SECTION 5
ADMINISTRATIVE SERVICES

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GENERAL INFORMATION

ADMINISTRATION

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

CORRESPONDENCE AND INQUIRIES

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

Department of Health and Human Services
Community Mental Health Services
Post Office Box 8206
Columbia, SC 29202-8206
(803) 898-2565

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 claims filing requirements have been met. 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 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 for assistance. To verify eligibility status, please call the Medicaid Interactive Voice Response System (IVRS) at (888) 809-3040 or use the South Carolina Medicaid Web-based Claims Submission Tool.

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SECTION 5 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

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

REPRODUCIBLE NEGATIVES

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

SOFTWARE

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

HARD COPY CLAIM FORMS

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

PRIVATE VENDORS

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

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

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

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PROCUREMENT OF FORMS

PRIVATE VENDORS (CONT'D.)

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

FAX REQUESTS

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

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

WEB ADDRESS

The most current version of this manual is available on the DHHS Web site at **www.dhhs.state.sc.us**.

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

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
Abbeville County	(864) 366-5638	Medicaid Eligibility Abbeville County DSS Human Services Building 903 W. Greenwood St. Abbeville, SC 29620
Aiken County	(803) 643-1938	Medicaid Eligibility Aiken County DSS County Commissioner's Building 1410 Park Ave S.E. Aiken, SC 29801
Allendale County	(803) 584-8137	Medicaid Eligibility Allendale County DHHS 611 Mulberry St. Allendale, SC 29810
Anderson County	(864) 260-4541	Medicaid Eligibility Anderson County DHHS 224 McGee Road Anderson, SC 29625
Bamberg County	(803) 245-4361	Medicaid Eligibility Bamberg County DHHS 374 Log Branch Road Bamberg, SC 29003
Barnwell County	(803) 541-1200	Medicaid Eligibility Barnwell County DSS T. Ed Richardson Building 10913 Ellenton St. Barnwell, SC 29812

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
Beaufort County	(843) 470-4625	Medicaid Eligibility Beaufort County DHHS 1905 Duke St. Beaufort, SC 29902
Berkeley County	(843) 719-1131	Medicaid Eligibility Berkeley County DSS 2 Belt Drive Moncks Corner, SC 29461
Calhoun County	(803) 874-3384	Medicaid Eligibility Calhoun County DHHS 2831 Old Belleville Road St. Matthews, SC 29135
Charleston County	(843) 792-0444	Medicaid Eligibility Charleston County DSS 326 Calhoun St. Charleston, SC 29403
Cherokee County	(864) 487-2521	Medicaid Eligibility Cherokee County DHHS 1434 N. Limestone St. Gaffney, SC 29340 Post Office Box 89 Gaffney, SC 29343
Chester County	(803) 377-8131	Medicaid Eligibility Chester County DHHS 115 Reedy St. Post Office Box 447 Chester, SC 29706
Chesterfield County	(843) 623-5226	Medicaid Eligibility Chesterfield County DHHS 202 N. Page St. Chesterfield, SC 29709
Clarendon County	(803) 435-4305	Medicaid Eligibility Clarendon County DSS 3 S. Church St. Manning, SC 29102

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
Colleton County	(843) 549-1894	Medicaid Eligibility Colleton County DSS Bernard Warshaw Building 215 S. Lemacks St. Walterboro, SC 29488
Darlington County	(843) 398-4420	Medicaid Eligibility Darlington County DHHS 300 Russell St., Room 145 Darlington, SC 29540-2077
	(843) 332-2289	404 S. Fourth St., Suite 300 Hartsville, SC 29550
Dillon County	(843) 774-2713	Medicaid Eligibility Dillon County DHHS 1213 Highway 34 W. Dillon, SC 29536
Dorchester County	(843) 563-9524	Medicaid Eligibility Dorchester County DSS 201 Johnson St, Bldg 17 Post Office Box 56 St. George, SC 29477
Edgefield County	(803) 637-4040	Medicaid Eligibility Edgefield County DSS 500 W. A. Reel Drive Edgefield, SC 29824
Fairfield County	(803) 635-5502 Ext. 425	Medicaid Eligibility Fairfield County DHHS 1136 Kincaid Bridge Road Post Office Box 1139 Winnsboro, SC 29180
Florence County	(843) 669-3354	Medicaid Eligibility Florence County DHHS 2685 S. Irby St., Box 1 Florence, SC 29505

