

FORMS

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DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 140	Medicaid Provider Inquiry	06/2007
DHHS 142	Request for Medicaid Forms and Publications	06/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
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CMS-1500	Sample Claim with NPI	08/2005
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DHHS 149	Medicaid Hospice Election Form	06/2008
DHHS 149A	Medicaid Hospice Prior Authorization Form	04/2008
DHHS 149A (reverse side)	Procedures For Appeals - Prior Authorization	04/2008
DHHS 151	Medicaid Hospice Physician Certification/ Recertification	06/2008
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**STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES**

CONFIDENTIAL COMPLAINT

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

PROGRAM INTEGRITY

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

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

NPI or MEDICAID PROVIDER ID: (if applicable)

MEDICAID RECIPIENT ID NUMBER: (if applicable)

ADDRESS OF SUSPECT:

LOCATION OF INCIDENT:

DATE OF INCIDENT:

COMPLAINT:

NAME OF PERSON REPORTING: (Please print)

SIGNATURE OF PERSON REPORTING:

DATE OF REPORT

ADDRESS OF PERSON REPORTING:

TELEPHONE NUMBER OF PERSON REPORTING:

SIGNATURE: (SCDHHS Representative Receiving Report)

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Grid for Original CCN (15 boxes)

Provider ID:

Grid for Provider ID (6 boxes)

NPI:

Grid for NPI (10 boxes)

Recipient ID:

Grid for Recipient ID (10 boxes)

Adjustment Type:

- Void, Void/Replace

Originator:

- DHHS, MCCS, Provider, MIVS

Reason For Adjustment: (Fill One Only)

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

For Agency Use Only

Analyst ID:

Grid for Analyst ID (6 boxes)

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

Comments:

Signature: _____ Date: _____

Phone: _____



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

MEDICAID PROVIDER INQUIRY

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

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

PATIENT'S NAME (First, Initial, Last)	MEDICAID NUMBER (10 Digits)	DATE OF SERVICE
HAS THE CLAIM APPEARED ON THE PROVIDER'S REMITTANCE ADVICE? (CHECK ONE) <input type="checkbox"/> YES <input type="checkbox"/> NO		IS MEDICARE COVERAGE INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO
CLAIMS STATUS ON REMITTANCE ADVICE	PAYMENT DATE	17-DIGIT CLAIM REFERENCE NUMBER
STATEMENT OF PROBLEM OR QUESTION		
SIGNATURE OF PROVIDER		
RESPONSE		
AGENCY REPRESENTATIVE		DATE



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

**REQUEST FOR MEDICAID
FORMS AND PUBLICATIONS**

WHEN COMPLETED PLEASE FORWARD TO:

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

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

NPI or MEDICAID PROVIDER ID:

TYPE OF PROVIDER:

TELEPHONE: - -

CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY (PLEASE PRINT OR TYPE)

ITEMS REQUESTED

FORM/PUBLICATION NO.	TITLE OF FORM OR PUBLICATION	QUANTITY

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

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

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

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

1. Provider Name: _____

2. Medicaid Legacy Provider #
(Six Characters)

OR

3. NPI#

& Taxonomy

4. Person to Contact: _____

5. Telephone Number: _____

6. Reason for Refund: [check appropriate box]

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

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

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

Other, describe in detail reason for refund:

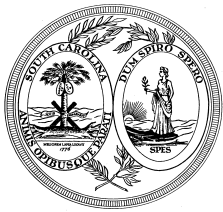
7. Patient/Service Identification:

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

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

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

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



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

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

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

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

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

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

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

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

Fax:	or	Mail:
803-252-0870		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:	or	Mail:
803-255-8225		Post Office Box 8206, Attention TPL
		Columbia, SC 29202-8206



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

PROVIDER _____ **DOS** _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

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

(SIGNATURE AND DATE)

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

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

PROVIDER INFORMATION

Provider Name _____
Medicaid Provider Number _____
Provider NPI Number _____
Provider Address _____
City _____ State _____ Zip _____

