FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 140	Medicaid Provider Inquiry	06/2007
DHHS 142	Request for Medicaid Forms and Publications	06/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	Reasonable Effort Documentation	05/2007
	Authorization Agreement for Electronic Funds Transfer	12/2005
UB-04	Sample UB-04	
	Sample Edit Correction Form	
	Sample Remittance Advice	
	DHHS Certification of Need Psychiatric Hospital Services for Children Under 21	
	Request for Emergency Admission Concurrence (REAC)	
	Notice of Non-Coverage for Inpatient Psychiatric Hospital Care (two pages)	
DHHS 254	Referral Form/Authorization for Services Children's Behavioral Health Services	05/2007
	Sample Attestation Letter	

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:	
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)

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) ☐ YES ☐ NO	IS MEDICARE COVERAGE INVOLVED? ☐ YES ☐ 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

SCDHHS Form 140 (revised 06/07)

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

REQUEST FOR MEDICAID FORMS AND PUBLICATIONS

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) 898-4528**

NPI or MEDICAID PROVIDER ID:

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

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

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

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

1. Provider Name: _____

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

OR

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

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

6. Reason for Refund: [check appropriate box]

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

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

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

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

7. Patient/Service Identification:

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

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

☐ Medicaid Remittance Advice (required)

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

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

☐ Refund check

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

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

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

Contact Person: _____ Phone #: _____ Date: _____

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

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

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

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

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

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

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

- new policy number is _____

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

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

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

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

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

Medicaid Beneficiary ID: _____ SSN: _____

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

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

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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
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.