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
Georgetown County	(843) 546-5134	Medicaid Eligibility Georgetown County DSS 330 Dozier St. Georgetown, SC 29440
Greenville County	(864) 467-7926	Medicaid Eligibility Greenville County DSS County Square 301 University Ridge, Suite 6700 Greenville, SC 29603
Greenwood County	(864) 229-5258	Medicaid Eligibility Greenwood County DSS 1118 Phoenix St. Greenwood, SC 29648
Hampton County	(803) 914-0053	Medicaid Eligibility Hampton County DHHS 102 Ginn Altman Ave. Hampton, SC 29924
Horry County	(843) 381-8260	Medicaid Eligibility Horry County DHHS 1601 11th Avenue, 2nd Floor Conway, SC 29526
Jasper County	(843) 726-7747	Medicaid Eligibility Jasper County DSS 204 N. Jacob Smart Blvd. Ridgeland, SC 29936
Kershaw County	(803) 432-7676 Ext. 106	Medicaid Eligibility Kershaw County DHHS 110 E. DeKalb St. Camden, SC 29020
Lancaster County	(803) 286-8208	Medicaid Eligibility Lancaster County DHHS 200 E. Dunlap St. Post Office Box 2169 Lancaster, SC 29720

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
Laurens County	(864) 833-0100	Medicaid Eligibility Laurens County DSS Human Services Complex Industrial Park Road Laurens, SC 29361
Lee County	(803) 484-5376	Medicaid Eligibility Lee County DSS County Welfare Building 820 Brown St. Bishopville, SC 29010
Lexington County	(803) 957-2975 (803) 957-2991	Medicaid Eligibility Lexington County DHHS Social Services Center 541 Gibson Road Lexington, SC 29072
McCormick County	(864) 465-2627	Medicaid Eligibility McCormick County DSS 215 N. Mine St. Highway 28 N. McCormick, SC 29835
Marion County	(843) 423-5417	Medicaid Eligibility Marion County DHHS 200 Airport Court Mullins, SC 29574
Marlboro County	(843) 479-4389	Medicaid Eligibility Marlboro County DSS County Complex Ag St. Bennettsville, SC 29512
Newberry County	(803) 321-1255	Medicaid Eligibility Newberry County DSS County Human Services Center 2107 Wilson Road Newberry, SC 29108

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
Oconee County	(864) 638-4400	Medicaid Eligibility Oconee County DHHS 100 Brown Square Drive Post Office Box 979 Walhalla, SC 29691
Orangeburg County	(803) 531-3101	Medicaid Eligibility Orangeburg County DSS 2570 Old St. Matthews Road, N.E. Orangeburg, SC 29116
Pickens County	(864) 898-5815	Medicaid Eligibility Pickens County DHHS Social Services Building 212 McDaniel Ave. Post Office Box 160 Pickens, SC 29671
Richland County	(803) 714-7562 (803) 714-7549	Medicaid Eligibility Richland County DHHS 3220 Two Notch Road Columbia, SC 29204
Saluda County	(843) 445-2139	Medicaid Eligibility Saluda County DSS Highway 121 N. Saluda, SC 29138
Spartanburg County	(864) 596-2714	Medicaid Eligibility Spartanburg County DHHS Pinewood Shopping Center 1000 N. Pine St., Suite 23 Spartanburg, SC 29303 Post Office Box 4847 Spartanburg, SC 29305
Sumter County	(803) 773-5531	Medicaid Eligibility Sumter County DSS 105 N. Magnolia St., 4th Floor Sumter, SC 29151

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
Union County	(843) 429-1660	Medicaid Eligibility Union County DHHS 200 S. Mountain St. Post Office Box 1068 Union, SC 29379
Williamsburg County	(843) 355-5411	Medicaid Eligibility Williamsburg County DSS 831 Eastland Ave. Kingstree, SC 29556
York County	(803) 327-9061	Medicaid Eligibility York County DHHS 1890 Neely's Creek Road Rock Hill, SC 29730 Post Office Box 710 Rock Hill, SC 29731

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DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

