

**FORMS**

<b>Number</b>	<b>Name</b>	<b>Revision Date</b>
DHHS 126	<a href="#">Confidential Complaint</a>	06/2007
DHHS 130	<a href="#">Claim Adjustment Form 130</a>	03/2007
DHHS 140	<a href="#">Medicaid Provider Inquiry</a>	06/2007
DHHS 142	<a href="#">Request for Medicaid Forms and Publications</a>	06/2007
DHHS 205	<a href="#">Medicaid Refunds</a>	01/2008
DHHS 931	<a href="#">Health Insurance Information Referral Form</a>	01/2008
	<a href="#">Reasonable Effort Documentation</a>	05/2007
	<a href="#">Authorization Agreement for Electronic Funds Transfer</a>	03/2011
	<a href="#">Duplicate Remittance Request Form</a>	11/2010
	<a href="#">Sample Edit Correction Form</a>	10/2008
	<a href="#">Sample Remittance Advice (three pages)</a>	06/2007
	<a href="#">Allied Professional Registration Form</a>	03/2012
	<a href="#">LISW Allied Professional Registration Form</a>	03/2012
	<a href="#">Mental Health Form</a>	04/2012



STATE OF SOUTH CAROLINA  
DEPARTMENT OF HEALTH  
AND HUMAN SERVICES

# CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

## PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

NPI or MEDICAID PROVIDER ID: (if applicable)

MEDICAID RECIPIENT ID NUMBER: (if applicable)

ADDRESS OF SUSPECT:

LOCATION OF INCIDENT:

DATE OF INCIDENT:

COMPLAINT:

NAME OF PERSON REPORTING: (Please print)

SIGNATURE OF PERSON REPORTING:

DATE OF REPORT

ADDRESS OF PERSON REPORTING:

TELEPHONE NUMBER OF PERSON REPORTING:

SIGNATURE: (SCDHHS Representative Receiving Report)

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:

--	--	--	--	--	--

NPI:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Recipient ID:

--	--	--	--	--	--	--	--	--	--

Adjustment Type:

☐ Void ☐ Void/Replace

Originator:

☐ DHHS ☐ MCCS ☐ Provider ☐ MIVS

Reason For Adjustment: (Fill One Only )

- |   |   |
|---|---|
| <input type="radio"/> Insurance payment different than original claim   | <input type="radio"/> Medicaid paid twice - void only |
| <input type="radio"/> Keying errors                                     | <input type="radio"/> Incorrect provider paid         |
| <input type="radio"/> Incorrect recipient billed                        | <input type="radio"/> Incorrect dates of service paid |
| <input type="radio"/> Voluntary provider refund due to health insurance | <input type="radio"/> Provider filing error           |
| <input type="radio"/> Voluntary provider refund due to casualty         | <input type="radio"/> Medicare adjusted the claim     |
| <input type="radio"/> Voluntary provider refund due to Medicare         | <input type="radio"/> Other                           |

For Agency Use Only

Analyst ID:

--	--	--	--	--	--

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

Comments:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_



STATE OF SOUTH CAROLINA  
DEPARTMENT OF HEALTH  
AND HUMAN SERVICES

MEDICAID PROVIDER INQUIRY

MAIL TO: ATTENTION _____ UNIT S.C. DEPT. OF HEALTH AND HUMAN SERVICES POST OFFICE BOX 8206 COLUMBIA, SOUTH CAROLINA 29202-8206	TODAY'S DATE:
	NPI or MEDICAID PROVIDER ID:
	TELEPHONE:
PROVIDER NAME AND ADDRESS:	TYPE OF PROVIDER (i.e., Dentist, Group, etc.)
	DATE CLAIM FILED:

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

PATIENT'S NAME (First, Initial, Last)	MEDICAID NUMBER (10 Digits)	DATE OF SERVICE
HAS THE CLAIM APPEARED ON THE PROVIDER'S REMITTANCE ADVICE? (CHECK ONE) <input type="checkbox"/> YES <input type="checkbox"/> NO		IS MEDICARE COVERAGE INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> 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



STATE OF SOUTH CAROLINA  
DEPARTMENT OF HEALTH  
AND HUMAN SERVICES

REQUEST FOR MEDICAID  
FORMS AND PUBLICATIONS

WHEN COMPLETED PLEASE FORWARD TO:

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

-OR- FAX TO: (803) 898-4528

NPI or MEDICAID PROVIDER ID:

TYPE OF PROVIDER:

TELEPHONE: - -

CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY (PLEASE PRINT OR TYPE)

ITEMS REQUESTED

FORM/PUBLICATION NO.