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

Financial Institution Name _____
Financial Institution Address _____
City _____ State _____ Zip _____
Routing Number (nine digit) _____
Account Number _____
Type of Account (check one) Checking Savings

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

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

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

Contact Name: _____ Phone Number: _____

Signed _____ (Signature)

_____ (Print)

Title _____ Date _____

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

RETURN COMPLETED FORM TO:

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

1500

Hospice Services
Sample Claim
with NPI

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																												
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>										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 1947					SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>																																							
5. PATIENT'S ADDRESS (No., Street) 123 Windy Lane										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																																							
CITY Anytown					STATE SC					8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY					STATE																																		
ZIP CODE 29999					TELEPHONE (Include Area Code) ()					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					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																																		
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																		
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										b. EMPLOYER'S NAME OR SCHOOL NAME																																		
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																																		
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																		
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. Signature on File SIGNED _____ DATE _____																														13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																								
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										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? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 593.9										23. PRIOR AUTHORIZATION NUMBER 0000NH																																												
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. D. QUAL.					J. RENDERING PROVIDER ID. #				
1 01 01 07 01 10 07 12										S9126										500.00					10					ZZ					1212121212																			
2 01 11 07 01 11 07 12										S9123										220.00					11					ZZ					1212121212																			
3 01 12 07 01 31 07 12										S9126										1000.00					20					ZZ					1212121212																			
4 01 01 07 01 31 07 12										T2046 TF										3100.00					31					ZZ					1212121212																			
5																														NPI																								
6																														NPI																								
25. FEDERAL TAX I.D. NUMBER 555555555										SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. DOE1234					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 4820.00					29. AMOUNT PAID \$ 0.00					30. BALANCE DUE \$ 4820.00																			
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 Home Health 111 Main Street Anytown, SC 22222-2222 a. 1234567890 b. ZZ1212121212																																		

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

RUN DATE 05/01/2007 000001204
REPORT NUMBER CLM3500

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM

CLAIM CONTROL #9999999999999999A
PAGE 1136 ECF 1136 PAGE 1 OF 1

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

HIC - 60 PRAC SPEC - 12
DOC IND N
SFL ZIP: PRV ZIP:
3 4 5 6 7 8 9
P AUTH TPL INJURY EMERG PC COORD
NUMBER CODE
---- DIAGNOSIS ----
PRIMARY SECONDARY
569.81 .

ORIGINAL CCN:
ADJ CCN:
EDITS
INSURANCE EDITS
CLAIM EDITS

10 RECIPIENT NAME - DOE, JANE

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

LINE EDITS
01) 892

13 RES	14 ALLOWED	15 LN NO	16 DATE OF SERVICE	17 PLACE	18 PROC CODE	19 INDIVIDUAL PROVIDER	20 CHARGE IND	21 PAY	22 UNITS
	.00	1	01/02/04	12	S9126	000	HHA000	100.00	1.000

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

NPI: 1234567890
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

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

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID	27 TOTAL CHARGE	28 AMT REC'D INS	29 BALANCE DUE	30 OWN REF #
			100.00		100.00	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 HOSPICE CARE
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.