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SECTION 5 ADMINISTRATIVE SERVICES

EXHIBITS

Form Number	Exhibit	Revision Date
CMS-1500	Health Insurance Claim Form (2 pages)	12/1990
DHHS Form 130	Claim Adjustment Form	11/2004
DHHS 205	Medicaid Refunds and Instructions (2 pages)	03/2000
DHHS126	Confidential Complaint Form	12/2004
	Health Insurance Information Referral Form	02/2004
	Reasonable Effort Documentation	
DHHS140	Medicaid Provider Inquiry	11/1987
142	Request for Medicaid Forms and Publications	05/1997
	Authorization Agreement for Electronic Funds Transfer	11/2004
	**Medical Necessity Statement Form	
DHHS Form 254	DHHS Referral Form/Authorization for Services Children's Behavioral Health Services (2 pages)	
	Sample Edit Correction Form	
	Sample Remittance Advice (3 pages)	

Sample CMS-1500 with Medicaid and Other Insurance Coverage

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) X | 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; 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: 12345

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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 BC/BS OF SC

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 1

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS F

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of 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

PHYSICIAN OR SUPPLIER INFORMATION

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 | MM DD YY TO

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 | MM DD YY TO

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. L 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	02 01 05 | 02 01 05	53		90801			102 00	2				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: EXAM 01

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

28. TOTAL CHARGE: $ 102 00

29. AMOUNT PAID: $ 00 00

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 #

LOCAL COMMUNITY MENTAL HEALTH CENTER
111 MEDICAID AVENUE
ANYTOWN, SC 29000

PIN# 123456 | GRP#

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 ◯ DHHS ◯ MCCS ◯ Provider ◯ MIVS

Reason For Adjustment: (Fill One Only)

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

For Agency Use Only

Analyst ID:

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

Comments:

Signature: _____ Date: _____

Phone: _____

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

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

Items 1 - 6 must be completed. ***Attach appropriate document(s) as listed in item 7.***

1. Provider Name: _____ **2. Medicaid Provider #** ☐☐☐☐☐☐
(Six Digits)

3. Person to Contact: _____ **4. Telephone Number:** _____

5. Reason for Refund: [check appropriate box]

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

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

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

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____
_____

6. Patient/Service Identification:

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

7. Attachment(s): [Check appropriate box]

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

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

Instructions
Form for Medicaid Refunds

Make all checks payable to: **South Carolina Department of Health and Human Services**

Mail all checks to:

Reporting and Receivables Division
South Carolina Department of Health and Human Services
Post Office Box 8355
Columbia, South Carolina 29202-8355

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

Item 1 – Provider Name. Self explanatory.

Item 2 – Medicaid Provider Number. Enter the six – digit provider number under which payment was made. This number appears in the upper left – hand corner of the Medicaid remittance advice.

Item 3 – Person to contact. Self – explanatory.

Item 4 – Telephone Number. Self – explanatory.

Item 5 – Reason for refund. Check one of the four boxes shown. If box one "Other Insurance Paid" is checked, items a – f must be completed.

Item 6 – Patient/Service Identification. Self – explanatory.

Item 7 – Attachments. Submit attachment(s) with this form.

Please complete Items 1 – 6. Attach appropriate document(s) as listed in Item 7.

STATE OF SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES	**CONFIDENTIAL COMPLAINT**

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

PROGRAM INTEGRITY

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

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:	
MEDICAID PROVIDER ENROLLMENT NUMBER: (if applicable)	MEDICAID RECIPIENT I.D. NUMBER: (if applicable)
ADDRESS OF SUSPECT:	LOCATION OF INCIDENT: DATE OF INCIDENT:
COMPLAINT:	

NAME OF PERSON REPORTING: (Please print)	SIGNATURE OF PERSON REPORTING:	DATE OF REPORT:
ADDRESS OF PERSON REPORTING:	TELEPHONE NUMBER OF PERSON REPORTING: SIGNATURE: (SCDHHS Representative Receiving Report)	

SCDHHS Form 126 (revised 12/04)

Medicaid Insurance Verification Services
For
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH INSURANCE INFORMATION REFERRAL FORM

This form is designed to give the Medicaid program information that can be used to verify or reverify private health insurance coverage for Medicaid beneficiaries.

