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	02/2018
	Reasonable Effort Documentation	04/2014
DHHS 160	Notification of Hospice and Home and Community Based Services (HCBS) Coordination Form	12/2024
	Duplicate Remittance Advice Request Form	09/2017
	Claim Reconsideration Form	11/2018
CMS-1500 (02/12)	Sample Claim with NPI	02/2012
	Sample Remittance Advice	04/2014
DHHS 149	Medicaid Hospice Election Form	12/2024
DHHS 151	Medicaid Hospice Physician Certification/ Recertification	09/2015
DHHS 152	Medicaid Hospice Provider Change Request Form	10/2012
DHHS 153	Medicaid Hospice Revocation Form	10/2012
DHHS 154	Medicaid Hospice Discharge Form	10/2012
DHHS 154 (reverse side)	Procedures For Appeals - Discharge Form	06/2008

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:

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:_____

DHHS Form 130 Revision date: 03-13-2007

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

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 THE FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014

SCDHHS Office of Waiver and Facility Services

Notification of Hospice and Home and Community Based Services (HCBS) Coordination Form

The purpose of this form is to facilitate care coordination between hospice and HCBS providers. This form must be completed pursuant to current policies located in the Hospice Provider Manual. The elected hospice provider must complete all applicable sections of this form and coordinate services with other providers, before beginning services to assure services are not duplicated.

Current Status:

☐ Active HCBS Waiver Services Beneficiary ☐ Pending HCBS Waiver Beneficiary

Required Attachments

☐ Individualized Hospice Plan of Care ☐ Individualized Hospice Aide Plan

☐ Online Service Plan from HCBS provider (if current waiver beneficiary)

☐ Other Supporting Documentation

Date of Request:		
RECIPIENT INFORMATION		
Last Name, First Name, Middle Initial:		
Recipient ID:	Translator Required? __ Yes __ No Language:	
DOB:	Phone:	
Address:		
Attending MD:	Hospice MD:	
Responsible Party if other than patient:		
Name of person to contact to schedule assessment, if other than the recipient:		
Contact Phone:		
Has this recipient utilized HCBS in the past? ____ Yes ____ No ____ Unknown		
HOSPICE AGENCY INFORMATION		
Name:	NPI:	Provider #
Phone:	Fax:	
Contact Name:	Contact Phone:	
HCBS PROVIDER INFORMATION		
Name:	NPI:	
Phone:	Fax:	
Waiver Case Manager Name:	Email: Fax:	

ACTIVITIES OF DAILY LIVING: In the appropriate row/column combination, enter an "H" for services performed by Hospice, "F" for services performed by the family and "P" for services performed by the HCBS Provider. "AM" signifies that services are performed 3:00 am-Noon, "Mid" signifies 12:01-6:00 pm and "PM" signifies 6:01 pm-2:59 am. * Indicates nurse tasks.

	Sunday			Monday			Tuesday			Wednesday			Thursday			Friday			Saturday		
	AM	MID	PM	AM	Mid	PM	AM	Mid	PM	AM	Mid	PM	AM	Mid	PM	AM	Mid	PM	AM	Mid	PM
Bathing																					
Mouth Care																					
Hair Care																					
Nail Care																					
Skin Care																					
Shampoo																					
Dressing																					
Toileting – Assist with Garments																					
Toileting – Hygiene																					
Toileting – Clean BSC/Bedpan /Area																					
Transfer/Positioning																					
Mobility																					
Ambulation																					
Clear/Declutter Pathways																					
Eating – Assist																					
Meal Preparation																					
Housekeeping																					
Laundry																					
Essential Shopping																					
BP Monitoring																					
Medication Reminders																					
Nursing Tasks																					
Blood Glucose Monitoring																					
Foley Care																					
Wound Care																					
Ostomy Care																					
Enteral Feeding Assist																					
Oxygen – Assist																					
Suctioning																					
Other_____																					

I choose to receive Hospice and Home and Community Based Services. The hospice provider informed me about the nature and extent of hospice and waiver services.

Beneficiary/Representative Signature: _____ Date: _____

Hospice Representative Signature: _____Date: _____

Electronic and handwritten signatures are accepted. It is the provider's responsibility to ensure all required signatures have been obtained before submitting this form.

