FORMS

Number	Name	Revision Date
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	06/2007
	Reasonable Effort Documentation	06/2007
	Authorization Agreement for Electronic Funds Transfer	12/2005
CMS-1500	Sample Claim Showing TPL Denial with NPI	08/2005
CMS-1500	Sample Claim Showing TPL Denial with NPI and Medicaid Provider ID	08/2005
	Sample Edit Correction Form	06/2007
	Remittance Advice	06/2007
DHHS 254	Referral Form/Authorization for Services-Children’s Behavioral Health Services	09/2009
	Medical Necessity Statement for Children’s Behavioral Health Services	07/2005

**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:____________________

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) ☐ 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 (revised 06/07)

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

SCDHHS FORM 142 (revised 06/07)

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

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: ______________________ NPI or Medicaid Provider ID: ____________

Contact Person: ________________________ Phone #: ________________

DHHS 931 – Updated June 2007

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
AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

Provider Name:____

Provider DBA Name *(if applicable)*: ______________________________

Medicaid Provider Number: ______________________________

Provider NPI Number: ______________________________

Provider EIN Number:______________________________

Address:____

City: ______________________ **State:** _________ **Zip:**_____________

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

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

I (we) certify that the information shown is correct and that this account is used solely for business purposes. I (we) further agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

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

Financial Institution: ____

Address: ____

City: ______________________ **State:** _________ **Zip:** _____________

Transit/ABA Number: ______________________________

Account No.: ______________________________

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

Signed: ______________________________ *(Signature)*

______________________________ *(Print)*

Title: ______________________________

Date: ______________________________

Contact Name:______________________ **Phone:** _____________

RETURN TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P. O. BOX 8806
COLUMBIA, S.C. 29202-8809
FAX (803) 699-8637

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Community Mental Health Services
Sample Claim Showing TPL Denial
with NPI

PICA | PICA

CARRIER

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 1947 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 [x] Married Other; Employed [x] 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: 222222222B

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. 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. 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	31	07	01	31	07	53		90801			102 00	1		NPI	1234567890
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

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

26. PATIENT'S ACCOUNT NO.: DOE1234

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

28. TOTAL CHARGE $ 102 00

29. AMOUNT PAID $ 0 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. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (555) 5555555
Local Community Mental Health Center
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Community Mental Health Services
Sample Claim Showing TPL Denial
with NPI and Medicaid Provider ID

PICA | PICA

CARRIER

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 1947 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 [x] Married Other; Employed [x] 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: 222222222B

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. 295 . 32 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. 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														1D	ABC123
01	31	07	01	31	07	53		90801			102 00	1		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) YES [x] NO

28. TOTAL CHARGE $ 102 00

29. AMOUNT PAID $ 0 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. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (555) 5555555
Local Community Mental Health Center
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. 1DABC123

PHYSICIAN OR SUPPLIER INFORMATION

RUN DATE 05/01/2007 000001204
REPORT NUMBER CLM3500
ANALYST ID
SIGNON ID

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 10 PRAC SPEC - 28
DOC IND N

CLAIM CONTROL #9999999999999999A
PAGE 1136 ECF 1136 PAGE 1 OF 1
EMC Y
ORIGINAL CCN:
ADJ CCN:

TAXONOMY: SFL ZIP: PRV ZIP:

1 PROVIDER ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 ---- DIAGNOSIS ---- PRIMARY	9 SECONDARY
ABC123 NPI: 1234567890	1111111111						298.9	.

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 IND	21 PAY	22 UNITS
	.00	1	12/22/04	53	90801	000		123456	40.00		1.000
	NPI: 1234567890		TAXONOMY:								
		2	/ /								
	NPI: 1234567890		TAXONOMY:	53	90862	000		123456	32.00		1.000
		3	/ /								
	NPI:		TAXONOMY:								
		4	/ /								
	NPI:		TAXONOMY:								
		5	/ /								
	NPI:		TAXONOMY:								
		6	/ /								
	NPI:		TAXONOMY:								
		7	/ /								
	NPI:		TAXONOMY:								
		8	/ /								
	NPI:		TAXONOMY:								

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

	24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID
01			
02			
03			

27 TOTAL CHARGE 72.00
28 AMT REC'D INS .00
29 BALANCE DUE 72.00
30 OWN REF # 012345

RESOLUTION DECISION _R_

ADDITIONAL DIAG CODES: . . . . . .