# HSP111 ABC HOSPICE CARE .121212121234.				PO BOX 000000				FLORENCE				SC000000000			
PROVIDER ID.				Y				PROFESSIONAL SERVICES				PAYMENT DATE			
+-----+ DEPT OF HEALTH AND HUMAN SERVICES				+-----+				+-----+				+-----+			
AB00080000								REMITTANCE ADVICE				03/26/2007			
+-----+ 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	S9126	800.00	P						0.00			
	02		021507	S9126	392.00	P						0.00			
VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04															
ABB222222	0406001089000400U			1412.00-	273.71-		1112233333	M CLARK							
	01		012107	S9126	1112.00-										
	02		012107	S9126	300.00-										
REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04															
ABB222222	0407701389002500A			1001.50	42.75	P	1112233333	M CLARK			0.00				
	01		012107	S9126	142.50	P						0.00			
	02		012107	S9126	859.00	R						0.00			
TOTALS			2		2193.50	286.46					0.00	0.00			
\$286.46															
FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".				CERT. PG TOT	MEDICAID PG TOT	STATUS CODES:				PROVIDER NAME AND ADDRESS					
				\$0.00	\$286.46	P = PAYMENT MADE	ABC HOSPICE CARE								
						R = REJECTED	PO BOX 000000								
						S = IN PROCESS	FLORENCE				SC 00000-0000				
						E = ENCOUNTER									
IF YOU STILL HAVE QUESTIONS															
PHONE THE D.H.H.S. NUMBER				\$0.00	\$0.00										
SPECIFIED FOR INQUIRY OF															
CLAIMS IN THAT MANUAL.				FEDERAL RELIEF	MAXIMUS AMT	CHECK TOTAL	CHECK NUMBER								

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.	DEPT OF HEALTH AND HUMAN SERVICES	ADJUSTMENTS	PAYMENT DATE	PAGE
HSP1110000	SOUTH CAROLINA MEDICAID PROGRAM		03/26/2007	3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME F M LAST NAME I I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	0408600003700000U	-						DEBIT	-2389.05	
TPL 4	0408600004700000U	-						DEBIT	-1949.90	
TPL 5	0408600005700000U	-						DEBIT	-477.25	
TPL 6	0408600006700000U	-						DEBIT	-477.25	
PAGE TOTAL:									5293.45	0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
0.00	0.00	0.00	0.00	0.00
0.00	ADJUSTMENTS	MAXIMUS AMT	PROVIDER NAME AND ADDRESS	
YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	ABC HOSPICE CARE PO BOX 000000 FLORENCE SC 00000-0000	
5293.45	0.00			

MEDICAID HOSPICE ELECTION FORM

EFFECTIVE DATE: **INCOMPLETE FORMS CANNOT BE PROCESSED BY SCDHHS**

RECIPIENT INFORMATION:

NAME: LAST		FIRST		MEDICAID ID NUMBER:	
CURRENT MAILING ADDRESS: STREET				SOCIAL SECURITY NUMBER:	
CITY:		STATE:	ZIP CODE:		MEDICARE NUMBER:
HOME PHONE NUMBER:		BIRTH DATE:		ICD-9 NUMBER INDICATING THE PRIMARY HOSPICE DIAGNOSIS::	
NAME OF NURSING FACILITY OF RESIDENCE, IF APPLICABLE::				MEDICAID PROVIDER NUMBER OF NURSING FACILITY::	
NAME OF PARENT, LEGAL GUARDIAN OR REPRESENTATIVE:				SEX: MALE / FEMALE	

HOSPICE PROVIDER INFORMATION:

NAME OF HOSPICE:		NPI Number:	
		MEDICAID PROVIDER NUMBER: HSP ___ _ _	
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:		HOSPICE PHONE NUMBER:	
ATTENDING PHYSICIAN'S NAME:		PHYSICIAN'S MEDICAID PROVIDER NUMBER:	

HOSPICE BENEFIT INFORMATION:

APPLICABLE BENEFIT PERIOD:

