SECTION 5

ADMINISTRATIVE SERVICES

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GENERAL INFORMATION

ADMINISTRATION

The Department of Health and Human Services (DHHS) administers the South Carolina Medicaid Program including Partners for Health. This section outlines the available resources for Medicaid providers, with telephone numbers, 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 manager. Inquiries concerning specific claims should also be directed to the appropriate program manager, after corrections have been made on rejected claims and all claims filing requirements have been met. Medicaid Provider Inquiry (DHHS Form 140) may be used to check the status on outstanding claims. Always include the provider's Medicaid number, the recipient's Medicaid number, and the date of service when requesting the status of outstanding claims. **Allow 45 days from the submission date before requesting the status of the claim.** See the sample form at the end of this section.

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

Department of Health and Human Services
Attn: Children's Behavioral Health Services
Post Office Box 8206
Columbia, SC 29202-8206
(803) 898-2565

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

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SECTION 5 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

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

REPRODUCIBLE NEGATIVES

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

SOFTWARE

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

HARD COPY CLAIM FORMS

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

PRIVATE VENDORS

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

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

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

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PROCUREMENT OF FORMS

PRIVATE VENDORS (CONT'D.)

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

FAX REQUESTS

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

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

WEB ADDRESS

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

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

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
5. Bamberg County	(803) 245-4361	Medicaid Eligibility Bamberg County DHHS 374 Log Branch Rd. Bamberg, SC 29003 Post Office Box 544 Bamberg, SC 29003
6. Barnwell County	(803) 541-1200	Medicaid Eligibility Barnwell County DHHS T. Ed Richardson Building 10913 Ellenton St. Barnwell, SC 29812 Post Office Box 648 Barnwell, SC 29812
7. Beaufort County	(843) 470-4625	Medicaid Eligibility Beaufort County DHHS 1905 Duke St. Beaufort, SC 29902 Post Office Box 1255 Beaufort, SC 29902
8. Berkeley County	(843) 719-1131	Medicaid Eligibility Berkeley County DSS 2 Belt Dr. Moncks Corner, SC 29461 Post Office Box 1409 Moncks Corner, SC 29461
9. Calhoun County	(803) 874-3384	Medicaid Eligibility Calhoun County DHHS 2831 Old Belleville Rd. St. Matthews, SC 29135 Post Office Box 378 St. Matthews, SC 29135

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
10. Charleston County	(843) 792-0444	Medicaid Eligibility Charleston County DHHS 326 Calhoun St. Charleston, SC 29403 Post Office Box 13748 Charleston, SC 29422
11. Cherokee County	(864) 487-2521	Medicaid Eligibility Cherokee County DHHS 1434 N. Limestone St. Gaffney, SC 29340 Post Office Box 89 Gaffney, SC 29342
12. Chester County	(803) 377-8131	Medicaid Eligibility Chester County DHHS 115 Reedy St. Chester, SC 29706 Post Office Box 447 Chester, SC 29706
13. Chesterfield County	(843) 623-5226	Medicaid Eligibility Chesterfield County DHHS 202 N. Page St. Chesterfield, SC 29709 Post Office Box 855 Chesterfield, SC 29709
14. Clarendon County	(803) 435-4305	Medicaid Eligibility Clarendon County DSS 3 S. Church St. Manning, SC 29102 Post Office Box 788 Manning, SC 29102

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
15. Colleton County	(843) 549-1894	Medicaid Eligibility Colleton County DHHS Bernard Warshaw Building 215 S. Lemacks St. Walterboro, SC 29488 Post Office Box 110 Walterboro, SC 29488
16. Darlington County	(843) 398-4420	Medicaid Eligibility Darlington County DHHS 300 Russell St., Room 145 Darlington, SC 29540-2077
	(843) 332-2289	404 S. Fourth St., Suite 300 Hartsville, SC 29550 Post Office Box 2077 Darlington, SC 29540
17. Dillon County	(843) 774-2713	Medicaid Eligibility Dillon County DHHS 1213 Highway 34 W. Dillon, SC 29536 Post Office Box 351 Dillon, SC 29536
18. Dorchester County	(843) 563-9524	Medicaid Eligibility Dorchester County DSS 201 Johnson St., Bldg. 17 St. George, SC 29477 Post Office Box 56 St. George, SC 29477
19. Edgefield County	(803) 637-4040	Medicaid Eligibility Edgefield County DHHS 500 W. A. Reel Dr. Edgefield, SC 29824 Post Office Box 386 Edgefield, SC 29824

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
20. Fairfield County	(803) 635-5502 Ext. 425	Medicaid Eligibility Fairfield County DHHS 1136 Kincaid Bridge Rd. Winnsboro, SC 29180 Post Office Box 1139 Winnsboro, SC 29180
21. Florence County	(843) 669-3354	Medicaid Eligibility Florence County DHHS 2685 S. Irby St., Box I Florence, SC 29505
22. Georgetown County	(843) 546-5134	Medicaid Eligibility Georgetown County DSS 330 Dozier St. Georgetown, SC 29440 Post Office Box 371 Georgetown, SC 29442
23. Greenville County	(864) 467-7926	Medicaid Eligibility Greenville County DSS County Square 301 University Ridge, Suite 6700 Greenville, SC 29603 Post Office Box 9399 Greenville, SC 29604
24. Greenwood County	(864) 229-5258	Medicaid Eligibility Greenwood County DHHS 1118 Phoenix St. Greenwood, SC 29646 Post Office Box 1016 Greenwood, SC 29648

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

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

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
30. Laurens County	(864) 833-0100	Medicaid Eligibility Laurens County DHHS 93 Human Services Complex Industrial Park Rd. Laurens, SC 29360 Post Office Box 388 Laurens, SC 29360
31. Lee County	(803) 484-5376	Medicaid Eligibility Lee County DHHS County Welfare Building 820 Brown St. Bishopville, SC 29010 Post Office Box 406 Bishopville, SC 29010
32. Lexington County	(803) 785-2991 (803) 785-2975	Medicaid Eligibility Lexington County DHHS 605 West Main St. Lexington, SC 29071 Post Office Box 805 Lexington, SC 29071
33. McCormick County	(864) 465-2627	Medicaid Eligibility McCormick County DSS 215 N. Mine St. Highway 28 N. McCormick, SC 29835
34. Marion County	(843) 423-5417	Medicaid Eligibility Marion County DHHS 200 Airport Court Mullins, SC 29574 Post Office Box 1837 Marion, SC 29571

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
35. Marlboro County	(843) 479-4389	Medicaid Eligibility Marlboro County DHHS County Complex 1 Ag St. Bennettsville, SC 29512 Post Office Box 1047 Bennettsville, SC 29512
36. Newberry County	(803) 321-2155	Medicaid Eligibility Newberry County DSS County Human Services Center 2107 Wilson Rd. Newberry, SC 29108 PO Box 1225 Newberry, SC 29108
37. Oconee County	(864) 638-4400	Medicaid Eligibility Oconee County DHHS 100 Brown Square Dr. Walhalla, SC 29691 Post Office Box 979 Walhalla, SC 29691
38. Orangeburg County	(803) 531-3101	Medicaid Eligibility Orangeburg County DSS 2570 Old St. Matthews Rd., N.E. Orangeburg, SC 29118 Post Office Box 1407 Orangeburg, SC 29116
39. Pickens County	(864) 898-5815	Medicaid Eligibility Pickens County DHHS Social Services Building 212 McDaniel Ave. Pickens, SC 29671 Post Office Box 160 Pickens, SC 29671

