SECTION 5
ADMINISTRATIVE SERVICES

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SECTION 5
ADMINISTRATIVE SERVICES

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SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

ADMINISTRATION

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

CORRESPONDENCE AND INQUIRIES

Correspondence concerning specific policy and procedural problems must be directed to the appropriate program representative. Inquiries concerning specific claims should also be directed to the appropriate program representative, after corrections have been made on rejected claims and all claims filing requirements have been met. The Medicaid Provider Inquiry, DHHS Form 140, may be used to check the status on outstanding claims. Inquiries should always include the name of the individual requesting the information and a brief description of the problem. Include your provider number, the recipient's Medicaid number and date of service when requesting the status on outstanding claims. **Please allow 45 days from submission date before requesting the status of the claim.**

All correspondence to Medicaid administrative staff should be directed to:

SCDHHS
Post Office Box 8206
Columbia, SC 29202-8206
Attn: (name of your program representative, J-2)
(803) 898-2665

Correspondence can also be sent by fax to (803) 255-8351 or by email.

SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

MEDICAID PROGRAM AREAS

Other health care services are compensable by Medicaid. Listed below are the appropriate numbers to call for specific questions regarding these health care services:

Service	Phone Number
Ambulance Services	898-2565
Ambulatory Surgical Centers	898-2665
Behavioral Health Services	898-2565
Long-Term Care Services	898-2590
CRNA Services	898-2660
Dental Services	898-2568
Durable Medical Equipment Services	898-2882
Early Intervention and School-Based Services	898-2655
ESRD Services	898-2665
FQHC Services	898-2660
Home Health Services	898-2590
Hospice	898-2590
Hospital Services	898-2665
Laboratory (Independent and X-ray)	898-2660
Managed Care Services	898-2660
Nurse Midwife Services	898-2660
Nursing Home Services	898-2590
Optician/Optometrist Services	898-2660
Optional State Supplementation Program	898-2590
Pharmacy Services	898-2876
Physician Services	898-2660
Psychologists (Ph.D., MR/RD Waiver only)	898-2590
Private Duty Nursing Services	898-2590
Qualified Medicaid Beneficiary Program	898-2655
Speech and Hearing Services	898-2660
Therapies (Physical and Occupational)	898-2660
Third-Party Liability	898-2630
Transportation Services	898-2565
Women & Family Services	898-2655

SECTION 5 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

The Department of Health and Human Services will not supply the UB-92 claim form to providers. Providers should purchase the form in its approved format from the private vendor of their choice.

FAX REQUESTS

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

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

WEB ADDRESS

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

PROCUREMENT OF FORMS

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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 11th Ave., 2nd 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., 4th 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
	Abortion Statement	
	Abortion Statement — sample version	
	Alcohol and Drug Medical Assessment (two pages)	09/1990
	Authorization Agreement for Electronic Funds Transfer	11/2004
DHHS 185	Community Long-Term Care Level of Care Certification Letter (two pages)	11/2003
	Community Long-Term Care Notification Form	12/2004
DHHS 126	Confidential Complaint	12/2004
	Edit Correction Form — sample version	
DHHS 218	ESRD Enrollment	04/1986
	Health Insurance Information Referral Form	03/2004
DHHS 1729	Hysterectomy Acknowledgement Form (two pages)	11/1995
	Hysterectomy Acknowledgement Form — sample version	
DHHS 1723	Individuals Informed Consent to Non-Therapeutic Sterilization for Medicaid Recipients	03/1997
	Notice of Noncoverage (At or Before Admission) (two pages)	12/2004
	Notice of Noncoverage (Non-Covered Admission — After Admission) (two pages)	12/2004
	Notice of Noncoverage for Continued Stay (Attending Physician Agrees) (two pages)	12/2004
	Notice of Noncoverage for Continued Stay (Attending Physician Disagrees but QIO Concurs) (two pages)	12/2004
	Notice of Termination of Administrative Days	12/2004
	Notification of Administrative Days Coverage	12/2004
DHHS 204	Pregnancy/Newborn Risk Assessment Form (two pages)	10/2003
DHHS 140	Provider Inquiry	01/1996
	Reasonable Effort Documentation	12/2004

SECTION 5 ADMINISTRATIVE SERVICES

EXHIBITS

Form Number	Exhibit	Revision Date
	Referral Request for Out-Of-State Services	
DHHS 205	Refunds (two pages)	03/2000
	Remittance Advice — sample version (three pages)	
DHHS 142	Request for Medicaid Forms and Publications	05/1997
DHHS 1716ME	Request for Medicaid ID Number	11/2003
	Request for Prior Approval Review	
	Surgical Justification Review for Hysterectomy	
	Surgical Justification Review for Hysterectomy — sample version	
UB-92	UB-92 — Uniform Bill (two pages)	12/1990
	UB-92 Required Fields for Outpatient Claims (hard copy)	
	UB-92 Required Fields for Inpatient Claims (hard copy)	
	UB-92 Required Fields for Outpatient Claims (electronic)	
	UB-92 Required Fields for Inpatient Claims (electronic)	

ABORTION STATEMENT

This certification meets FFP requirements and must include all of the aforementioned criteria.

Patient's Name:_____

Patient's Medicaid ID#:_____

Patient's Address:_____

_____

Physician Certification Statement

I, _____ certify that it was necessary to terminate the pregnancy of_____

_____ for the following reason:

a. ( ) Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition:

_____

b. ( ) The patient has certified to me the pregnancy was a result of rape or incest and the police report is attached.

c. ( ) The patient has certified to me the pregnancy was a result of rape or incest and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

_____ _____

Physician's Signature Date

****

The patient's certification statement is only required in cases of rape or incest.

Patient's Certification Statement

I, _____certify that my pregnancy was the result of an act of rape or incest.

(Patient's Name)

_____ _____

Patient's Signature Date

Both the completed Abortion Statement and appropriate medical records must be submitted with the claim form.

ABORTION STATEMENT

This certification meets FFP requirements and must include all of the aforementioned criteria.

Patient's Name: Jane Doe

Patient's Medicaid ID#: 1234567891

Patient's Address: 111 Maple Drive
Anytown, SC 29999

Physician Certification Statement

I, John Brown certify that it was necessary to terminate the pregnancy of Jane Doe for the following reason:

a. (X) Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition: End Stage Renal Failure and Cancer

b. ( ) The patient has certified to me the pregnancy was a result of rape or [illegible] and the police report is attached.

c. ( ) The patient has certified to me the pregnancy was a result [illegible] the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

John Brown — 12/12/04
Physician's Signature — Date

****

The patient's certification statement is only required in cases of rape or incest.

Patient's Certification Statement

I, _____ certify that my pregnancy was the result of an act of rape or incest.
(Patient's Name)

_____ _____
Patient's Signature — Date

Both the completed Abortion Statement and appropriate medical records must be submitted with the claim form.

Alcohol and Drug Medical Assessment

Patient's Name (Last, First, MI) and I.D. #	
Medicaid Client #	Date of Medical Assessment
Physician's Name and Address	

1. Brief medical history to include hospital admissions, surgeries, allergies. present medications, information (where appropriate) about shared needles, sexual activity/orientation and history of hepatitis and liver disease.

2. History of patient /family involvement with alcohol/drugs.

3. Assessment of patient nutritional status.

ADMA 9/20/90
SCCADA FORM

4. Physical examination to include, but not be limited to, vital signs, inspection of ears, nose, mouth, teeth and gums. Also, inspection of skin for recent and/or old needle marks/tracking, abscesses or scarring from healed abscesses.

5. General assessment of patient cardiovascular system, respiratory system, gastro-intestinal system abd neurological status.

6. Screening for anemia (hematocrit or hemoglobin may be used when physician has machinery available in office).

7.

It is ordered that _____ receive alcohol/drug rehabilitative services.

Physician's Signature and Date

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
Revised 11/04

SOUTH CAROLINA COMMUNITY LONG TERM CARE
LEVEL OF CARE CERTIFICATION LETTER
FOR
MEDICAID-SPONSORED NURSING HOME CARE

NAME: _____ COUNTY OF RESIDENCE: _____

SOCIAL SECURITY #: _____ MEDICAID #: _____

LOCATION AT ASSESSMENT:

South Carolina Community Long Term Care has evaluated your application and has determined that:

☐ According to Medicaid criteria, you do not meet requirements for skilled or intermediate care. This does not mean that you do not need personal or other medical care, and does not mean that you cannot be admitted to a long term care facility. It does mean that the Medicaid program will not be responsible to pay for your care in a long term care facility. Please do not hesitate to contact this office if there is a change in your health status or you become more limited in your ability to care for yourself.

☐ According to Medicaid criteria, you meet the requirements to receive long term care at the following level:

☐ SKILLED ☐ INTERMEDIATE

This Certification Letter is not an approval for financial eligibility for Medicaid. You must establish financial eligibility with the County Department of Social Services.

This letter must be presented to the long term care facility to which you are admitted. IF YOU HAVE NOT ENTERED A FACILITY BY THE EXPIRATION DATE BELOW, YOU MUST CONTACT THE CLTC OFFICE AT _____ TO REAPPLY.
Telephone No.

If you change locations from where your assessment was made (i.e., hospital to home) your assessment must be updated and a new effective period established.

Medicaid certification is automatically cancelled when a client enters a facility with a payment source other than Medicaid; you must again be certified before a Medicaid conversion will be allowed.