FIRST 90 DAYS
 SECOND 90 DAYS
 () PERIOD OF 60 DAYS

ELECTION STATEMENT

- The South Carolina Medicaid Hospice Benefit program has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitations of this program and the terms of the election statement.
- I understand that by signing the election statement, I am waiving all rights to regular Medicaid services except for payment to my attending physicians, treatment for medical conditions unrelated to my terminal illness, medical transportation, dental services and Medicaid pharmacy services for prescriptions not covered under hospice.
- I understand that I will be entitled to Medicaid sponsored hospice services as long as I am Medicaid eligible. These services are provided in benefits periods of an initial 90 day period, a subsequent 90 day period and unlimited subsequent 60 day periods.
- I understand that I may revoke the hospice benefits at any time by completing the appropriate form, specifying the date when the revocation is to be effective and submitting the statement to the hospice prior to that date; however, that if I choose to revoke services during a benefit period, I am not entitled to coverage for the remaining days of that benefit period. At the same time I revoke hospice services, I understand my rights to other Medicaid of that benefit period. At the same time I revoke hospice services, I understand my rights to other Medicaid services will resume, provided I continue to be Medicaid eligible.
- I understand that I may change the designated hospice provider, one time during a benefit period, without affecting the provision of my hospice benefits. To change the designation of hospice programs, I must disenroll with the hospice from which care has been received and elect a new hospice provider.
- I understand that if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefits.
- I understand that if I elected the Medicare Hospice Benefit and am eligible for Medicaid, I must also elect the Medicaid Hospice Benefit.

SIGNATURES:

RECIPIENT OF RECIPIENT REPRESENTATIVE SIGNATURE / DATE:	WITNESS SIGNATURE / DATE:
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** This form must be forwarded to the SCDHHS Medicaid Hospice Programs within ten (10) days of election of benefits. Failure to submit this form within that time frame will result in a change of the election date to the date this form is received by SCDHHS.

SOUTH CAROLINA MEDICAID HOSPICE PRIOR AUTHORIZATION FORM

The Medicaid Hospice Benefit must be prior authorized. The prior authorization benefit period cannot exceed six (6) months. To continue hospice services beyond six (6) months, a new prior authorization request with medical documentation must be submitted. Request must be submitted to: **SCDHHS Medicaid Hospice Program Post Office Box 8206 Columbia, SC 29202-8206**. Request must be submitted within ten (10) days along with the required documentation listed below.

RECIPIENT INFORMATION

NAME	LAST	FIRST	MEDICAID ID NUMBER
CURRENT MAILING ADDRESS		STREET	SOCIAL SECURITY NUMBER
CITY	STATE		ZIP CODE
BIRTH DATE	ICD-9 NUMBER INDICATING THE PRIMARY HOSPICE DIAGNOSIS		
NAME OF NURSING FACILITY OF RESIDENCE, IF APPLICABLE		MEDICAID PROVIDER NUMBER OF NURSING FACILITY	

HOSPICE PROVIDER INFORMATION

NAME OF HOSPICE	MEDICAID PROVIDER NUMBER	HOSPICE PHONE NUMBER
HOSPICE FAX NUMBER	HSP ____-____-____	
		SIGNATURE OF AUTHORIZED HOSPICE REPRESENTATIVE

HOSPICE BENEFIT INFORMATION

APPLICABLE BENEFIT PERIOD
 FIRST 90 DAYS SECOND 90 DAYS PERIOD OF 60 DAYS

STATEMENT OF TERMINAL ILLNESS

STATEMENT TO SUPPORT TERMINAL STATUS OR FUNCTIONAL DECLINE (REASON FOR HOSPICE RECOMMENDATION)

SIGNATURE

PHYSICIAN'S NAME	PHYSICIAN'S TELEPHONE NUMBER
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Required Attachments:

- Signed Election Statement - SCDHHS Form 149
- Physician Certification/Recertification - SCDHHS Form 151
- Hospice Plan of Care
- Supporting Documentation (i.e., medical history, prognosis)
- Managed Care Disenrollment Form (If necessary)

TO BE COMPLETED BY SCDHHS REPRESENTATIVE

- Approved Effective Date From _____ To _____
- Denied Reason(s) _____

SCDHHS Representative _____ Date: _____

Once request is approved/denied, SCDHHS will forward a completed copy of this form to the Hospice within five (5) days. If request is denied, SCDHHS will forward a completed copy of this form to the Recipient within five (5) days.

PROCEDURES FOR APPEALS

When a Medicaid recipient is denied hospice, the recipient has the right to a fair hearing regarding the decision.

The recipient or his/her representative has the right to appeal the decision within thirty (30) days from the denial date of the MEDICAID HOSPICE PRIOR AUTHORIZATION, SCDHHS FORM 149A by submitting a written request to the following address:

Director, Division of Appeals and Fair Hearings
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

A copy of the MEDICAID HOSPICE PRIOR AUTHORIZATION, SCDHHS FORM 149A must accompany the request and the request must state with specificity which issues are being appealed.

A request for a fair hearing is considered filed if postmarked by the thirtieth (30th) calendar day following receipt of the MEDICAID HOSPICE PRIOR AUTHORIZATION, SCDHHS FORM 149A. Both the Medicaid recipient and the provider will be notified of the date, time and place the fair hearing will take place.

MEDICAID HOSPICE PHYSICIAN CERTIFICATION / RECERTIFICATION

RECIPIENT INFORMATION:

NAME: LAST		FIRST		MEDICAID ID NUMBER:
CURRENT MAILING ADDRESS: STREET			SOCIAL SECURITY NUMBER:	
CITY:	STATE:	ZIP CODE:	MEDICARE NUMBER:	
HOME PHONE NUMBER (INCLUDE AREA CODE):			BIRTH DATE:	
NAME OF NURSING FACILITY OF RESIDENCE, IF APPLICABLE::			MEDICAID PROVIDER NUMBER OF NURSING FACILITY::	
NAME OF PARENT, LEGAL GUARDIAN OR REPRESENTATIVE:			ICD-9 NUMBER INDICATING THE PRIMARY HOSPICE DIAGNOSIS:	
NAME OF HOSPICE:			NPI Number:	
			MEDICAID PROVIDER NUMBER: HSP ____	

CERTIFICATIONS AND SIGNATURES: TO BE COMPLETED BY ATTENDING PHYSICIAN / MEDICAL DIRECTOR

PHYSICIANS, PLEASE SIGN AND DATE TO INDICATE CERTIFICATION.

FIRST BENEFIT PERIOD (90 DAYS):

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

SIGNATURE OF ATTENDING PHYSICIAN	CERTIFICATION DATE
SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE

Second BENEFIT PERIOD (90 DAYS):

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE
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_____ BENEFIT PERIOD (60 DAYS):

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE
---------------------------------------	--------------------

_____ BENEFIT PERIOD (60 DAYS):

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE
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_____ BENEFIT PERIOD (60 DAYS):

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE
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DHHS FORM 151 (10/96) (REVISED 06/08) Forward a copy of this form and a copy of the plan of care within then (10) working days of the beginning of each benefit period to the SCDHHS Medicaid Hospice Program. Failure to submit this form within the given time frame may result in delay or loss of payment for hospice service

MEDICAID HOSPICE PROVIDER CHANGE REQUEST FORM

EFFECTIVE CHANGE DATE: _____

APPLICABLE BENEFIT PERIOD:

FIRST 90 DAYS
 SECOND 90 DAYS
 PERIOD OF 60 DAYS

RECIPIENT INFORMATION:

NAME:	LAST	FIRST	SOCIAL SECURITY NUMBER:
MEDICAID ID NUMBER:			MEDICARE NUMBER:

RELEASING HOSPICE PROVIDER INFORMATION: The above recipient request that the designation of their selected hospice be changed from:

NAME OF HOSPICE:	NPI Number:
	MEDICAID PROVIDER NUMBER: HSP ___ ___ ___
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:

The sending hospice must complete the above section. A copy of this form must be sent to the SCDHHS Medicaid Hospice Program within five (5) days of the effective date and be forwarded to the receiving hospice within two (2) days of the effective date.

RECEIVING PROVIDER INFORMATION: The above recipient request that the designation of their selected hospice be changed:

NAME OF HOSPICE:	NPI Number:
	MEDICAID PROVIDER NUMBER: HSP ___ ___ ___
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:

The receiving hospice must forward a completed copy to the SCDHHS Medicaid Hospice Program within five (5) working days of the effective date.