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

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

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
45. Williamsburg County	(843) 355-5411	Medicaid Eligibility Williamsburg County DSS 831 Eastland Ave. Kingstree, SC 29556 Post Office Box 767 Kingstree, SC 29556
46. York County	(803) 327-9061	Medicaid Eligibility York County DHHS 18 West Liberty St. Rock Hill, SC 29731 Post Office Box 710 Rock Hill, SC 29731

SECTION 5 ADMINISTRATIVE SERVICES

EXHIBITS

Form Number	Exhibit	Revision Date
DHHS 254	Referral Form/Authorization for Services	03/2006
	Medical Necessity Statement for Children's Behavioral Health Services	
	Medical Necessity Statement for Therapeutic Behavioral Services	
	Referral Request for Out-of-State Therapeutic Treatment Services	
DHHS 560	Therapeutic Behavioral Services Assessment (2 pages) *Providers are not required to use this sample format.*	08/2005
DHHS 561	Therapeutic Behavioral Services Weekly Progress Summary Notes *Providers are not required to use this sample format.*	02/2005
DHHS 562	Therapeutic Behavioral Services Individual Treatment Plan *Providers are not required to use this sample format.*	02/2005
	Consumer Satisfaction Survey	
	Sex Offender Protocol Endorsement Sheet	
	Critical Incident Report	
	Financial and Statistical Report -- Instructions	
	Financial and Statistical Report -- Sample	
CMS-1500	Sample Health Insurance Claim Form	12/1990
DHHS 130	Claim Adjustment Form	11/2004
205	Medicaid Refunds (two pages)	03/2000
126	Confidential Complaint	12/2004
	Health Insurance Information Referral Form	03/2004
	Reasonable Effort Documentation	
140	Medicaid Provider Inquiry	11/1987
142	Request for Medicaid Forms and Publications	05/1997
	Authorization Agreement for Electronic Funds Transfer	12/2005
	Sample Edit Correction Form	
	Sample Remittance Advice	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

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

FORM 254

PROVIDER'S MEDICAID I. D. #

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 REHABILITATIVE 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

INSTRUCTIONS FOR COMPLETING REFERRAL FORM 254

(Items of information not listed are self-explanatory)

Please Print Clearly)

PROVIDER'S MEDICAID I.D.#: Enter the Provider's 6-digit Medicaid identification number.

CHILD'S MEDICAID I.D.#: Enter the recipient's complete 10-digit Medicaid identification number.

REFERRED TO: Enter the name and address of the facility/program to which the recipient is being referred.

AUTHORIZATION DATE: Enter the date the authorized period begins.

EXPIRATION DATE: Enter the date the authorized period ends. (The date range must not crossover into the following state fiscal year. If the Medicaid recipient is to continue in the facility/program past June 30th, a new referral form must be completed).

NAME, ADDRESS, ETC.: Enter recipient's current information.

AGENCY REFERENCE NO.: Enter up to nine (9) numeric and/or alpha characters, which will assist your agency with identification of the recipient. (optional)

PRIOR AUTHORIZATION NO.: Enter the agency assigned number (alpha and numeric) specific to this recipient and this referral form. The first two (2) characters must reflect the agency origin (DSS - SS; DOE - ED; COC - CC; DJJ - YS; DDSN - MR; DMH - MH; United Way - UW). The remaining five (5) characters are left up to the Authorizing Agency, unless otherwise instructed.

AUTHORIZED SERVICES: Indicate the type(s) of service(s) that the designated provider is authorized to render by checking the applicable box(es). **NOTE:** When applicable, be sure to specify the appropriate level of care. Also, if entering the authorized service on the blank line, be specific in the type of service and include the five (5) digit procedure code in the space provided.

AGENCY REPRESENTATIVE: Enter the name of the Authorized Agency Representative, genera one completing the form.

TITLE: Enter the Authorized Agency Representative's title.

SIGNATURE: In order to be valid, this form must be signed by the Authorized Agency Representative.

PHONE: Enter the Authorized Agency Representative's telephone number.

AUTHORIZING AGENCY: The appropriate box must be checked.

AGENCY USE ONLY: This box is for use, if needed, by the Referring Agency only.

When the form is complete, mail appropriate copies to the designated locations listed on the bottom of the form. If any required information is left off or incorrect, the Authorized Agency Representative will be notified and asked to correct or complete a new form.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL NECESSITY STATEMENT
FOR
CHILDREN'S BEHAVIORAL HEALTH SERVICES

Child's Name:_____ Social Security Number:_____

Date of Birth:_____ Medicaid Number:_____

Based on professional staffing recommendations, review of treatment history and/or personal observation or evaluation, I recommend that the above-named Medicaid recipient receive _____

_____
(Specific Rehabilitative Service)

for maximum reduction of physical or mental disability and restoration of the recipient to his/her highest level of functioning. This recipient meets the medical necessity criteria for this level of care.

_____ _____
(Signature of Physician or other Licensed Practitioner of the Healing Arts) (Professional Title)

_____ _____
(Please print name signed above) (Phone Number)

Date of Signature: _____ (Services must be initiated within 90 days)

Diagnosis and Diagnosis Code: _____

In the absence of a full clinical assessment and evaluation, use of a V-Code may be appropriate. A more thorough diagnosis and the corresponding diagnosis code should replace the V-Code when available.

V61.20	Parent-child relational problem	V62.81	Interpersonal problems, not elsewhere classified
V61.21	Neglect/Abuse of Child	V62.82	Bereavement
V61.9	Relational Problem Related to a Mental Disorder	V71.02	Child or Adolescent Antisocial Behavior

Child's identified problems areas or needs. These may be based on professional staffing recommendations, review of treatment history and/or personal observation or evaluation.

_____

_____

_____

_____

_____

S. C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL NECESSITY STATEMENT
FOR
THERAPEUTIC BEHAVIORAL SERVICES

Beneficiary's Name: _____

Beneficiary's Date of Birth: ____ / ____ / _____

Beneficiary's Social Security Number: ____ / ____ / _____

Beneficiary's Medicaid Number: _____

Diagnosis Code: _____ ICD-9 CM or Acceptable V-Code

I recommend that the above named Medicaid recipient receive Therapeutic Behavioral Services for maximum reduction of physical or mental disability and restoration of the recipient to his/her best possible functional level. The recipient meets the medical necessity criteria for this service as evidenced by

1. The attached developmental and emotional screening tool used. (Must be comparable to the Denver Developmental Screening Test II as used in Early and Periodic Screening Diagnosis and Treatment (EPSDT) screenings), and

2. Meeting one of the following criteria: (circle the appropriate criteria(s))

    2.1 The child is unable to attend regular child care due to substantiated developmental or behavioral problems,

    2.2 The child exhibits developmental or behavioral problems as a result of substantiated cases of abuse /neglect with behavior problems, or

    2.3 The child is in imminent danger of being removed from the home due to substantiated developmental or behavioral problems.

