SECTION 5

ADMINISTRATIVE SERVICES

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SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

ADMINISTRATION

The Department of Health and Human Services (DHHS) administers the South Carolina Medicaid Program. This section outlines the available resources for Medicaid providers, with telephone numbers and addresses for county DHHS offices.

CORRESPONDENCE AND INQUIRIES

Within DHHS, administrative staff of the Behavioral Health Services program area are available to assist providers with questions about Medicaid program policies, procedures, and claims resolutions.

Behavioral Health Services administrative staff can be contacted by telephone at (803) 898-2565, or by fax at (803) 255-8204. Correspondence should be directed to:

Psychological Services
Department of Health and Human Services
Behavioral Health Services
PO Box 8206
Columbia, SC 29202-8206

Correspondence concerning specific policy and procedural problems must be directed to a DHHS 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 claim filing requirements have been met. The Medicaid Provider Inquiry (DHHS Form 140) may be used to check the status on outstanding claims. (See the sample form in this section.) Always include the provider's Medicaid number, the beneficiary'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 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 county DHHS office. To verify eligibility status, call the Medicaid Interactive Voice Response System (IVRS) at (888) 809-3040 or use the South Carolina Medicaid Web-based Claims Submission Tool.

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GENERAL INFORMATION

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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 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 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

DHHS COUNTY OFFICES

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

DHHS 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 29902-4403 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

DHHS 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

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DHHS 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

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DHHS 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

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DHHS 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

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DHHS 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

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DHHS 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

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DHHS 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

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DHHS 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
252	Referral Form/Authorization for Psychological Services	06/2005
	Treatment Plan Example	
	Psychological Testing/Evaluation Example	
	Psychological Counseling Note Example	
	Consultation Note Example	
	Enrollment Data Form (three pages)	08/2003
CMS-1500	Health Insurance Claim Form	12/1990
205	Medicaid Refunds (two pages)	03/2000
126	Confidential Complaint	12/2004
	Health Insurance Information Referral Form	03/2004
130	Claim Adjustment Form	11/2004
	Reasonable Effort Documentation	
140	Medicaid Provider Inquiry	11/1987
142	Request for Medicaid Forms	05/1997
	Authorization Agreement for Electronic Funds Transfer	12/2005
	Sample Edit Correction Form	
	Sample Remittance Advice (three pages)	

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STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

REFERRAL FORM/AUTHORIZATION FOR SERVICES (Form 252)

FORM 252

PROVIDER'S MEDICAID ID#

___|___|___|___|___|___

CLIENT'S MEDICAID ID#

___|___|___|___|___|___|___|___|___|___|___|___

REFERRED TO: _____
_____
_____

AUTHORIZATION DATE: ____/____/____

EXPIRATION DATE: ____/____/____

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

The provider named above is hereby authorized to render the following service(s) on or within the designated time period. The number of units should be based on the medical needs of the client with input from the referral source as appropriate. Only the number of units rendered may be billed. This referral is valid only for the dates on which the client is eligible for Medicaid. Claims for clients who become ineligible for Medicaid should be submitted to the Authorized Referral Entity.

☐ PSYCHOLOGICAL TESTING/EVALUATION

☐ PSYCHOLOGICAL COUNSELING

Agency Representative:_____ Title: _____

Signature: _____ Phone: _____

Authorized Referral Entities (one must be checked):

☐ Department of Social Services

☐ Department of Mental Health

☐ Department of Juvenile Justice

☐ Department of Health and Environmental Control

☐ Continuum of Care for Emotionally Disturbed Children

☐ Department of Disabilities and Special Needs

☐ School District/ Department of Education

AGENCY USE ONLY

Treatment Plan Example

CLIENT NAME: _____
MEDICAID NUMBER: _____
DATE: _____

PROBLEMS	INTERVENTIONS	GOALS	GOAL MET

PSYCHOLOGIST'S SIGNATURE/DATE: _____

PERIODIC REVIEW / PSYCHOLOGIST'S SIGNATURE/DATE:

_____

NOTE: THIS SAMPLE IS INTENDED AS A GUIDE TO ASSIST PROVIDERS IN IDENTIFYING MEDICAID DOCUMENTATION REQUIREMENTS. EACH PROVIDER SHOULD TAILOR THE DOCUMENTATION TO APPROPRIATELY REFLECT THE SERVICES RENDERED.