Beneficiary Name: _____ Date Referral Completed _____

Medicaid ID#: _____ SSN: _____

Insurance Company Name:_____

Policy Number: _____ Group Number: _____

Insured's Name: _____

Employer's Name: _____

Employer's Address: _____

REASON FOR REFERRAL: (PLEASE SUPPLY AS MUCH INFORMATION AS POSSIBLE)

_____ 1. The beneficiary's Medicaid Eligibility File does not list the policy above.

_____ 2. Insurance documentation gives information that should be used to update Medicaid's files, such as the following:

_____ a. beneficiary has never been covered by the policy

_____ b. beneficiary's coverage ended (date) _____

_____ c. policy lapsed (date) _____

_____ d. carrier has changed; new carrier is _____

_____ e. other _____

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

Fax this information to Medicaid Insurance Verification Services at 803 252 0870 **OR**
Please send this form to the following address: Medicaid Insurance Verification Services
Post Office Box 101110
Columbia, SC 29211-9804

Provider or Department Name: _____ Provider ID# _____

Contact Person: _____ Phone #: _____

March 2004

REASONABLE EFFORT DOCUMENTATION

HOSPITAL _____ **DOS** _____

MEDICAID BENEFICIARY NAME _____

MEDICAID ID# _____

INSURANCE COMPANY NAME _____

POLICY HOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP CALL _____

RESULT OF CALL:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP CALL _____

RESULT OF CALL:

THE ABOVE EFFORTS WERE TAKEN AND NO REPLY WAS RECEIVED FROM THE INSURANCE COMPANY.

_____

(SIGNATURE AND DATE)

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

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

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

PATIENT'S NAME (First, Initial, Last)	MEDICAID NUMBER (10 Digits)	DATE OF SERVICE

HAS THE CLAIM APPEARED ON THE PROVIDER'S REMITTANCE ADVICE? (CHECK ONE) ☐ YES ☐ NO	IS MEDICARE COVERAGE INVOLVED? ☐ YES ☐ NO

CLAIMS STATUS ON REMITTANCE ADVICE	PAYMENT DATE	17 DIGIT CLAIM REFERENCE NUMBER

STATEMENT OF PROBLEM OR QUESTION	SIGNATURE OF PROVIDER

RESPONSE	AGENCY REPRESENTATIVE	DATE

SCDHHS FORM 140 (NOV. 87) Replaces Form 1735 (Feb. 81) which obselete.

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR MEDICAID FORMS AND PUBLICATIONS

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

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

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

NAME OF PROVIDER

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

ITEMS REQUESTED

FORM/PUBLICATION NO.	TITLE OF FORM OR PUBLICATION	QUANTITY

DHHS FORM 142 (5/97)

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

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR STATEMENT OF PHARMACY SERVICES

DHHS FORM 3211 (11/96)

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

MEDICAID NO:
TELEPHONE: - -
CONTACT NAME:

NAME OF PROVIDER

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

QUANTITY REQUESTED

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

DHHS FORM 142 (5/97)

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

Provider Name: _____

Medicaid Provider Type: _____ **Medicaid Provider Number:** _____
Provider EIN Number: _____
Address: _____

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

I (we) hereby authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to my account indicated below and the financial institution named below, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.
I (we) understand that credit entries to the account of the above named payee are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws.
I (we) certify that the information shown is correct and that this account is used solely for business purposes. I (we) further agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

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

Financial Institution: _____

Address: _____

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

Transit/ABA Number: _____

Account No.: _____

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

Signed: _____ *(Signature)*

_____ *(Print)*

Title: _____ _____ **Date:**

_____

Contact Name: _____ **Phone:** _____

ATTACH VOIDED CHECK OR DEPOSIT SLIP

RETURN TO:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID PROVIDER ENROLLMENT
P.O. BOX 8809
COLUMBIA, S.C. 29202-8809
FAX: (803) 699-8637

Revised 11/04

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

Child's Name:_____ Social Security Number:_____

Date of Birth:_____ Medicaid Number:_____

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

_____
(Specific Rehabilitative Service)

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

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

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

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

Diagnosis and Diagnosis Code: _____

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

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

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

_____

_____

_____

_____

_____

_____

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.
Prior Authorization Number		Parent/Guardian

