 1 2 3 4
Alcohol/Substance Use	0 1 2 3 4	Hallucinations	0 1 2 3 4	Side Effects	0 1 2 3 4
Anxiety/Panic	0 1 2 3 4	Impulsivity	0 1 2 3 4	Sleep Effects	0 1 2 3 4
Appetite Disturbance	0 1 2 3 4	Job/School Problems	0 1 2 3 4	Sleep Disturbance	0 1 2 3 4
Attention/Concentration	0 1 2 3 4	Mania	0 1 2 3 4	Weight Loss	0 1 2 3 4
Deficit in ADLs	0 1 2 3 4	Medical Illness	0 1 2 3 4	Other	0 1 2 3 4
Delusions	0 1 2 3 4	Memory	0 1 2 3 4	Current Stressors	0 1 2 3 4

Services

- | | | |
|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> 90805 | <input type="checkbox"/> 90847 | <input type="checkbox"/> 90804 |
| <input type="checkbox"/> 90807 | <input type="checkbox"/> 96101 | <input type="checkbox"/> 90806 |
| <input type="checkbox"/> 90862 | <input type="checkbox"/> 90853 | |

Current Medications	Name	Dose	Frequency	Side Effects
<input type="checkbox"/> New	1. _____	_____	_____	_____
<input type="checkbox"/> New	2. _____	_____	_____	_____
<input type="checkbox"/> New	3. _____	_____	_____	_____
<input type="checkbox"/> New	4. _____	_____	_____	_____
Compliance	<input type="checkbox"/> >90%	<input type="checkbox"/> 50-90%	<input type="checkbox"/>	<50%
Reasons for Noncompliance: _____				

Physician/Non physician Practitioner's Name () _____ () _____
Phone: Fax

Physician/Non physician Practitioner's Signature Date

Clinical documentation must be submitted with this request and faxed to the QIO at 1-888-669-7197.
Approved authorizations from the QIO should be faxed to your Division of Family Services program manager at (803) 255-8204.

Disclaimer: Authorization indicates that SCDHHS determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary's eligibility and benefit limitations at the time services are rendered. The Physician Assistant is not authorized to sign this form.

Division of Family Services
Post Office Box 8206
Columbia, South Carolina 29202-8206