Psychological Testing/Evaluation Example

CLIENT'S NAME: _____
MEDICAID NUMBER:_____
DIAGNOSIS CODE: _____

DATE	TIME	TEST	BILL TIME	UNITS
_____	_____	DIAGNOSTIC INTERVIEW	X MINS	X
_____	_____	WISC-III	Y MINS	Y
_____	_____	WPPSI-R	Z MINS	Z
_____	_____	WAIS-R	A MINS	A
_____	_____	KBIT	B MINS	B
_____	_____	PPVT-R	C MINS	C
_____	_____	BEERY DTVMI	*	*
_____	_____	BENDER-GESTALT	*	*
_____	_____	WIAT	*	*
_____	_____	WRAT-3	*	*
_____	_____	BURKS BEH RATING SCALE	*	*
_____	_____	ADDES-HOME VERSION	*	*
_____	_____	MMPI-A	*	*
_____	_____	MMPI-2	*	*
_____	_____	BECK DEPRESSION INV	*	*
_____	_____	BECK ANXIETY INV	*	*
_____	_____	BECK HOPELESSNESS SCALE	*	*
_____	_____	REYNOLDS CHILD DEP SCALE	*	*
_____	_____	REYNOLDS ADOL DEP SCALE	*	*
_____	_____	CHILDREN'S DEPRES. INV	*	*
_____	_____	REYNOLDS SUICIDE IDEA	*	*
_____	_____	RCMAS	*	*
_____	_____	ROBERTS APPERCEPTION	*	*
_____	_____	RORSCHACH INKBLOT	*	*
_____	_____	SENTENCE COMPLETION	*	*
_____	_____	KINETIC FAMILY DRAWING	*	*
_____	_____	FACES	*	*
_____	_____	ISEL	*	*
_____	_____	FAMILY EVAL SCALE	*	*
_____	_____	OTHER	*	*

PSYCHOLOGIST'S SIGNATURE:_____
DATE: _____

NOTE: THIS SAMPLE IS INTENDED AS A GUIDE TO ASSIST PROVIDERS IN IDENTIFYING MEDICAID DOCUMENTATION REQUIREMENTS. EACH PROVIDER SHOULD TAILOR HIS/HER DOCUMENTATION TO APPROPRIATELY REFLECT THE SERVICES RENDERED.

Psychological Counseling Note Example

CLIENT NAME: _____

DATE: _____

START TIME: _____

END TIME: _____

TYPE OF TREATMENT RENDERED: INDIVIDUAL ____ FAMILY _____ GROUP ____

1. Observations (Description of client affect):

2. Focus of session (as related to treatment goals):

3. Interventions:

4. Response –- client/family's response, input, reactions to interventions:

5. Plan –- plans for follow-up:

PSYCHOLOGIST'S SIGNATURE: _____

DATE: _____

NOTE: THIS SAMPLE IS INTENDED AS A GUIDE TO ASSIST PROVIDERS IN IDENTIFYING MEDICAID DOCUMENTATION REQUIREMENTS. EACH PROVIDER SHOULD TAILOR HIS/HER DOCUMENTATION TO APPROPRIATELY AND ACCURATELY REFLECT THE SERVICES RENDERED.

Consultation Note Example

CLIENT:_____

DATE: _____

START TIME:_____ **END TIME:**_____

_____Telephone contact with: _____

relation to client: _____

_____Face-to-face contact with: _____

relation to client: _____

_____Interpretation/explanation of the results of tests/evaluations/procedures or other accumulated data to: _____

relation to client: _____

NOTES:

PSYCHOLOGIST'S SIGNATURE: _____

DATE: _____

NOTE: THIS SAMPLE IS INTENDED AS A GUIDE TO ASSIST PROVIDERS IN IDENTIFYING MEDICAID DOCUMENTATION REQUIREMENTS. EACH PROVIDER SHOULD TAILOR HIS/HER DOCUMENTATION TO APPROPRIATELY AND ACCURATELY REFLECT THE SERVICES RENDERED.

South Carolina
Department of Health and Human Services

Forward the completed form to: Medicaid Provider Enrollment
Post Office Box 8809
Columbia, South Carolina 29202-8809

Medicaid Enrollment Data
Other Medical Professionals

1 Medicaid No. | 2 Provider Type (1 9) | 4 Sort Key

3 ***PROVIDER'S NAME***

5 Tax Payer Identification Name (if different from provider name)

Items in ***ITALIC CAPITALS*** must be completed or this form will be returned to you.

Mailing Address (Physical Location of the Practice)

7 ***NUMBER AND STREET, P.O. BOX OR ROUTE NO.***

Shaded Items are for Agency use only and no information should be entered by the Medicaid provider.

9 ***CITY*** | 10 ***STATE*** | 11 ***ZIP***

Payment Address (Where Checks and Remits will be received If different from mailing address)

6 In Care of, Attention, Building Name, etc.

8 Number and Street, PO Box or Route No.

Items marked with an asterisk (*) should be completed based on the codes listed on the the attachment to this form.

12 City | 13 State | 14 Zip

15 COUNTY* | ***16 TELEPHONE (INCL. AREA CODE)*** | 17 Type Owner | 18 EC Ind.

20 SOC. SEC. NO. | 21 Medicare ID No

22 LICENSE NO. | ***23 LIC. ISSUE DATE*** (Mo - Day - Year) | ***24 LICENSE STATE**** | ***25 PRACTICE SPECIALTY****

26 Group Numbers

If a member of a PA, enter ID number assigned by Medicaid.

27 Enroll Status | 28 Enroll Date

ATTENTION: A statistically valid random sampling technique may be used for determining overpayments/underpayments to medical providers.

29 CLIA
Number
Cert Type *
Effective Date
Expiration Date

I certify that I have read the conditions of participation and payment on the reverse side of this form, that I understand and agree to the conditions of participation on the reverse side of this form, that the enrollment information I have furnished is true, accurate, and complete and that I will report any change affecting my enrollment. I further certify that I will obtain authorization from each Medicaid Patient to release to SCDHHS medical information necessary for processing Medicaid claims.

Signature of Person listed in field 3: _____ Date: _____

A facsimile stamp is not acceptable.

AS A CONDITION OF PARTICIPATION AND PAYMENT, I UNDERSTAND AND AGREE;

