SECTION 5

ADMINISTRATIVE SERVICES

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SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

ADMINISTRATION

The South Carolina 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 and addresses for county SCDHHS offices.

CORRESPONDENCE AND INQUIRIES

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

Department of Health and Human Services
Division of Family Services
Post Office Box 8206
Columbia, SC 29202-8206

SC Department of Alcohol & Drug Abuse Services
Managed Care Division
101 Business Park Boulevard
Columbia, SC 290203-9498
(803) 896-5555

Correspondence concerning specific policy and procedural problems must be directed to a SCDHHS program representative. Inquiries concerning specific claims should also be directed to a program representative, but only after corrections have been made on rejected claims and all claims filing requirements have been met. A Medicaid Provider Inquiry (DHHS Form 140) may be used to check the status on outstanding claims. (See the blank form in this section.) Always include the provider's Medicaid number, the recipient's Medicaid number, and the date of service when requesting the status of outstanding claims. **Allow 45 days from the submission date before requesting the status of the claim.**

Questions concerning beneficiary eligibility or identification numbers should be directed to the SCDHHS county office in the beneficiary's county of residence. Beneficiaries who have questions regarding specific coverage issues should be referred to the appropriate staff of their county SCDHHS office for assistance. To verify eligibility status, please call the Medicaid Interactive Voice

SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

CORRESPONDENCE AND INQUIRIES (CONT'D.)

Response System (IVRS) at (888) 809-3040, or use the South Carolina Medicaid Web-based Claims Submission Tool.

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 SCDHHS.

REPRODUCIBLE NEGATIVES

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

SOFTWARE

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

HARD COPY CLAIM FORMS

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

PRIVATE VENDORS

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

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

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

SECTION 5 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

PRIVATE VENDORS (CONT'D.)

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

FAX REQUESTS

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

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

WEB ADDRESS

The most current version of this manual is available on the SCDHHS 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 29224-0326
4.	Anderson County	(864) 260-4541	Medicaid Eligibility Anderson County DHHS 224 McGee Rd. Anderson, SC 29625 Post Office Box 160 Anderson, SC 29622-0160

SECTION 5 ADMINISTRATIVE SERVICES

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) 541-3825	Medicaid Eligibility Barnwell County DHHS 29 Allen 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 29902-4403 Post Office Box 1255 Beaufort, SC 29901-1255
8. Berkeley County	(843) 719-1131	Medicaid Eligibility Berkeley County DSS 2 Belt Dr. Moncks Corner, SC 29461 Post Office Box 13748 Charleston, SC 29422-3748
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) 740-5900	Medicaid Eligibility Charleston County DHHS 326 Calhoun St. Charleston, SC 29401-1124 Post Office Box 13748 Charleston, SC 29422-3748
11. Cherokee County	(864) 487-2521	Medicaid Eligibility Cherokee County DHHS 1434 N. Limestone St. Gaffney, SC 29340-4734 Post Office Box 89 Gaffney, SC 29342
12. Chester County	(803) 377-8135	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 201 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

SECTION 5 ADMINISTRATIVE SERVICES

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 29532 Post Office Box 2077 Darlington, SC 29532
	(843) 332-2289	404 S. Fourth St., Suite 300 Hartsville, SC 29550
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) 821-0444	Medicaid Eligibility Dorchester County DSS 201 Johnson St., Bldg. 17 St. George, SC 29477 Post Office Box 13748 Charleston, SC 29422-3748
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

SECTION 5 ADMINISTRATIVE SERVICES

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 29180-7116 Post Office Box 1139 Winnsboro, SC 29180-5139
21. Florence County	(843) 669-3354	Medicaid Eligibility Florence County DHHS 2685 S. Irby St., Box I Florence, SC 29505
	(843) 394-8575	245 S. Ron McNair Blvd Lake City, SC 29560
22. Georgetown County	(843) 546-5134	Medicaid Eligibility Georgetown County DSS 330 Dozier St. Georgetown, SC 29440-3219 Post Office Box 371 Georgetown, SC 29442
23. Greenville County	(864) 467-7926	Medicaid Eligibility Greenville County DSS 301 University Ridge, Suite 6700 Greenville, SC 29601 Post Office Box 9399 Greenville, SC 29604-9399
24. Greenwood County	(864) 229-5258	Medicaid Eligibility Greenwood County DHHS 1118 Phoenix St. Greenwood, SC 29646-3918 Post Office Box 1016 Greenwood, SC 29648