RETURN TO: INSURANCE POLICY INFORMATION
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

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.: AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE: 03/26/2007

PAGE: 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME F I M I LAST NAME	MOD	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	0406001089000400A				1192.00	243.71	P	1112233333	M CLARK			0.00	
	01		021507	H0032	800.00	117.71	P			000			0.00
	02		021507	H2015	392.00	126.00	P			000			0.00
	VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0406001089000400U				1412.00-	273.71-		1112233333	M CLARK				
	01		012107	H0032	1112.00-	143.71-				000			
	02		012107	H2015	300.00-	130.00-				000			
	REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0407701389002500A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		012107	H0032	142.50	42.75	P			000			0.00
	02		012107	H2015	859.00	0.00	R			000			0.00
	TOTALS		2		2193.50	286.46						0.00	0.00

SAMPLE ONLY

	CERT. PG TOT	MEDICAID PG TOT
		$286.46
	$0.00	$286.46
	CERTIFIED AMT	MEDICAID TOTAL

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.

FEDERAL RELIEF	MAXIMUS AMT	CHECK TOTAL	CHECK NUMBER
$0.00	$0.00	0.00	

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 00000-0000

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.: AB11110000

DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE: 03/26/2007

PAGE: 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	H0032	453.00	160.71-	P					000		
	02		012107	H2015	60.00	33.00-	P					000		
	TOTALS		1		513.00-	193.71-								

SAMPLE ONLY

Item	Amount
DEBIT BALANCE PRIOR TO THIS REMITTANCE	0.00
MEDICAID TOTAL	$243.71
CERTIFIED AMT	0.00
FEDERAL RELIEF	0.00
TO BE REFUNDED IN THE FUTURE	0.00
ADJUSTMENTS	$193.71-
MAXIMUS AMT	
YOUR CURRENT DEBIT BALANCE	0.00
CHECK TOTAL	$50.00
CHECK NUMBER	4197304

PROVIDER NAME AND ADDRESS

Community Mental Health Center
PO BOX 000000
ANYTOWN SC 00000-0000

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.			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

SAMPLE ONLY

Item	Amount
DEBIT BALANCE PRIOR TO THIS REMITTANCE	0.00
YOUR CURRENT DEBIT BALANCE	5293.45
MEDICAID TOTAL	0.00
ADJUSTMENTS	0.00
CHECK TOTAL	0.00
CERTIFIED AMT	0.00
MAXIMUS AMT	0.00
CHECK NUMBER	
FEDERAL RELIEF	0.00
TO BE REFUNDED IN THE FUTURE	0.00

PROVIDER NAME AND ADDRESS

Community Mental Health Center
PO BOX 000000
ANYTOWN SC 00000-0000

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.

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
REFERRAL FORM/AUTHORIZATION FOR SERVICES (Form 254)
CHILDREN'S BEHAVIORAL HEALTH SERVICES

FORM 254

NPI or Medicaid Provider ID | | | | | | | | | | |

CHILD'S MEDICAID I. D. # | | | | | | | | | | |

REFERRED TO: ______________________________

____

____

AUTHORIZATION DATE: ___/___/___

EXPIRATION DATE: ___/___/___

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

SAMPLE ONLY

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. This referral is valid only for the dates on which the client is eligible for Medicaid.

- ☐ PSYCHIATRIC HOSPITAL
- ☐ RESIDENTIAL TREATMENT FACILITY
- ☐ THERAPEUTIC FOSTER CARE
  - ☐ LEVEL I (S5145) ☐ LEVEL II (S5145-TF) ☐ LEVEL III (S5145-TG)
- ☐ MENTAL HEALTH SERVICES NOT OTHERWISE SPECIFIED (Formerly Intensive Family Services) (H0046)
- ☐ PSYCHOSOCIAL REHABILITATION SERVICES (Formerly Clinical Day Programming) (H2018)
- ☐ THERAPEUTIC BEHAVIORAL SERVICES (Formerly Therapeutic Child Treatment) (H2019 & H2020-HA)
- ☐ OTHER ______________________________

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

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.

Code	Description	Code	Description
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.

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