_____ _____
(Signature of Physician or Licensed Practitioner of the Healing Arts) (Professional Title)

Date of Signature: ___/___/_____ (Service must be initiated within 90 days)

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

REFERRAL REQUEST FOR OUT-OF-STATE THERAPEUTIC TREATMENT SERVICES

Child Placing State Agency:_____

Child's Name:_____ Medicaid #: _____

Facility Being Referred To:

Name: _____

Address: _____

_____

Telephone: _____

Date Approval Received From Children's Case Resolution System: _____
(Approval **must** be obtained from CCRS if placement is more than 50 miles from the SC borders)

Medicaid patients being referred out-of-state may be provided transportation, as well as the patient's escort, when necessary. Adequate advance travel notice as well as prior approval is mandatory in order to make the necessary travel arrangements. Travel arrangements can be made by calling the Transportation Department at (803) 898-2565.

Will the patient require transportation? YES_____ NO _____

Recommended mode of transportation: _____

Any special instructions or requirements for travel assistance: _____

Other resources utilized/considered:_____

_____

Justification For Services: Check one of the following:

____ I certify that residential services appropriate to meet the child's therapeutic needs are not available within the South Carolina service area, which includes North Carolina and Georgia within 25 miles of the border.

____ Although services are available within the South Carolina service area, the distance to the in-state facility would prevent the family and child placing state agency from being actively involved in the child's treatment regime.

_____ _____
Signature of Child Placing State Agency Date

Provider must be enrolled in the South Carolina Medicaid program for the Department of Health and Human Services to reimburse for services.

Therapeutic Behavioral Services
(formerly Therapeutic Child Treatment)
Assessment

Attachment H

Client: Birth Date: / /

DATES
Admission: / / Plan: / /

Participants	Initial Goals / Desired Outcomes	Strengths	Barriers
Primary Caregiver			
Secondary Caregiver			
Other Family			
TBS Child			
School / Day Care			
Neighborhood/Community			

_____ _____
Lead Clinical Staff (LCS) Signature Date

_____ _____
Supervising LCS Signature Date

Genogram	Presenting Problem and the Impacting Issues

_____ _____

Lead Clinical Staff (LCS) Signature Date

_____ _____

Supervising LCS Signature Date

Therapeutic Behavioral Services

(formerly Therapeutic Child Treatment)

WEEKLY PROGRESS SUMMARY NOTES

Client:
Birth Date: / /

	Mon	Tue	Wed	Thu	Fri
Date					
Number of Units					

Page 1 Attachment DHHS Form 561

Short Term Goals addressed this week (These should complement the Overarching and Short Term Goals listed in the child's ITP)	**Intervention(s) used to address Short Term Goals**	**Barriers to Short Term Goals**	**Advancement in Treatment**	**Changes in Assessment**	**Short Term Goals for Next Week**

Non-LCS Signature (When Required) _____ Date _____

Lead Clinical Staff (LCS) Signature_____ Date _____

Supervising LCS Signature:_____Date _____

Therapeutic Behavioral Services

(formerly Therapeutic Child Treatment)

INDIVIDUAL TREATMENT PLAN

Attachment G

Client:

Birth Date: / /

DATES

Admission: / /

Plan: / /

1st Review: / /

2nd Review: / /

3rd Review: / /

Re-Development: / /

Reasons for Referral / Presenting Problems:

Overarching Goals	Criteria for Achievement	Target Date	Completion Date
1		/ /	/ /
2.		/ /	/ /
3.		/ /	/ /
4.		/ /	/ /

Therapeutic Behavioral Services
(formerly Therapeutic Child Treatment)
Individual Treatment Plan

Client:

DHHS Form 562 (02/2005 Version)

_____ _____ _____ _____

Primary Caregiver Signature Date Lead Clinical Staff (LCS) Signature Date

_____ _____ _____ _____

Other Caregiver Signature Date Supervising LCS Signature Date

Consumer Satisfaction Survey

Please help us improve this program by answering some questions about the services you have gotten over the past several months. We are interested in your honest opinions, good or bad. Please answer all the questions. Thank you very much. We appreciate your help.

(Circle your answer)

1. How would you rate the quality of service you and your child received?

   Excellent | Good | Fair | Poor

2. Did your child get the kind of service you wanted?

   No, definitely not | Not really | Yes, generally | Yes, definitely

3. Have these services met your child's needs?

   Almost all of his/her needs have been met. | Most of his/her needs have been met. | Only a few of his/her needs have been met. | None of his/her needs have been met.

4. How satisfied are you with the amount of help you and your child received?

   Quite dissatisfied | Indifferent or Mildly dissatisfied | Mostly satisfied | Very satisfied

5. Have the services your child has received helped you to deal with your child's problems?

   Yes, they helped a great deal. | Yes, they helped somewhat. | No, they didn't really help. | No, they seemed to make things worse.

6. If you were to look for help again, would you use these same services?

   No, definitely not | No, not really | Yes, generally | Yes, definitely

Sex Offender Protocol Endorsement Sheet

Client Name: _____ SS#: _____

DOB: _____ County: _____

Agency: _____

1. Has the client ever been adjudicated by a court for a sex offense? Yes: ___ No: ___
   Date(s):
   Offense(s):
   Disposition(s):

2. If no to the above, has the client ever been charged with a sex offense which was pled down to a lesser offense, which was adjudicated? Yes: ___ No: ___

3. Is a well-documented history of sexual offending behavior available? Yes: ___ No: ___
   If yes, summarize (include self-report, witness testimony, assessment, etc.):
   _____
   _____
   _____

4. Has an independent clinical assessment which documents the existence of the sexual problem been completed by a qualified child behavioral professional? Yes: ___
   No: ___

5. Has the client ever received sex offender treatment? Yes: ___ No: ___

   Facility, agency, or therapist name:: _____ Telephone: _____
   Length of stay: _____
   Did the client successfully complete the program? Yes: ___ No: ___
   If no, identify the reason(s) for terminating treatment: _____
   _____

6. In what treatment program is the child being placed?
   Facility name and location: _____

7. Has the Parent Consent Form been signed? Yes: ___ No: ___

Please check one of the following:

___ Based on the information reviewed above, the designated agency representative confirms the need for residential sex offender treatment.

Signature: _____ Date: _____

___ Based on the information reviewed above, the designated agency representative denies the request for residential sex offender treatment

Signature: _____ Date: _____

Please note: Question 1, 2, or 3 must be checked "Yes" for the client to be eligible for residential care under the sex offender protocol.