SECTION 5 ADMINISTRATIVE SERVICES

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., Suite B 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 29020-4432 Post Office Box 220 Camden, SC 29020-0220
29. Lancaster County	(803) 286-8208	Medicaid Eligibility Lancaster County DHHS 200 E. Dunlap St. Lancaster, SC 29720 Post Office Box 2169 Lancaster, SC 29721-2169

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
30. Laurens County	(864) 833-6109	Medicaid Eligibility Laurens County DHHS 93 Human Services Rd. Clinton, SC 29325-7546 Post Office Box 388 Laurens, SC 29360-0388
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 29072-2550
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 1311 N. Main St. Marion, SC 29571-6012 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 1074 Bennettsville, SC 29512-1074
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 Browns Square Dr. Walhalla, SC 29691 Post Office Box 979 Walhalla, SC 29691-0979
38. Orangeburg County	(803) 531-3101	Medicaid Eligibility Orangeburg County DSS 2570 Old St. Matthews Rd., N.E. Orangeburg, SC 29115 Post Office Box 1407 Orangeburg, SC 29116
39. Pickens County	(864) 898-5815	Medicaid Eligibility Pickens County DHHS 212 McDaniel Ave. Pickens, SC 29671 Post Office Box 160 Pickens, SC 29671-0160

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 29204-2826
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 29150-4941 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 1890 Neelys Creek Road Rock Hill, SC 29730 Post Office Box 710 Rock Hill, SC 29731-6710

SECTION 5 ADMINISTRATIVE SERVICES

EXHIBITS

Form Number	Exhibit	Revision Date
DAODAS Form PE	Physical Examination*	11/2001
	Medical Necessity Statement for Children's Behavioral Health Services	
	Medical Necessity Statement for Therapeutic Behavioral Services	7/2005
254	Referral Form/Authorization for Services — Children's Behavioral Health Services	03/2006
	Consumer Satisfaction Survey	
560	Therapeutic Behavioral Services** (formerly Therapeutic Child Treatment) Assessment — Attachment H (two pages) *Providers are not required to use this sample format.*	09/2005
561	Therapeutic Behavioral Services** (formerly Therapeutic Child Treatment) Weekly Progress Summary Notes *Providers are not required to use this sample format.*	02/2005
562	Therapeutic Behavioral Services** (formerly Therapeutic Child Treatment) Individual Treatment Plan — Attachment G *Providers are not required to use this sample format.*	02/2005
CMS-1500	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	08/2006
140	Medicaid Provider Inquiry	11/1987
142	Request for Medicaid Forms and Publications	05/1997
	Authorization Agreement for Electronic Funds Transfer	12/2005
	Sample Remittance Advice	
	Sample Edit Correction Form	

* Request forms from county AOD Abuse Commission
** Request forms from SCDHHS

SECTION 5 ADMINISTRATIVE SERVICES

EXHIBITS

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Physical Examination

Client Name (Last, First, MI) _____ ID# _____

Medicaid Client # _____ Date of Physical Examination _____

Physician Name and Address _____

1. Brief medical history to include hospital admissions, surgeries, allergies, present medications (include names and telephone numbers of prescribing physicians), 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

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: _____

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.