Revised 05/2007

South Carolina

Department of Health and Human Services

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

Provider Name: _____

Provider DBA Name *(if applicable)*: _____

Medicaid Provider Number: _____

Provider NPI Number: _____

Provider EIN Number: _____

Address: _____

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

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

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

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

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

Financial Institution: _____

Address: _____

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

Transit/ABA Number: _____

Account No.: _____

Type of Account: ___ **Checking** ___ **Savings**

Signed: _____ *(Signature)*

_____ *(Print)*

Title: _____

Date: _____

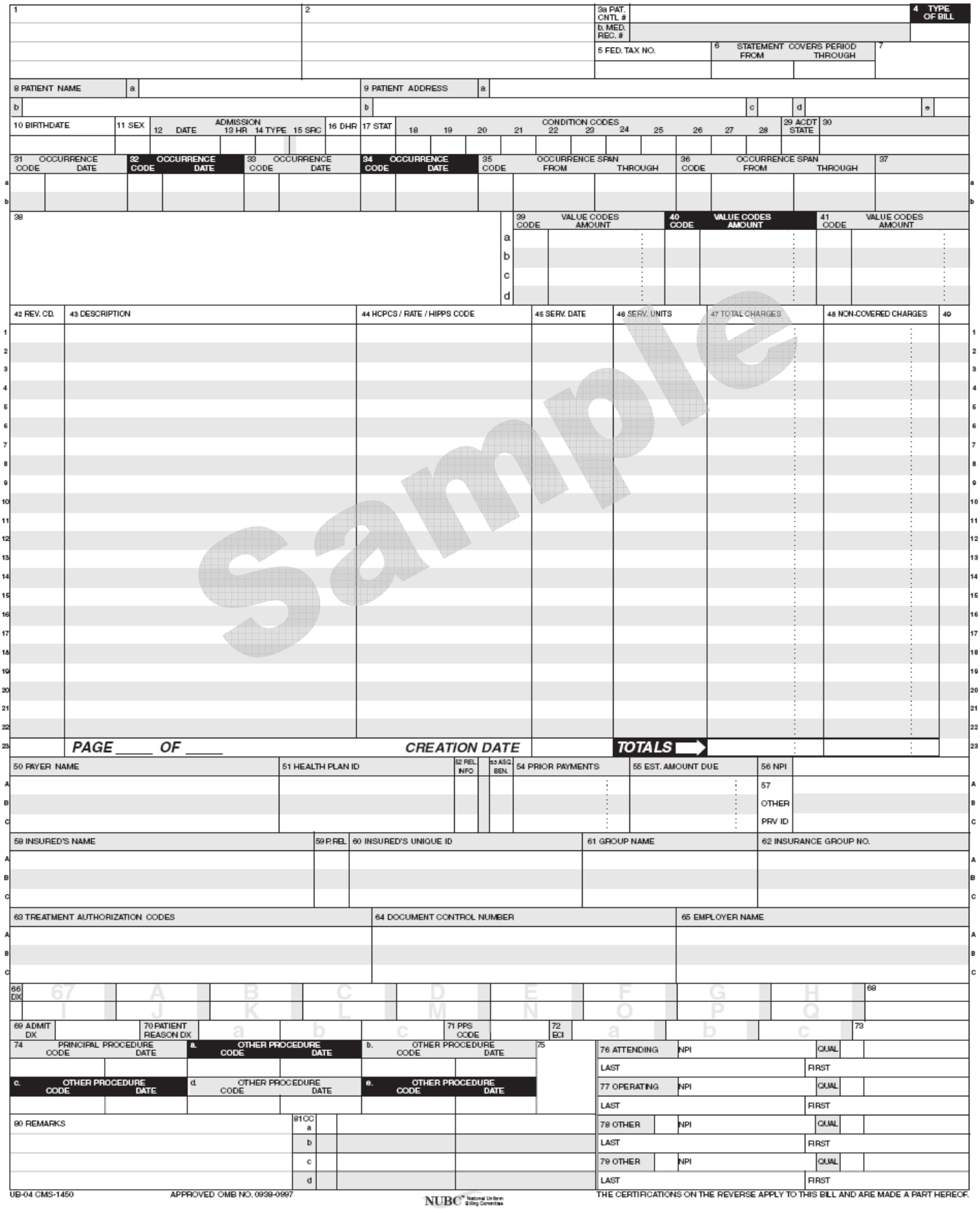
Contact Name: _____ **Phone:** _____

RETURN TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P. O. BOX 8806
COLUMBIA, S.C. 29202-8809
FAX (803) 699-8637

Revised 12/05

Sample UB-04



RUN DATE 10/09/2007 D00108760 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #D9999999999999999Z
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 18290 ECF 99999 PAGE 1 OF 1
ANALYST ID INPATIENT/OUTPATIENT - 01 EMC Y
SIGNON ID DOC IND ORIGINAL CCN: 9999999999999999Z
ADJ CCN: 1234567891234567U
INSURANCE EDITS
RECIP NAME JANE DOE DOB 01/01/1991 SEX F CLAIM EDITS

NPI: 1234567890 TAXONOMY: 323P00000M PRV ZIP: 29526
51) PRTF029 3) WOO895C1251493 4) 117 6) 10/03/07 10/07/04 7) 004 004 60) MEDICAID RCP ID 0123456789

17) 10/17/06 19) 1 20) 7 22)20 23) 24) C5 25) 26) 27) 28) 29) 30) CLAIM EDITS 000-593

32A) 42 09/07/07 33A) / / 34A) / / 35A) / / 36A) / / - / /

32B) / / 33B) / / 34B) / / 35B) / / 36B) / / - / /

37)012600031230500Z

39A) 40A) 41A)
39B) 40B) 41B)
39C) 40C) 41C)
39D) 40D) 41D)

MEDICAID CARRIER ID 619

1ST OTHER PAYER 50) 54) 60)
2ND OTHER PAYER 50) 54) 60)

54P) 63) PP40122 DRG 99B REIMBURSEMENT G

(67)	(68)	(69)	(70)	(71)	(72)	(73)	(74)	(75)	(76)
296.54				.	.	.	.	.	296.54

80) . / / 81A) . / / 81B) . / / 82) 1194826081

81C) . / / 81D) . / / 81E) . / / 83A) 1194826081 INSURANCE POLICY INFORMATION
83B)

RES	LINE	(42)	(44)	(45)	(46)	(47)	(48)	
	001	124			0004	1126.60	0.00	UNISON HEALTH PLAN OF SC
						1126.60	0.00	(800) 366-7304