☐ ADMINISTRATIVE DAYS ☐ SUBACUTE CARE

☐ **If the location of care is hospital, your assessment must be re-evaluated and a new effective period established PRIOR TO TRANSFER TO A LONG TERM CARE FACILITY.**

FOR LONG TERM CARE FACILITY USE

☐ TIME-LIMITED CERTIFICATION. LTC FACILITY STAFF MUST SUBMIT AN ASSESSMENT AT LEAST FIVE WORKING DAYS BEFORE THE EXPIRATION DATE DUE. (See Expiration Date Below)

☐ THIS CLIENT HAS BEEN RECEIVING HOME AND COMMUNITY-BASED SERVICES FROM CLTC. CONTACT THE DSS OFFICE IN THE CLIENT'S COUNTY OF RESIDENCE TO DETERMINE IF THE 30 CONSECUTIVE DAYS REQUIREMENT HAS BEEN MET.

Effective Date: _____ Expiration Date: _____

Nurse Consultant Signature: _____ Date: _____

☐ CLIENT ☐ CO. DSS ☐ LTC FACILITY ☐ PHYSICIAN ☐ HOSPITAL ☐ OTHER

SENT: Date: _____ Initials: _____

DHHS FORM 185 (Nov 2003)

APPEALS

As a Medicaid nursing home or home and community-based wiaver applicant/recipient, you have the right to a fair hearing regarding this decision. To initiate the appeal process, you or your representative must submit a written request to the following address no later than thirty (30) days from the receipt of this notification.

Division of Appeals and Fair Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

You may be eligible to receive continued benefits pending a hearing decision. If you are interested in continued benefits you must contact your CLTC representative before the effective date of the action indicated above. If the hearing decision is not in your favor, you may be required to repay Medicaid benefits received pending the decision to the South Carolina Department of Health and Human Services.

Please attach a copy of this notification with your request. You or your representative will be notified of the date, time and place the hearing will take place.

In your request for a fair hearing you must state with specificity which issues(s) you with to appeal.

Unless a request is made within thirty (30) calendar days of receipt of this notification, this decision will be final and binding.

A request for a fair hearing is considered filed if postmarked by the thirtieth (30th) calendar day following receipt of this notification.

COMMUNITY LONG TERM CARE NOTIFICATION FORM

TO:

FROM: CLTC Central Office
Post Office Box 8206
Columbia, SC 29202-8206
803-898-2590

CLIENT NAME: SS# MA#

- 's level of care appears to be skilled. (THIS IS NOT A CERTIFIED LEVEL OF CARE. CLIENT INFORMATION MUST AGAIN BE REVIEWED PRIOR TO CERTIFICATION.)

- has been referred to you for case follow-up and services, as appropriate.

IF YOU DISAGREE WITH THIS DETERMINATION, PLEASE READ THE APPEALS NOTICE BELOW:

APPEALS

As a Medicaid recipient, you have the right to a fair hearing regarding this decision. To initiate the appeals process, you or your representative must submit a written request to the following address no later than thirty (30) days from the receipt of this notification.

Division of Appeals and Fair Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Please attach a copy of this notification with your request. You or your representative will be notified of the date, time, and place the hearing will take place. In your request for a fair hearing, you must state with specificity which issue(s) you wish to appeal.

Unless a request is made within thirty (30) calendar days of receipt of this notification, this decision will be final and binding.

A request for a fair hearing is considered filed if postmarked by the thirtieth (30^{th}) calendar day following receipt of this notification.

Signature: Date:

Copies sent to:

CLIENT [ ] HOSPITAL [ ] LTC FACILITY [ ] COUNTY DSS [ ]
PHYSICIAN [ ] CAREGIVER/RESPONSIBLE PARTY [ ] OTHER [ ]

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)

SCDHHS Form 126 (revised 12/04)

RUN DATE 11/09/2004 000000000 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #99999999999999999Z
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 99999 ECF 99999 PAGE 1 OF 1
ANALYST ID INPATIENT/OUTPATIENT - 01 EMC
SIGNON ID CLAIM RESTART DATE / / DOC IND Y

EDITS

RECIP NAME JANE DOE DOB 01/01/1911 SEX F

INSURANCE EDITS

51) 298023 3) L0757991 4) 111 6) 10/17/04 10/17/04 7) 001 001 60) MEDICAID RCP ID 0123456789 000-555

17) 10/17/04 19) 1 20) 7 22)20 23) M032638 24) C5 25) 26) 27) 28) 29) 30)

CLAIM EDITS

32A) 11 10/17/04 33A) 42 10/17/04 34A) / / 35A) / / 36A) / / - / /

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

37)

39A) 02 0.00 40A) A1 876.00 41A)
39B) 40B) 41B)
39C) 40C)
39D) 40D) 41

MEDICAID CARRIER ID 619

1ST OTHER PAYER 50) 618 54) 8102.68 60) 406
2ND OTHER PAYER 50) 54) 60)
MEDICARE DEDUCT A1+
54P) 63) DRG 416 REIMBU

(67) (68) (69) (70) (71) (72) (73) (7 (76)
038.9 153.9 197.0 276.5 . . . 038.9

80) . / / 81A) . / / B) . / / 82) H50364

81C) . / /) / / . / / 83A)

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

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

INSURANCE POLICY INFORMATION

RES	LINE	(42)	(44)	(45)	(46)	(47)	(48)
	001	110			0001	539.00	0.00
	002	270			0003	134.00	0.00
	003	272			0004	16.00	0.00
	004	300			0002	49.00	0.00
	005	301			0002	421.00	0.00
	006	305			0001	101.00	0.00
	007	306			0003	246.00	0.00
	008	307			0001	50.00	0.00
	009	450			0001	231.00	0.00
TOTAL CHARGES		001				1787.00	0.00

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"

STATE HEALTH AND HUMAN SERVICES

ESRD - ENROLLMENT MEDICAID RECIPIENT

PART I - PATIENT INFORMATION

Name:	Date of Birth:	Social Security No:

Address:	Medicaid ID No:	Medicare Eligible
STREET OR RFD	Medicare Application Submitted	
CITY STATE ZIP CODE	Yes Date	

County:	Medicare No.:	Effective Date:	Medicare Denied: ☐ Yes ☐ No

REASON FOR DENIAL: _____

PART II - TREATMENT INFORMATION - DIALYSIS

Date of First Treatment:	Transplant Candidate: ☐ Yes ☐ No

Name of Facility Transferred From:

Mode of Treatment:	Home Dialysis:
☐ HEMODIALYSIS	TYPE: _____
☐ PERITONEAL DIALYSIS	SUPPLIER: _____
☐ SELF DIALYSIS	

PART III - MEDICAL TRANSPORTATION

Reimbursed by DSS: ☐ Yes ☐ No	Provider of Transportation:

ESRD PROVIDER INFORMATION

Clinic Name:

Provider Number:

Physician's Name:

Form Completed By:

NAME TELEPHONE NO.

TITLE DATE

MAIL TO:

ESRD SERVICES
S.C. HEALTH AND HUMAN SERVICES

P.O. BOX 8206
COLUMBIA, S.C. 29202 - 8206

HHSFC USE ONLY

ESRD Enrolled:

Code:

Effective Date:

Approved By:

Date Approved:

Comments:

HHSFC 218 (Apr 86) Replaces DSS Form 17112 (Aug 83) which is obsolete.

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 #: _____

March 2004

HYSTERECTOMY ACKNOWLEDGEMENT FORM
ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

→ ALWAYS COMPLETE THIS SECTION ←

Recipient Name _____ Medicaid ID No. _____

Physician's Name _____ Date of Hysterectomy _____

→ COMPLETE ONLY ONE OF REMAINING SECTIONS: COMPLETE ALL BLANKS IN THAT SECTION ←

SECTION A: COMPLETE THIS SECTION FOR RECIPIENT WHO ACKNOWLEDGES RECEIPT PRIOR TO HYSTERECTOMY

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomies being performed, that if a hysterectomy is performed on me it will render me permanently incapable of reproducing.

_____
PATIENT'S SIGNATURE DATE

_____
WITNESS' SIGNATURE DATE

_____
INTERPRETER'S SIGNATURE (if necessary) DATE

PHYSICIAN STATEMENT

IT HAS BEEN EXPLAINED TO THE ABOVE PATIENT AND/OR HER REPRESENTATIVE BY ME PRIOR TO SURGERY BOTH ORALLY AND IN WRITING THAT THE HYSTERECTOMY TO BE PERFORMED IS MEDICALLY NECESSARY AND NOT FOR THE SOLE PURPOSE OF RENDERING HER INCAPABLE OF BEARING CHILDREN (REPRODUCING) NOR IS THE HYSTERECTOMY FOR MEDICAL PURPOSES WHICH BY THEMSELVES DO NOT MANDATE A HYSTERECTOMY.

_____
PHYSICIAN'S SIGNATURE

SECTION B: COMPLETE THIS SECTION WHEN ANY OF THE EXCEPTIONS LISTED BELOW ARE APPLICABLE

I certify that before I performed the hysterectomy procedure on the recipient listed above:

	check one	
1	☐	I informed her that this operation would make her permanently incapable of reproducing (This certification for retroactively eligible recipient only - a copy of the Medicaid card which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before the reimbursement can be made).
2	☐	Patient was already sterile due to _____. CAUSE OF STERILITY
3	☐	Patient had a hysterectomy performed because of a life-threatening situation due to _____. DESCRIBE EMERGENCY SITUATION and the information concerning sterility could not be given prior to the hysterectomy.