CRITICAL INCIDENT REPORT

1. Name of program/level of care: _____

2. Location of incident: _____

3. Name of client: _____

4. Date of incident: _____(month, day and year) Time: _____ AM/PM (circle one)

5. Name of staff(s) involved in the incident: _____

6. Type of critical incident (check all that apply)

   - Attempted suicide by a client
   - Death of a client
   - Off-site emergency medical treatment (location: _____)
   - Off-site emergency assessment (location: _____)
   - Absence without leave/runaway (date and time of return: _____)
   - Possession of a weapon (type: _____)
   - Possession of an illegal substance (type: _____)
   - Report or involvement of an outside regulatory agency (agency involved: _____)
   - Placement in Seclusion or Restraints
   - Emergency change of placement:
     □ Discharge □ Hospitalization □ Incarceration □ Internal Transfer
     □ Other: _____
   - Removal from school:
     □ Suspension (# of days: _____) □ Expulsion □ Medical Homebound
     □ Homebased □ Other: _____
   - Other: _____

7. Describe the incident and the circumstances surrounding it (attach additional pages if necessary):

_____

_____

_____

_____

_____

_____

8. What precipitating factors may have contributed to the incident? (attach additional pages if necessary)

_____

_____

_____

_____

_____

9. Describe the behavior management/intervention technique used to de-escalate the client and the client's response (attach additional pages if necessary):

_____

_____

_____

_____

_____

10. Describe follow-up actions taken (attach additional pages if necessary):

_____

_____

_____

_____

_____

11. NOTIFICATIONS	Name and Title of Person Notified/Agency Affiliation:	Date:	Time:	Name of Person Notifying:
Internal Staff				
Referring Agency				
Parent/Guardian				
Regulatory Agency				
Law Enforcement				
Other				

12. Signatures:

_____ _____

Signature and Title of Person Who Completed This Report — Date

_____ _____

Signature and Title of Clinical Reviewer — Date

_____ _____

Signature and Title of Administrative Reviewer — Date

_____ _____

Signature and Title of LIP (for seclusion and restraint only) — Date

Each report should be reviewed for completeness and quality by considering the following:

1. The information contained in the report is comprehensive and relevant.
2. The appropriate authorities/agencies, program/supervisory staff and parents/guardians were notified of the incident.
3. The actions taken in response to the incident were timely and appropriate.
4. The report is appropriately signed and dated.

THE STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
INSTRUCTIONS FOR THE PREPARATION OF THE
FINANCIAL AND STATISTICAL REPORT

General Comments

The accompanying report may be used to establish reimbursement rates for providers on either a prospective or a historical basis. Complete the entire report, including the supplemental schedules, for each service for which you receive Medicaid reimbursement. If you have multiple sites that provide the same service(s) and are paid the same rate for each service, then you may complete the report to reflect the actual cost and statistical data for all sites for each service. However, if you wish to pursue different rates for the same service at multiple sites, then a separate report must be completed for each site. Further, provide a narrative explanation of the basis of allocation, which you have used to distribute expenditures between the various components, i.e., Administrative Expenses, Treatment Expenses, Child Care Expenses and Other Expenses. Documentation supporting those allocations (such as time sheets, or time studies, leave records, square footage allocations, etc.) should be retained for audit purposes. All direct costs that are identified as administrative costs associated with operating the program for which this report is being submitted, should be listed in the "Administrative Expenses" column. All indirect costs or management fees should also be specified as "Administrative Expenses." No cost should be included as a direct cost and as an indirect cost or management fee. All cost which are associated with the actual provision of treatment should be listed in the "Treatment Expenses" column. For purposes of this report, the term "Child Care" refers to the cost of basic supervision and custodial care of the client including the provision of meals and shelter, i.e., room and board. The "Other Expenses" column should include all other costs, such as unallowable costs (e.g., educational costs, including teachers' salaries and fringe, educational supplies, etc.) as well as cost of staff not allocated to the program for which the report is being submitted. Provide a narrative justification of the expenses outlined in your completed report.

The original and one copy of each completed report should be mailed to: Division of Ancillary Reimbursements, South Carolina Department of Health and Human Services, Post Office Box 8206, Columbia, South Carolina 29202-8206. Or, it may be hand delivered to the Division of Ancillary Reimbursements, SCDHHS, 1813 Main Street, Suite 137, Columbia, South Carolina 29201. *Failure to submit this report, within the requested time frame, will result in a twenty-five percent (25%) withholding or suspension of your daily reimbursement rates*.

While much of the report is self-explanatory, each page of the report will be addressed to assist you as you prepare the report. If further assistance is needed, please contact the Division of Ancillary Reimbursements at the SCDHHS at (803) 898-1040. You may fax information and/or questions to (803) 898-4523.

Page 1 of 6 Pages

Most of the information on this page represents provider-identifying type of information. Complete the entire page in its entirety.

Item 1: Provider Name and Address: Include the provider's official name as well as any name that the provider may be doing business as, and the provider's mailing address. Following the address, include the telephone number and fax number (if applicable). If the provider's physical address location is different than the mailing address, include this address in "Item 6. Site Location(s) covered by this report."

Item 2: Provider's Medicaid Number: Include the provider's six digit Medicaid provider number. The digits may be alpha or numeric or a combination alphanumeric number. If multiple sites are being reported on one report, include all applicable Medicaid provider numbers.

Item 3: E.I. Number: Enter the federal employer identification number assigned by the Internal Revenue Service.

Item 4: Reporting Period: Include the from/to dates of the reporting period covered by this report. This should coincide with the dates of your most recently completed fiscal period.

Item 5: Type of Control (Check One): Check the appropriate type of provider that represents your legal status. Only one block should be checked.

Item 6: Site Location(s) covered by this report: Include the actual address of the physical location of each site covered by this report. If you are reporting for a single site and the physical address is the same as the mailing address in "Item 1", then you may simply state "Same as Item 1." However, if multiple sites are being reported, please include the Medicaid Provider Number for each site immediately following the address for each site. These numbers should coincide with the numbers stated in "Item 2."

Item 7: Provider Agency Owned By: Enter the full name of the owner of the entity providing the service(s) being reported. Include the owner's address and phone number. If there is more than one owner, provide the same information for all owners. Attach additional pages as may be necessary. In addition, complete Supplemental Schedule III.

Item 8: Service Information: Identify the service for which this report is being completed. Do not include multiple services on one report. A separate report should be completed for each service for which you receive Medicaid reimbursement. Following the "Certification by Officer or Administrator of Provider," this page requires the signature of the officer or administrator of the provider. Include the title of the individual signing the report as well as the date signed. Immediately following this information and signature, include the name of the person that actually prepared the report, the preparer's title and the telephone number of the preparer.

Page 2 of 6 Pages

This page represents the expenditures for personnel services that were incurred during the reporting period. As noted, in the general comments, provide a narrative explanation or justification for the manner in which you have allocated these expenditures between components identified in columns 1, 2, 3 and 4. For clarification, the amount shown on line 1, column 5 for "Salary and Wages" should coincide with the amount shown as the total of "Personnel – Paid" in Section A, column 3 on page 3 of 6 pages. Similar cross-references from pages 2 and 3 of 6 pages occur for "Administrative, Treatment, Child Care and Other" columns on the two pages. If any of the expenditures were made for "Other Employer Contributions," include an explanation of what these were. Examples of "Other Employer Contributions' are dental insurance and life insurance. In regards to life insurance, Medicaid will not participate in the cost of life insurance premiums if the beneficiary is the employing agency.

Page 3 of 6 Pages

Column 1: Indicate the name of each position that was paid in whole or in part as part of the service being reported. If there are several employees who occupy a position of the same title, then that position can be indicated once with the number of employees shown beside the name of the position.

Column 2: Indicate the number of hours worked each employee for each position listed that was paid in whole or in part as part of the service being reported during reporting period. If there are several employees occupying a position of the same title, then the average hours per employee should be indicated in this column.

Column 3: Indicate the "Salary and Wages" for each position. The total of this column should be the same amount shown as total of "Salary and Wages" on line 1, column 5 on page 2. Also, please note: INDICATE THE TOTAL SALARY FOR EACH POSITION IN THIS COLUMN. IF THE POSITION IS SPENDING TIME IN OTHER PROGRAMS BESIDES THE SERVICE BEING REPORTED, THE AMOUNT OF SALARIES AND WAGES ALLOCATED TO THE OTHER PROGRAM SHOULD BE INCLUDED IN COLUMN 7.

Column 4: Indicate the dollar amount of the expenditures for each position that is allocated to "Administrative" efforts for the service being reported. The total of this column should be the same as column 2, line 1 on page 2.

Column 5: Indicate the dollar amount of the expenditures for each position that is allocated to the "Treatment" efforts for the service being reported. The total of this column should be the same as column 2, line 1 on page 2.

Column 6: Indicate the dollar amount of the expenditures for each position that is allocated to "Child Care" (room and board) efforts for the service being reported. The total of this column should be the same as column 3, line 1 on page 2.

Column 7: Indicate the dollar amount of the expenditures for each position that is allocated to "Other" efforts for the service being reported. The total of this column should be the same as column 4, line 1 on page 2.

Page 3 of 6 Pages (Continued)

Section A of page 3 of 6 pages is for indicating the "Hours, Salary and Wages, and allocations to Administrative, Treatment, Child Care and/or Other" categories for actual payments made to staff.

Page 3 of 6 is commonly referred to as the "Personnel Schedule." If the "Personnel Schedule" is not completed in its entirety, then the report will not be considered filed.

Page 4 of 6 Pages

This page lists potential line items of expenditures for Contractual Services and for Supplies. If expenditures are made for "Other Contractual Services" and/or for "Other Supplies," include an explanation of the purpose of these expenditures. Note that necessary and proper interest on both current and capital indebtedness is an allowable cost. Interest on current indebtedness is usually for purposes such as working capital interest for normal operating expenses, and should be reported on page 4 of 6 pages under "Other" (Contractual Services). Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as the acquisition of facilities, equipment and capital improvements. The interest expenses associated with equipment and permanent improvements should be reported on page 5 of 6 pages in either the "Equipment" or "Permanent Improvement" section, whichever is appropriate**. As noted earlier, include the dollar amount of any donated goods and/or services in the appropriate spaces. Be sure to include a notation in your narrative explanation of any donated goods and/or services.**

Column 1: Indicate the dollar amount of the expenditures for each line item that is allocated to "Administrative" efforts for the service being reported.

Column 2: Indicate the dollar amount of the expenditures for each line item that is allocated to the "Treatment" efforts for the service being reported.

Column 3: Indicate the dollar amount of the expenditures for each line item that is allocated to "Child Care" (room and board) efforts for the service being reported.

Column 4: Indicate the dollar amount of the expenditures for each position that is allocated to "Other" efforts for the service being reported.

Column 5: Indicate the total amount of expenditures for each line item. This amount should be the sum of the amounts indicated in columns 1, 2, 3 and 4.

Page 5 of 6 Pages

This page list potential line items of expenditures for Fixed Changes, Travel, Equipment, Permanent Improvements, Training and Education of Staff and Indirect Costs. If expenditures are made for "Fixed Charges – Other," include an explanation of the purpose of these expenditures. ***If any costs or expenditures are made for Rent/Lease – Real Property, Rent/Lease – Photocopying Equipment, or for Rent/Lease – Motor Vehicles, then attach a copy of each lease involved for which expenditures were made. If copies of the lease(s) are not included, then the report shall not be considered as filed.***

In regards to interest charges related to equipment purchases and/or for capital improvements (permanent improvements), please see the special note on Page 4 of these instructions. Further, if a depreciable asset has at the time of its acquisition an estimated useful life of at least 2 years and a historical cost of less than $5000, its cost must be capitalized and written off ratably over the estimated useful life of the asset, using one of the approved methods of depreciation. **If a depreciable asset has a historical cost of less than $5000, or if the asset has a useful life less than 2 years, its cost is allowable in the year it is acquired.** The provider may, if it desires, establish a capitalization policy with lower minimum criteria, but under no circumstances may the above minimum limits be exceeded. The SCDHHS utilizes the "Estimated Useful Lives of Depreciable Hospital Assets," as revised 05/08/95, which is published by the "American Hospital Association."

Equipment: For expenditures designated for "Equipment," note that you may claim only the appropriate amount of depreciation of the equipment for the reporting period. If expenditures are indicated for "Equipment," then complete "Supplemental Schedule I - Schedule of Fixed Assets."

Permanent Improvements: For expenditures designated for "Permanent Improvements," please note that you may claim only the appropriate amount of depreciation of the permanent improvements for the reporting period. If expenditures are indicated for "Permanent Improvements," then complete "Supplemental Schedule II - Schedule of Permanent Improvements."

Indirect Costs: Providers may claim some of their non-traceable administrative costs either as indirect cost or as management fees, *but not both.* No cost should be included as a direct cost and as a part of the indirect cost or management fee. Indirect costs are those expenditures for real administrative costs, which cannot be readily allocated to a specific line item in the budget, e.g., the portion of an accountant's personal services costs, which are spread across a number of different programs. If a provider has as approved indirect cost rate, approved by a federal cognizant agency, the SCDHHS will accept the rate if it is less than or equal to ten percent (10%). However, if the approved rate exceeds ten percent (10%), SCDHHS will limit its participation to ten percent (10%) of the approved base. (As approved by the federal cognizant agency.) The approved base may or may not be total programs cost. *A copy of the federally approved indirect cost rate and the applicable base must be attached to the completed financial and statistical report.* If the provider does not have a federally approved indirect cost rate, SCDHHS has the option of approving up to ten percent (10%) of direct salaries and wages, exclusive of fringe benefits, overtime and shift differentials. ***Any costs included in indirect costs may not be included in any other line item(s) on the financial and statistical report.***

Management fees are those expenditures for home office costs, which cannot be readily allocated to a specific line item. Up to ten percent (10%) of direct salaries and wages, exclusive of fringe benefits, overtime and shift differentials may be claimed as management fees if all of the following conditions exist: (1) The costs are not shown in any other line item in the financial and statistical report; (2) The program is one of several facilities administered by a single corporate entity; and (3) The provider can justify the costs as a benefit to the State based on such reasons as provision of overall administrative oversight, policy development and implementation, etc. If management fees are provided through related organizations and the amount of cost is less than ten percent (10%) of direct salaries and wages (exclusive of fringe benefits, overtime and shift differentials), then the provider is entitled to receive management fees not to exceed the actual cost of such benefits received and not ten percent (10%). Again, a provider may not claim both indirect costs and management fees.

Page 6 of 6 Pages:

Section A: List revenues received for the service from which the financial and statistical report is being submitted. Include all sources of revenue. Specify the amount received from each source of the revenue.

Section B: This section deals with "Client and Service" information. Provide the information as indicated on the report and as described below:

Line B-1: "Total Number of Clients Served": State the total number of clients that received this service during the reporting period. This number should be representative of Medicaid and non-Medicaid clients.

Line B-2: "Number of Medicaid Eligible Clients Served": Specify the total number of Medicaid clients who received this service during the reporting period.

Line B-3: "Total Number of Units Provided": Specify the total number of units of this service your agency provided during the reporting period. Include both Medicaid eligible and non-Medicaid eligible units.

Line B-4: "Number of Medicaid Units Provided": Specify the total number of units of this service, which were provided to Medicaid recipients during the reporting period.

Line B-5: "Capacity (Maximum Number of Units at 100% Occupancy)": Indicate the total number of units which you could have provided for if you had been fully occupied each day of the reporting period.

SUPPLEMENTAL SCHEDULE I – Schedule of Fixed Assets

Line A, Column 6: The amount shown on Line A, Column 6 should be the amount of depreciation claimed during this reporting period for fixed assets purchased prior to this reporting period.

Line B: "Asset Additions – This Period": List all fixed assets purchased during this reporting period. In column 2, indicate the date of acquisition. In column 3, indicate the cost of each asset, including taxes and all ancillary charges such as shipping, installation, etc. In column 4, indicate the estimated useful life of each fixed asset purchased during this reporting period. In column 6, indicate the amount of depreciation claimed during this reporting period for each fixed asset purchased also during this reporting period.

Line C: "Total Depreciation of Fixed Assets" acquired during this reporting period. This is the sum of the amounts listed in Column 6 of Line B.

Line D: "The Total Depreciation" for this reporting period is the sum of Column 6, Line A and Column 6, Line C.

SUPPLEMENTAL SCHEDULE II – Schedule of Permanent Improvements

Line A – Column 6: The amount shown on Line A, Column 6 should be the amount of depreciation claimed during this reporting period for permanent improvements, which were made prior to this reporting period.

Line B: "Permanent Improvements – This Period": List all permanent improvements made during this reporting period. In column 2, indicate the date of each permanent improvement. In column 3, indicate the cost of each permanent improvement. In column 4, indicate the estimated useful life of each permanent improvement made during this reporting period. In column 6, indicate the amount of depreciation claimed during this reporting period for each permanent improvement made during this reporting period.

Line C: Indicate the "Total Depreciation of Permanent Improvements" made during this reporting period. This is the sum of the amounts listed in Column 6 of Line B.

Line D: The "Total Depreciation" for this reporting period is the sum of Column 6, Line A and Column 6, Line C.

SUPPLEMENTAL SCHEDULE III – Schedule of Owner(s)/Relative(s)Compensation

Section A: This section deals with owner(s) compensation. Please complete each column as indicated:

Column 1: Enter the owner(s) full name.

Column 2: Indicate the job title, e.g. administrator, clinical director, cook etc.

Column 3: Enter the total hours actually worked during the reporting period. Include all hours, whether allowable or not, if paid as part of this service. Allowable compensation will be based on 40 hours per week (2080 hours annually). ***If hours are not reported, then salary and fringe benefits associated with the salary will be considered non-allowable.***

Column 4 and 5: Enter both a description (column 4) and an amount (column 5) for each type of compensation, such as salary, bonus, consultant fees, etc. Also include any other form of compensation such as personal auto allowances/expenses, meals, etc. Both allowable and non-allowable compensation should be shown on this schedule.

Column 6: Indicate the page number and line number where the costs are included in the related section(s) of the Financial and Statistical report.

Column 7: If compensation was made for this person at another facility or in another program operated by the provider, then yes should be indicated in this column. If not, then no should be indicated. There should be "yes" or "no" indication for each person listed. If yes, indicate the other facility or program from which that person has received compensation. Attach additional narrative as may be necessary.

Supplemental Schedule III – Schedule of Owner(s)/Relative(s) Compensation (Continued)

Section B: This section deals with "Relative(s) Compensation." Please complete this section for all persons related by blood or marriage. For detailed instructions, refer to Section A, Columns1 through 7 as stated above.

Section C: The amount indicated here should be the grand total of all owner(s) and relative(s) compensation in Column 5.

SUPPLEMENTAL SCHEDULE IV: Transactions with Related Organizations

Section A: This section deals with the "Expenses" incurred in doing business with a "Related Organization."

Column 1: Enter the name of the "Related Organization."

Column 2: Indicate the item involved in the transaction.

Column 3: Enter the amount resulting from the described transaction with a "Related Organization," which was included as an expense.

Column 4: Enter the actual cost to the "Related Organization" of acquiring or producing the goods or services supplied to the provider for which the reported expenses were entered in the preceding column.

Column 5: Enter the page and line where the costs were included in the financial report.

Section B: This section deals with the "Revenue" incurred in doing business with a "Related Organization."

Column 1: Enter the name of the "Related Organization."

Column 2: Indicate the item involved in the transaction.

Column 3: Enter the amount resulting from the described transaction with a "Related Organization" that was included as "Revenue."

Column 4: Enter the actual cost to the "Related Organization" of acquiring or producing the goods or services supplied to the provider for which the reported "Revenues" were entered in the preceding column.

Column 5: Enter the page and line where the "Revenues" were included in the financial report.

If you need additional assistance in completing the Financial and Statistical Report, contact the Division of Ancillary Reimbursements at the South Carolina Department of Health and Human Services at the following address: P.O. Box 8206, Columbia, South Carolina 29202-8206. Or, you may call at (803) 898-1040. Our fax number is (803) 898-4523.

FINANCIAL & STATISTICAL REPORT

1. Provider Name and Address:	
2. Provider's Medicaid Number:	**3. E. I. Number:**
4. Reporting Period: From:	**To**

5. Type of Control (check one):

Voluntary Corporation [ ] **Government: Federal [ ] State [ ] City [ ]**

Private for Profit [ ] **County [ ] Other [ ]**

6. Site Location(s) covered by this report:

7. Provider Agency Owned By:

8. Service Information (check one):

Moderate Management Rehabilitative Services [ ] **Clinical Day Program [ ]**

High Management Rehabilitative Services [ ] **Other (Specify):** _____

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

I do solemnly swear (or affirm) that I have examined the information contained in this report; that all such information has been prepared from the books and records of the provider named within; that the aforesaid information is true and correct to the best of my knowledge and belief; and, that no other request for reimbursement from other federal and/or state funds has been made nor has any other reimbursement been received, applied for, nor will they be applied for, for the services herein described; that our agency has on file proper client authorization for these services claimed and the necessary documentation to support these claims; and, that all claims reported are within the period of authorized eligibility.

Signature (Officer or Administrator of Provider):	**Title:**	**Date:**
Report Prepared By:	**Title:**	**Telephone:**

Provider's Name: _____

For the Period beginning _____ **and ending** _____

Service Name: _____

EXPENSE & REVENUE REPORT

		(1)	(2)	(3)	(4)	(5)
	Personnel Services	**Administrative Expenses**	**Treatment Expenses**	**Child Care Expenses (Room and Board)**	**Other Expenses**	**Total Expenses**
1.	**Salary and Wages**					$0
2.	**Social Security**					$0
3.	**Health Insurance**					$0
4.	**Retirement**					$0
5.	**Workers Compensation**					$0
6.	**Unemployment Compensation**					$0
7.	**Other Employer Contributions**					$0
8.	**Sub-Total Employer Paid Benefits**	$0	$0	$0	$0	$0
9.	**TOTAL PERSONNEL SERVICES:**	$0	$0	$0	$0	$0

Provider's Name: _____

For the Period beginning _____ **and ending** _____

PERSONNEL SCHEDULE: ****

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Position	**Total Hours Worked**	**Total Salary and Wages**	**$ allocated based on % of time to specified areas (Attach a narrative explanation of the basis of each allocation)**			
			ADMIN.	**TREATMENT**	**CHILD CARE**	**OTHER**
	TOTAL:	$0	$0	$0	$0	$0

****** Do not include any positions and salaries on this page that are included in your indirect costs or management fees.**

Provider's Name: _____

For the Period beginning _____ **and ending** _____

EXPENSE & REVENUE REPORT

	(1)	(2)	(3)	(4)	(5)
CONTRACTUAL SERVICES	**Administrative Expenses**	**Treatment Expenses**	**Child Care Expenses**	**Other Expenses**	**Total Expenses**
Printing & Advertising (recruitment of staff)					$0
Utilities (water, sewerage, etc.)					$0
Telephone & Telegraph					$0
Auditing, Accounting, & Finance					$0
Building Repairs					$0
Other Contractual					$0
TOTAL CONTRACTUAL SERVICES:	$0	$0	$0	$0	$0

SUPPLIES	**Administrative Expenses**	**Treatment Expenses**	**Child Care Expenses**	**Other Expenses**	**Total Expenses**
Office Supplies					$0
Household, Laundry, & Janitorial Supplies					$0
Educational Supplies					$0
Motor Vehicle Supplies (fuel, motor oil, etc.)					$0
Postage					$0
Food					$0
Building Maintenance Supplies					$0
Clothing					$0
Recreational Supplies					$0
Medical Supplies					$0
Other Supplies (including personal needs)					$0
TOTAL SUPPLIES:	$0	$0	$0	$0	$0

Provider's Name: _____

For the Period beginning _____ **and ending** _____

EXPENSE & REVENUE REPORT

	(1)	(2)	(3)	(4)	(5)
FIXED CHARGES	**Administrative Expenses**	**Treatment Expenses**	**Child Care Expenses**	**Other Expenses**	**Total Expenses**
Rent/Lease -- Real Property					$0
Rent/Lease -- Office Equipment					$0
Rent/Lease -- Motor Vehicles					$0
Insurance (other than fringe benefit)					$0
Other					$0
TOTAL FIXED CHARGES:	$0	$0	$0	$0	$0

TRAVEL	**Administrative Expenses**	**Treatment Expenses**	**Child Care Expenses**	**Other Expenses**	**Total Expenses**
Travel (meals, lodging, mileage)*					$0
TOTAL TRAVEL:	$0	$0	$0	$0	$0

*May not exceed State of South Carolina Travel Policies.

EQUIPMENT	**Administrative Expenses**	**Treatment Expenses**	**Child Care Expenses**	**Other Expenses**	**Total Expenses**
Interest					$0
Equipment Depreciation					$0
TOTAL EQUIPMENT:	$0	$0	$0	$0	$0

PERMANENT IMPROVEMENTS	**Administrative Expenses**	**Treatment Expenses**	**Child Care Expenses**	**Other Expenses**	**Total Expenses**
Interest					$0
Permanent Improvements Depreciation					$0
TOTAL PERM IMPROVEMENTS:	$0	$0	$0	$0	$0

TRAINING & EDUCATION OF STAFF (including memberships)	**Administrative Expenses**	**Treatment Expenses**	**Child Care Expenses**	**Other Expenses**	**Total Expenses**
Training and Education					$0
TOTAL TRAINING & EDUCATION:	$0	$0	$0	$0	$0

INDIRECT COSTS	**Administrative Expenses**	**Treatment Expenses**	**Child Care Expenses**	**Other Expenses**	**Total Expenses**
Indirect Costs					$0
TOTAL INDIRECT COSTS:	$0	$0	$0	$0	$0

TOTAL PROGRAM EXPENSES:	$0	$0	$0	$0	$0

Provider's Name: _____

For the Period beginning _____ **and ending** _____

EXPENSE & REVENUE REPORT

A. REVENUES RECEIVED:

		AMOUNT
1.	CONTRIBUTIONS:	
2.	MEDICAID	
3.	OTHER (please specify)	
4.		
5.		
6.		
7.		
8.	TOTAL REVENUES:	

B. SERVICE INFORMATION:

1. TOTAL NUMBER OF CLIENTS SERVED: _____
2. NUMBER OF MEDICAID ELIGIBLE CLIENTS SERVED: _____
3. TOTAL NUMBER OF UNITS PROVIDED: _____
4. NUMBER OF MEDICAID UNITS PROVIDED: _____
5. CAPACITY (Maximum number of units at 100% occupancy): _____

SUPPLEMENTAL SCHEDULE I

SCHEDULE OF FIXED ASSETS

	(1) Description	(2) Date Acquired	(3) Historical Cost	(4) Estimated Life	(5) Accumulated Depreciation	(6) Depreciation Expense
A.						
B.	**Asset Additions - this period:**					
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
C.	**Total Depreciation - Additions this period:**					
D.	**Total Depreciation - This reporting period:**					

SUPPLEMENTAL SCHEDULE II

SCHEDULE OF PERMANENT IMPROVEMENTS

	(1) Description	(2) Acquisition Date	(3) Historical Cost	(4) Estimated Life	(5) Accumulated Depreciation	(6) Depreciation Expense
A.						
B.	Permanent Improvements - this pe					
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						

C.	Total Depreciation - Permanent Improvements this period:	
D.	Total Depreciation - This reporting period:	

SUPPLEMENTAL SCHEDULE III
SCHEDULE OF OWNER(S)/RELATIVE(S) COMPENSATION:

A.

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	OWNER(S) NAME	JOB TITLE	TOTAL HOURS WORKED	COMPENSATION DESCRIPTION	COMPENSATION AMOUNT	COST REPORT REFERENCE PAGE, LINE	DO YOU CLAIM COMPENSATION AT ANOTHER FACILITY OR PROGRAM? ***
1.							
2.							
3.							
4.							
A - 5.	TOTAL:						

B.

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	RELATIVE(S) NAME	JOB TITLE	TOTAL HOURS WORKED	COMPENSATION DESCRIPTION	COMPENSATION AMOUNT	COST REPORT REFERENCE PAGE, LINE	DO YOU CLAIM COMPENSATION AT ANOTHER FACILITY OR PROGRAM? ***
1.							
2.							
3.							
4.							
B - 5.	TOTAL:						

C **GRAND TOTAL:**

***** If compensation is claimed at another facility or in another program, the other facility's name and/or program has to be identified. Attach additional pages as may be necessary.**

SUPPLEMENTAL SCHEDULE IV
TRANSACTIONS WITH RELATED ORGANIZATIONS:

Does this facility participate in transactions with related organizations? Yes: ( ) No: ( )
If yes, the following information must be completed:

A. EXPENSES: (Supplies, rent, management fees, etc.)

	(1) RELATED ORGANIZATION NAME	(2) ITEM DESCRIPTION	(3) COST PER BOOKS	(4) COST TO RELATED PARTY	(5) COST REPORT REFERENCE PAGE, LINE
1.					
2.					
3.					
4.					
A - 5.	TOTAL:				

B. REVENUES:

	(1) RELATED ORGANIZATION NAME	(2) ITEM DESCRIPTION	(3) REVENUE PER BOOKS	(4) ACTUAL COST	(5) COST REPORT REFERENCE PAGE, LINE
1.					
2.					
3.					
4.					
B - 5.	TOTAL:				

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): X 1112345678

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN A.