TITLE OF FORM OR PUBLICATION

QUANTITY

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

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

**Items 1, 2 or 3, 4, 5, 6, & 7 must be completed.**

**Attach appropriate document(s) as listed in item 8.**

**1. Provider Name:** \_\_\_\_\_

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

**OR**

**3. NPI#**

**& Taxonomy**

**4. Person to Contact:** \_\_\_\_\_

**5. Telephone Number:** \_\_\_\_\_

**6. Reason for Refund:** [check appropriate box]

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

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

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

☐ Other, describe in detail reason for refund:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

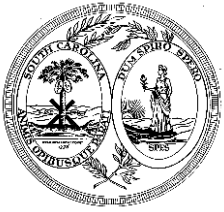
**7. Patient/Service Identification:**

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

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

- ☐ Medicaid Remittance Advice (required)  
☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)  
☐ Explanation of Benefits (EOMB) from Medicare (if applicable)  
☐ Refund check

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



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

Provider or Department Name: \_\_\_\_\_ Provider ID or NPI: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ Date: \_\_\_\_\_

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

Beneficiary Name: \_\_\_\_\_ Date Referral Completed: \_\_\_\_\_

Medicaid ID#: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured SSN: \_\_\_\_\_

Employer's Name/Address: \_\_\_\_\_

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

- \_\_\_\_\_ a. beneficiary has never been covered by the policy – close insurance.
- \_\_\_\_\_ b. beneficiary coverage ended - terminate coverage (date) \_\_\_\_\_
- \_\_\_\_\_ c. subscriber coverage lapsed - terminate coverage (date) \_\_\_\_\_
- \_\_\_\_\_ d. subscriber changed plans under employer - new carrier is \_\_\_\_\_  
- new policy number is \_\_\_\_\_
- \_\_\_\_\_ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.  
(name) \_\_\_\_\_

**ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.**

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

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

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

Medicaid Beneficiary ID: \_\_\_\_\_ SSN: \_\_\_\_\_

Carrier Name/Code: \_\_\_\_\_ New Unique Policy Number: \_\_\_\_\_

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

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



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
REASONABLE EFFORT DOCUMENTATION**

**PROVIDER** \_\_\_\_\_ **DOS** \_\_\_\_\_

**NPI or MEDICAID PROVIDER ID** \_\_\_\_\_

**MEDICAID BENEFICIARY NAME** \_\_\_\_\_

**MEDICAID BENEFICIARY ID#** \_\_\_\_\_

**INSURANCE COMPANY NAME** \_\_\_\_\_

**POLICYHOLDER** \_\_\_\_\_

**POLICY NUMBER** \_\_\_\_\_

**ORIGINAL DATE FILED TO INSURANCE COMPANY** \_\_\_\_\_

**DATE OF FOLLOW UP ACTIVITY** \_\_\_\_\_

**RESULT:**

**FURTHER ACTION TAKEN:**

**DATE OF SECOND FOLLOW UP** \_\_\_\_\_

**RESULT:**

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

\_\_\_\_\_  
(SIGNATURE AND DATE)

**ATTACH A COPY OF FORM TO THE APPROPRIATE CLAIM OR ECF AND FORWARD TO  
YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.**



**South Carolina  
Department of Health and Human Services  
Electronic Funds Transfer (EFT) Authorization Agreement**

**PROVIDER INFORMATION**

Provider Name \_\_\_\_\_  
Medicaid Provider Number \_\_\_\_\_  
Provider NPI Number \_\_\_\_\_  
Provider Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**BANKING INFORMATION** *(Please include a copy of the electronic deposit information on bank letterhead. This is required and the information will be used to verify your bank account information).*

Financial Institution Name \_\_\_\_\_  
Financial Institution Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Routing Number (nine digit) \_\_\_\_\_  
Account Number \_\_\_\_\_

Type of Account (check one) ☐ Checking ☐ Savings

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. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signed \_\_\_\_\_ (Signature)  
\_\_\_\_\_ (Print)

Title \_\_\_\_\_ Date \_\_\_\_\_

***All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.***

**RETURN COMPLETED FORM & BANK VERIFICATION DOCUMENT TO:**

**Department of Health and Human Services  
Medicaid Provider Enrollment  
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809  
FAX (803) 870-9022**

## **South Carolina Department of Health and Human Services Duplicate Remittance Request Form**

**Purpose:** This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

Please contact your South Carolina Medicaid program manager for instructions on submission of your request via program facsimile number or mailing address.