- That this agreement shall not be assigned or transferred.
- That upon acceptance of this agreement, the South Carolina Department of Health and Human Services (SCDHHS) will issue a Medicaid provider number which must be used in filing all claims.
- That services shall be provided to Medicaid recipients in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, as amended, and the Age Discrimination Act of 1975 and any regulations promulgated pursuant to any of these Acts.
- In accordance with Title VI of the Civil rights Act of 1964 (42 U.S.C. 2000 et seq.) and regulations pursant thereto, (45 C.F.R. Part 80, 1996. as amended). In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 et. Seq.) and its implementing regulation at 45 CFR Part 80, the provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement
- That adequate and correct fiscal and medical records shall be kept to disclose the extent of services rendered and to assure that claims for funds are in accordance with all applicable laws, regulations, and policies.
- That all fiscal and medical records shall be retained for a period of three (3) years after last payment was made for services rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the three (3) years, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the three (3) year period, whichever is later.
- That, for the purposes of reviewing, copying, and reproducing documents, access shall be allowed to all records concerning services and payment under this agreement to the SCDHHS, the State Auditor's Office, the South Carolina Attorney General's Office, the Department of Health and Human Services and/or their designee during normal business hours.
- That upon request, information must be furnished regarding any claim for payment to the SCDHHS.
- That requests for reimbursement for services shall reflect any third party payment received and that any payment received subsequent to claims filing shall be reported.
- That Medicaid will reimburse the co-insurance and/or deductible portions (cost sharing) of Medicare claims for recipients with both coverages only if the provider accepts Medicare assignment. Cost sharing is limited by the Medicaid allowed amount for the service.
- That Medicaid reimbursement is always made to the provider of services and that the recipient shall not be billed pending receipt of such payment.
- That Medicaid reimbursement is payment in full and that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient or any other person, family member, relative, organization or entity for care or services to a recipient/patient except as may otherwise be allowed under Federal regulations or in accordance with SCDHHS policy.
- That this statement applies only to those recipients for whom Medicaid claims are filed and that it in no way requires that the provider render services to any Medicaid recipient.
- Either party may terminate this agreement upon providing the other party with thirty (30) days written notice termination. Such termination shall be sent by Certified Mail, Return Receipt Requested, and be effective thirty (30) days after the date of receipt.
- That the provider shall disclose full and complete information as to ownership, business transactions and criminal activity in accordance with 42 CFR 455.104 through 455.106 (1999). Furthermore, the provider shall disclose any felony convictions under Federal or State law in accordance with 42 CFR 1001.101 Subpart B through 1001.1701 Subpart C (1999).
- That, for any dispute arising under this agreement, the provider shall have as his sole and exclusive remedy the right to request a hearing from SCDHHS within thirty (30) calendar days of the Commission action which he believes himself aggrieved. Such proceeding shall be in accordance with SCDHHS appeals procedures and S.C. Code Ann. 1-23-310 et. seq. (1976, as amended). Judicial review of any final agency administrative decision shall be in accordance with S.C. Code Ann. 1-23-380 (1976, as amended).
- That the provider shall safeguard the use and disclosure of information concerning applicants for or recipients of Title XIX (Medicaid) services in accordance with 42 CFR Part 431 Subpart F (1991), SHHSFC's regulation R.126-170, et. seq., Code of laws of South Carolina (1976) Volume 27 as amended, and all applicable State laws and regulations.
- Tthat none of the funds provided under this agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for polititat office, or otherwise in violation of the "Hatch Act."
- That all services rendered and claims submitted shall be in compliance with all applicable federal and state laws and regulations and in accordance with SCDHHS policies, procedures, and Medicaid Provider Manuals.
- That all information provided on the Medicaid enrollment form is incorporated as a part of this agreement.
- That the provider shall be held personally liable for all claims submitted by him or in his behalf as evidenced by his endorsement of his Medicaid reimbursement check.
- That Medicaid reimbursement (payment of claims) is from state and federal funds and that any falsification (false claims, statement or documents) or concealment of material fact may be prosecuted under applicable state and federal laws.
- That the provider must comply with all requirements of the Americans with Disabilities Act of 1990 (ADA), as applicable.
- That the provider shall comply with all terms and conditions of the Drug Free Workplace Act, S.C. Code Ann. Section 44-107-10 et. seq. (1976, as amended) if this agreement is for a stated or estimated value of Fifty Thousand Dollars or more.
- That in accordance with 31 U.S.C. 1352, funds received through this agreement may not be expended to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered Federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. This restriction is applicable to all contractors and subcontractors.