TOTAL CHARGES 001

****
** AGENCY USE ONLY **
** APPROVED EDITS **
**
****

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
90

RESOLUTION DECISION ___ RETURN TO: MEDICAID CLAIMS RECEIPT, P.O. BOX 1458, COLUMBIA, SC 29202-1458

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

Sample Remittance Advice

```
 # AB0008 ABC PROVIDER                                    PO BOX 000000                ANYWHERE          SC000000000
                                                .121212121234.                  Y
  PROVIDER ID.                                          PROFESSIONAL SERVICES          PAYMENT DATE                PAGE
+--------------+  DEPT OF HEALTH AND HUMAN SERVICES                                    +------------+              +----+
| AB00080000   |                                          REMITTANCE ADVICE          | 03/26/2008 |              |  1 |
+--------------+   SOUTH CAROLINA MEDICAID PROGRAM                                    +------------+              +----+
+---------+----------------+------+---------+------+--------+--------+-+----------+------------------+---+-------+-------+-------+
|PROVIDERS|     CLAIM      |      |SERVICE RENDERED|  AMOUNT|TITLE 19|S|RECIPIENT |RECIPIENT NAME    |M  |TLE. 18| COPAY | TITLE |
| OWN REF.|   REFERENCE    |      | DATE(S) |      |  BILLED|PAYMENT |T|    ID.   |F M               | O |ALLOWED|  AMT  |  18   |
|  NUMBER |     NUMBER     |PY IND| MMDDYY  | PROC.|        |MEDICAID|S|  NUMBER  |I I LAST NAME     |  D|CHARGES|       |PAYMENT|
+---------+----------------+------+---------+------+--------+--------+-+----------+------------------+---+-------+-------+-------+
|         |                |      |         |      |        |        | |          |                  |   |       |       |       |
|2212345  |0406001089000400A|      |         |      |  50.00 |  50.00 |P|1112233333|M   CLARK         |   |       |       |       |
|         |              01 |      |021508   |T2028 |  50.00 |  50.00 |P|          |                  |   |       |       |       |
|         |                 |      |         |      |        |        |P|          |                  |000|       | 0.00  | 0.00  |
|         |                 |      |         |      |        |        | |          | EDITS: L00*578   |   |L00*583|       |       |
|         |                 |      |         |      |        |        | |          |                  |   |       |       |       |
|         |                 |      |         |      |        |        | |          |                  |   |       |       |       |
|1122322  |0406001089000400U|      |         |      |110.00  | 110.00 |P|1112233333|M   SMITH         |   |       |       |       |
|         |              01 |      |012108   |T2020 |50.00   |  50.00 |P|          |                  |000|       | 0.00  | 0.00  |
|         |              02 |      |012108   |E2019 |60.00   |  60.00 |P|          | EDITS  LOO*578   |000|L00*583| 0.00  | 0.00  |
|         |                 |      |         |      |        |        | |          |                  |   |       |       |       |
|1124533  |0407701389002500A|      |         |      | 106.00 | 106.00 |P|1112233333|M   CLARK         |   |       |  0.00 |       |
|         |              01 |      |012108   |E2020 |  60.00 |  60.00 |P|          |                  |0TF|       |       |  0.00 |
|         |              02 |      |012108   |E2019 |  46.00 |  46.00 |P|          |                  |000|       |       |  0.00 |
|         |                 |      |         |      |        |        | |          |                  |   |       |       |       |
|         |          TOTALS |      |       3 |      | 266.00 | 266.00 | |          |                  |   |       |  0.00 |  0.00 |
|         |                 |      |         |      |        |        | |          |                  |   |       |       |       |
|         |                 |      |         |      |        |        | |          |                  |   |       |       |       |
+---------+----------------+------+---------+------+--------+--------+-+-+--------+------------------+---+-------+-------+-------+
                                                  |          |   |     $266.00|
                          +------------+   +------------+    STATUS CODES:          PROVIDER NAME AND ADDRESS
FOR AN EXPLANATION OF THE                   CERT. PG TOT    MEDICAID PG TOT                    +---------------------------------+
ERROR CODES LISTED ON THIS                +-------------+  +-------------+    P = PAYMENT MADE  |  ABC PROVIDER                   |
FORM REFER TO:  "MEDICAID                 |       $0.00 |  |      $266.00|    R = REJECTED     |                                 |
PROVIDER MANUAL".                         +-------------+  +-------------+    S = IN PROCESS    |  PO BOX 000000                  |
                     CERTIFIED AMT   MEDICAID TOTAL    E = ENCOUNTER     |  ANYWHERE XO  00000-0000        |
IF YOU STILL HAVE QUESTIONS+-------------+ +-------------+  +-------------+    +---------+       |                                 |
PHONE THE D.H.H.S. NUMBER  |       $0.00 | |       $0.00 |  |      $266.00|    |9999999  |       +---------------------------------+
                    SPECIFIED FOR INQUIRY OF   +-------------+ +-------------+  +-------------+    +---------+
                    CLAIMS IN THAT MANUAL.      FEDERAL RELIEF   MAXIMUS AMT      CHECK TOTAL      CHECK NUMBER
```

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
CERTIFICATION OF NEED
Psychiatric Hospital Services for Children Under 21

Client's Name: _____ Date of Birth:_____

Social Security Number: _____

NPI or Medicaid Provider ID: _____

A review team has evaluated all of the information submitted by the physician and other professionals to justify the client's admission to and certifies that:

( ) Ambulatory services available in the community do not meet the current treatment needs of the client; and
( ) Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
( ) The inpatient services can reasonably be expected to improve the client's condition or prevent further regression so that the inpatient services will no longer be needed.
OR
( ) According to current criteria, the client does not meet the requirements for Medicaid-sponsored inpatient psychiatric care.

