# FORMS

| Number | Name | Revision Date |
|---|---|---|
| DHHS 126 | Confidential Complaint | 06/2007 |
| DHHS 931 | Health Insurance Information Referral Form | 01/2008 |
| | Authorization Agreement for Electronic Funds Transfer | 01/2009 |
| --- | MedWatch | 07/2001 |
| --- | Prior Authorization Request | 07/2005 |
| | South Carolina Medicaid Growth Hormone Prior Authorization Request form | 01/2005 |

**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:

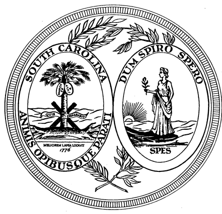
DATE OF REPORT

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
# 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<br>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<br>Columbia, SC 29202-8206 |

# 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**

**SOUTH CAROLINA MEDICAID**

# MEDWATCH

**DEPT. OF HEALTH AND HUMAN SERVICES**
**First Health Services Clinical Call Center**
**1-866-247-1181 (toll-free) ◆ Telephone**
**1-888-603-7696 (toll-free) ◆ Fax**

## A. Patient information

| 1. Patient Identifier | **2. Age at time of event:** Or Date of birth: | 3. Sex ☐ Female ☐ Male | 4. Weight lbs. Or kgs |
|---|---|---|---|

## B. Adverse event or product problem

1. ☐ Adverse Event and/or

2. Outcomes attributed to adverse event (check all that apply)

☐ death ____________(date)
☐ life-threatening
☐ hospitalization-initial or prolonged
☐ disability
☐ congenital anomaly
☐ required intervention to prevent permanent impairment/damage
☐ other ________

3. Date of event (mm/dd/yy): ____________________

4. Date of this report (mm/dd/yy): ____________________

5. Describe event or problem:

6. Relevant tests/laboratory data, including dates:

7. Other relevant history, including pre-existing medical conditions (e.g., allergies, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.)

## C. Suspect medication(s)

1. Drug Name:

2. Strength:

3. Therapy Dates (if unknown, give duration) from/to or best estimate)

4. Diagnosis for use (indication)

5. Event abated after use stopped or dose reduced
☐ yes ☐ no ☐ doesn't apply

6. Lot # (if known)

7. Exp. date (if known)

8. Event reappeared after reintroduction
☐ yes ☐ no ☐ doesn't apply

9. NDC # (for product problems only)

10. Concomitant medical products and therapy dates (exclude treatment of event)

## D. PRESCRIBING PHYSICIAN

First Name Last Name

Signature of Prescriber: ____________________

South Carolina Medical License Number (not DEA Number): ____________________

Telephone Number: ( ) ____________________

Fax Number: ( ) ____________________

## SOUTH CAROLINA MEDICAID RECIPIENT

First Name Last Name

Recipient's Medicaid ID #: ____________________

Date Of Birth (mm/dd/yy): ____________________

Request Date (mm/dd/yy): ____________________

## E. Reporter

1. Name, address, & phone #

| 2. Health professional? ☐ yes ☐ no | 3. Occupation | 4. Also reported to: ☐ manufacturer ☐ user facility ☐ distributor |
|---|---|---|

If you do NOT want your identity disclosed to the manufacturer, place an "X" in this box: ☐

Revised July 2001

Pharmacy Fax Number (if known): ( ) ____________________

# SOUTH CAROLINA MEDICAID PROGRAM

## PRIOR AUTHORIZATION REQUEST

**PRESCRIBER:**

**NAME:** ______________________________
FIRST LAST

**DEA LICENSE #** ______________________________

**PHONE #** ( ) ______________________________

**FAX #** ( ) ______________________________

**BENEFICIARY:**

**NAME:** ______________________________
FIRST LAST

**MEDICAID # / SSN:** ______________________________

**DATE OF BIRTH:** ______________ **SEX:** ________

**REQUEST DATE:** ______________________________

**PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM:** ______________________________

**PHARMACY:** ______________________________ **PHONE:** ( ) ______________________________

**PRIOR AUTHORIZATION REQUESTED FOR:** (Please check appropriate prior authorization type)

- ☐ **Anti-Ulcer Therapy**
- ☐ **COX-2 Inhibitor Therapy**
- ☐ **Orlistat** (Include information regarding height, weight, diet plans, nutritional counseling, etc., with all orlistat requests.)
- ☐ **Panretin®/Targretin®**
- ☐ **Preferred Drug List**
- ☐ **Quantity Limits**
- ☐ **Sildenafil for Pulmonary Arterial Hypertension**

**Other:** ______________________________

**NOTE:**

**"Brand Medically Necessary"** PA requests require a *South Carolina Medicaid MedWatch form.*

**"Growth Hormone"** PA requests require a *Growth Hormone request form.*

| DRUG NAME | DOSE | STRENGTH | LENGTH OF THERAPY |
|---|---|---|---|
| | | | |

**DIAGNOSIS:** ______________________________

**DIAGNOSTIC PROCEDURES AND FINDINGS (please list dates):** ______________________________

______________________________

**MEDICAL JUSTIFICATION FOR PRODUCT USE:** ______________________________

______________________________

**PRESCRIBER'S SIGNATURE AND SPECIALTY:** ______________________________

**FIRST HEALTH SERVICES USE ONLY:** ☐ **APPROVED** ☐ **DENIED**

**DATE:** ____/____/______

**MAP RPh/TECH:** ______________________________

**NDC:** ______________________________

**COMMENTS:** ______________________________

______________________________

______________________________

**SUBMIT REQUESTS TO:** **FIRST HEALTH SERVICES** **FAX: (888) 603-7696**

**All Fax requests will be processed in one business day. To check on the status you may call: TELEPHONE: (866) 247-1181**

Revised: July 2005

**South Carolina Medicaid Growth Hormone Prior Authorization Request**
**Fax to First Health Services at: 888-603-7696**

**Patient Name:** ______________________________________________

**Medicaid ID #:** ______________________________ **Date of Birth** _____/_____/_______

**Prescribing Physician Name:** ______________________________________

**Contact Person at Office:** ________________________________________

**Phone #: (    )** ________________________ **Fax #: (    )**________________________

**Drug Name:** ____________________ **Strength:** ____________________ **Duration:** ________

**Diagnosis :** ______________________________**ICD-9 CODE**____________________

**Initiation of Therapy** _____**yes**_____**no**    **Continuation of Therapy** ______ **yes**_____**no**

**AUTHORIZATION FOR CHILDREN:**

**Bone age studies results**______________________________________________

**Epiphyses**_______**open** ________**closed**

**Has Patient been evaluated by Endocrinologist**________ **Pediatric Nephrologist**_________

**For renewal, is growth velocity greater than 2.5cm per year?** _______**yes** _________**no**

**AUTHORIZATION FOR ADULTS:**

**Provocative stimulation test and Findings**______________________________________

**Is patient receiving full supplementation of deficient pituitary hormones?** ______**yes** _______**no**
**If yes, please list** ______________________________________________

**Does the patient have reduced bone mineral density (BMD) using the WHO criteria?** ____**yes**____**no**
**If yes, please provide T-score** ______________________________

**Does the patient have a high risk lipid profile?** _________**yes** ____________**no**
**If yes, please provide total cholesterol level or LDL level** ____________________

**Does the patient have at least 2 pituitary hormone deficiencies other than Growth Hormone?**
________**yes** ________**no** **If yes, please list** ________________________________

**For renewal, is the patient showing improvement?** ___________**yes** _____________**no**
*** Increase in BMD per DEXA scan** _________**yes** ____________**no**
*** Reduction in lipid panel** ___________**yes** ________________**no**
**Document percent reduction** ________________

*Prescriber's Signature;* ______________________________ *Date:* ________________

**SUBMIT REQUESTS TO: FIRST HEALTH SERVICES FAX: (888) 603-7696**
**All Fax requests will be processed in one business day. To check on the status you may call:**
**TELEPHONE: (866) 247 -1181**
*updated January 2005*