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 Medicaid 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: _____ Telephone Number: _____

4. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:
   _____
   _____
   _____
   _____
   _____

   Note: Remittance advices are available electronically through the Web Tool. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

5. Street Address for delivery of request:

   Street: _____

   City: _____

   State: _____

   Zip Code: _____

6. Charges for duplicate remittance advice(s) 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**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Submit your Claim Reconsideration request to:

Fax: 1-855-563-7086

or

Mail: South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

CLAIM RECONSIDERATION FORM

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. A separate SCDHHS CR form is required for each claim control number (CCN). Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709. **Note:** Timely filing guidelines apply.

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____ Medicaid Beneficiary ID: _____

Section 2: Provider Information

Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other (DME, Lab, Home Health Agency, etc.): _____

NPI: _____ Medicaid Provider ID: _____ Facility/Group/Provider Name: _____

Return Mailing Address: _____
Street or Post Office Box *State* *ZIP*

Contact: _____ Email: _____ Telephone #: _____ Fax #: _____

Section 3: Claim Information *(Only one CCN allowed per request.)*

Communication ID: _____ CCN: _____ Date(s) of Service: _____

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below)

- ☐ Ambulance Services
- ☐ Autism Spectrum Disorder (ASD) Services
- ☐ Clinic Services
- ☐ Community Long Term Care (CLTC)
- ☐ Community Mental Health Services
- ☐ Department of Disabilities and Special Needs (DDSN) Waivers
- ☐ Durable Medical Equipment (DME)
- ☐ Early Intervention Services
- ☐ Enhanced Services
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Home Health Services
- ☐ Hospice Services
- ☐ Hospital Services
- ☐ Licensed Independent Practitioner's Rehabilitative Services (LIPS)
- ☐ Local Education Agencies (LEA)
- ☐ Medically Complex Children's (MCC) Waivers
- ☐ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- ☐ Optional State Supplementation (OSS)
- ☐ Pharmacy Services
- ☐ Physicians Laboratories, and Other Medical Professionals Specify: _____
- ☐ Private Rehabilitative Therapy and Audiological Services
- ☐ Psychiatric Hospital Services
- ☐ Rehabilitative Behavioral Health Services (RBHS)
- ☐ Rural Health Clinic (RHC)
- ☐ Targeted Case Management (TCM)
- ☐ Other: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature: _____ Date: _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Hospice Services
Sample Claim
with NPI

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
	X					

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: 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. RESERVED FOR NUCC USE

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:

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. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES NO X PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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:

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL:

15. OTHER DATE QUAL: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE:

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 593 9 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

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. ID. QUAL	J. RENDERING PROVIDER ID. #
1	01	01 14	01	10	14	12		S9126			500 00	10		ZZ	1212121212
														NPI	1234567890
2	01	11 14	01	11	14	12		S9123			220 00	11		ZZ	1212121212
														NPI	1234567890
3	01	12 14	01	31	14	12		S9126			1000 00	20		ZZ	1212121212
														NPI	1234567890
4	01	01 14	01	31	14	12		T2046	TF		3100 00	31		ZZ	1212121212
														NPI	1234567890
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: $ 4820 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use: 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 Hospice
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Remittance Advice (page 1)

This page of the sample Remittance Advice shows a paid claim, suspended claim and rejected claim.

PROVIDER ID. | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE

AB00080000

DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

REMITTANCE ADVICE

02/14/2014

1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB1AA	1403004803012700A				27.00	6.72	P	1112233333	M CLARK				
	01		101713	71010	27.00	6.72	P			026		0.00	0.00
ABB2AA	1403004804012700A				259.00	0.00	S	1112233333	M CLARK				
	01		101713	74176	259.00	0.00	S			026		0.00	0.00
ABB3AA	1403004805012700A				24.00	0.00	R	1112233333	M CLARK			0.00	
	01		071913	A5120	12.00	0.00	R			000			0.00
	02		071913	A4927	12.00	0.00	R			000			0.00
									Edits: L00 946 L02 852 08/30/13				
	TOTALS		3		310.00							0.00	0.00

$6.72

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.

CERT. PG TOT	MEDICAID PG TOT
$0.00	$286.46

CERTIFIED AMT	MEDICAID TOTAL
	0.00

CHECK TOTAL

CHECK NUMBER

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 2)

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. AB00080000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE: 02/28/2014

PAGE: 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	1405200415812200A				1192.00	243.71	P	1112233333	M CLARK			0.00	
	01		021814	S0315	800.00	117.71	P			000			0.00
	02		021814	S9445	392.00	126.00	P			000			0.00
	VOID OF ORIGINAL CCN 13283002244813300A PAID 20131018												
ABB222222	1405200077700000U				1412.00-	273.71-	P	1112233333	M CLARK				
	01		100213	S0315	1112.00-	143.71-	P			000			
	02		100213	S9445	300.00-	130.00-	P			000			
	REPLACEMENT OF ORIGINAL CCN 1304711253670430A PAID 20131018												
ABB222222	1405200414812200A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		100213	S0315	142.50	42.75	P			000			0.00
	02		100313	S9445	859.00	0.00	R			000			0.00
												0.00	0.00

$286.46

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.

CERT. PG TOT	MEDICAID PG TOT
$0.00	$286.46

CERTIFIED AMT	MEDICAID TOTAL
	0.00

CHECK TOTAL

CHECK NUMBER

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

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 3)

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: 02/28/2014

PAGE: 2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	ORG CHECK D	CHECK DATE	ORIGINAL CCN
ABB222222	14052000777000000U				513.00-	197.71-	P	1112233333	CLARK		M	000	131018	1328300224813300A
	01		100213	S0315	453.00	160.71-	P					000		
	02		100213	S9445	60.00	33.00-	P					000		
	TOTALS	1			513.00-	193.71-								

PROVDER INCENTIVE CREDIT AMOUNT: 0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 0.00

MEDICAID TOTAL: $243.71

ADJUSTMENTS: $193.71-

CHECK TOTAL: $50.00

CERTIFIED AMT: 0.00

CHECK NUMBER: 4197304

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 4)

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.: AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE: 02/28/2014

PAGE: 3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME F M I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	1404900004000100U	-						DEBIT	-2389.05	
TPL 4	1405500076000400U	-						DEBIT	-1949.90	
TPL 5	1404900004000100U	-						DEBIT	-477.25	
TPL 6	1405500076000400U	-						CREDIT	477.25	
							PAGE TOTAL:		4338.95	0.00

PROVDER INCENTIVE CREDIT AMOUNT: 0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 0.00

MEDICAID TOTAL: 0.00

ADJUSTMENTS: -4338.95

CHECK TOTAL: 0.00

CERTIFIED AMT: 0.00

CHECK NUMBER:

0.00

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

MEDICAID HOSPICE ELECTION FORM

INCOMPLETE FORMS CANNOT BE PROCESSED BY SCDHHS

EFFECTIVE DATE:

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-10 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, 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 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 OR RECIPIENT REPRESENTATIVE SIGNATURE / DATE:	WITNESS SIGNATURE / DATE:

MEDICAID HOSPICE PHYSICAN 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:	
For dates of service on or before September 1, 2015: ICD-9 NUMBER INDICATING THE PRIMARY HOSPICE DIAGNOSIS:	**For dates of service on or after October 1, 2015:** ICD-10 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 INDICTATE CERTIFICATION.

FIRST BENEFIT PERIOD (90 DAYS) DATES

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	PHYSICIAN DATE SIGNATURE
SIGNATURE OF HOSPICE MEDICAL DIRECTOR	PHYSICIAN DATED SIGNATURE

SECOND BENEFIT PERIOD (90 DAYS) DATES

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	PHYSICIAN DATE SIGNATURE

_______ BENEFIT PERIOD (60 DAYS) DATES:

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	PHYSICIAN DATE SIGNATURE

_______ BENEFIT PERIOD (60 DAYS) DATES:

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	PHYSICIAN DATE SIGNATURE

_______ BENEFIT PERIOD (60 DAYS) DATES:

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	PHYSICIAN DATE SIGNATURE

NOTE: Forward a copy of this form and a copy of the plan of care within fifteen (15) working days along with the prior authorization request to KePRO. 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

NOTE: Each hospice must maintain a copy of this Provider Change Request Form. It is the responsibility of the receiving hospice to forward a completed copy to the SCDHHS Medicaid Hospice Program within five (5) days of the effective date of the change for dually eligible recipients and within five (5) days to KePRO for Medicaid only recipients. Additionally for Medicaid only recipients, the KePRO Hospice Prior Authorization Form must be completed in conjunction with this form.

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:

NOTE: This form must be forwarded to the SCDHHS Medicaid Hospice Program within five (5) working days of the effective date of the revocation for dually eligible recipients and five (5) working days to KePRO for Medicaid only recipients.

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:

NOTE: This form must be forward to the SCDHHS Medicaid Hospice Program within five (5) working days of the effective of the discharge for dually eligible recipients and five (5) working days to KePRO for Medicaid only recipients.

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 (30^{th}) 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.