SIGNATURES:

As a recipient of hospice services, I understand that I may change hospice providers only ONCE during each hospice benefit period. I also understand that this request for a change of hospice provider is not a revocation of the remainder of my current election benefit period.

SIGNATURE OF RECIPIENT OR RECIPIENT REPRESENTATIVE	DATE OF SIGNATURE
SIGNATURE OF WITNESS	DATE OF SIGNATURE

MEDICAID HOSPICE REVOCATION FORM

EFFECTIVE DATE OF REVOCATION:

APPLICABLE BENEFIT PERIOD:

FIRST 90 DAYS

SECOND 90 DAYS

() PERIOD OF 60 DAYS

RECIPIENT INFORMATION:

NAME:

LAST

FIRST

SOCIAL SECURITY NUMBER:

MEDICAID ID NUMBER:

MEDICARE NUMBER:

HOSPICE PROVIDER INFORMATION:

NAME OF HOSPICE:

NPI Number:

MEDICAID PROVIDER NUMBER:

HSP _ _ _

SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:

HOSPICE PHONE NUMBER:

REVOCATION STATEMENT:

- **The South Carolina Medicaid Hospice Services Program has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitation of the program and the terms of the revocation of these services.**
- **I understand that by signing the revocation statement that, if eligible, I will resume Medicaid coverage of benefits waived when hospice care was elected.**
- **I will forfeit all hospice coverage days remaining in this benefit period.**
- **I may at any time elect to receive hospice coverage for any other hospice benefit period for which I am eligible.**

SIGNATURE OF RECIPIENT OR RECIPIENT REPRESENTATIVE

DATE OF SIGNATURE:

MEDICAID HOSPICE DISCHARGE FORM

RECIPIENT INFORMATION:

NAME:	LAST	FIRST	SOCIAL SECURITY NUMBER:
MEDICAID ID NUMBER:			MEDICARE NUMBER:

PROVIDER INFORMATION:

NAME OF HOSPICE:	NPI Number:
	MEDICAID PROVIDER NUMBER: HSP ___ _ _
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:

DISCHARGE STATEMENT:

Hospice benefits for the above named recipient, enrolled with this agency since _____ terminated _____ for the following reason: (check all that apply):

_____ Recipient is deceased. Date of death is ____/____/____.

_____ Prognosis is now more than six (6) months.

_____ Recipient moved out of state / service area.

_____ Safety of recipient or hospice staff is compromised. (Explanation must appear below)

_____ Recipient is non-compliant. (Explanation must appear below and documentation of efforts to counsel the recipient must be attached).

EXPLANATION:

When a Medicaid recipient is discharged from a hospice program for one of the reasons listed above recipient has the right to a fair hearing regarding the decision. Procedures regarding that appeal are found on the reverse side of this page. The signature below indicates that the recipient was given this statement for his/her records/use.

SIGNATURE OF RECIPIENT OR RECIPIENT REPRESENTATIVE	DATE OF SIGNATURE:
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PROCEDURES FOR APPEALS

When a Medicaid recipient is discharged from a hospice program for one of the reasons listed on the reverse side of this page, the recipient has the right to a fair hearing regarding the decision.

The recipient or his representative has the right to appeal the hospice discharge within thirty (30) days of the receipt of the MEDICAID HOSPICE DISCHARGE STATEMENT, DHHS FORM 154 by submitting a written request to the following address:

Director, Division of Appeals and Fair Hearings
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

A copy of the MEDICAID HOSPICE DISCHARGE STATEMENT, DHHS FORM 154 must accompany the request and the request must state with specificity which issues are being appealed.

A request for a fair hearing is considered filed if postmarked by the thirtieth (30th) calendar day following receipt of the MEDICAID HOSPICE DISCHARGE STATEMENT, DHHS FORM 154. Both the Medicaid recipient and the provider will be notified of the date, time and place the fair hearing will take place.