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

_____

_____

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

Recipient's Name: _____

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

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

Recipient'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)

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

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

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

Therapeutic Behavioral Services Assessment

Client:

DHHS Form 560 (09/2005 Version)

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.		/ /	/ /

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

Other Caregiver Signature _____ Date _____ Supervising LCS Signature _____ Date _____

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? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

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		H2020			$ 102 00		1			
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 #

RICHLAND DISTRICT 2
111 MEDICAID AVE
ANYTOWN SC 29000

PIN# 123456 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: _____

DHHS Form 130 Revision date: 11-15-2004

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

PROVIDER _____ DOS _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

_____

(SIGNATURE AND DATE)

ATTACH A COPY OF FORM TO THE APPROPIATE CLAIM OR 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: _____

Provider DBA Name *(if applicable)*: _____

Medicaid Provider Number: _____

Provider NPI Number: _____

Provider EIN Number: _____

Address: _____

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

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

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

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

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

Financial Institution:_____

Address: _____

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

Transit/ABA Number: _____

Account No.: _____

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

Signed: _____ *(Signature)*

_____ *(Print)*

Title: _____

Date: _____

Contact Name: _____ **Phone:** _____

RETURN TO:

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

Revised 12/05

Sample 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 PROVIDER — PO BOX 000000 — FLORENCE — SC000000000

.121212121234. Y

PROVIDER ID. — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

AB0008 — DEPT OF HEALTH AND HUMAN SERVICES — 03/26/2004 — 1

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE

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
2212345	0406001089000400A				1192.00	243.71	P	1112233333	M CLARK				
	01		021504	H2020	800.00	117.71	P			0TF		0.00	0.00
	02		021504	H2019	392.00	126.00	P			000		0.00	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	H2019	300.00-	130.00-				000			
	REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0407701389002500A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		012104	H2020	142.50	42.75	P			0TF			0.00
	02		012104	H2019	859.00	0.00	R			000			0.00
	TOTALS		2		2193.50	286.46						0.00	0.00

$286.46

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.

CERT. PG TOT	MEDICAID PG TOT
$0.00	$286.46

CERTIFIED AMT	MEDICAID TOTAL
$0.00	0.00

FEDERAL RELIEF	MAXIMUS AMT	CHECK TOTAL	CHECK NUMBER

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

ABC PROVIDER
PO BOX 000000
ANYWHERE XO 00000-00000

Sample Remittance Advice (page 2)

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

PROVIDER ID. AB0008

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	TS	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	ORG CODE	CHECK DATE	ORIGINAL CCN
ABB222222	0406001089000400U				513.00-	197.71-		1112233333	CLARK		M	0TF	022804	0404711253670430A
	01		012104	H2020	453.00	160.71-	P					000		
	02		012104	H2019	60.00	33.00-	P							
	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 PROVIDER
PO BOX 000000
ANYWHERE XO 00000-00000

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. AB0008

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	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: 0.00

YOUR CURRENT DEBIT BALANCE: 5293.45

MEDICAID TOTAL: 0.00

ADJUSTMENTS: 0.00

CHECK TOTAL: 0.00

CERTIFIED AMT: 0.00

MAXIMUS AMT: 0.00

CHECK NUMBER:

FEDERAL RELIEF: 0.00

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

ABC PROVIDER
PO BOX 000000
ANYWHERE XO 00000-00000

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 PRAC SPEC - EMC N
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	SECONDARY
ABC000	2022222301	YSG1399					V71.02	.

EDITS

INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 712 951

10 RECIPIENT NAME – DOE, JOHN 11 DATE OF BIRTH 01/31/1947 12 SEX M

13 RES	14 ALLOWED	15 LN NO	DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD MD2 MD3 MD4	19 INDIVIDUAL PROVIDER	20 CHARGE IND	21 PAY	22 UNITS
	.00	1	05/07/02	99	H2020	HA	900MXH	836.00		017
	.00	2	/ /							
	.00	3	/ /							
		4	/ /							
		5	/ /							
		6	/ /							
		7	/ /							
		8	/ /							

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

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

23 INS CARR NUMBER	24 POLICY NUMBER	25 INS CARR PAID			
01			26	TOTAL CHARGE	836.00
					.00
02			27	AMT REC'D INS	
03			28	BALANCE DUE	836.00
			29	OWN REF # 012345	

RESOLUTION DECISION _R_

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

INSURANCE POLICY INFORMATION

PROVIDER:
ABC PROVIDER
PO BOX 00000
ANYWHERE XO 00000-0000

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM