FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	Reasonable Effort Documentation	06/2007
	Authorization Agreement for Electronic Funds Transfer	03/2011
	Duplicate Remittance Advice Request Form	10/2012
CMS-1500	Sample Claim Showing TPL Denial with NPI	08/2005
	Sample Edit Correction Form	10/2008
	Sample Remittance Advice	06/2007
DHHS 254	Referral Form/Authorization for Rehabilitative Services	02/2013
	Medical Necessity Statement for Rehabilitative Services	05/2010
	RBHS Provider Enrollment for LEA	07/2012
	Sample Attestation Letter (two pages)	05/2010
	MAPPS Documentation Points	
	MAPPS Screening Form (four pages)	10/2006
	MAPPS Case Plan	10/2006
	MAPPS Individual or Group Session Form (two pages)	02/2013

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)	

SCDHHS Form 126 (revised 06/07)

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)

- ◯ 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, 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]

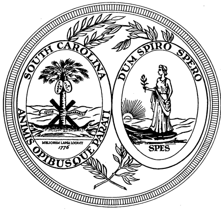
☐ Medicaid Remittance Advice (required)

☐ 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.

Revised 05/2007

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 Advice 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 the SCDHHS Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for instructions on submission of your request.

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:**

   ____
   ____
   ____
   ____
   ____

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

   Street: ____________________________
   City: ____________________________
   State: ____________________________
   Zip Code: ____________________________

8. **Charges for a duplicate remittance advice are as follows:**

   Request Processing Fee - $20.00

   Page(s) copied - .20 per page

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**

SCDHHS (Revised 10/2012)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Local Education Agency Services
Sample Claim Showing TPL Denial
With NPI

PICA | CARRIER | PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [x] | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) [x] | FECA BLK LUNG (SSN) | OTHER (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 MM DD YY: 01 01 1999 — SEX: M [x] F

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

5. PATIENT'S ADDRESS (No., Street): 123 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: 29999 — TELEPHONE (Include Area Code): ( )

ZIP CODE — TELEPHONE (Include Area Code): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES / NO [x]

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 [x] — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: 0.00

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES / NO [x]

c. INSURANCE PLAN NAME OR PROGRAM NAME: 401

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 1

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED 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

PATIENT AND INSURED 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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES / NO — $ CHARGES

Sample Only

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 784 . 5
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. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1															ZZ	1212121212
	01	20	07	01	20	07	12		92508			108 00	2		NPI	1234567890
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 — SSN / EIN [x]

26. PATIENT'S ACCOUNT NO.: DOE1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back): [x] YES / NO

28. TOTAL CHARGE: $ 108 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 108 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. SERVICE FACILITY LOCATION INFORMATION

a. NPI — b.

33. BILLING PROVIDER INFO & PH #: (555) 5555555
ABC School District
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 — b. ZZ1212121212

PHYSICIAN OR SUPPLIER INFORMATION

RUN DATE 05/01/2007 000001204 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #9999999999999999A

REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 1136 ECF 1136 PAGE 1 OF 1

ANALYST ID HIC - 76 PRAC SPEC - EMC Y

SIGNON ID DOC IND N ORIGINAL CCN:

TAXONOMY: SFL ZIP: PRV ZIP: ADJ CCN:

1 PROV/XWALK ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 DIAGNOSIS PRIMARY	9 DIAGNOSIS SECONDARY
ABC123 NPI: 1234567890	1111111111						V71.02	.

EDITS

INSURANCE EDITS

CLAIM EDITS

LINE EDITS

01) 712 951

10 RECIPIENT NAME - DOE, JANE 11 DATE OF BIRTH 01/25/1992 12 SEX F

13 RES	14 ALLOWED	LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	23 NDC	19 INDIVIDUAL PROVIDER	20 CHARGE	21 PAY IND	22 UNITS
	.00	1	02/01/00	99	H2020	HA		900MXH	836.00		017
	NPI: 1234567890		TAXONOMY:								
		2	/ /								
	NPI:		TAXONOMY:								
		3	/ /								
	NPI:		TAXONOMY:								
		4	/ /								
	NPI:		TAXONOMY:								
		5	/ /								
	NPI:		TAXONOMY:								
		6	/ /								
	NPI:		TAXONOMY:								
		7	/ /								
	NPI:		TAXONOMY:								
		8	/ /								
	NPI:		TAXONOMY:								

****

** AGENCY USE ONLY **

** APPROVED EDITS **

** **

** REJECTED LINE EDITS **

** **

****

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

! CLAIMS/LINE PAYMENT INFO !

! !

! EDIT PAYMENT DATE !

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID		
			27 TOTAL CHARGE	836.55
01			28 AMT REC'D INS	
02			29 BALANCE DUE	836.55
03			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 SCHOOL DISTRICT
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 SCHOOL DISTRICT                                       PO BOX 000000            FLORENCE            SC000000000
 .121212121234.                  Y
  PROVIDER ID.                                                  PROFESSIONAL SERVICES             PAYMENT DATE                 PAGE
+--------------+  DEPT OF HEALTH AND HUMAN SERVICES                                            +-------------+               +----+
| AB00080000   |                                                  REMITTANCE ADVICE             | 03/26/2007 |               |  1 |
+--------------+   SOUTH CAROLINA MEDICAID PROGRAM                                             +-------------+               +----+
+---------+-----------------+------+---------+------+--------+--------+-+----------+-------------------+---+-------+-------+-------+
|PROVIDERS|      CLAIM      |      |SERVICE RENDERED|  AMOUNT|TITLE 19|S|RECIPIENT |RECIPIENT NAME     |M  |TLE. 18| COPAY | TITLE |
| OWN REF.|    REFERENCE    |      | DATE(S) |      |  BILLED| PAYMENT|T|    ID.   |F M                | O |ALLOWED|  AMT  |  18   |
| NUMBER  |      NUMBER     |PY IND|MMDDYY   | PROC.|        |MEDICAID|S|  NUMBER  |I I LAST NAME      |  D|CHARGES|       |PAYMENT|
+---------+-----------------+------+---------+------+--------+--------+-+----------+-------------------+---+-------+-------+-------+
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|ABB222222|0406001089000400A|      |         |      | 1192.00|  243.71|P|1112233333|M   CLARK          |   |       |   0.00|       |
|         |               01 |     |021507   |H2020 |  800.00|  117.71|P|          |                   | HA|       |       |   0.00|
|         |               02 |     |021507   |H2021 |  392.00|  126.00|P|          |                   |   |       |       |   0.00|
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|         |VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04       | |          |                   |   |       |       |       |
|ABB222222|0406001089000400U|      |         |      |1412.00-| 273.71-| |1112233333|M   CLARK          |   |       |       |       |
|         |               01 |     |012107   |H2020 |1112.00-| 143.71-| |          |                   | HA|       |       |       |
|         |               02 |     |012107   |H2021 | 300.00-| 130.00-| |          |                   |   |       |       |       |
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|         |REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04| |          |                   |   |       |       |       |
|ABB222222|0407701389002500A|      |         |      | 1001.50|   42.75|P|1112233333|M   CLARK          |   |       |   0.00|       |
|         |               01 |     |012107   |H2020 |  142.50|   42.75|P|          |                   | HA|       |       |   0.00|
|         |               02 |     |012107   |H2021 |  859.00|    0.00|R|          |                   |   |       |       |   0.00|
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|         |           TOTALS|      |        2|      | 2193.50|  286.46| |          |                   |   |       |   0.00|   0.00|
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
|         |                 |      |         |      |        |        | |          |                   |   |       |       |       |
+---------+-----------------+------+---------+------+--------+--------+-+-+--------+-------------------+---+-------+-------+-------+
                                            |             |   |     $286.46|
                                            +-------------+   +-------------+     STATUS CODES:       PROVIDER NAME AND ADDRESS
FOR AN EXPLANATION OF THE                     CERT. PG TOT     MEDICAID PG TOT                         +--------------------------------+
ERROR CODES LISTED ON THIS                  +-------------+   +-------------+     P = PAYMENT MADE  |ABC SCHOOL DISTRICT             |
FORM REFER TO:  "MEDICAID                   |       $0.00 |   |     $286.46|     R = REJECTED      |                                |
PROVIDER MANUAL".                           +-------------+   +-------------+     S = IN PROCESS    |PO BOX 000000                   |
                                              CERTIFIED AMT    MEDICAID TOTAL     E = ENCOUNTER     |FLORENCE       SC 00000-0000   |
IF YOU STILL HAVE QUESTIONS+-------------+ +-------------+   +-------------+     +---------+       |                                |
PHONE THE D.H.H.S. NUMBER  |       $0.00 | |       $0.00 |   |        0.00|     |         |       +--------------------------------+
SPECIFIED FOR INQUIRY OF   +-------------+ +-------------+   +-------------+     +---------+
CLAIMS IN THAT MANUAL.       FEDERAL RELIEF   MAXIMUS AMT       CHECK TOTAL       CHECK NUMBER
```

Sample Remittance Advice (page 2)

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

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

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	SERVICE RENDERED PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	MOD	ORG CHECK DATE	ORIGINAL CCN
ABB222222	0406001089000400U				513.00-	197.71-		1112233333	CLARK	M			022807	0404711253670430A
	01		012107	H2020	453.00	160.71-	P							
	02		012107	H2021	60.00	33.00-	P					HA		
	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

YOUR CURRENT DEBIT BALANCE	ADJUSTMENTS	MAXIMUS AMT	CHECK TOTAL	CHECK NUMBER
0.00	$193.71-		$50.00	4197304

PROVIDER NAME AND ADDRESS

ABC SCHOOL DISTRICT
PO BOX 000000
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
AB11110000	DEPT OF HEALTH AND HUMAN SERVICES SOUTH CAROLINA MEDICAID PROGRAM	ADJUSTMENTS	03/26/2007	3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME F I M 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
	0.00	0.00

YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER
5293.45	0.00	

PROVIDER NAME AND ADDRESS

ABC SCHOOL DISTRICT
PO BOX 000000
FLORENCE SC 00000-0000

South Carolina Department of Health & Human Services

REFERRAL FORM / AUTHORIZATION FOR REHABILITATIVE SERVICES

FORM 254

NATIONAL PROVIDER IDENTIFIER #

BENEFICIARY'S MEDICAID #

REFERRED TO: ______________________

AUTHORIZATION DATE: ______________________

EXPIRATION DATE: ______________________
Last Date of Service

Name			County	Address		
Date of Birth	Sex	Agency Reference No.	City		State	Zip

Prior Authorization Number *(1st two letters reflect the agency's origin. Remaining 5 characters are left up to referring agency or SCDHHS QIO.)*	Parent/Guardian

SAMPLE

The provider named above is hereby authorized to render the following service(s) on or within the designated time period for the Medicaid-eligible beneficiary which is not to exceed 6 months. The number of units and staff to provide services should be based on the medical needs of the beneficiary and from the referral source. Please refer to the Rehabilitative Behavioral Health Service Provider Manual for Modifiers and Procedure codes. Only the number of units authorized may be billed.

✓		Service Description	Procedure Code	Modifier	Unit	Total Units Authorized	Frequency
	Assessment Services						
		Behavioral Health Screening	H0002		15 minutes		
		Diagnostic Assessment without medical	90791	AH,HO	Per Encounter		
		Diagnostic Assessment with medical	90792	AF,AM,SA	Per Encounter		
		Psychological Testing / Evaluation	96101	AH	60 minutes		
		Comprehensive Evaluation – Initial	H2000	AH,HO	Per Encounter		
		Comprehensive Evaluation – Follow up	H0031	AH,HO	Per Encounter		
	Treatment Plan Development Services						
		Service Plan Development (Mental Health)	H0032	AH,HO,HN	15 minutes		
		Interdisciplinary Tem-Service Plan Development (Team w/ Client)	99366		Per Encounter		
		Interdisciplinary Tem-Service Plan Development (Team w/o Client)	99367		Per Encounter		
	Therapy Services						
		Individual Psychotherapy	90832, 90834 90837		Per Encounter		
		Group Psychotherapy	90853		Per Encounter		
		Family Psychotherapy w/o client	90846		Per Encounter		
		Family Psychotherapy with client	90847		Per Encounter		
	Community Support Services						
		Crisis Management	H2011		15 minutes		
		Medication Management	H0034		15 minutes		
		Rehabilitative Psychosocial Service	H2017		15 minutes		
		Behavior Modification (B-Mod)	H2014		15 minutes		
		Family Support	S9482		15 minutes		

Authorizing Agency: (One must be marked)

- ____ Department of Social Services
- ____ Department of Mental Health
- ____ Continuum of Care For Emotionally Disturbed Children
- ____ Department of Disabilities and Special Needs
- ____ Department of Juvenile Justice
- ____ School District / Department of Education
- ____ United Way
- ____ SCDHHS Quality Improvement Organization

Authorized Agency Representative ______________________

Title ______________________

Phone ______________________

Signature ______________________

Date ______________________

State Agency Use Only:

South Carolina Department of Health & Human Services

MEDICAL NECESSITY STATEMENT
FOR
REHABILITATIVE SERVICES

Beneficiary's Name: ____________________________ Social Security Number: _________________

Date of Birth: ____________________________ Medicaid Number: ______________________

Diagnosis code(s): _________________________________

[Diagnosis codes must be based on the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* or the International *Classification of Diseases (ICD).*]

I recommend that the above-named Medicaid beneficiary receive Rehabilitative Services(s) for the maximum reduction of emotional, behavioral, and functional developmental delays and restoration of the beneficiary to his or her best possible functioning level. This beneficiary meets the Medical Necessity criteria for Rehabilitative Services as evidenced by a Psychiatric diagnosis from the current edition of the DSM or the ICD.

Indicate the specific Rehabilitative Service(s) being recommended on each line below.

Rehabilitative Service(s): ____________________, ______________________, ____________________

Rehabilitative Service(s): ____________________, ______________________, ____________________

Rehabilitative Service(s): ____________________, ______________________, ____________________

Rehabilitative Service(s): ____________________, ______________________, ____________________

Identify the Beneficiary's problem areas for Rehabilitative Services listed above. The recommendation must be based on recent clinical information, staffing recommendations, review(s) of treatment history and/ or evaluation(s) made within federal and state standards

SAMPLE ONLY

____ _______________________________

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

____ _______________________________

(Please print name signed above) (Phone Number)

Signature Date: ________________________________ (Services must be initiated within 45 calendar days.)

Must be handwritten

Note: The Referral/Authorization for Rehabilitative Services form (DHHS Form 254) and the MNS must be sent to the provider prior to the provision of services, or at the time the services are rendered.

Revised: 05/2010

To: Existing and New Local Education Agencies (LEA):

In order to ensure a smooth transition to Rehabilitative Behavioral Health Services (RBHS), please submit the following information to the Division of Family Services as soon as possible:

1. LEA providers must submit a completed Attestation Statement which confirms that you will comply with all RBHS policies and procedures. This letter must be on the organization's letterhead and the statements to which the LEA provider is attesting to may be found in the sample attestation letter attached. The attestation must be signed by the LEA Director.

2. Submit a list detailing the specific RBHS that your LEA intends to provide. The list of RBHS can be found in the RBHS Policy Manual, Section 2 located on the DHHS website at www.scdhhs.gov. DHHS will have the LEA Manual available on line prior to July 1, 2010.

3. Submit a list detailing the licensed professional staff employed that may be supervising or rendering the RBHS. The list must include the staff's name, credentials, professional license held (i.e., LPC), and license number.

Please submit the above-referenced information to the following:

Division of Family Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

or please fax to 803-255-8204

Thank you for your participation.

Sample Attestation Letter

An individual who has the legal authority to obligate the Local Education Agency (LEA) must sign the attestation. The Letter must be on the LEA's letterhead.

<Name of the LEA
<Address and site location of Services
<City, State, Zip Code
<Telephone Number
<Fax Number
<NPI registered with Medicaid
<DHHS prior authorization prefix

To: SC DHHS (Division of Family Services)

I make the following certification concerning Medicaid Rehabilitative Behavioral Health Services. Based upon my personal knowledge and belief, I attest that the <name of LEA> will be in compliance with all of the Medicaid policy requirements set forth in the Rehabilitative Behavioral Health Services Policy Manual, effective July 1, 2010 and agree to comply with all future terms, conditions, standards, and updates as established by the South Carolina Department of Health and Human Services (SCDHHS).

I attest that the <name of LEA> agrees to accept the reimbursement fee schedule determined by the South Carolina Department of Health and Human Services.

I certify that the < name of LEA > acknowledges the right of SCDHHS (or its designee) to conduct an on-site audit at any time to validate compliance with the requirements of Medicaid Rehabilitative Behavioral Health Services and to investigate complaints lodged against < name of LEA >.

I certify that the < name of LEA > is enrolled with the SC Medicaid Program and in good standing.

I certify that the < name of LEA > is in compliance with all applicable sections of the Medicaid policy that govern staff education and qualifications, including work experience, background screenings (i.e., criminal record checks, child abuse/central registry checks, sexual offender registry checks and motor vehicle record checks), training requirements, etc…

I attest that the < name of LEA > meets all of the applicable state licensure requirements and insurance coverage as applicable during the terms of Medicaid enrollment.

I certify to the best of my knowledge and belief that < name of LEA > and/or its Principles are not presently debarred or suspended.

In addition, I will notify the SC Medicaid Program if I vacate this position so that an attestation can be submitted by my successor. I will also notify the participating state agencies and other agencies as appropriate if it is my belief that < name of LEA > is out of compliance with the Medicaid requirements .

Signature,

<Printed Name>
<Title>
<Date>

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES
DOCUMENTATION POINTS

S9445-FP — **Patient Education, not otherwise classified, non-physician provider, Individual, per session. Address a minimum of three (3) documentation points from the list below plus the client's response.**

S9446-FP — **Patient Education, not otherwise classified, non-physician provider, Group, per session. Address a minimum of five (5) documentation points from the list below plus the client's response.**

1) Discussion of adolescent development as it relates to human growth, development, sexuality, and pregnancy prevention
2) Information on the importance of family planning, responsible sexual behavior, and its effect on overall reproductive health
3) Discussion of the benefits of abstinence as it relates to normal growth and development for teens and pregnancy prevention
4) Discussion of the benefits of delaying sexual activity as it relates to healthier birth outcomes and pregnancy prevention
5) Discussion of the benefits of delaying pregnancy
6) Discussion of the long- and short-term health risks related to early sexual activity
7) Discussion of birth control methods, including abstinence, and the options available
8) Instruction on the proper and appropriate use of birth control methods
9) Importance of compliance with prescribed family planning methods and follow-up medical visits
10) Information on the benefits and risks of long-term birth control methods
11) Identification of family planning problems
12) Discussion of the availability of other health care resources related to family planning
13) Information on STDs and prevention of STDs as it relates to reproductive health and family planning

SCREENING FORM

1. Name of Participant: (First, Middle Initial, Last) ________________________________
2. Case Number Identification:

Medicaid Number	
Social Security Number	
Patient Account Number	

3. Eligibility: ☐ Medicaid ☐ Foster Care ☐ Child Protective Services
4. Date of Assessment: (Month, Date, Year) ____
5. Age of Participant: ___________ Date of Birth: (Month, Date, Year) ____________
6. Gender of Participant: ☐ Male ☐ Female
7. Racial or Ethnic Background of Participant: (Check one)

☐ White or Anglo, Not of Hispanic Origin ☐ Asian or Pacific Islander ☐ Black, Not of Hispanic Origin

☐ Hispanic ☐ American Indian ☐ Other: ____

8. Parent/Guardian: ____SSN: _____

Environmental

9. Address of Participant:

Street Address:		
Mailing Address: (If Different from Street Address)		
City/Town:	State:	Zip Code:
Telephone: (Home)	(Other)	☐ No Telephone

10. Household Members:

Name	**Relationship to Participant**	**Age**	**Grade**	**School or Place of Employment of Household Members**

11. Financial Support: (Check All That Apply)

 Employment Unemployment Benefits Family Independence Food Stamps

 Social Security Disability Other: (Specify) ____

12. Dwelling and Living Conditions:

 Apartment House Manufactured Home Public Housing

 Own Rent Housing Assistance Other: __________________________________

 Condition of the Home: ____

13. Access to Transportation: (Check One)

 Have Transportation No Transportation Have Access to Transportation No Access to Transportation

14. Name of the Head of Household: __________________________________ SSN: ________________

15. Household Income: (Check One)

 Less than $9,900 $10,000 - $12,000 $12,001 - $14,999 Over $15,000

16. Employment Status of the Mother/Guardian: Full-Time Part-Time Not Employed Other:_______

17. Employment Status of the Father/Guardian: Full-Time Part-Time Not Employed Other: _______

18. Marital Status of Parent (s): Married Single Separated Widowed Other:_______

19. Does Parent (s), guardian or other household member have a history of drug/alcohol abuse?

 Yes No Unknown

If yes, specify name of individual and relationship to participant: _________________________

Type of drug/alcohol: ____

Referral/ Health Risk Factors

20. What was the referral source for MAPPS? (Check One)

 DSS Teacher Counselor Relative Friend Other: (Specify) ________________

21. Referral Risk Factor (s): (Check All That Apply)

 Parent (s) were Teen Parents Sibling is Pregnant and/or Teen Parent Participant is a Teen Parent

 Peer Pressure to engage in sexual activity is identified as a problem by the adolescent

 Participant is Sexually Active and/or has a history of Sexual Abuse

22. Is the participant currently sexually active? Yes No

If no, has the participant ever been sexually active? Yes No

23. Has the participant ever been an expecting parent (abortion/fetal death)? Yes No

24. Has the participant ever used a birth control method? Yes No

Method Used: (Check All That Apply)

 Birth Control Pills Condom Depo-Provera Shot Diaphragm IUD Norplant

 Rhythm Other: ____

25. Does the participant understand or know the health risks associated with having sex? Yes No

26. Has the participant ever had a STD? Yes No If yes, specify: _____________________________________

27. Has the participant ever experimented with alcohol, tobacco, and/or other drugs? Yes No

If yes, what kind? ____

Educational/Career

28. Name of school the participant attends: ____________________

29. Present grade of participant: ____________________

30. Special needs of the participant: (Check All That Apply)

 None Attention Deficit Disorder (ADD) Learning Disability Emotionally Handicapped

 Other: (Specify) ____________________

31. What are the parent/guardian’s educational/career goals for the participant? (Check One)

 Partial High School High School Diploma College (B.S., etc.) Professional Degree (Ph.D., etc.)

 Technical School Work Don’t Know Other: ____________________

What are the participant’s education/career goals? (Check One)

 Partial High School High School Diploma College (B.S., etc.) Professional Degree (Ph.D., etc.)

 Technical School Work Don’t Know Other: ____________________

32. Does the participant engage in extracurricular activities? Yes No

If yes, list activities: ____________________

33. How does the participant spend his/her free time?

After School: ____________________

Weekends: ____________________

34. Does the participant have any household rules to follow? Yes No

If yes, what are some household rules that the participant has to follow? (Keep Room Clean, Do Housework, Wash Dishes or Cook, Curfew, No Dating, Do School Work, etc.)

1. ____________________ 4. ____________________

2. ____________________ 5. ____________________

3. ____________________ 6. ____________________

Does the participant abide by the rules? Always Most of the time Sometimes Rarely Not at all

35. Do the household rules cause any conflict for the parent/guardian and the participant? Yes No

If yes, explain: ____________________

____

What are the parent/guardian’s and the participant’s feelings about the household rules? ____________________

____

36. Does the participant have a curfew? Yes No

If yes, specify time and day (s) of the week: ____________________

Does the participant adhere to the curfew? Always Most of the time Sometimes Rarely Not at all

37. Does participant have friends? Yes No

If yes, gender and age? ____________________

When they spend time together, what do they do? ____________________

How does the participant get along with friends? ____________________

38. How does the participant get along with adults? (Including teachers) ____________________

____

____

SCREENING/NEEDS ASSESSMENT
(T1023-FP)

Participant's Name: ____

Date of Service: ____________________ **Medicaid Number**: ________________________________

(Provider of Service)
Licensed/Certified Signature: ____________________________________ **Date**: _______________________

CASE PLAN

Treatment Protocol (T1023-FP)

Participant's Name ____________________________ Medicaid Number ________________

Needs Statement: ____

____

____

____

____

____

Plan of Care: ____

____

____

____

____

____

____

____

____

Goals and Objectives	Frequency	Completion Date

This ICP will be reviewed on (6 months from ICP date): ____________________________

Date Reviewed: ________________________ (Review case plan during Individual Session)

Participant's Signature:_____________________________________ Date: ______________

Parent/Guardian's Signature:________________________________ Date: ______________

(Provider of Service)
Licensed/Certified Signature: ________________________________

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES

Individual or Group Session Form

Participant's Name: ____

Date of Service: ______________________ **DOB**: ___________________ **Age**: ________

Medicaid Number: __________________________ ☐ **Individual** ☐ **Group**

Place:
☐ Participant's Home ☐ Office ☐ School ☐ Other

Units of Service: ___________________________

Risk Factors: (Check All That Apply)

☐ Participant is a Teen Parent ☐ Peer Pressure to engage in sexual activity is identified as a problem by the adolescent

☐ Participant is sexually and/or has a history of sexual abuse

A narrative description of services must be provided. Documentation of session must support time billed and points discussed. Check the Documentation Points discussed:

☐ 1. Discussion of adolescent development as it relates to human growth, development, sexuality, and pregnancy prevention

☐ 2. Information on the importance of family planning, responsible sexual behavior, and its affect on overall reproductive health

☐ 3. Discussion of the benefits of abstinence as it relates to normal growth and development for teens and pregnancy prevention

☐ 4. Discussion of the benefits of delaying sexual activity as it relates to healthier birth outcomes and pregnancy prevention

☐ 5. Discussion of the benefits of delaying pregnancy

☐ 6. Discussion of the long and short-term health risks related to early sexual activity

☐ 7. Discussion of birth control methods, including abstinence, and the options available

☐ 8. Instruction on the proper and appropriate use of birth control methods

☐ 9. Importance of compliance with prescribed family planning methods and follow up medical visits

☐ 10. Information on the benefits and risks of long term birth control methods

☐ 11. Identification of family planning problems

☐ 12. Discussion of the availability of other health care resources related to family planning

☐ 13. Information on STDs and prevention of STDs as it relates to reproductive health and family planning

PATIENT EDUCATION

☐ Individual ☐ Group

Participant's Name: ______________________________

Date of Service: ____________________ **Medicaid Number**: ____________________

Service Provider

SIGNATURE (and credentials): ______________________________ Date: ____________

Supervisor

CO-SIGNATURE (and credentials) ______________________________ Date: ____________