**1. Provider Name:** \_\_\_\_\_

**2. Medicaid Legacy Provider #** \_\_\_\_\_ (Six Characters)

**NPI#** \_\_\_\_\_ **& Taxonomy** \_\_\_\_\_

**3. Person to Contact:** \_\_\_\_\_ **4. Telephone Number:** \_\_\_\_\_

**5. Requesting:**

☐ **Complete  
Remittance  
Package**

☐ **Remittance Pages  
Only**

☐ **Edit Correction  
Pages Only**

**6. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy.**

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**7. Street Address for delivery of request:**

**Street:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.

\_\_\_\_\_  
**Authorizing Signature**

\_\_\_\_\_  
**Date**

1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Sample Claim Showing TPL Denial  
With NPI

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>														
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (#ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John A.										3. PATIENT'S BIRTH DATE SEX MM DD YY M F 01 01 1999 M <input checked="" type="checkbox"/> F <input type="checkbox"/>														
5. PATIENT'S ADDRESS (No., Street) 123 Windy Lane										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>														
CITY Anytown					STATE SC					7. INSURED'S ADDRESS (No., Street)					CITY					STATE				
ZIP CODE 29999					TELEPHONE (Include Area Code) ( )					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY					STATE				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER					a. INSURED'S DATE OF BIRTH SEX MM DD YY M F b. EMPLOYER'S NAME OR SCHOOL NAME									
a. OTHER INSURED'S POLICY OR GROUP NUMBER A123450A					b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M F c. EMPLOYER'S NAME OR SCHOOL NAME 0.00					10d. RESERVED FOR LOCAL USE 1					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.									
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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY														
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY														
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 295 32 3. 4.										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.														
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSPOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER														
1 01 20 07 01 20 07 11 90804 60 00 2 ZZ 1212121212										NPI 1234567890														
2 3 4 5 6										NPI														
25. FEDERAL TAX I.D. NUMBER SSN EIN 55555555 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. DOE1234														
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 60 00														
29. AMOUNT PAID \$ 0 00										30. BALANCE DUE \$ 60 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.)										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.														
33. BILLING PROVIDER INFO & PH # (555) 5555555 Jane Smith, MD 111 Main Street Anytown, SC 22222-2222										a. 1234567890 b. ZZ1212121212														

RUN DATE 05/01/2007 000001204

REPORT NUMBER CLM3500

ANALYST ID

SIGNON ID

TAXONOMY:

1 2  
PROV/XWALK RECIPIENT  
ID ID  
ABC123 1111111111  
NPI: 1234567890

SFL ZIP:

3 4  
P AUTH TPL  
NUMBER

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES

EDIT CORRECTION FORM

HIC - 76 SPEC -

PRV ZIP:

5 6 7  
INJURY EMERG PC COORD  
CODE

DOC IND N

8 9  
---- DIAGNOSIS ----  
PRIMARY SECONDARY  
871.3 .

CLAIM CONTROL #9999999999999999A

PAGE 1136 ECF 1136 PAGE 1 OF 1

EMC Y

ORIGINAL CCN:

ADJ CCN:

EDITS  
INSURANCE EDITS

CLAIM EDITS

LINE EDITS

01) 234

10 RECIPIENT NAME - DOE, JANE

11 DATE OF BIRTH 01/25/1992 12 SEX F

13 14 15 16 17 18 19 20 21 22  
RES ALLOWED LN DATE OF PLACE PROC MOD INDIVIDUAL CHARGE PAY UNITS  
NO SERVICE CODE PROVIDER IND

23  
NDC

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

.00 1 02/01/04 96100 000 000 30.00 001  
NPI: 1234567890 TAXONOMY:  
2 / /  
NPI: TAXONOMY:  
3 / /  
NPI: TAXONOMY:  
4 / /  
NPI: TAXONOMY:  
5 / /  
NPI: TAXONOMY:  
6 / /  
NPI: TAXONOMY:  
7 / /  
NPI: TAXONOMY:  
8 / /  
NPI: TAXONOMY:

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

24 25 26  
INS CARR POLICY INS CARR  
NUMBER NUMBER PAID  
01 27 TOTAL CHARGE 90.00  
02 28 AMT REC'D INS  
03 29 BALANCE DUE 90.00  
30 OWN REF # 012345