This certification is not an approval for Medicaid to pay. Medicaid eligibility or continued eligibility must be established by the appropriate County Department of Social Services.

TEAM PHYSICIAN'S SIGNATURE: _____

Effective Date: _____ Check One: Interdisciplinary Team ___ Independent Team ___

OTHER TEAM MEMBERS' SIGNATURES, TITLES, AND DATE SIGNED:
A minimum of two signatures must be present.

	Date:
	Date:
	Date:
	Date:
	Date:
	Date:
	Date:

REQUEST FOR EMERGENCY ADMISSION CONCURRENCE (REAC)

Psychiatric Hospital: ____________________ **NPI or Medicaid Provider ID:** __________________

Client Name: ____________________ **Date of Birth:** __________________

Client Medicaid #: ____________________ **SSN:** __________________

Referral Source: ____________________ **Date of Admission:** __________________

The above named client was admitted as an emergency based on the following conditions:

____________________________________ ________________________

Representative Signature & Title **Date**

- -

__________________ Date Received by _________________ Community Mental Health Center

__________ Based only on the above information, the above named client DOES appear to meet Medicaid's administrative definition of an emergency admission.

__________ Based only on the above information, the above named client DOES NOT appear to meet Medicaid's administrative definition of an emergency admission. However, the client DOES appear to require psychiatric hospital services and can be admitted as an urgent admission. (DMH must complete the CON)

__________ Based only on the above information, the above named client DOES NOT appear to meet Medicaid's administrative definition of an emergency admission NOR does the client appear to need any psychiatric hospital services at this time.

MHC Representative and Title: ___________________________ **Date:** _________________

MHC Physician Signature: _______________________________ **Date:** _________________

PSYCHIATRIC HOSPITALS
FOR INDIVIDUALS UNDER AGE 21
SOUTH CAROLINA MEDICAID
NOTICE OF NON-COVERAGE FOR
INPATIENT PSYCHIATRIC HOSPITAL CARE

DATE _____ **NPI OR MEDICAID PROVIDER ID**_____

NAME OF CLIENT _____

ADDRESS _____

CITY, STATE, ZIP CODE_____

ATTENDING PHYSICIANS NAME_____ **ATTENDING PHYSICIAN'S PHONE #**_____

Dear: :

The purpose of this letter is to inform you that _____ Hospital:

( ) Has determined that your psychiatric hospital admission is not covered under the Medicaid program because _____
_____

( ) Has determined that further inpatient psychiatric hospital treatment is no longer medically necessary. Furthermore, (Check One):

Your attending physician **agrees** that continued hospitalization is no longer needed.

Your attending physician **disagrees** that continued hospitalization is no longer needed, but Qualis concurs with our facility.

If you elect to be admitted and/or remain in the hospital, you are financially liable for all costs of the care you receive except for any convenience services or items normally not covered by the Medicaid program, beginning on _____. This determination does not mean additional psychiatric services are not needed. Medicaid reimbursement may be available for these additional services; however, you do not need inpatient hospital placement to receive these services. You should discuss, with your attending physician and/or a representative from the agency that made your placement, other arrangements for any further health care you may require.

This notice is not an official Medicaid determination. Qualis is the Quality Improvement Organization authorized by the Medicaid program to review inpatient psychiatric hospital services provided to Medicaid clients in the state of South Carolina.

If you disagree with our decision, you may request immediately, by noon of the first working day after receipt of this notice, an immediate review by telephone, or in writing. You may make this request through the facility or directly to Qualis at the address listed below:

Qualis Health
440 Knox Abbott Drive Suite 220
Cayce, SC 29033
(803)-739-2755

Qualis will request your views about your case and respond to you within one working day of receipt of your request and your medical records (sent by the facility).

If you do not request a review by noon of the first working day after receipt of this notice you may still request that Qualis review at any point during your stay or within 30 days after you receive this notice, whichever is longer.

Qualis will send you a formal determination of the medical necessity and appropriateness of your hospitalization and will inform you of your reconsideration rights.

If Qualis disagrees with the facility, you will be refunded any amount collected by the facility except for any convenience services or items normally not covered by Medicaid.