For the above reason(s), I am requesting an exception to the acknowledgement requirement for the hysterectomy.

_____
PHYSICIAN'S SIGNATURE

DHHS Form 1729 (11/95)

This form may be reproduced locally

INSTRUCTIONS FOR COMPLETING THE HYSTERECTOMY ACKNOWLEDGEMENT FORM

Always complete this section

1. Enrollee Name: Enrollee's Name can be typed or handwritten. Must be completed.

2. Medicaid ID No: Enrollee's Identification Number can be typed or handwritten. Must be completed.

3. Physician's Name: Physician's Name can be typed or handwritten. Must be completed.

4. Date of Hysterectomy: Date the hysterectomy was performed. This can be typed or handwritten. Must be completed.

Section A: Complete this section for enrollee who acknowledges receipt prior to hysterectomy

5. Patient's Signature/Date: Patient must sign her name and date in her own handwriting simultaneously prior to surgery (if the patient cannot sign her name she can mark an "X" in patient's signature blank if there is a witness).

6. Witness Signature/Date: The witness must sign and simultaneously date the day they witnessed the recipient make their mark. This must be in the witness' own handwriting.

7. Physician's Signature/Date: The physician must sign his/her name and date simultaneously in his/her own handwriting.

If Section A is completed, **STOP HERE.**

Section B: Complete this section when any of the exception listed below are applicable

8. Retroactive Eligible Enrollee Only: This box is checked only if the enrollee was approved retroactively. A copy of the Medicaid care, which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before reimbursement can be made.

9. This box is checked if the patient was already sterile prior to the surgery. Describe cause of sterility. This can be typed or handwritten.

10. This box is checked if the patient had a hysterectomy performed because of a life-threatening situation and the information concerning sterility could not be given prior to the hysterectomy. Describe the emergency situation. This can be typed or handwritten.

11. Physician's Signature/Date: The physician must sign his/her name and date simultaneously in his/her own handwriting.

HYSTERECTOMY ACKNOWLEDGEMENT FORM
ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

→ ALWAYS COMPLETE THIS SECTION ←

Recipient Name Jane Doe Medicaid ID No. 1234567891

Physician's Name Dr. John Brown Date of Hysterectomy 02/13/04

→ COMPLETE ONLY ONE OF REMAINING SECTIONS: COMPLETE ALL BLANKS IN THAT SECTION ←

SECTION A: COMPLETE THIS SECTION FOR RECIPIENT WHO ACKNOWLEDGES RECEIPT PRIOR TO HYSTERECTOMY

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomies being performed, that if a hysterectomy is performed on me it will render me permanently incapable of reproducing.

Jane Doe 02/12/04
PATIENT'S SIGNATURE — DATE

WITNESS' SIGNATURE — DATE

INTERPRETER'S SIGNATURE (if necessary) — DATE

PHYSICIAN STATEMENT

IT HAS BEEN EXPLAINED TO THE ABOVE PATIENT AND/OR [illegible]TIVE BY ME PRIOR TO SURGERY BOTH ORALLY AND IN WRITING THAT THE HYSTERECTOMY TO B[illegible]RFO[illegible]D [illegible]EDICALLY NECESSARY AND NOT FOR THE SOLE PURPOSE OF RENDERING HER INCAPA[illegible]E B[illegible]NG [illegible]LDREN (REPRODUCING) NOR IS THE HYSTERECTOMY FOR MEDICAL PURPOSES W[illegible]EM[illegible]DO NOT MANDATE A HYSTERECTOMY.

PHYSICIAN'S SIGNATURE

SECTION B: C[illegible]E THI[illegible]SE[illegible]A[illegible]WH[illegible]ANY OF THE EXCEPTIONS LISTED BELOW ARE APPLICABLE

I certify that be[illegible]d t[illegible]erectomy procedure on the recipient listed above:

check one

1 ☐ I inf[illegible]d her that this operation would make her permanently incapable of reproducing (This certification for retroactively eligible recipient only - a copy of the Medicaid card which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before the reimbursement can be made).

2 ☐ Patient was already sterile due to _____.
CAUSE OF STERILITY

3 ☐ Patient had a hysterectomy performed because of a life-threatening situation due to _____.
DESCRIBE EMERGENCY SITUATION
and the information concerning sterility could not be given prior to the hysterectomy.

For the above reason(s), I am requesting an exception to the acknowledgement requirement for the hysterectomy.

PHYSICIAN'S SIGNATURE

DEPT. OF HEALTH & HUMAN SERVICES
P.O. Box 8206
Columbia, S.C. 29202-8206

INDIVIDUALS INFORMED CONSENT TO NON — THERAPEUTIC STERILIZATION FOR MEDICAID RECIPIENTS

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

PART I CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____. When I first asked
(doctor or clinic)
for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benfits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____.
Month Day Year

I, _____, hereby consent of my own free will to be sterilized by _____ (DOCTOR) by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date:_____
Signature Month Day Year

MEDICAID ID NUMBER

You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check):

( ) American Indian or Alaska Native
( ) Black (not of Hispanic origin)
( ) Hispanic
( ) Asian or Pacific Islander
( ) White (not of Hispanic origin)

PART II INTERPRETER'S STATEMENT

If an interperter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and behalf he/she understood this explanation.

_____ _____
Interpreter Date

FORM
DHHS 1723
3-97

PART III STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the
(name of individual)
consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____
Signature of person obtaining consent Date

_____
Facility

_____
Address

PART IV PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on _____,
(Name: individual to be sterilized) (Date sterilized)
I explained to him/her the nature of the sterilization operation _____,
(specify type of operation)
the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. CROSS OUT THE PARAGRAPH WHICH IS NOT USED.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstance (check applicable box and fill in information requested):

( ) Premature delivery
Individual's expected date of delivery:_____
( ) Emergency abdominal surgery (describe circumstances):

_____
Physician

License No.:_____ Date _____

Instructions for Completing DHHS Form 1723
(Individuals Informed Consent to Non-Therapeutic Sterilization for Medicaid Recipients)

Part I

1. Name of the physician or group scheduled to do the sterilization procedure. If the name of the physician or group is unknown, enter the phrase "OB on call."
2. Name of the sterilization procedure (*e.g.*, bilateral tubal ligation)
3. Birth date of the beneficiary. The beneficiary must be 21 years old when he or she signs the consent form, which would be 30 days prior to the procedure being performed.
4. Beneficiary's name
5. Name of the physician or group scheduled to do the sterilization or the phrase "OB on call"
6. Name of the sterilization procedure
7. Beneficiary's signature and date. If the beneficiary signs with an "X," an explanation must accompany the consent form.
8. Beneficiary's 10-digit Medicaid ID number

Part II

If the beneficiary had an interpreter translate the consent form information into a foreign language, the interpreter must complete this section. If an interpreter was not necessary, put an "N/A" in these blanks.

Part III

1. Beneficiary's name
2. Name of the sterilization procedure
3. Signature and date of the person who counseled the beneficiary on the sterilization procedure. This date should be the same as the date of the beneficiary's signature date. Also complete the facility address. An address stamp is acceptable if legible.

Part IV

1. Beneficiary's name
2. Date of the sterilization procedure (must match date billed on claim)
3. Name of the sterilization procedure
4. EDC date is required if sterilization is within the 30-day waiting period and the beneficiary was pregnant. At least 72 hours must pass before the sterilization procedure may be performed.
5. An explanation must be attached if an emergency abdominal surgery was performed within the 30-day waiting period. At least 72 hours must pass before the sterilization. The sterilization cannot be the reason for the emergency surgery.
6. Physician signature and date. A physician stamp is acceptable. The physician's date must be the same as the sterilization date or after. In the license number field, put the Medicaid Provider ID (either the group or individual physician's Medicaid number).

SOUTH CAROLINA MEDICAID
NOTICE OF NONCOVERAGE
(AT OR BEFORE ADMISSION)

Date	Medicaid Number
Name of Patient	Attending Physician's Name
Address	Attending Physician's Phone Number
City, State, Zip Code	

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

The purpose of this letter is to inform you that _____ Hospital, acting through its Utilization Review Committee, has determined that your admission for treatment of _____ is not covered under the Medicaid program because _____
_____
_____.

You should discuss, with your attending Physician, other arrangements for any further health care you may require. If you decide to be admitted to the hospital, you will be financially responsible for all costs associated with this admission.

This notice, however, is not an official Medicaid determination. Carolina Medical Review (CMR) is the Quality Improvement Organization (QIO) authorized by the Medicaid program to review inpatient hospital services provided to Medicaid patients in the State of South Carolina.

If you disagree with our decision and elect to be admitted, you may request, within 3 days of receipt of this notice, an immediate review of your case by the QIO. You may make this request through the hospital or directly to the QIO by telephone or in writing to:

Carolina Medical Review
Attention: HINN
250 Berryhill Road, Suite 101
Columbia, SC 29210

The QIO will respond to you within 3 working days of receipt of your request. The decision of the QIO is final. Remember, if you decide to be admitted before you receive a determination from the QIO and the QIO determines that your case is not covered by Medicaid, <u>you will be held financially responsible</u> for all costs associated with your admission.