City	State	Zip

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
- ☐ HIGH MANAGEMENT REHABILITATIVE SERVICES
- ☐ MODERATE MANAGEMENT REHABILITATIVE SERVICES
- ☐ THERAPEUTIC FOSTER CARE
  - ☐ LEVEL I ☐ LEVEL II ☐ LEVEL II I
- ☐ INTENSIVE FAMILY SERVICE
- ☐ CLINICAL DAY PROGRAMMING
- ☐ THERAPEUTIC CHILD TREATMENT
- ☐ SUPERVISED INDEPENDENT LIVING

Agency Representative: _____ Title: _____

Signature: _____ Phone: _____

Authorizing Agency: (one must be checked)

- ☐ Department of Social Services
- ☐ Continuum of Care for Emotionally Disturbed Children
- ☐ United Way
- ☐ Department of Mental Health
- ☐ Department of Disabilities and Special Needs
- ☐ Department of Juvenile Justice
- ☐ School District/ Department of Education

AGENCY USE ONLY

INSTRUCTIONS FOR COMPLETING REFERRAL FORM 254

(Items of information not listed are self-explanatory)

Please Print Clearly)

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

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

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

AUTHORIZATION DATE: Enter the date the authorized period begins.

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

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

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

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

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

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

TITLE: Enter the Authorized Agency Representative's title.

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

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

AUTHORIZING AGENCY: The appropriate box must be checked.

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

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

RUN DATE 02/04/2005 0000 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #0503600045000100A
REPORT NUMBER CLM3500 **EDIT CORRECTION FORM** PAGE 37267 ECF 37249 PAGE 1 OF 1
ANALYST ID HIC - 10 PRAC SPEC - 28 EMC Y
SIGNON ID CLAIM RESTART DATE / / DOC IND N

1 PROVIDER ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 DIAGNOSIS PRIMARY	9 DIAGNOSIS SECONDARY
123456	1122334455						298.9	.

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	12/22/04	53	90801	000	123456	40.00		1.000
	.00	2	12/23/04	53	90862	000	123456	32.00		1.000
	.00	3	/ /							
		4	/ /							
		5	/ /							
		6	/ /							
		7	/ /							
		8	/ /							

EDITS

INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 510
02)
03)

****
** 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		
02		

26 TOTAL CHARGE 72.00
27 AMT REC'D INS
28 BALANCE DUE 72.00
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:
LOCAL COMMUNITY MENTAL HEALTH CENTER
PO BOX 00000
ANYTOWN SC 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.

PROVIDER ID. AB1111

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE: 02/04/2005

PAGE: 1

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	H0032	800.00	117.71		P			000			0.00
	02		021504	H2015	392.00	126.00		P			000			0.00
	VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04													
ABB222222	0406001089000400U				1412.00-	273.71-				CLARK				
	01		012104	H0032	1112.00-	143.71-					000			
	02		012104	H2015	300.00-	130.00-					000			
	REPLACEMENT OF ORIGINAL CCN 0404711253670430 PAID 02/28/04													
ABB222222	0407701389002500A				1192.00	242.75		P	1112233333	M CLARK			0.00	
	01		012104	H0032	800.00	42.75		P			000			0.00
	02		012104	H2015	392.00	0.00		R			000			0.00
	TOTALS			2	2193.50	286.46							0.00	0.00

			$286.46
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

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

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

PROVIDER NAME AND ADDRESS
Community Mental Health Center
PO BOX 000000
ANYTOWN SC 00000

Please note that the procedure codes and payment amounts used in these samples are examples only. They are not the actual charge amounts for the services listed.

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	T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	M O D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	04060010890004000U				513.00-	197.71-	1	1112233333	CLARK		M		022804	0404711253670430A
	01		012104	H0032	453.00	160.71-	P					000		
	02		012104	H2015	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

Community Mental Health Center
PO BOX 000000
ANYTOWN SC 00000

Please note that the procedure codes and payment amounts used in these samples are examples only. They are not the actual charge amounts for the services listed.

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

Community Mental Health Center
PO BOX 000000
ANYTOWN SC 00000

Please note that the procedure codes and payment amounts used in these samples are examples only. They are not the actual charge amounts for the services listed.