RESOLUTION DECISION \_\_\_\_

ADDITIONAL DIAG CODES:

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"

\* INDICATES A SPLIT CLAIM

# 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 .121212121234. PROVIDER ID.	Y	PO BOX 000000	FLORENCE	SC0000000000
DEPT OF HEALTH AND HUMAN SERVICES		PROFESSIONAL SERVICES	PAYMENT DATE	PAGE
AB00080000		REMITTANCE ADVICE	03/26/2007	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	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		021507	96100	800.00	117.71 P			000			0.00
	02		021507	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		012107	90804	1112.00-	143.71-			000			
	02		012107	96100	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		012107	90804	142.50	42.75 P			000			0.00
	02		012107	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".	CERT. PG TOT	MEDICAID PG TOT	STATUS CODES:	
	\$0.00	\$286.46	P = PAYMENT MADE	
			R = REJECTED	
			S = IN PROCESS	
			E = ENCOUNTER	
IF YOU STILL HAVE QUESTIONS+ PHONE THE D.H.H.S. NUMBER	\$0.00	\$0.00		
SPECIFIED FOR INQUIRY OF		0.00		
CLAIMS IN THAT MANUAL.	FEDERAL RELIEF	MAXIMUS AMT	CHECK TOTAL	CHECK NUMBER

PROVIDER NAME AND ADDRESS
ABC GROUP HOME
PO BOX 000000
FLORENCE SC 00000-0000

# Sample Remittance Advice (page 2)

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

PROVIDER ID.		DEPT OF HEALTH AND HUMAN SERVICES		CLAIM ADJUSTMENTS		PAYMENT DATE		PAGE	
AB11110000		SOUTH CAROLINA MEDICAID PROGRAM				03/26/2007		2	

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F M I	M O D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	0406001089000400U		012107	90804	513.00-	197.71-	1112233333	CLARK	M		022807	0404711253670430A
	01		012107	90804	453.00	160.71- P					000	
	02		012107	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	PROVIDER NAME AND ADDRESS	
	\$193.71		ABC GROUP HOME	
YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PO BOX 000000	
0.00	\$50.00	4197304	FLORENCE SC 00000-0000	

# 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.				PAYMENT DATE		PAGE	
DEPT OF HEALTH AND HUMAN SERVICES				03/26/2007		3	
AB11110000							
SOUTH CAROLINA MEDICAID PROGRAM							

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME F M LAST NAME I I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	0408600003700000U	-						DEBIT	-2389.05	
TPL 4	0408600004700000U	-						DEBIT	-1949.90	
TPL 5	0408600005700000U	-						DEBIT	-477.25	
TPL 6	0408600006700000U	-						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	PROVIDER NAME AND ADDRESS		
0.00	0.00	ABC GROUP HOME		
YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PO BOX 000000	
5293.45	0.00		FLORENCE SC 00000-0000	



**Please return signed original Attestation to:**

**Mailing Address:**

SC Dept. of Health and Human Services c/o  
Division of Family Services  
Post Office Box 8206  
Columbia, South Carolina 29202-8206

**Tel: (803) 898-2565**

**Fax: (803) 255-8204**

**Section I: Demographic Information**

Please Print:

<b>Physician or APRN Name</b>	
<b>Address:</b>	
<b>Telephone:</b>	
<b>National Provider Identifier Number (NPI)</b>	
<b>Fax:</b>	
<b>Email:</b>	

**Section II: Allied Professional Update Form**

The Allied Professional(s) listed below are under my supervision and services rendered and billed to South Carolina Medicaid will be in compliance with the guidelines as provided in the South Carolina Medicaid FQHC or RHC Standard. All allied professionals must be listed and a maximum of three allied professionals are permitted.

Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage and Family Therapist

<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	
<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	
<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	

If there are any changes to this list, i.e. the allied professional's qualifications, physician or APRN information, I will notify South Carolina Medicaid utilizing this form within thirty days (30). Failure to comply shall result in the recoupment for services rendered. My signature and signature date certifies, that the information provided in the **Attestation** is correct.