However, if you decide to be admitted and the QIO determines that your case is covered by Medicaid, you will receive a refund from this hospital for any charges you have paid, except for any convenience services or items normally not covered by Medicaid.

Sincerely,

_____

Chairman, Hospital Utilization Review Committee

cc: Carolina Medical Review

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage 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

Patient refused to sign this notice, but was told that this admission is not covered by Medicaid.

_____ _____

Witness Date

SOUTH CAROLINA MEDICAID
NOTICE OF NONCOVERAGE
(NON-COVERED ADMISSION – AFTER ADMISSION)

Date	Medicaid Number
Name of Patient	Attending Physician's Name
Address	Attending Physician's Phone Number
City, State, Zip Code	

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

The purpose of this letter is to inform you that _____ Hospital, acting through its Utilization Review Committee, has determined that your admission for treatment of _____ is not covered under the Medicaid program because _____
_____
_____.

You should discuss with your attending physician other arrangements for any further health care you may require. If you decide to remain in the hospital, beginning on _____ you will be financially responsible for payment of all services provided to you by the hospital from this date through discharge.

This notice, however, is not an official Medicaid determination. Carolina Medical Review (CMR) is the Quality Improvement Organization (QIO) authorized by the Medicaid program to review inpatient hospital services provided to Medicaid patients in the State of South Carolina.

If you disagree with our decision and elect to remain in the hospital you may request, within 3 days of receipt of this notice, an immediate review of your case by the QIO. You may make this request through the hospital or directly to the QIO by telephone or in writing to:

Carolina Medical Review
Attention: HINN
250 Berryhill Road, Suite 101
Columbia, SC 29210

The QIO will respond to you within 3 working days of receipt of your request. The decision of the QIO is final.

Remember, if you decide to remain in the hospital and the QIO determines that further inpatient hospital care is no longer necessary, you will be held financially responsible for payment of all services provided to you by the hospital from _____ through discharge. However, if the QIO determines that you did require further inpatient hospital care beyond the date indicated by the hospital, you will receive a refund from this hospital for any charges you have paid, except for convenience items and services not normally covered by Medicaid.

Sincerely,

_____
Chairman, Hospital Utilization Review Committee

cc: Carolina Medical Review
Attending Physician

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage 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

Patient refused to sign this notice, but was told that this admission is not covered by Medicaid.

_____ _____
Witness Date

SOUTH CAROLINA MEDICAID
NOTICE OF NONCOVERAGE FOR CONTINUED STAY
(ATTENDING PHYSICIAN AGREES)

Date	Medicaid Number
Name of Patient	Attending Physician's Name
Address	Attending Physician's Phone Number
City, State, Zip Code	

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

The purpose of this letter is to inform you that _____ Hospital, acting through its Utilization Review Committee, has reviewed the medical care you received for treatment of _____ and has determined that beginning on _____, further treatment of this condition in an acute hospital setting is no longer medically necessary and could be safely rendered _____. Your attending physician has been advised and agrees that continued hospitalization is not necessary. You should discuss with your attending physician other arrangements for any further health care you may require.

If you elect to remain in the hospital beginning on _____, you will be responsible for payment of all services provided to you by the hospital from this date through discharge. However, you are not responsible for payment of the hospital services provided you from admission through the day normally not covered by the Medicaid program.

This notice, however, is not an official Medicaid determination. Carolina Medical Review (CMR) is the Quality Improvement Organization (QIO) authorized by the Medicaid Program to review inpatient hospital services provided to Medicaid patients in the State of South Carolina.

If you disagree with our decision and elect to remain in the hospital, you may request, within 3 days of receipt of this notice, an immediate review of your case by the QIO. You may make this request through the hospital or directly to the QIO by telephone or in writing to:

Carolina Medical Review
Attention: HINN
250 Berryhill Road, Suite 101
Columbia, SC 29210

The QIO will respond to you within 3 working days of receipt of your request. The decision of the CMR is final.

Remember, if you decide to remain in the hospital and the QIO determines that further inpatient hospital care is no longer necessary, you will be held financially responsible for payment of all services provided to you by the hospital from _____ through discharge. However, if the QIO determines that you did require further inpatient hospital care beyond the date indicated by the hospital, you will receive a refund from this hospital for any charges you have paid, except for convenience items and services not normally covered by Medicaid.

Sincerely,

_____
Chairman, Hospital Utilization Review Committee

cc: Carolina Medical Review
Attending Physician

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage 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

Patient refused to sign this notice, but was told that this admission is not covered by Medicaid.

_____ _____
Witness Date

SOUTH CAROLINA MEDICAID
NOTICE OF NONCOVERAGE FOR CONTINUED STAY
(ATTENDING PHYSICIAN DISAGREES BUT QIO CONCURS)

Date	Medicaid Number
Name of Patient	Attending Physician's Name
Address	Attending Physician's Phone Number
City, State, Zip Code	

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear_____:

This letter is to inform you that _____Hospital, acting through its Utilization Review Committee, has reviewed the medical care you received for treatment of _____and has determined that beginning on _____, further treatment of this condition in an acute hospital setting is no longer medically necessary and could be safely rendered _____.

Carolina Medical Review (CMR) is the Quality Improvement Organization (QIO) authorized by the Medicaid Program to review inpatient hospital services provided to Medicaid patients in the State of South Carolina. CMR has reviewed this case and agrees with the hospital's decision that, beginning on _____, further hospitalization is no longer necessary. We have advised your attending physician of the non-coverage of further inpatient hospital care. You should discuss with your attending physician other arrangements for any further health care you may require.

If you elect to remain in the hospital, beginning on _____, you will be responsible for payment of all services provided to you by the hospital from this date through discharge. However, you are not responsible for payment of the hospital services proved to you from admission through the day immediately preceding this date, except any convenience services or items normally not covered by the Medicaid program. This notice, however, is not an official Medicaid determination. If you disagree with our decision, you may request, within 3 days of receipt of this notice, an immediate review of your case by the QIO. You may make this request through the hospital or directly to the QIO by telephone or in writing to:

Carolina Medical Review
Attention: HINN
250 Berryhill Road, Suite 101
Columbia, SC 29210

The QIO will respond to you within 3 working days of receipt of your request. The decision of the QIO is final.

However, if you decide to be admitted and the QIO determines that your case is covered by Medicaid, you will receive a refund from this hospital for any charges you have paid, except for any convenience services or items normally not covered by Medicaid.

Sincerely,

_____

Chairman, Hospital Utilization Review Committee

cc: Carolina Medical Review

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage 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

Patient refused to sign this notice, but was told that this admission is not covered by Medicaid.

_____ _____

Witness Date

_____
ADMISSION DATE

_____ _____
DATE MEDICAID ID NUMBER

_____
ATTENDING PHYSICIAN'S NAME

_____

_____

_____

NOTICE OF TERMINATION OF ADMINISTRATIVE DAYS

This is to inform you that a nursing home bed has been found for you at _____ _____ in _____, South Carolina. The bed will be available to you on _____. If you elect to remain in the hospital after this date, you will be responsible for payment of all services provided to you by _____ _____ Hospital beginning on _____.

You may appeal this Notice of Termination with a written request to:

SCDHHS
Division of Appeals and Hearings
P. O. Box 8206
Columbia, SC 29202-8206

The appeal request must be received by SHHSFC within 30 calendar days from receipt of this letter. If the appeal rules in your favor, you will not be responsible for additional charges. However, if the appeal upholds the Notice of Termination, you are responsible for all charges beginning on the date the nursing home bed was located.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

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

_____ _____ _____
(Signature of recipient or person acting on behalf of the recipient) (Time) (Date)

cc: Division of Hospital Services
DHHS

ADMISSION DATE

DATE

MEDICAID ID NUMBER

ATTENDING PHYSICIAN'S NAME

NOTIFICATION OF ADMINISTRATIVE DAYS COVERAGE

This notice is to inform you that the hospital's Utilization Review Committee has determined that beginning _____ further acute hospital care is no longer necessary. Your condition, however, qualifies you for nursing home care.

Limited additional days in the hospital may be approved subject to Medicaid coverage regulations while you and your family actively seek a nursing home bed. In order for Medicaid to pay for your Administrative Day expenses in the hospital, you must agree to accept placement in any nursing facility within 50 miles which will provide an appropriate level of care.