If Qualis agrees with the facility, you are financially responsible for all services beginning on _____ through your discharge date unless you request an immediate review. If you request an immediate review (i.e, you make your request for review by noon of the first working day after receipt of this notice), you will not be responsible for payment until noon of the next day after you received Qualis's notification.

Sincerely,

Hospital Representative

cc: Qualis Health
Beneficiary
Attending Physician
Legal Guardian
Authorized Referral Entity
SCDHHS Department of Behavioral Health Services, Attn: Non-Coverage

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of non-coverage from _____ on _____. I understand that my signature below does not indicate that I agree with this notice, only that I have received a copy of this notice.

_____ _____
Signature of beneficiary or legally responsible party **Date**

Client or legally responsible party refused to sign this notice, but was told that this admission is not covered by Medicaid.

_____ _____
Witness **Date**

_____ _____
Witness **Date**

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
REFERRAL FORM/AUTHORIZATION FOR SERVICES (Form 254)
CHILDREN'S BEHAVIORAL HEALTH SERVICES

FORM 254

NPI or Medicaid Provider ID

CHILD'S MEDICAID I. D. #

REFERRED TO: _____

AUTHORIZATION DATE: / /

EXPIRATION DATE: / /

Name	County	Address		
Date of Birth / /	Sex	Agency Reference No.	City	State Zip
Prior Authorization Number		Parent/Guardian		

Services are authorized for the period from the Authorization Date through the Expiration Date as noted above. The authorization period is subject to change pending notification by the Authorizing Agency or by the Department of Health and Human Services.

- ☐ PSYCHIATRIC HOSPITAL
- ☐ RESIDENTIAL TREATMENT FACILITY
- ☐ THERAPEUTIC BEHAVIORAL SERVICES (Formerly High Management Rehabilitative Services) (H2020-TG)
- ☐ THERAPEUTIC BEHAVIORAL SERVICES (Formerly Moderate Management Rehabilitative Services) (H2020-TF)
- ☐ THERAPEUTIC FOSTER CARE
  - ☐ LEVEL I (S5145) ☐ LEVEL II (S5145-TF) ☐ LEVEL III (S5145-TG)
- ☐ MENTAL HEALTH SERVICES NOT OTHERWISE SPECIFIED (Formerly Intensive Family Services) (H0046)
- ☐ PSYCHOSOCIAL REHABILITATION SERVICES (Formerly Clinical Day Programming) (H2018)
- ☐ THERAPEUTIC BEHAVIORAL SERVICES (Formerly Therapeutic Child Treatment) (H2019 & H2020-HA)
- ☐ THERAPEUTIC BEHAVIORAL SERVICES (Formerly Supervised Independent Living) (H2020)
- ☐ SEXUAL OFFENDERS TREATMENT SERVICES (Formerly Specialized Treatment Services For Sexual Offenders) (H2029)
- ☐ OTHER _____

Agency Representative:_____ Title: _____

Signature: _____ Phone: _____

Authorizing Agency: (one must be checked)

- ☐ Department of Social Services
- ☐ Continuum of Care for Emotionally Disturbed Children
- ☐ United Way
- ☐ Department of Mental Health
- ☐ Department of Disabilities and Special Needs
- ☐ Department of Juvenile Justice
- ☐ School District/ Department of Education

AGENCY USE ONLY

Sample Attestation Letter

An individual who has the legal authority to obligate the facility must sign this attestation.

[Name of the Psychiatric Residential Treatment Facility]
[Address]
[City, State, Zip Code]
[Telephone Number]
[Fax Number (if applicable)]

Provider Number

Dear <State Medicaid Director>:

A reasonable investigation subject to my control having been conducted in the subject facility, I make the following certification. Based upon my personal knowledge and belief, I attest that the <NAME of the FACILITY> hereby complies with all of the requirements set forth in the interim final rule governing the use of restraint and seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under age 21 published on January 22, 2001, and amended with the publication of May 22, 2001 (Psych Under 21 rule).

I understand that the Centers for Medicare and Medicaid Services (CMS) (formerly HCFA), SCDHHS or their representatives may rely on this attestation in determining whether the facility is entitled to payment for it services and, pursuant to Medicaid regulations at 431.610, have the right to validate that <Name of the Facility> is in compliance with the requirements set forth in the Psych Under 21 rules, and to investigate serious occurrences as defined under this rule.

In addition, I will notify the SCDHHS immediately if I vacate this position so that an attestation can be submitted by my successor. I will also notify SCDHHS if it is my belief that <Name of the Facility> is out of compliance with the requirements set forth in the Psych Under 21 rule.

Signature
Printed Name
Title
Date