\_\_\_\_\_  
Physician or APRN Signature

\_\_\_\_\_  
Date





Please return signed original Attestation to:

**Mailing Address:**

SC Dept. of Health and Human Services c/o  
Division of Family Services  
Post Office Box 8206  
Columbia, South Carolina 29202-8206

Tel: (803) 898-2565

Fax: (803) 255-8204

**Section I: Demographic Information**

Please Print:

<b>LISW-CP Name</b>	
<b>Address:</b>	
<b>Telephone:</b>	
<b>National Provider Identifier Number (NPI)</b>	
<b>Fax:</b>	
<b>Email:</b>	

**Section II: Allied Professional LMSW Update Form**

The Allied Professional(s) LMSW listed below are under my LISW-CP (licensed Independent social worker-clinical practice) supervision and services rendered and billed to South Carolina Medicaid will be in compliance with the guidelines as provided in the South Carolina Medicaid FQHC or RHC Standard. All allied professional(s) LMSW must be listed and a maximum of three LMSW(s) are permitted to be supervised by the LISW-CP.

Licensed Master Social Worker (LMSW)

<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	
<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	
<b>Name (as it appears on their license):</b>	
<b>License Number &amp; Expiration Date:</b>	

If there are any changes to this list, i.e. the allied professional's qualifications, LISW-CP information, I will notify South Carolina Medicaid utilizing this form within thirty days (30). Failure to comply shall result in the recoupment for services rendered. My signature and signature date certifies, that the information provided in the **Attestation** is correct.

\_\_\_\_\_  
LISW-CP Signature

\_\_\_\_\_  
Date

**South Carolina  
Department of Health and Human Services  
Mental Health Form**

**FILL OUT COMPLETELY TO AVOID DELAYS**

<b>Beneficiary's Name:</b>		<b>Organization NPI:</b>	
<b>Medicaid ID #:</b>		<b>Center's Name:</b>	
<b>Date of Birth:</b>		<b>Service Location Address:</b>	
<b>Individual NPI:</b>		<b>City &amp; State:</b>	

**DSM-IV TR Diagnosis**

Axis I \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Axis II \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Axis III \_\_\_\_\_ / \_\_\_\_\_

**Date first seen:** \_\_\_\_\_ **Date of last service:** \_\_\_\_\_ **# of additional visits requested:** \_\_\_\_\_

*Current Clinical Information: (Circle each. Scale 0=None, 1=Mild, 2=Moderate, 3=Severe, 4=Extreme)*

Aggression	0 1 2 3 4	Depressions	0 1 2 3 4	Relationship Problems	0 1 2 3 4
Alcohol/Substance Use	0 1 2 3 4	Hallucinations	0 1 2 3 4	Side Effects	0 1 2 3 4
Anxiety/Panic	0 1 2 3 4	Impulsivity	0 1 2 3 4	Sleep Effects	0 1 2 3 4
Appetite Disturbance	0 1 2 3 4	Job/School Problems	0 1 2 3 4	Sleep Disturbance	0 1 2 3 4
Attention/Concentration	0 1 2 3 4	Mania	0 1 2 3 4	Weight Loss	0 1 2 3 4
Deficit in ADLs	0 1 2 3 4	Medical Illness	0 1 2 3 4	Other	0 1 2 3 4
Delusions	0 1 2 3 4	Memory	0 1 2 3 4	Current Stressors	0 1 2 3 4

***Services***

<p>◇ 90805</p> <p>◇ 90807</p> <p>◇ 90862</p>	<p>◇ 90847</p> <p>◇ 96101</p> <p>◇ 90853</p>	<p>◇ 90804</p> <p>◇ 90806</p>
--	--	-------------------------------

Current Medications	Name	Dose	Frequency	Side Effects
◇ <b>New</b>	1. _____	_____	_____	_____
◇ <b>New</b>	2. _____	_____	_____	_____
◇ <b>New</b>	3. _____	_____	_____	_____
◇ <b>New</b>	4. _____	_____	_____	_____
<b>Compliance</b>	◇ >90%	◇ 50-90%	◇	<50%
<b>Reasons for Noncompliance:</b> _____				

\_\_\_\_\_  
Physician/Non physician Practitioner's Name      ( ) \_\_\_\_\_      ( ) \_\_\_\_\_  
Phone:      Fax:

\_\_\_\_\_  
Physician/Non physician Practitioner's Signature      Date

**Clinical documentation must be submitted with this request and faxed to the QIO at 1-888-669-7197.**

**Approved authorizations from the QIO should be faxed to your Division of Family Services program manager at (803) 255-8204.**

**Disclaimer:** Authorization indicates that SCDHHS determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary's eligibility and benefit limitations at the time services are rendered. The Physician Assistant is not authorized to sign this form.

Division of Family Services  
Post Office Box 8206  
Columbia, South Carolina 29202-8206