The hospital social worker will assist you with placement by contacting weekly all nursing homes within a 50-mile service area. Once an available bed is located, Medicaid payment of your hospital bill will stop. If you refuse to accept an available nursing home bed and remain in the hospital, you will be personally responsible for the additional expense in the hospital.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

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

(Signature of recipient or person acting on behalf of the recipient)

(Date)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PREGNANCY/NEWBORN RISK ASSESSMENT FORM

1. RECIPIENT'S/MOTHER'S NAME:	2. RECIPIENT'S/MOTHER'S ID NUMBER:	3. COUNTY:
4. PERMANENT ADDRESS: (Number, Street, City, State, Zip Code)		RECIPIENT PHONE NO. CONTACT PHONE NO.
5. PROVIDER'S NAME:		6. PROVIDER'S MEDICAID ID NUMBER:
7. PROVIDER'S ADDRESS: (Number, Street, City, Zip Code)		PROVIDER'S PHONE NUMBER:

CONFIDENTIAL INFORMATION

PREGNANCY RISK ASSESSMENT

8. Assessment mo da yr	9. EDC mo da yr	10. Wks Gestation	11. Birthdate mo da yr

12. Gravida	13. Para	14. Preterm	15. Abortions Spontaneous Induced	16. Living

LAST PREGNANCY—Check Box(es)

- ☐ 17. Not Applicable; Prima Gravida
- ☐ 18. Three Consecutive Spontaneous Abortions
- ☐ 19. Fetal Death - Greater than 20 wks/Greater than 500 grams
- ☐ 20. Low birth Weight - Less than 2,500 grams
- ☐ 21. Neonatal Death - Less than 28 days
- ☐ 22. Congenital Anomaly - Explain below
- ☐ 23. History of Incompetent Cervix
- ☐ 24. Other - Explain Below

CURRENT PREGNANCY—Check Box(es)

- ☐ 25. RH Sensitization
- ☐ 26. Sickle Cell Anemia
- ☐ 27. Heart Disease
- ☐ 28. Hypertensive Vascular Disease
- ☐ 29. Diabetes Mellitus
- ☐ 30. Upper Renal Tract Disease
- ☐ 31. Multiple Gestation (twins, etc.)
- ☐ 32. Incompetent Cervix
- ☐ 33. Placenta Previa
- ☐ 34. Premature Labor
- ☐ 35. Premature Ruptured Membranes
- ☐ 36. Pre-Eclampsia
- ☐ 37. Eclampsia
- ☐ 38. Alcohol or Other Drug Problems
- ☐ 39. Other

NEWBORN RISK ASSESSMENT

40. Infant's Name	41. Medicaid ID Number

42. Mother's Admit. mo da yr	43. Mother's Disch mo da yr	44. Infant's Birthdate mo da yr	45. Assessment mo da yr

46. Birthweight Grams	47. Wks. Gestation	48. Hospital

49. Death mo da yr	50. Infant's Disch/Trans mo da yr	51. Hospital of Transfer 2nd Transfer

CONDITIONS REQUIRING LEVEL II INTERMEDIATE CARE - Check Box(es)

- ☐ 52. Wt. Greater than 1,500 grams but less than 2,000 grams
- ☐ 53. Nasal CPAP (Continuous Positive Airway Pressure)
- ☐ 54. Moderately Severe Superficial or Localized Infections
- ☐ 55. Uncomplicated Sepsis or Meningitis
- ☐ 56. Moderately Severe Cardio - Respiratory Problems
- ☐ 57. Moderately Severe Congenital Malformation- Explain below
- ☐ 58. Easily Controlled Seizures
- ☐ 59. Mild Hypoglycemia
- ☐ 60. Other

CONDITIONS REQUIRING LEVEL III INTENSIVE CARE - Check Box(es)

- ☐ 61. Wt. Less than 1,500 grams
- ☐ 62. Major Congenital Malformation - Explain below
- ☐ 63. Major Neonatal Surgery - Explain below
- ☐ 64. Sepsis - Meningitis with Shock, Respiratory Failure, or Unstable Clinical Condition
- ☐ 65. Persistent Seizures
- ☐ 66. Cardio-Respiratory Problem Requiring Mechanical Ventilation or Endotracheal CPAP
- ☐ 67. Severe/Refractory Hypoglycemia
- ☐ 68. Other

- ☐ 69. Alcohol or Other Drug Exposure

CONFIDENTIAL INFORMATION

COMMENTS / EXPLANATION

NOTE: (ATTACH ADDITIONAL DOCUMENTATION IF NECESSARY)

☐ INFANT HOME VISIT REFERRAL

BILLING PROCEDURES

99420 Administration and interpretation of health risk assessment instrument (Pregnancy Assessment - Low Risk, block 17 or LR written in comment section)

99420 Administration and interpretation of health risk assessment instrument (Pregnancy Assessment - High Risk, one or more items in blocks 18-39 are checked)

99420 Administration and interpretation of health risk assessment instrument (Neonatal Assessment - Low Risk, no items checked or normal newborn written in comment section)

99420 Administration and interpretation of health risk assessment instrument (Neonatal Assessment - High Risk, one or more items checked in blocks 52-69 are checked)

DEFINITIONS

LAST PREGNANCY (or past pregnancy without an intervening good outcome)

12. **Gravida.** The number of times a woman has been pregnant.
13. **Para.** The number of live or stillborn infants of more than 20 weeks gestation a woman has delivered.
14. **Preterm.** The number of infants with a gestational age of less than 38 weeks.
15. **Spontaneous Abortion.** The number of spontaneous expulsions of a nonviable fetus.

    Induced Abortion. The number of deliberate interruptions of a pregnancy.
16. **Living.** The number of living children.
18. **Three consecutive Spontaneous Abortions.** Fetuses of last three pregnancies each weighed less than 500 grams (about 1lb 1 oz.) and/or each gestation period was less than 20 weeks.
19. **Fetal Death.** Dead fetus of last pregnancy with documented weight of greater than 500 grams (about 1lb 1 oz.) and gestation period was greater than 20 weeks.
20. **Low birth weight.** Liveborn infant of last pregnancy weighed less than 2,500 grams (about 5lbs. 8 oz.).
21. **Neonatal death.** Liveborn infant of last pregnancy died during the first 28 days of life.
22. **Congenital Anomaly.** Infant of last completed pregnancy had a severe life threatening congenital anomaly requiring major medical or surgical intervention.
23. **History of Incompetent Cervix.** History of miscarriage in the second trimester related to cervical incompetence or patient received anteparial treatment for incompetent cervix in a past pregnancy.

CURRENT PREGNANCY

25. **RH Sensitization.** RH negative patient with Rh antibodies.
26. **Sickle Cell Anemia.** Not sickle cell trait.
27. **Heart Disease.** Patient currently has organic heart disease regardless of functional classification. Provide documentation.
28. **Hypertensive Vascular Disease (HVD).** Patient has diagnosed chronic HVD as evidence by repeated elevated blood pressure readings greater than 140/90 prior to this pregnancy or has developed hypertension without proteinuria and/or edema (see pre-eclampsia, item 36).
29. **Diabetes Mellitus.** Patient has diagnosed diabetes mellitus (includes gestational diabetes) as evidence by altered carbohydrate metabolism. Give results of 3-hour glucose tolerance test, if ordered.
30. **Upper Renal Tract disease.** Pathologic conditions of the kidney are present, i.e. pyelonephritis, chronic or recurrent urinary tract infections with chills, fever, back pain, or CVA tenderness. NOTE: Not signs and symptoms of cystitis.
31. **Multiple gestation.** Twins, triplets, etc., documented by ultrasound.
32. **Incompetent Cervix.** Early effacement and/or dilation of the cervix is present. Provide documentation if previous history of incompetent cervix is absent.
33. **Placenta Previa.** Evidence of the placenta in the lower uterine segment is verified by ultrasound in the third trimester.
34. **Premature Labor.** Progressive dilation and effacement of the cervix occurs before 37 weeks gestation are completed.

    Level II hospital can provide care for patients in premature labor at 33 to 36 weeks gestation and if the fetus is estimated to weigh 1500 grams or more.

    Level III hospitals can provide care regardless of weeks gestation or weight.
35. **Premature Ruptured Membranes.** Patient has evidence (fluid escaping, positive fern or nitrazine test) or ruptured membranes at less than 37 weeks gestation.
36. **Pre-eclampsia.** Patient has a blood pressure reading greater than 140/90 and/or greater than 30mm rise in systolic or greater than 15mm rise in diastolic pressure and proteinuria and/or edema is present.
37. **Eclampsia.** As evidenced by generalized convulsion or coma.
38. **Maternal Alcohol or Other Drug Problems.** Patient admits to drinking two or more drinks per day, binge drinking, and/or using <u>any</u> illicit drugs at any time during pregnancy, and/ or patient is suspected of (based on medical and/or phychosocial indicators), or assessment reveals chronic/habitual misuse of alcohol or other drugs (including psychoactive prescription drugs such as Valium, Xanax, Nembutol, Dilaudid, and Dexedrine) and illicit drugs such as marijuana, cocaine, heroine, methamphetamine, PCP, etc.)
69. **Newborn: Alcohol or other Drug Exposure.** Suspected or confirmed misuse of alcohol or other drugs by the mother at any time during pregnancy; regardless of level (I, II, III) of hospital care and/or need for transfer for medical treatment. (See Definition #38)

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAID PROVIDER INQUIRY

MAIL TO:

ATTENTION_____UNIT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
POST OFFICE BOX 8206
COLUMBIA, SOUTH CAROLINA 29202-8206

TODAY'S DATE

PROVIDER NUMBER, SIX DIGITS - INCLUDE GROUP NR, 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)* ☐ YES ☐ NO

IS MEDICARE COVERAGE INVOLVED? ☐ YES ☐ NO

CLAIMS STATUS ON REMITTANCE ADVICE	**PAYMENT DATE**	**17 DIGIT CLAIM REFERENCE NUMBER**
☐ P ☐ S ☐ R ☐ A		

STATEMENT OF PROBLEM OR QUESTION

SIGNATURE OF REQUESTER

RESPONSE

AGENCY REPRESENTATIVE	**DATE**

DHHS FORM 140 (1/96)

REASONABLE EFFORT DOCUMENTATION

HOSPITAL _____ **DOS** _____

MEDICAID BENEFICIARY NAME _____

MEDICAID ID# _____

INSURANCE COMPANY NAME _____

POLICY HOLDER _____

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.