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 777 WINDY LANE

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN | STATE: SC

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 29000 | TELEPHONE (Include Area Code): ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: A12345

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: 0.00

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: 401 BCBS of South Carolina

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO — *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 295.32
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11	01	03	11	01	03	53		H2030			$ 102.00	12				
2																
3																
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: EXAM01

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE: $ $ 102.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ $ 102.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

ABC GROUP HOME
111 MEDICAID AVE
ANYTOWN SC 29000 123456

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

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

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

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

Provider Address:

Provider City, State, Zip:

Total paid amount on the original claim:

Original CCN:

Provider ID:

Recipient ID:

Adjustment Type:

◯ Void ◯ Void/Replace

Originator:

◯ DHHS ◯ MCCS ◯ Provider ◯ MIVS

Reason For Adjustment: (Fill One Only)

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

For Agency Use Only

Analyst ID:

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

Comments:

Signature: _____ Date: _____

Phone: _____

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.

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)

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

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.

STATE OF SOUTH CAROLINA HEALTH AND HUMAN SERVICES	MEDICAID PROVIDER INQUIRY
MAIL TO: ATTENTION _____ UNIT SC DEPT OF HEALTH AND HUMAN SERVICES POST OFFICE BOX 8206 COLUMBIA, SOUTH CAROLINA 29202-8206	TODAY'S DATE PROVIDER NUMBER, SIX DIGITS – INCLUDE GROUP NBR, IF ANY TELEPHONE
PROVIDER NAME AND ADDRESS	TYPE OF PROVIDER I.E. DENTIST – GP, ETC. DATE CLAIM FILED:

---------- FOLD HERE ----------

PATIENT'S NAME (First, Initial, Last)	MEDICAID NUMBER (10 Digits)	DATE OF SERVICE
HAS THE CLAIM APPEARED ON THE PROVIDER'S REMITTANCE ADVICE? (CHECK ONE) ☐ 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 (NOV. 87) Replaces Form 1735 (Feb. 81) which obselete.

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR MEDICAID FORMS AND PUBLICATIONS

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

WHEN COMPLETED PLEASE FORWARD TO:
SC Department of Health and Human Services
Supply
Post Office Box 8206
- or- Columbia, South Carolina 29202-8206
FAX TO: (803) 253-4027

MEDICAID NO:
TYPE OF PROVIDER:
TELEPHONE: - -
CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY *(PLEASE PRINT OR TYPE)*

ITEMS REQUESTED

FORM/PUBLICATION NO.	TITLE OF FORM OR PUBLICATION	QUANTITY

DHHS FORM 142 (5/97)

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

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR STATEMENT OF PHARMACY SERVICES

DHHS FORM 3211 (11/96)

WHEN COMPLETED PLEASE FORWARD OR FAX:
- **REQUEST FOR PREPRINTED FORMS TO YOUR PROVIDER REPRESENTATIVE; OR**
- **REQUEST FOR BLANK FORMS 3211 TO SUPPLY**

MEDICAID NO:
TELEPHONE: - -
CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY *(PLEASE PRINT OR TYPE)*

QUANTITY REQUESTED

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

DHHS FORM 142 (5/97)

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

Provider Name: _____

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

Sample Edit Correction Form

RUN DATE 01/31/2004 0000 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #0401000123810220A
REPORT NUMBER CLM3500 **EDIT CORRECTION FORM** PAGE 37267 ECF 37249 PAGE 1 OF 1
ANALYST ID HIC – 76 SPEC - EMC Y
SIGNON ID CLAIM RESTART DATE / / DOC IND N

1 PROVIDER ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 ---- DIAGNOSIS ---- PRIMARY	9 SECONDARY
DME000	2022222301	YSG1399					V71.02	

10 RECIPIENT NAME – JANE R DOE 11 DATE OF BIRTH 03/17/1974 12 SEX F

13 RES	14 ALLOWED	LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	19 INDIVIDUAL PROVIDER	20 CHARGE	21 PAY IND	22 UNITS
	.00	1	02/01/00	99	H2020	0TF	900MXH	836.00		017
	.00	2							**	
		3	/ /							
		4	/ /							
		5	/ /							
		6	/ /							
		7	/ /							
		8	/ /							

23 INS CARR NUMBER	24 POLICY NUMBER	25 INS CARR PAID
01		
02		

RESOLUTION DECISION _R_

26 TOTAL CHARGE 836.55
27 AMT REC'D INS .00
28 BALANCE DUE 836.55
29 OWN REF # 012345

EDITS

INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 712 951

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

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

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

INSURANCE POLICY INFORMATION

PROVIDER:
ABC GROUP HOME
PO BOX 00000
ANYWHERE, XO 00000-0000

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

Sample Remittance Advice (page 1)

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

AB0008 ABC GROUP HOME PO BOX 000000 FLORENCE SC000000000
.121212121234. Y
PROVIDER ID. PROFESSIONAL SERVICES PAYMENT DATE PAGE

DEPT OF HEALTH AND HUMAN SERVICES

AB0008

REMITTANCE ADVICE 03/26/2004 1

SOUTH CAROLINA MEDICAID PROGRAM

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	0406001089000400A				1192.00	243.71	P	1112233333	M CLARK			0.00	
	01		021504	H2020	800.00	117.71	P			0TF			0.00
	02		021504	H0046	392.00	126.00	P			000			0.00
	VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0406001089000400U				1412.00-	273.71-		1112233333	M CLARK				
	01		012104	H2020	1112.00-	143.71-				0TF			
	02		012104	H0046	300.00-	130.00-				O00			
	REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0407701389002500A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		012104	H2020	142.50	42.75	P			0TF			0.00
	02		012104	H0046	859.00	0.00	R			000			0.00
	TOTALS		2		2193.50	286.46						0.00	0.00

$286.46

CERT. PG TOT $0.00 | MEDICAID PG TOT $286.46

CERTIFIED AMT $0.00 | MEDICAID TOTAL 0.00

FEDERAL RELIEF $0.00 | MAXIMUS AMT $0.00 | CHECK TOTAL | CHECK NUMBER

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.

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS
ABC GROUP HOME
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 2)

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

PROVIDER ID.: AB1111

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE: 03/26/2004

PAGE: 2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	M O D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	00000000000000000U				513.00-	197.71-		1112233333	CLARK		M		022804	09999999999999999A
	01		012104	H2020	453.00	160.71-	P					0TF		
	02		012104	H0046	60.00	33.00-	P					O00		
	TOTALS	1			513.00-	193.71-								

DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
0.00	$243.71	0.00	0.00	0.00

ADJUSTMENTS	MAXIMUS AMT
$193.71-	

YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER
0.00	$50.00	4197304

PROVIDER NAME AND ADDRESS

ABC GROUP HOME
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 3)

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

PROVIDER ID.: AB1111

DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE: 03/26/2004

PAGE: 3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME F M I I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	04086000037000000U	-						DEBIT	-2389.05	
TPL 4	04086000047000000U	-						DEBIT	-1949.90	
TPL 5	04086000057000000U	-						DEBIT	-477.25	
TPL 6	04086000067000000U	-						DEBIT	-477.25	
							PAGE TOTAL:		5293.45	0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
0.00	0.00	0.00	0.00	0.00

ADJUSTMENTS	MAXIMUS AMT
0.00	0.00

YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER
5293.45	0.00	

PROVIDER NAME AND ADDRESS

ABC GROUP HOME
PO BOX 000000
FLORENCE SC 00000