County Codes (Item 15)	State Board Codes (Item 24)	Practice Spec. (Item 25)	CLIA (Item 29)
01 Abbeville	01 Alabama	04 Audiologist	A Accreditation
02 Aiken	02 Alaska	06 Certified Nurse Midwife or Licensed Midwife	C Compliance
03 Allendale	03 Arizona	25 Cert. Registered Nurse Anesthetist/Assistant Anesthetist	P PPMP
04 Anderson	04 Arkansas	82 Psychologist	R Registration
05 Bamberg	05 California	84 Speech Pathologist	T Partial Accredited
06 Barnwell	06 Colorado	85 Physical Therapist	W Waiver
07 Beaufort	07 Connecticut	86 Nurse Pract. / Clinical Nurse Specialist	
08 Berkeley	08 Delaware	87 Occupational Therapist	
09 Calhoun	09 Florida		
10 Charleston	10 Georgia		
11 Cherokee	11 Hawaii		
12 Chester	12 Idaho		
13 Chesterfield	13 Illinois		
14 Clarendon	14 Indiana		
15 Colleton	15 Iowa		
16 Darlington	16 Kansas		
17 Dillon	17 Kentucky		
18 Dorchester	18 Louisiana		
19 Edgefield	19 Maine		
20 Fairfield	20 Maryland		
21 Florence	21 Massachusetts		
22 Georgetown	22 Michigan		
23 Greenville	23 Minnesota		
24 Greenwood	24 Mississippi		
25 Hampton	25 Missouri		
26 Horry	26 Montana		
27 Jasper	27 Nebraska		
28 Kershaw	28 Nevada		
29 Lancaster	29 New Hampshire		
30 Laurens	30 New Jersey		
31 Lee	31 New Mexico		
32 Lexington	32 New York		
33 McCormick	33 North Carolina		
34 Marion	34 North Dakota		
35 Marlboro	35 Ohio		
36 Newberry	36 Oklahoma		
37 Oconee	37 Oregon		
38 Orangeburg	38 Pennsylvania		
39 Pickens	39 Rhode Island		
40 Richland	40 South Carolina		
41 Saluda	41 South Dakota		
42 Spartanburg	42 Tennessee		
43 Sumter	43 Texas		
44 Union	44 Utah		
45 Williamsburg	45 Vermont		
46 York	46 Virginia		
60 Georgia within SC Service Area	47 Washington		
61 Georgia outside SC Service Area	48 West Virginia		
62 North Carolina within SC Service Area	49 Wisconsin		
63 North Carolina outside SC Service Area	50 Wyoming		
64 Other	51 Canada		

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [X] 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): 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 [ ]	CITY; STATE
ZIP CODE: 29000; TELEPHONE (Include Area Code): ( )	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	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? YES [ ] NO [X] *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: SIGNATURE ON FILE DATE:

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

SIGNED:

14. DATE OF CURRENT: 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 3. 2. 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		90853			$ 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) YES [X] 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 # Dr. Jane Smith ABC Mental Health Services Anytown, SC 22229 PIN# GRP#

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

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: _____

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 APPROPRIATE 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

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

RUN DATE 11/31/2004 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	SECONDARY
ABC000	2022222301						871.3	.

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 MD2 MD3 MD4	19 INDIVIDUAL PROVIDER	20 CHARGE	21 PAY IND	22 UNITS
	.00	1	02/01/04		96100	O00	000	60.00		001
	.00	2	02/01/04		90804	O00	000	30.00		001
	.00	3	/ /							
		4	/ /							
		5	/ /							
		6	/ /							
		7	/ /							
		8	/ /							

23 INS CARR NUMBER	24 POLICY NUMBER	25 INS CARR PAID
01		
02		
03		

26 TOTAL CHARGE 90.00
27 AMT REC'D INS .00
28 BALANCE DUE 90.00
29 OWN REF # 012345

RESOLUTION DECISION _R_

EDITS

INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 234
02) 234
03)

```
******************************
**    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	96100	800.00	117.71	P			000			0.00
	02		021504	90804	392.00	126.00	P			000			0.00
	VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0406001089000400U				1412.00-	273.71-		1112233333	M CLARK				
	01		012104	90804	1112.00-	143.71-				000			
	02		012104	96100	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	90804	142.50	42.75	P			000			0.00
	02		012104	96100	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 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	0406001089000400U				513.00-	197.71-		1112233333	CLARK		M		022804	0404711253670430A
	01		012104	90804	453.00	160.71-	P					000		
	02		012104	96100	60.00	33.00-	P					000		
	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	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