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206

REFERRAL REQUEST FOR OUT-OF-STATE SERVICES

Referring Physician: _____

Recipient's Name: _____ Medicaid #: _____

Patient is being referred to: _____
Name of Facility and Physician(s)

Address: _____

_____

Telephone and Fax #: _____

for the condition of _____

Diagnosis code(s): _____ Procedure code(s): _____

Anticipated Date of Service: _____ Anticipated Date of Return: _____

Medicaid patients being referred out-of-state can be provided transportation, as well as the patient's escort, when necessary. Adequate advance notice as well as prior approval is mandatory in order to make the necessary travel arrangements. Travel arrangements can be made by calling Preventive Care at (803) 898-2655.

Will the patient require transportation? YES_____ NO_____

Recommended mode of transportation: _____

I certify that the out-of-state provider has been contacted by me. The out-of-state provider has agreed to enroll into our SC Medicaid program and to accept our reimbursement rate as payment in full. I also certify that these services are not available and cannot be provided within the SC service area, which includes North Carolina and Georgia within 25 miles of the border.

_____ _____
Signature of Referring Physician Date

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)

DHHS Form 205 (3/00) (92 edition obsolete)

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.

777777

111111111111 Y

PROVIDER ID. **A**

777777

IN/OUT-PATIENT SERVICES
DEPT OF HEALTH AND HUMAN SERVICES
REMITTANCE ADVICE
SOUTH CAROLINA MEDICAID PROGRAM

PAYMENT DATE **B** 09/10/2004

PAGE 1

PROVIDERS OWN REF. NUMBER **C**	CLAIM REFERENCE NUMBER **D**	SERVICE RENDERED PERIOD MMDDYY-MMDD **E**	DAYS **F**	AMOUNT BILLED **G**	TITLE 19 PAYMENT MEDICAID **H**	ST **I**	RECIPIENT ID. NUMBER **J**	RECIPIENT NAME FM I I LAST NAME **K**	CO PY **L**	LV CL **M**	POS IND **N**	TYP REM **N**	XOV IND **O**
V99999999	99999999999999Z	062504-0625	1 0	3,015.88	675.00	P	2222222222	B B JACKSON	C	1		1	
V99999999	99999999999999Z	070104-0701	1 0	3,690.88	0.00	R	1111111111	A B SMITH					
							EDITS: L00 758	L00 990					
							EDITS: L06 714						
V99999999	99999999999999Z	070104-0701	1 0	3,690.88	0.00	R	1111111111	A B SMITH					
							EDITS: L00 758 **AA**	L00 990					
							EDITS: L06 714						
	TOTALS	CLAIMS 3 **P**	0 **Q**	10,397.64 **R**	675.00 **S**								

SCHAP PG TOT **T** $0.00

MEDICAID PG TOT **V** $675.00

SCHAP TOTAL **U** $0.00

MEDICAID TOTAL **W** $675.00

* CHECK TOTAL **X** $675.00

CHECK NUMBER **Y** 9999999

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS

PROVIDER NAME AND ADDRESS **Z**

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.

0* FUNDS AUTOMATICALLY DEPOSITED TO:
BANK NAME: ABC BANK BANK NUMBER: ACCOUNT #:
NOTIFY MEDICAID PROVIDER ENROLLMENT BEFORE CLOSING OR CHANGING YOUR BANK ACCOUNT.

777777

PROVIDER ID. 000099999 | IN/OUT-PATIENT SERVICES | PAYMENT DATE | PAGE

| 777777 A | DEPT OF HEALTH AND HUMAN SERVICES | REMITTANCE ADVICE | 11/12/2004 B | 2 |

SOUTH CAROLINA MEDICAID PROGRAM

PROVIDERS OWN REF. NUMBER C	CLAIM REFERENCE NUMBER D	SERVICE RENDERED PERIOD MMDDYY-MMDD E	DAYS F	AMOUNT BILLED G	TITLE 19 PAYMENT MEDICAID H	ST S I	RECIPIENT ID. NUMBER J	RECIPIENT NAME F M I LAST NAME K	COPY L	DRG M	TYPE REIM N	XOV IND O
L0000000	99999999999999002	091804-0919	1 1	1,339.25	429.37	P	1234567890	A B SMITH		391	A	
L0000000	99999999999999002	101504-1027	12 12	24,536.78	7,162.25	P	1234567890	C B JONES	D	138	C	
L0000000	99999999999999002	102204-1026	4 4	3,088.25	429.37	P	1234567890	J Q DOE		391	A	
L0000000	99999999999999002	102204-1026	4 4	13,085.84	3,720.97	P	1234567890	R R ROE	D	370	A	
L0000000	99999999999999002	101804-1021	3 3	13,152.95	3,438.85	P	1234567890	C D SMITH	D	336	A	
L0000000	99999999999999002	102804-1030	2 2	4,672.75	1,394.10	P	1234567890	A B JOHNSON		373	A	
L0000000	99999999999999002	102904-1030	1 0	2,873.00	0.00	R	1234567890	J Q PUBLIC		143	U	
								EDITS: L06 761 AA				
	TOTALS	CLAIMS 27 P	74 Q	317,236.27 R	50,011.83 S							

T $0.00 SCHAP PG TOT | V $44,539.54 MEDICAID PG TOT

U $0.00 SCHAP TOTAL | W $50,011.83 MEDICAID TOTAL

X $50,011.83 * CHECK TOTAL

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS

| 9999999 Y | CHECK NUMBER

PROVIDER NAME AND ADDRESS

Z

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.

* FUNDS AUTOMATICALLY DEPOSITED TO:
BANK NAME: BRANCH BANK & TRUST BANK NUMBER: ACCOUNT #:
NOTIFY MEDICAID PROVIDER ENROLLMENT BEFORE CLOSING OR CHANGING YOUR BANK ACCOUNT.

PROVIDER ID. 000097427 — IN/OUT-PATIENT SERVICES — PAYMENT DATE — PAGE

PROVIDER ID. (A)	DEPT OF HEALTH AND HUMAN SERVICES	PAYMENT DATE (B)	PAGE
777777	REMITTANCE ADVICE	11/12/2004	3
	SOUTH CAROLINA MEDICAID PROGRAM		

PROVIDERS OWN REF. NUMBER (C)	CLAIM REFERENCE NUMBER (D)	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F	M I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
A999999999999	99999999999999900U	-								DEBIT	-27.00	
									PAGE TOTAL:		27.00	0.00

(BB) DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT		TO BE REFUNDED IN THE FUTURE
$0.00	91430.19	0.00	0.00	0.00

ADJUSTMENTS		PROVIDER NAME AND ADDRESS
-27.00	0.00	

YOUR CURRENT DEBIT BALANCE	* CHECK TOTAL	CHECK NUMBER
0.00	91403.19	9999999

* FUNDS AUTOMATICALLY DEPOSITED TO:
BANK NAME: BRANCH BANK & TRUST BANK NUMBER: ACCOUNT #:
NOTIFY MEDICAID PROVIDER ENROLLMENT BEFORE CLOSING OR CHANGING YOUR BANK ACCOUNT.

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR MEDICAID FORMS AND PUBLICATIONS

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

WHEN COMPLETED PLEASE FORWARD TO:
SC Department of Health and Human Services
Supply
Post Office Box 8206
-or- Columbia, South Carolina 29202-8206
FAX TO: (803) 898-4528

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 [ ] N

DHHS FORM 142 (5/97)

South Carolina Department of Health and Human Services
REQUEST FOR MEDICAID ID NUMBER

FROM (Provider name and address):	TO: (DHHS Medicaid Eligibility)

IDENTIFYING INFORMATION FURNISHED BY MEDICAID PROVIDER

A. MOTHER:

Name: _____

Address: _____

Social Security Number: _____ Date of Birth: _____

Did the mother have a permanent sterilization procedure? ___Yes ___No

Medicaid ID Number: _____ County: _____

Medicaid Eligibility Worker Name (if known): _____

B. CHILD:

Name: _____

Date of Birth: _____ Race: _____ Sex: _____

Has application been made for a SSN for the child? _____Yes _____No

Is the child a member of the mother's household? _____Yes _____ No

Provider representative furnishing information: _____

Telephone number: _____ Date: _____

MEDICAID ELIGIBILITY INFORMATION FURNISHED BY DHHS
(within 5 working days)

Child's Medicaid ID Number: _____

Effective date of eligibility: _____

Medicaid Eligibility Worker: _____ Date: _____

Location: _____ Telephone number: _____

SOUTH CAROLINA MEDICAID PROGRAM

REQUEST FOR PRIOR APPROVAL REVIEW

MAIL COMPLETED REQUEST FORM WITH MEDICAL RECORDS TO:

MEDICAID PRIOR APPROVAL REVIEW
CAROLINA MEDICAL REVIEW
250 BERRYHILL ROAD, SUITE 101
COLUMBIA, SC 29210
Phone: 803-731-8225 1-800-922-3089

PATIENT NAME_____
LAST FIRST MI

BIRTHDATE_____ *MEDICAID ID#_____
MONTH/DAY/YEAR

PROCEDURE_____ CODE_____

FACILITY_____ _____
NAME MEDICAID PROVIDER #

PLANNED SURGERY DATE_____

* TO AVOID THE RISK OF NON – PAYMENT, PROVIDERS SHOULD CHECK ELIGIBILITY OF RECIPIENT PRIOR TO REQUEST FOR PRIOR APPROVAL REVIEW. IF THE RECIPIENT IS MANAGED CARE, PRIOR APPROVAL MUST BE OBTAINED THROUGH THE MANAGED CARE PROVIDER.

PHYSICIAN'S NAME_____
LAST FIRST MI

ADDRESS_____

_____ MEDICAID PROVIDER # _____

CONTACT PERSON _____ TELEPHONE (____) _____

DATE_____ FAX NUMBER (____) _____

- **OFFICE NOTES DOCUMENTING THE REQUESTED INFORMATION MUST BE ATTACHED**
- **PROVIDERS WILL BE NOTIFIED OF DETERMINATION VIA MAIL**
- **APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE**

SOUTH CAROLINA MEDICAID PROGRAM
SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY

COMPLETED FORM, ACCOMPANIED BY ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION FORM, MUST BE RECEIVED 30 DAYS PRIOR TO SCHEDULED SURGERY.

MAIL TO:
PRE-ADMISSION REVIEW
CAROLINA MEDICAL REVIEW
250 BERRYHILL ROAD, SUITE 101
COLUMBIA, SC 29210
Phone: 803-731-8225

PATIENT

NAME_____ **MEDICAID #**_____
LAST FIRST MI

BIRTHDATE_____ **GRAVITY**_____ **PARITY**_____
MONTH/DAY/YEAR

PROCEDURE

HOSPITAL_____ _____
NAME ID# (IF AVAILABLE)

PLANNED ADMISSION DATE_____ **PLANNED SURGERY DATE**_____

____ **VAGINAL HYSTERECTOMY** ____ **ABDOMINAL HYSTERECTOMY**

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:

_____

_____

_____

_____

_____

_____

_____

_____

HCT_____ **HGB**_____ **CHECK ONE: PREMENOPAUSAL**_____ **POSTMENOPAUSAL** _____

CONSERVATIVE TREATMENT/MEDICATION WITH DATES:

_____

_____

_____

PRIOR GYN SURGERY/DIAGNOSTIC PROCEDURES (INCLUDE COPIES OF ALL REPORTS):

_____

_____

_____

OFFICE NOTES DOCUMENTING THE REQUESTED INFORMATION SHOULD BE ATTACHED.

ATTENDING PHYSICIAN'S NAME_____ _____
LAST FIRST MI STATE ID #

ADDRESS_____

CONTACT PERSON _____ **TELEPHONE** (____) _____

SIGNATURE_____ **DATE** _____
ATTENDING PHYSICIAN

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

SOUTH CAROLINA MEDICAID PROGRAM
SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY

COMPLETED FORM, ACCOMPANIED BY ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION FORM, MUST BE RECEIVED 30 DAYS PRIOR TO SCHEDULED SURGERY.

MAIL TO:
PRE-ADMISSION REVIEW
CAROLINA MEDICAL REVIEW
250 BERRYHILL ROAD, SUITE 101
COLUMBIA, SC 29210
Phone: 803-731-8225

PATIENT

NAME DOE (LAST) JANE (FIRST) (MI) **MEDICAID #** 1234567891

BIRTHDATE 09/09/70 (MONTH/DAY/YEAR) **GRAVITY** 2 **PARITY** 2

PROCEDURE

HOSPITAL MEMORIAL HOSPITAL (NAME) 123456 (ID# (IF AVAILABLE))

PLANNED ADMISSION DATE 02/15/05 **PLANNED SURGERY DATE** 02/15/05

X **VAGINAL HYSTERECTOMY** ___ **ABDOMINAL HYSTERECTOMY**

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:

Dysfunctional uterine bleeding >3 mos and unresponsive to hormonal therapy x 3 consecutive cycles, bleeding, anemia with transfusion x 1. Neg. for endometrial lesion per biopsy 10/04.

HCT 28 **HGB** 6 **CHECK ONE: PREMENO** **USA** **STMENOPAUSAL** X

CONSERVATIVE TREATMENT/MEDICATION W **AT**

D&C 10/05/04 Dx Lap. 11/04

PRIOR GYN SURG **/D** **OST** **PR** **EDURES (INCLUDE COPIES OF ALL REPORTS):**

OFFICE NOTES DOCUMENTING THE REQUESTED INFORMATION SHOULD BE ATTACHED.

ATTENDING PHYSICIAN'S NAME BROWN (LAST) JOHN (FIRST) Z (MI) PA1111 (STATE ID #)

ADDRESS 101 EAST STREET ANYWHERE, SC

CONTACT PERSON MARY BROWN **TELEPHONE** (803) 123-4567

SIGNATURE *John Brown, MD* (ATTENDING PHYSICIAN) **DATE** *01/10/05*

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

APPROVED OMB NO. 0938-0279

ST 1184 31FLYUB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV'D.	8 N-C D.	9 C-I D.	10 L-R D.	11

12 PATIENT NAME	13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

	32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE DATE	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37	
a												A	A
b												B	B
												C	C

38	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT	
	a						a
	b						b
	c						c
	d						d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR P. AYMENTS	55 EST. AMOUNT DUE	56	
A							A
B							B
C							C
57	DUE FROM PATIENT ▶						

58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GR OUP NAME	62 INSURANCE GR OUP NO.	
A					A
B					B
C					C

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLO YER LOCATION	
A				A
B				B
C				C

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
			A		B		
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID
	C		D		E		A

	84 REMARKS	OTHER PHYS. ID	
a			a
b		B	b
c		85 PROVIDER REPRESENTATIVE	86 DATE
d		X	

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanitoriums, verifications and if nece[illegible] verifications of the patient's need for sanitorium services a[illegible] file.

5. Signature of patient or his/her representa[illegible] tific[illegible], authorization to release inform[illegible] d pay[illegible] req[illegible]s re[illegible] be Federal law and regul[illegible] USC 1935f, [illegible] CH[illegible] 4.36, 10 USC 1071 thru 1086, 32 [illegible] 199) and any oth[illegible] appli[illegible] contract regulations, is on file.

6. This claim, to the best of my knowledge[illegible] orrect and complete and is in conformance with the C[illegible] ct of 1964 as amended. Records adequately disclos[illegible] ces will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.

   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if th[illegible] t resides within a catchment area of such a[illegible]ity, a co[illegible]r a[illegible] Availability Statement (DD Form 1251) is [illegible] or t[illegible]hys[illegible]n has certified to a medical emergency in an[illegible]ista[illegible]here[illegible]opy of a Non-Availability Statement is not on[illegible]

   (c) the p[illegible]ati[illegible]arent or guardian has responded directly to t[illegible]ovide[illegible]ique[illegible]dentify all health insurance coverages, and t[illegible]l suc[illegible]erages are identified on the face the claim except [illegible]ose[illegible]lusively supplemental payments to CHAMPUS-[illegible]erm[illegible]enefits;

   (d) t[illegible]moun[illegible]d to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

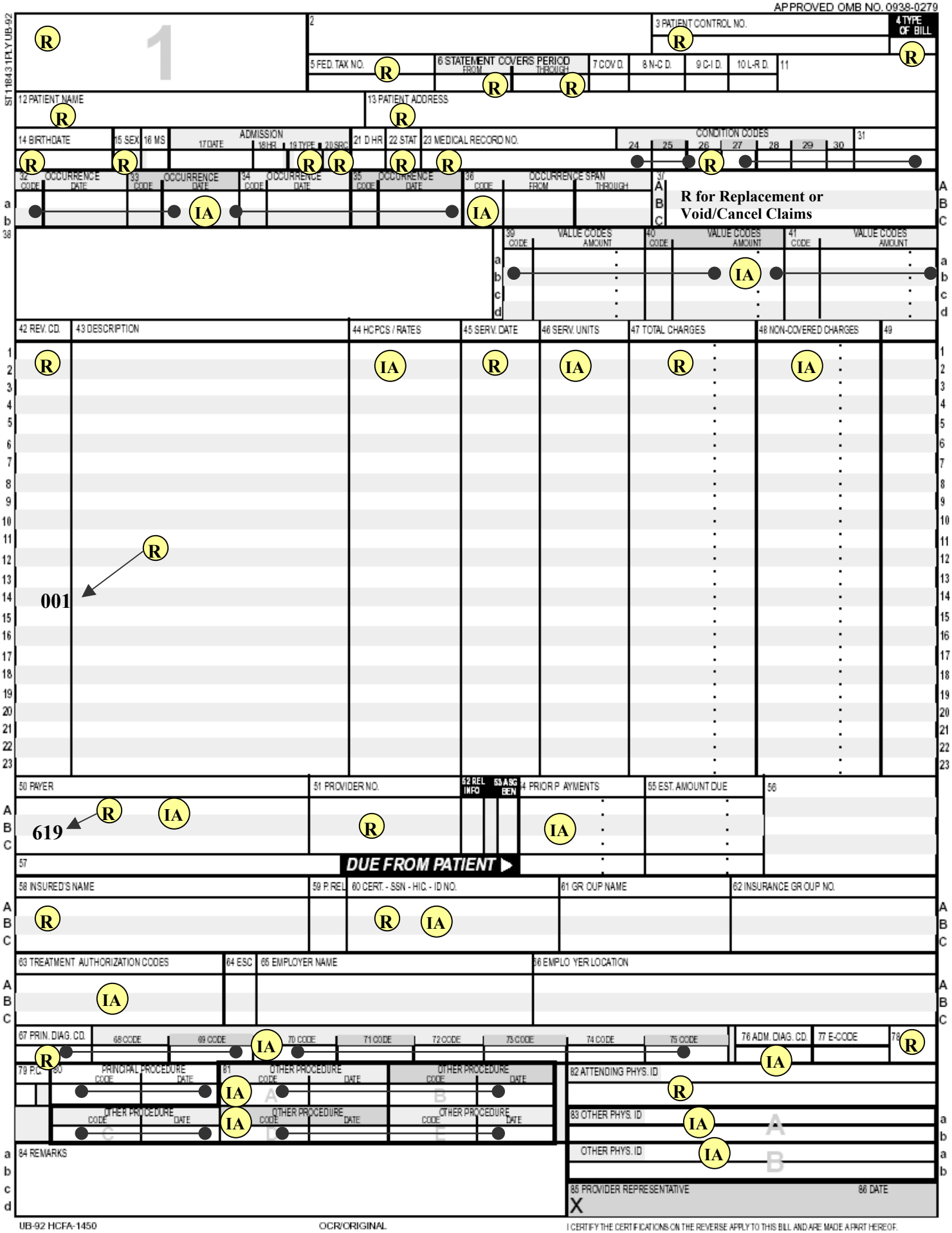
   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

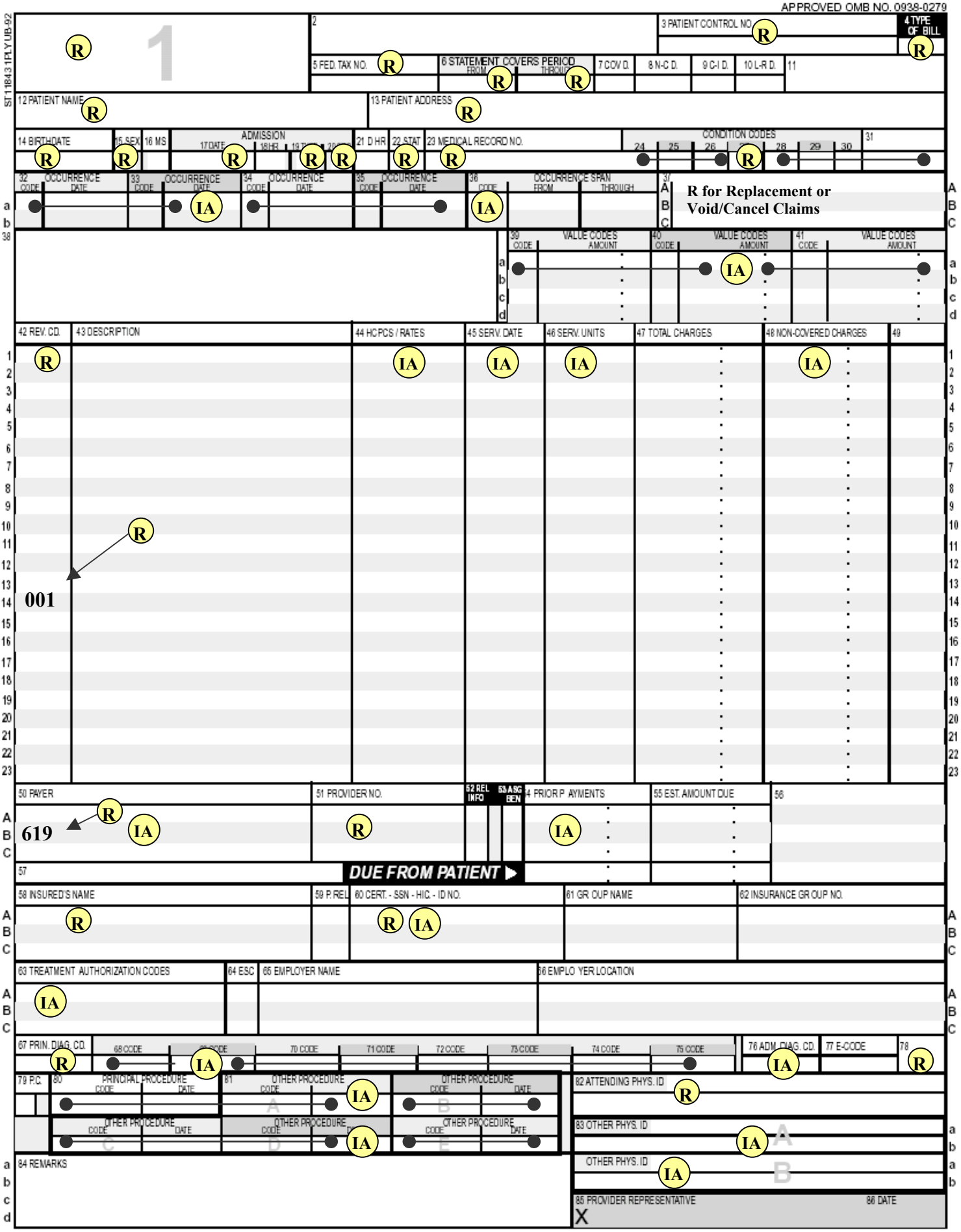
   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

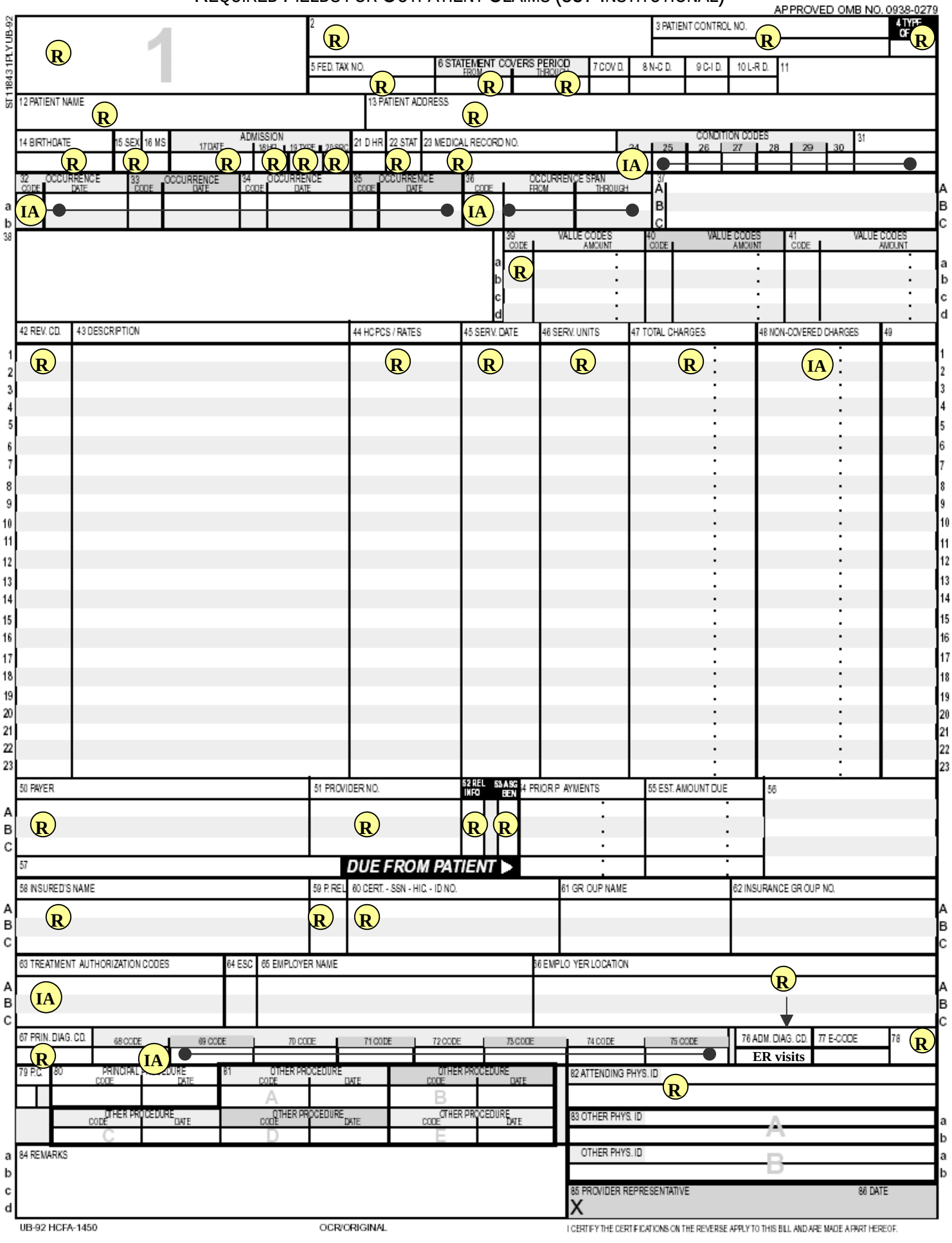
REQUIRED FIELDS FOR OUTPATIENT CLAIMS (HARD COPY)



REQUIRED FIELDS FOR INPATIENT CLAIMS (HARD COPY)



Required Fields for Outpatient Claims (837 Institutional)



REQUIRED FIELDS FOR INPATIENT CLAIMS (837 INSTITUTIONAL)